Brown

September 25, 2017

STATEMENT FOR THE RECORD
BY AIDS UNITED, NASTAD, NATIONAL COALITION OF STD DIRECTORS, NMAC, AND THE AIDS INSTITUTE
HEARING TO CONSIDER THE CASSIDY-GRAHAM-HELLER-JOHNSON PROPOSAL
SEPTEMBER 25, 2017

Dear Members of the Senate Finance Committee:

We urge you to protect the health care needs of vulnerable individuals living with and at risk for HIV and other STDs by opposing the Cassidy-Graham-Heller-Johnson Amendment to H.R. 1628, the "American Health Care Act of 2017." The proposal would strip coverage from those who need it the most, people with low incomes, living with life-threatening and chronic conditions, or with pre-existing medical conditions. The plan would raise costs for people with insurance and slash support to states that have acted with compassion to expand the health care safety net.

If passed, this plan effectively would:

- Eliminate the most vital protections of the ACA including premium and cost-sharing support and replace them with an underfunded and simplistic block grant to the states;
- Pave the way for insurers to deny coverage to people with a history of medical conditions, such as HIV;
- Reduce coverage for essential health benefits including prescription drugs, mental health, substance use treatment, and preventative health services;
- Open the door to annual and lifetime caps on coverage;
- Eliminate funding for Medicaid expansion coverage of more than 10 million people living on low incomes;
- Repeal the 52-year-old Medicaid entitlement of coverage for those who are low-income and people with disabilities while putting per person caps on federal Medicaid funding to the states;

AIDS United
1101 14th St NW
Suite 300
Washington, DC 20005

NASTAD
444 N. Capitol St NW
Suite 339
Washington, DC 20001

NCSD
1029 Vermont Ave., NW
Suite 500
Washington, DC 20005

NMAC
1000 Vermont Ave. NW
Suite 200
Washington, DC 20005

The AIDS Institute
1705 DeSales St. NW
Suite 700
Washington, DC 20036

- Turns back progress made in eliminating racial health disparities, which are estimated to have an economic cost of $35 billion in excess health care expenditures, $10 billion in illness-related lost productivity, and nearly $200 billion in premature deaths.

While exact estimates are not yet known, it is estimated the legislation could lead to more than 32 million people losing coverage.

This proposal would devastate people living with and who are vulnerable of HIV at a time when the U.S. is making progress toward ending the epidemic. The proposed cuts will deeply impact the Ryan White Program as many thousands of people living with HIV seek assistance. Unfortunately, this will inevitably lead to waiting lists for drugs, doctor visits and many people going without care. It would also be disastrous for the response to other STDs at a time when the incidence is rising for gonorrhea, syphilis, and chlamydia. It would undermine our nation's public health efforts to conquer diseases and provide high-quality care to those who need it.

Central to our progress toward fighting HIV and STDs has been expanding access to care and treatment. The ACA has allowed 11 million people to join the Medicaid program, including tens of thousands of people living with HIV who had been previously ineligible. The Cassidy-Graham-Heller-Johnson proposal would wipe out the Medicaid expansion and make deep, permanent cuts to Medicaid overall. Millions of people will lose coverage, including many with HIV and other STDs. This will inevitably lead to fewer people getting needed care and increased infections.

As your Committee and the Senate considers the Cassidy-Graham-Heller-Johnson Amendment, we ask that you keep in the mind the harmful impact this piece of legislation will have on our nation's most vulnerable communities, including those living with or vulnerable to HIV and STDs. Our nation has made great progress in our fight against HIV/AIDS, partly because of the increased access to high-quality, comprehensive healthcare made possible by the ACA. As new medical innovations become available to treat, prevent and care for people with HIV, it is important that our community does not lose access to care. This is not the time to roll back progress and add instability to the healthcare system.

We join the numerous elected officials and organizations representing patients, health care providers, insurers, and others in calling for its defeat. Instead we ask that you work together on bipartisan, commonsense solutions to the real problems people face.

AIDS United (AU), NASTAD, the National Coalition of STD Directors (NCSD), NMAC, and The AIDS Institute (TAI) are national non-partisan, non-profit organizations focused on ending HIV in the U.S. They have been working in partnership to identify and share resources to sustain successes and progress we have made in HIV and STD prevention, care and treatment in the United States

Disability Rights OHIO

Disability Rights Ohio
50 W. Broad St., Suite 1400
Columbus, Ohio
43215-5923

614-466-7264 or 800-282-9181
FAX 614-644-1888
TTY 614-728-2553 or 800-858-3542
disabilityrightsohio.org

Testimony of Disability Rights Ohio
on the Graham-Cassidy-Heller-Johnson Health Care Proposal
United States Senate Committee on Finance
September 25, 2017

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

Michael Kirkman, Esq.
Executive Director
614-466-7264,113
mkirkman@disabilityrightsohio.org

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 IMPLICAITONS

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. GHCJ makes drastic cuts and changes to the Medicaid program that would create devastating impacts on the lives of people with disabilities who live

[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

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 GHCJ 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.

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 healthcare 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.

September 19, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
317 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Charles E. Schumer
Minority Leader
United States Senate
322 Hart Senate Office Building
Washington, D.C. 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

As you continue to consider changes to the American health care system, we ask you not to consider the Graham-Cassidy-Heller-Johnson amendment and renew support for bipartisan efforts to make health care more available and affordable for all Americans. Only open, bipartisan approaches can achieve true, lasting reforms.

Chairman Lamar Alexander and Ranking Member Patty Murray have held bipartisan hearings in the Senate's Health, Education, Labor and Pensions (HELP) Committee, and have negotiated in good faith to stabilize the individual market. At the committee's recent hearing with Governors, there was broad bipartisan agreement about many of the initial steps that need to be taken to make individual health insurance more stable and affordable. We are hopeful that the HELP committee, through an open process, can develop bipartisan legislation and we believe their efforts deserve support.

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 health committees and input from the appropriate health-related parties. Improvements to our health insurance markets should control costs, stabilize the market, and positively impact coverage and care of millions of Americans, including many who are dealing with mental illness, chronic health problems, and drug addiction.

We look forward to continuing to work with you to improve the American health care system.

Sincerely,

John Hickenlooper
Governor
State of Colorado

John Kasich
Governor
State of Ohio

Bill Walker
Governor
State of Alaska

Steve Bullock
Governor
State of Montana

Tom Wolf
Governor
State of Pennsylvania

Terence R. McAuliffe
Governor
State of Virginia

John Bel Edwards
Governor
State of Louisiana

Brian Sandoval
Governor
State of Nevada

Charles D. Baker
Governor
State of Massachusetts

Phil Scott
Governor
State of Vermont

NAMI Ohio
National Alliance on Mental Illness *The State's Voice on Mental Illness*
1225 Dublin Road, Suite 125 • Columbus, Ohio 43215

September 21, 2017

U.S. Senator Sherrod Brown
801 W. Superior Ave. Suite 1400
Cleveland, OH 44113

Dear Senator Brown,

For 43 years I have been an advocate for the severely mentally disabled. I have been blessed to be the state's voice for mental illness as Director of NAMI Ohio for the past 19 years.

The politics surrounding the issue of serving the severely mentally disabled and those addicted is vulgar. As a person of faith, the story of the good Samaritan appears to be being re-enacted but this time it is the senators going to the other side of the road leaving those with mental illness and addiction to suffer.

Whether or not you support Governor Kasich, I believe that nobody can argue that during his presidential campaign he had a central theme of helping those left in the shadows. Maybe in today's tough society that message is not as important as the political divide that is destroying this country.

Senator Brown, you are one of my most admired statesmen. On behalf of the 500,000 Ohio citizens who by no fault of their own deal everyday with mental illness, I ask you to reject the Graham-Cassidy Bill. I believe healthcare reform is absolutely something that needs to be addressed in Washington D.C. However, without a bipartisan bill nothing can be sustainable. The appearance is that healthcare is a political issue that needs to be addressed because of political promises. This is an opportunity to develop a healthcare system that works for everyone.

Please **REJECT** a bill that will be so devastating to those I represent.

God bless,

Terry L. Russell

Tel: 614/224-2700 • Fax: 614/224-5400 • Helpline: 800-686-2646
email: namiohio@namiohio.org • website: www.namiohio.org

OHIO HOSPITAL ASSOCIATION

Collaborating to
Ensure a Healthy Ohio

September 22, 2017

The Honorable Sherrod Brown
United States Senate
713 Hart Senate Office Building
Washington, DC 20510

The Honorable Rob Portman
United States Senate
448 Russell Senate Office Building
Washington, DC 20510

Re: Graham-Cassidy-Heller-Johnson Health Care Reform Legislation

Dear Senators Portman and Brown:

On behalf of Ohio's 220 hospitals and 13 health systems, we thank you for your continued work on today's most urgent health care issues. **As you consider the Graham-Cassidy-Heller-Johnson proposal, we urge you to protect health care coverage and oppose the legislation based on the negative consequences it would have on Ohio.**

OHA and our member hospitals oppose the Graham-Cassidy-Heller-Johnson legislation for the following reasons:

✓ **The bill will cause more Ohioans to become uninsured and eliminate vital protections for patients and consumers.**
- The bill threatens the health care coverage of the almost one million Ohioans who gained health insurance through the ACA. Through the elimination of Medicaid Expansion, more than 750,000 Ohioans would lose coverage and access to care.
- Instability in the insurance market would worsen and premiums would continue to rise. The cost-sharing reductions and subsidies for individuals purchasing coverage on the exchange would be eliminated, causing insurers to pull out of the market or raise premiums to even more unaffordable levels.
- The bill would allow states to waive many insurance rules for coverage provided through the new block grant program. This would make it possible to eliminate essential health benefits, allow insurers to charge individuals with pre-existing conditions exorbitant rates, and/or allow insurers to raise premiums based on age or other factors.

✓ **The bill will lead to unsustainable funding challenges for Ohio's hospitals and health systems.**
- The bill causes a significant redistribution of federal funding across states and especially harms states that have expanded Medicaid—like Ohio.
- These funding reductions are unsustainable for many Ohio hospitals. Nearly 20 percent of facilities in the state operate with negative margins and one in four operate below a two percent margin.

- The bill would reduce the amount of 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 and services for our most vulnerable.

✓ **The bill has been rushed through the legislative process and doesn't provide enough time to plan and implement new programs.**

- Many of the bill's changes go into effect in just two years and past experience with major health care programs suggest this timeframe will be insufficient and likely contribute to gaps in care.
- This process has been too rushed and there is too little information about the bill's impact and operationalization. The bill was only released last week, has had no CBO score and no hearings.

We stand ready to collaborate with you on legislation that will achieve our shared goals of improving our health care system. Again, we urge you to oppose this legislation.

Sincerely,

Mike Abrams
President & CEO

Ohio Children's Hospital Association

Saving, protecting and enhancing children's lives

September 18, 2017

The Honorable Rob Portman
United States Senate
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Sherrod Brown
United States Senate
713 Hart Senate Office Building
Washington, DC 20510

RE: Cassidy-Graham Health Care Reform Legislation

Dear Senators Portman & Brown:

On behalf of the six members of the Ohio Children's Hospital Association and the 1.3 million children who rely on Medicaid and CHIP in Ohio for health care coverage, we thank you for your continued leadership to protect children and their primary source of health insurance – Medicaid and CHIP.

We are opposed to the Cassidy-Graham bill, as it has a projected negative impact of a more than $40 billion reduction in spending on children's health care and respectfully ask you to voice your vigorous opposition to this bill. While their proposal incorporates some provisions to mitigate the impact on children, Medicaid funding cuts for children's health care of this magnitude will put severe economic pressure on states like Ohio and ultimately impair access to needed health care for Ohio's children. These cuts in Medicaid funding will compound the burden of severe Medicaid cuts already being shouldered by Ohio's children's hospitals in our state.

Immediately after passage of the recently enacted state of Ohio biennial budget, children's hospitals along with our adult hospital colleagues, were informed of unprecedented Medicaid reimbursement cuts. If enacted as proposed, children's hospitals will sustain a minimum 7% Medicaid reimbursement cut – amounting to more than $240 million over the SFY 2018–2019 biennium. It is possible this cut could be even larger.

We are strongly opposed to the Cassidy-Graham legislation for the following reasons:

- The provisions in the bill put at risk the health of more than 30 million children who rely on Medicaid by cutting the program for kids by tens of billions of dollars and undermining their health coverage, benefits and access.
- Per enrollee, children are already the lowest funded Medicaid population, and the capped funding provisions risk their financing more so than adults, given that children represent nearly 50 percent of Medicaid enrollees.

Children's hospitals ask Congress to work with us on better, longer-term, bipartisan solutions to improve care for children — we can do better for kids and the future of our country. We respectfully ask you to oppose this legislation.

Sincerely,

Nick Lashutka
President & CEO

Akron Children's Hospital
Cincinnati Children's — changing the outcome together
dayton children's
Nationwide Children's — When your child needs a hospital, everything matters.
University Hospitals — Rainbow Babies & Children's Hospital
ProMedica Toledo Children's Hospital

Jewish Federation
OF CLEVELAND

September 19, 2017

Senator Sherrod Brown
713 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Brown:

The Jewish Federation of Cleveland is deeply troubled by the recently released legislation offered by Senators Cassidy and Graham to cap Medicaid and end the state Medicaid Expansion. The Congressional Budget Office (CBO) score of the Senate Republican leadership's defeated "Better Care Reconciliation Act", which also proposed to cap Medicaid and phase out the expansion, predicted a loss in coverage for 22 million people and a $772 billion reduction in federal funding for the Medicaid program. With these projections for devastating cuts in coverage and funding, the Senate should not move forward with this bill or similar efforts to cap or block grant Medicaid and end the state Medicaid expansion.

Instead, the Senate needs to start again -- working in a bipartisan and open process -- towards reform that maintains coverage standards, and sustains a strong and secure safety net. We are committed to working with you to develop a new framework of policies to improve Medicaid quality, efficiency, and sustainability.

A per capita cap and/or a block grant for Medicaid would restructure its long-standing and fundamental federal-state financing partnership and would lead to devastating federal funding cuts to the program over time. Medicaid is a vital program for the Jewish federations in Ohio and particularly for our communal health and long-term care partner agencies, such as Menorah Park, Montefiore, Jewish Family Services Association and Bellefaire JCB. This critical federal-state safety net allows our providers to continue caring for the most vulnerable populations in our communities, such as low-income children, pregnant women, older adults, and people with disabilities. Converting Medicaid to a per capita cap and/or a block grant not only would adversely impact the many people living in our community who depend heavily on Medicaid coverage, but also our providers who serve them.

For providers affiliated with our Jewish community, Medicaid is the major source of funding for health care, home and community-based services, and long-term care.

Jewish Federation of Cleveland
Jack, Joseph and Morton Mandel Building
25701 Science Park Drive
Cleveland, Ohio 44122

Phone 216-593-2900
Fax 216-593-2901
www.jewishcleveland.org
info@jfcleve.org

Prior analyses by the Congressional Budget Office (CBO) of similar senate proposals projected a 26% reduction in the federal Medicaid contribution by 2026, and 35% over twenty years. **We still believe that under this proposal Medicaid will not be sufficiently flexible to address key factors affecting Medicaid spending, such as disasters, economic downturns, unexpected health care cost increases, and demographic changes like the rapidly aging baby boomer generation. It makes no sense to undermine the only long-term care option available to most Americans just as our country undergoes a transformational demographic shift to an aging nation.**

Such a drastic reduction in the federal share of Medicaid will shift substantial costs to state and local governments, our providers, and our patients, thus exacerbating the existing strain on the program. We fear that states will be left with no choice but to sharply cut Medicaid enrollment, eligibility for Medicaid, benefits, and payment rates.

States will not be able to innovate their way out of cuts of this magnitude, and philanthropies, such as Jewish federations, will not be able to make up the difference. Many people who now qualify for Medicaid could end up uninsured, including low-income children, pregnant women, older adults, and people with disabilities who are in the workforce.

Ultimately, we believe these proposals would lead to the denial of critical health care, home and community-based services, and long-term care services for millions of vulnerable Americans.
We are deeply concerned that some of the legislation's unintended consequences will be:

- People in need of Medicaid and who are currently eligible will become uninsured;

- Our state will be forced to cut back on crucial Medicaid services, such as home and community-based services;

- People who are capable of living in our communities with proper home and community-based services will be forced to live in nursing homes, thus undermining the laudable and cost effective trend of moving people with disabilities and older adults out of institutions if they prefer;

- Health care providers and entities that care for vulnerable populations will suffer significant financial strain, forcing them to cut services, lay off

staff or close their doors thereby causing additional job losses and further harming state economies.

We urge you to vote "NO" on the Graham-Cassidy proposal because it caps Medicaid and ends the state Medicaid expansion. We stand ready to work with you in tandem with our Jewish communal health and long-term care providers to promote more targeted ways to reduce Medicaid spending and improve the quality of care.

Sincerely,

Amy R. Kaplan

Amy R. Kaplan
Assistant Vice President, External Affairs

ACA Update | September 15, 2017: Cassidy-Graham Repeal Plan Is Devastating for Patients—and Is Gaining Support in the Senate

September 15, 2017 | In Cancer News, Cancer Policy Blog | Add Comment

Prior to the Affordable Care Act (ACA), cancer survivors were at the mercy of the health care system, often forced to pay exorbitant premiums or simply denied coverage altogether. Today, America's 16 million cancer survivors benefit from the ACA's patient protections that are critical to providing them with quality, affordable, and accessible health care coverage. NCCS is actively engaged in advocating to ensure this unprecedented access for cancer patients and providers continues.

We have been monitoring and reporting on the proposed Cassidy-Graham repeal bill for several weeks, and now its threat is imminent. Yesterday, Senators Cassidy (R-LA) and Graham (R-SC) unveiled their health care plan at a press conference on Capitol Hill. Indications are that the sponsors of

the bill are only a couple of votes away and this has moved up on the priority list for Senate Republican leadership to get done in September.

The bill not only gets rid of the ACA exchanges and block grants the law's funding, but it also eliminates the Medicaid expansion and key patient protections, all of which have been critical for cancer survivors across the U.S. and is necessary for their access to affordable and comprehensive health care. We cannot let the Senate pass this terrible bill that would leave millions without health insurance. The Senate has started to work in a bipartisan fashion to stabilize the ACA markets, and this bill undermines those productive efforts. Senator McCain (R-AZ), whose dramatic vote against so-called "skinny" repeal killed the crusade in July, has spoken positively about the bill, giving

supporters of the bill further hope that repeal can be achieved. Vox reports that while it will be difficult to get the 50 votes necessary for this bill, it is certainly possible.

As the Center for Budget and Policy Priorities reports, the bill would permit states to access waivers that would allow insurers to charge people with cancer more for their health care, a discriminatory practice that was made illegal under the ACA. Cancer survivors cannot go back to the days when insurers could deny or charge exorbitant premiums to those who have pre-existing conditions. Another concerning piece to the Cassidy-Graham bill is the fact that the funding for the health care block grants face a cliff in year 2026, meaning every dollar disappears thereafter.

This legislation is not only dangerous and irresponsible, but it would be devastating for patients who would be left with expensive health plans that did not cover prescription drugs, chemo therapy, or other critical services.

This is unacceptable and NOW is the time to call the NCCS hotline at (844) 257-6227 and ask your Senators to say NO to the Cassidy-Graham repeal bill. We need a bipartisan and transparent process to strengthen the ACA and help provide critical long-term stability.

For more information on how you can get involved, check out our

#ProtectOurCare page »

Follow NCCS on Twitter to stay updated on developments:

@CancerAdvocacy.

Senate Committee on Finance
219 Dirksen Senate Office Building

Washington, D.C. 20510

September 22, 2017

Chairman Hatch, Ranking Member Wyden, and Members of the Senate Finance Committee:

eliminating racism
empowering women
ywca

YWCA Warren

375 North Park Ave.
Warren, OH 44481

P 330.373.1010

YWCA Youngstown

25 W. Rayen Ave.
Youngstown, OH 44503

P 330.746.6361

As service providers focusing on affordable housing, women's economic empowerment, and child and youth development, the YWCAs of Warren and Youngstown work every day with vulnerable populations experiencing hardships resulting from systemic racism and inequality.

We have seen the transformative power of the Affordable Care Act at work with the women we serve, many of whom come to us having experienced job loss, chronic homelessness, and years of inadequate access to health care. The Affordable Care Act has proven to be a lifeline for 9.5 million women nationwide who otherwise could not afford health insurance, and has opened the door to providing them with maternity and well-woman care and mental health and addiction treatment.

Ohio stands to lose money that has been used wisely to serve our citizens. The people we serve have benefited in particular from the

eliminating racism
empowering women
ywca

YWCA Warren

375 North Park Ave.
Warren, OH 44481

P 330.373.1010

YWCA Youngstown

25 W. Rayen Ave.
Youngstown, OH 44503

P 330.746.6361

expansion of Medicaid, which we know is saving lives and improving health outcomes for our clients. Under Graham-Cassidy, that funding that has proven so critical for our state's vulnerable populations would be reduced through the block grant program. Ohio has one of the highest rates of pre-existing conditions per-capita, and we are gravely concerned that many of these conditions would be uninsurable under this new legislation's provision allowing states flexibility in determining coverage.

The Graham-Cassidy legislation is yet another dangerous attempt to roll back progress that has made health care available to women who would otherwise go without. Any health care legislation must protect and expand access for women, girls, and communities of color, and Graham-Cassidy fails to do that. Instead, it would heighten the inequities that persist in our health care system, stripping coverage from millions and raising costs to unacceptable and unsustainable levels. It would make the routine care that women require inaccessible.

The Graham-Cassidy legislation would harm our state's most vulnerable people and undermine the progress made to open up access to health care

for women, girls, and communities of color. We respectfully urge a "no" vote on Senate Bill.

Please do not hesitate to contact us should you have any questions.

eliminating racism
empowering women
ywca

YWCA Warren

375 North Park Ave.
Warren, OH 44481

P 330.373.1010

YWCA Youngstown

25 W. Rayen Ave.
Youngstown, OH 44503

P 330.746.6361

Sincerely,

Leah Merritt
CEO, YWCA Youngstown

Kenya A. Roberts-Howard
Executive Director, YWCA Warren

Elise Skolnick
Advocacy Contact, YWCA Youngstown

Molly Toth
Advocacy Coordinator, YWCA Warren

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org

Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org

facs.org

September 22, 2017

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
317 Russell Senate Office Building
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
U.S. Senate
322 Hart Senate Office Building
Washington, DC 20510

Dear Senators McConnell and Schumer:

The American College of Surgeons (ACS) has deep concerns with provisions in the Graham-Cassidy amendment to H.R. 1628, the American Health Care Act (AHCA), and how they would impact access to surgical care. Accordingly, the ACS is unable to support the proposal in its current form and we urge the Senate to make significant changes through the amendment process as it is being considered on the Senate floor.

According to the Congressional Budget Office (CBO), it will not be able to provide an estimate on the impact of the amendment's effects on health insurance coverage or premiums for several weeks. An increase in the amount of individuals who are uninsured runs directly contrary to the College's health care reform principles. The ACS believes strongly that legislation should not facilitate a reduction in the number of Americans currently insured.

The ACS stands by its four key principles on health care reform and feels strongly that any health care reform legislation should include provisions that provide for:

- **Quality and Safety** - The ACS believes that well-designed clinical comparative effectiveness research, physician quality data, appropriate public reporting, and realistic expectations relative to the use of health information technology (HIT) are cornerstones in efforts toward the achievement of the goals of quality and safety.

- **Patient Access to Surgical Care** - The ACS has a long-standing policy supporting universal access to affordable, high-quality surgical care delivered to all with skill and fidelity in a timely and appropriate manner.

- **Reduction of Health Care Costs** - The ACS' surgical quality programs improve surgical care and cut costs by helping to reduce inefficiencies and prevent complications through a continuous improvement process. The ACS is also a strong supporter of and participant in the efforts toward quality-based payment reform, and voluntary participation in alternative payment models.

- **Medical Liability Reform** - The ACS believes our nation's medical liability system is broken and that it fails both patients and physicians. Because medical liability reform helps to reduce costs to the health care system and improves access to care, the ACS actively supports reforms based on safety, quality, and accountability.

The ACS is committed to continuing to partner with policy makers of both parties as the Senate considers amendments to the underlying legislation. The ACS urges the Senate to include revisions to the Graham-Cassidy amendment that reflect ACS' health care reform principles and to address the following concerns related to access to surgical care:

Individual and Employer Mandate
The American College of Surgeons maintains that preserving the insurance reforms directed at pre-existing conditions and the prohibitions on annual and lifetime limits are critical components of any health reform legislation. We believe these protections have improved access to surgical services and we have significant concerns with providing states the option to waive caps on annual and lifetime limits as well as the ability to waive the prohibition on health status rating. Specifically, we are concerned that the proposed elimination of the employer mandate to provide affordable coverage could lead to employers dropping insurance benefits or increasing costs on employees. Lack of health care coverage presents a significant barrier to both surgical services and preventive health care screenings.

Medicaid Expansion
The ACS has long supported universal access to affordable, high-quality, and safe surgical care, delivered in a timely and appropriate manner. Accordingly, we believe the expansion of Medicaid has served to provide coverage for millions of previously uninsured Americans. The Graham-Cassidy amendment eliminates Affordable Care Act (ACA) Medicaid expansion levels and would eliminate the current enhanced federal funding match. The proposal would also

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

change state Medicaid payments to a per capita allotment. According to an analysis by Avelere Health, federal funding devoted to Medicaid and private insurance subsidies would shrink by $215 billion between 2020 and 2026. The analysis also shows the greatest reduction in aid would occur in states that have had the most insurance gains under ACA Medicaid expansion. The ACS has concerns with the Senate moving forward on the Graham-Cassidy amendment without comprehensive CBO estimates on the impact of insurance coverage gains or losses. Based on our principles, the ACS believes any further efforts directed at health care reform must not only ensure that these Americans do not lose coverage, but that the coverage they receive is adequate and provides for all necessary services.

Essential Health Benefits and Community Rating Waivers
The College believes that the Essential Health Benefits (EHBs) mandated under the Affordable Care Act are critical to protecting access to surgical care. We are concerned that allowing states the opportunity to waive any of these ten EHBs may have a significant negative consequence for patients. In addition, we are concerned that the language allowing states to opt out of the prohibition on health status rating could have a negative impact on patients who have pre-existing conditions who subsequently may need surgical care.

Health Savings Accounts
Out of pocket health care expenses have continued to increase and have become a mounting burden on patients. We applaud the Graham-Cassidy amendment for raising the caps on contributions to Health Saving Accounts. The ACS believes such will provide substantive relief to patients to defray out of pocket expenses and incentivize them to make better informed, cost-conscious decisions about their healthcare.

Subsidies for Premiums and Out-of-Pocket Expenses
The Affordable Care Act created premium and cost-sharing subsidies based on income. The Graham-Cassidy amendment would completely eliminate all current subsidies and would repeal the tax credits paid to individuals under the ACA which were designed to defray the costs of deductibles and copayments. Even though states could use a portion of their Market-based Health Care Grant Program funding to provide cost-sharing subsidies, these decisions would be made on a state-by-state basis and there is no guarantee states would elect to do so. The ACS is concerned that this change could also affect access to surgical care. As result of the reduction in subsidies, individuals may only be able to afford insurance with high deductibles or possibly, may not be able to

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes
100+*years*

afford any insurance at all. Either outcome would obviously have a negative impact on the ability of patients to access needed surgical care.

The American College of Surgeons remains committed to working with Congress toward needed reforms to our health care system in order to improve patient access to surgical care. We are hopeful the Senate will consider changes to the Graham-Cassidy amendment to address the concerns we have raised.

Sincerely,

Courtney M. Townsend, Jr., MD, FACS
ACS President

Michael J. Zinner, MD, FACS
ACS Chair, Board of Regents

David B. Hoyt, MD, FACS
ACS Executive Director

Marshall Z. Schwartz, MD, FACS
Chair, Health Policy Advocacy Group

Chicago Headquarters:
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office:
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

Bishop Zubik Speaks Out Against Graham-Cassidy Health Care Bill, Urges Bipartisanship

September 22, 2017 12:09 PM

PITTSBURGH (NewsRadio 1020 KDKA/AP) – Pittsburgh Catholic Bishop David Zubik says he has "serious concerns" about the latest Republican attempt to repeal the Affordable Care Act.

In a statement released Thursday, Bishop Zubik said the proposed Graham-Cassidy health care bill could negatively affect seniors, pregnant women, those suffering from mental illness and people with pre-existing conditions.

The new bill would repeal central elements of former President Barack Obama's health care law and would essentially give health care control to the states.

GOP Sens. Bill Cassidy and Lindsey Graham have spent weeks concocting and selling a new approach to scrapping President Obama's 2010 law after this summer's collapse of the effort in the Senate.

President Donald Trump and bill co-sponsor Sen. Cassidy insist that the bill covers pre-existing conditions. But there's a catch. It allows states to get a waiver from requirements that insurers charge the same to people with health problems as they do to healthy people.

Bishop Zubik tells the "KDKA Morning News" he isn't speaking out on the bill as a politician but as a religious leader, and he fears a vote on the Graham-Cassidy bill is coming too quickly.

"A bi-partisan group of senators that have been taking a look at a good health care program. They should take the time to be able to put together a health care program that's not going to put any lives in danger," said Bishop Zubik.

Bishop Zubik has his name on a Supreme Court case seeking to reform the Affordable Care Act so that it respects religious freedom, and while he says the Graham-Cassidy bill does that, the ACA's "core mechanisms benefit millions of us."

"When you take a look at the Medicaid portion of [the bill] could, in fact, hurt people who are in nursing homes or pregnant women or families who are really steeped in poverty," said Zubik.

Bishop Zubik encourages people to write and call Pennsylvania Sens. Bob Casey and Pat Toomey, and hopes that they think of the "most vulnerable of our society, [so] that they can receive good health care."

A vote on the bill could happen as early as next week.

Governor Carney's Statement on Graham-Cassidy Health Care Legislation in U.S. Senate

Date Posted: ***Thursday, September 21st, 2017***

WILMINGTON, Del. – *Governor John Carney on Thursday released the following statement on the Graham-Cassidy Health Care legislation in the U.S. Senate, which could cost Delaware more than $2 billion in federal funding reductions by 2026, cuts that would reduce access to quality health care and shift costs onto Delaware families and the state budget:*

"This bill would be a disaster for Delaware seniors, Delawareans with disabilities, and children and adults in low-income households who depend on Medicaid as their connection to care. It would force our Medicaid program to limit eligibility, cut benefits or pay a far greater share of the cost for the Delawareans who are covered today. This bill also would eliminate the Affordable Care Act's federal assistance for individuals and families buying coverage on the Health Insurance Marketplace, raising premiums for most of the 27,000 Delawareans who get their coverage there. This bill is clearly the wrong direction for Delaware and the wrong direction for our country."

Tufts Health Plan
Statement on Graham-Cassidy Legislation

The Graham-Cassidy proposal currently being discussed in the U.S. Senate is extremely harmful

We cannot support a bill that will take away coverage from 10s of millions of Americans and drive up costs for people with pre-existing conditions. It goes against Tufts Health Plan's mission of improving the health and wellness of the diverse communities we serve. We cannot support any proposal that takes away benefits or access to care from the most vulnerable of our society.

CEO Statement on the Graham-Cassidy Health Care Bill

Date: Wednesday, September 20, 2017

L.A. Care is strongly opposed to the Graham-Cassidy health care bill, which is worse for L.A. Care members – and all of California – than the Repeal and Replace bill passed by the House in May and the bill that was defeated in the Senate in August.

What is it?*

The Graham-Cassidy bill is a last ditch effort by several Republican Senators that lumps Medicaid and the subsidies for the Exchange into block grants in 2020, leaving it to the states to decide how to allocate funding between Medicaid and the Exchange. It moves the funding formula for the block grants to a method that penalizes the states that expanded Medicaid, like California. Due to these changes, the Medicaid expansion population would be essentially eliminated by 2027. It also eliminates the mandate for individuals to have health insurance – a move that could destabilize the Exchange.

This bill will fundamentally alter the federal/state partnership that has been in place since Medicaid's inception since 1965. These changes will not only impact those who gained coverage through Medicaid expansion under the Affordable Care Act (ACA), but also for mothers, children, developmentally disabled and elderly in nursing homes – all who have limited incomes. According to a recent Avelere study, California would be the hardest hit under this proposal, with a reduction in federal funding between $50 billion to $78 billion by 2027.

The Graham-Cassidy bill was drafted behind closed doors, has had no committee hearings, and was written without any testimony from doctors, hospitals, consumers, health plans, or any other group with a stake in the outcome. The bill is completely driven by election campaign promises regardless of the facts or the consequences to tens of millions of our fellow citizens.

What will the Graham-Cassidy Health Care Bill do to the ACA?

- Medicaid Expansion: Eliminates (2027)
- Cost Sharing Subsidies: Eliminates (2020)
- Individual Mandate: Eliminates (2020)
- Tax Credits: Eliminates (2020)

- Essential Health Benefits: Allows states to get a waiver to reduce

What will L.A. Care do?

L.A. Care has signed on to a Fight4OurHealth Coalition opposition letter with more than 100 California community based organizations. We are in the process of gathering together the coalition of ten Medicaid health plans who opposed the previous Senate bill to come out in strong opposition to the proposal. We will also be working with several prominent trade associations to ensure our members' voices are heard in Washington D.C.

I am mad. Mad that a bill of this magnitude is being considered in a rush without public input. Mad that politics is driving health care policy rather than data-driven evidence. Mad that the needs of people, particularly people living in poverty, are not at the forefront of this bill.

Whatever happens between now and September 30, we at L.A. Care will not be deterred from our mission to provide access to quality health for vulnerable populations and support the safety net of providers that serve them.

John Baackes

**The Cassidy-Graham-Heller-Johnson Amendment (Graham-Cassidy Bill) to H.R. 1628, the "American Health Care Act of 2017*

About L.A. Care Health Plan

L.A. Care Health Plan is a public entity and community-accountable health plan serving residents of Los Angeles County through a variety of health coverage programs including L.A. Care Covered™, Medi-Cal, L.A. Care Cal MediConnect Plan and PASC-SEIU Homecare Workers Health Care Plan. L.A. Care is a leader in developing new programs through innovative partnerships designed to provide health coverage to vulnerable populations and to support the safety net. With more than 2 million members, L.A. Care is the nation's largest publicly operated health plan.

Top Louisiana health official warns GOP healthcare bill's author that it'll screw his state

Sen. Bill Cassidy of Louisiana, one of the authors of the new Republican Obamacare repeal bill, received intense blowback Monday from a top health official in his own state.

Dr. Rebekah Gee, the secretary of health in Louisiana, sent a letter to Cassidy on Monday expressing concern with the bill and saying that the proposal would eviscerate the state's healthcare system.

"In its current form, the harm to Louisiana from this legislation far outweighs any benefits; therefore I must register our deep concerns and hope we can find a better path forward towards fixing the broken parts of our healthcare system," Gee wrote.

The bill, called the Graham-Cassidy-Heller-Johnson (GCHJ) plan, would shift federal funding for healthcare to a block-grant system in which states would receive money up front based on the number

of enrollees. The current system provides a percentage of the state's annual healthcare funding, which fluctuates based on how much they spend.

Gee said the proposed shift would be a serious negative for many Louisianians and would "jeopardize coverage for some of our most vulnerable citizens."

She also took issue with the bill's elimination of the Affordable Care Act's Medicaid expansion and the proposed ability for states to obtain waivers that would weaken protections for people with preexisting conditions.

Overall, the state of Louisiana would lose $3.2 billion in federal healthcare funding through 2026 under the legislation, according to a study from the Center for Budget and Policy Priorities. Gee said that would threaten the health of the "most vulnerable Medicaid populations."

The letter praised Cassidy's commitment to improving healthcare, but Gee said that his plan fails to make the system better.

"I appreciate your determination to see reform happen." Gee wrote. "Nevertheless, the legislation you've introduced this past week gravely threatens healthcare access and coverage for our state and its people."

Cassidy responded to Gee by saying that Louisiana will have enough control over its healthcare system to fix the issues she raised. Here's Cassidy's statement, which was provided to Business Insider:

"If Dr. Gee had called and asked how this bill would impact Louisiana, she could have been walked through as to why her concerns are unfounded. Instead, she chose to echo a left wing think tank which is working to preserve Obamacare. On the other hand, on one thing, the letter is correct. Our proposal spends less money than Obamacare. We eliminate the penalties paid by individuals and business which do not conform to Obamacare mandates. If Dr. Gee thinks that more money is needed, she should suggest that these taxes be re-imposed on state level. For the record, I oppose this as 58% of individual mandate penalties are paid by families earning less than $50,000 per year. I think these families should be helped, not penalized.

Statement on the Graham-Cassidy Proposal

AHA Press Release

We believe that coverage could be at risk for tens of millions of Americans under the Graham-Cassidy proposal. We continue to urge senators to work in a bipartisan manner to address the challenges facing our health care system.

Joint Statement Regarding Graham-Cassidy Proposal to Repeal and Replace the Affordable Care Act (ACA)

September 20, 2017

MASSACHUSETTS MEDICAL SOCIETY

HEALTH CARE FOR ALL

ASSOCIATED INDUSTRIES OF MASSACHUSETTS

Boston, MA - "Massachusetts residents, physicians and businesses are concerned about the potential impact of the Graham-Cassidy proposal in Massachusetts. This new attempt to repeal and replace the Affordable Care Act (ACA) and to undermine Medicaid is just as bad as the prior bills defeated in the Senate, if not worse.

"Between 25 and 38 states would see their health care funding slashed in the short term, Massachusetts being one of the most impacted by the cuts. Ultimately all states will see a negative financial impact in the long run, as the block grants included in the plan are temporary, with the appropriation ending by 2026.

"U.S. census data released last week highlighted the progress that the Commonwealth has made in terms of expanding health insurance, with almost 97.5% of the population covered. This achievement is on the line if the Graham-Cassidy bill moves forward in the Senate. Massachusetts could see a reduction in federal funding of more than $5B. This would strain the state budget and leave thousands of residents - including seniors, children and people with disabilities - without access to quality and affordable health care.

"Moreover, by overturning protections for patients with preexisting conditions and by slashing essential health benefits, the bill would make it so that even patients that still have coverage might be unable to access meaningful care.

"Massachusetts is an example of how health reform can work when all stakeholders share and value a culture of coverage. Consumers, patients, the business community, physicians, providers, insurers and policy-makers have worked together over the years in advancing a common health care agenda. We are joining efforts again to say no to this damaging proposal."

# # #

Health Care For All (HCFA) *is a Massachusetts nonprofit advocacy organization working to create a health care system that provides comprehensive, affordable, accessible, and culturally competent care to everyone, especially the most vulnerable among us. We achieve this as leaders in public policy, advocacy, education and service to consumers in Massachusetts. For more information about HCFA, visit our website at www.hcfama.org. You can also call our free HelpLine (800) 272-4232 if you need help applying for health insurance.*

The Massachusetts Medical Society, *with some 25,000 physicians and student members, is dedicated to educating and advocating for the patients and physicians of Massachusetts. The Society, under the auspices of NEJM Group, publishes the New England Journal of Medicine, a leading global medical journal and web site, and Journal Watch alerts and newsletters covering 13 specialties. The Society is also a leader in continuing medical education providing accredited and certified activities*

across the globe for physicians and other health care professionals. Founded in 1781, MMS is the oldest continuously operating medical society in the country. For more information please visit www.massmed.org, www.nejm.org, or www.jwatch.org.

***The Associated Industries of Massachusetts** is a dynamic and innovative organization dedicated to supporting pro-business legislation and helping employers make sense of confusing employment laws. AIM engages in public policy work on behalf of 4,000 Massachusetts employers who together employ one out of five residents of the commonwealth. We do so guided by the belief that only a vibrant, private-sector economy creates opportunity that binds the social, governmental and economic foundations of our commonwealth.*

Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

Revised September 20, 2017

Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market

By Jacob Leibenluft, Edwin Park, Matt Broaddus, and Aviva Aron-Dine

In releasing a revised version of their legislation to repeal and replace the Affordable Care Act (ACA), Senators Bill Cassidy and Lindsey Graham, along with co-sponsors Dean Heller and Ron Johnson, claimed that their bill isn't a "partisan" approach and doesn't include "draconian cuts." In reality, however, the Cassidy-Graham bill would have the same harmful consequences as those prior bills. It would cause many millions of people to lose coverage, radically restructure and deeply cut Medicaid, eliminate or weaken protections for people with pre-existing conditions, and increase out-of-pocket costs for individual market consumers.

Cassidy-Graham would:

- Eliminate the ACA's marketplace subsidies and enhanced matching rate for the Medicaid expansion and replace them with an inadequate block grant. Block grant funding would be well below current law federal funding for coverage, would not adjust based on need, would disappear altogether after 2026, and could be spent on virtually any health care purpose, with no requirement to offer low- and moderate-income people coverage or financial assistance.
- Convert Medicaid's current federal-state financial partnership to a per capita cap, which would cap and cut federal Medicaid per-beneficiary funding for seniors, people with disabilities, and families with children.
- Eliminate or weaken protections for people with pre-existing conditions by allowing states to waive the ACA's prohibition against charging higher premiums based on health status and the requirement that insurers cover essential health benefits including mental health, substance abuse treatment, and maternity care.
- Destabilize the individual insurance market in the short run — by eliminating the ACA's federal subsidies to purchase individual market coverage and eliminating the ACA's individual mandate to have insurance or pay a penalty —and risk collapse of the individual market in the long run.
- Eventually result in larger coverage losses than under proposals to repeal ACA's major coverage provisions without replacement. The Congressional Budget Office (CBO) has previously estimated that repeal-without-replace would cause 32 million people to lose coverage. The Cassidy-Graham bill would likely lead to greater numbers of uninsured after

2026, however, because it would not only entirely eliminate its block grant funding — effectively repealing the ACA's major coverage expansions — but also make increasingly severe federal funding cuts to the rest of the Medicaid program (outside of the expansion) under its per capita cap.

By attempting to push this bill forward now, Senators Cassidy and Graham are reverting to a damaging, partisan approach to repealing the ACA that would reverse the historic coverage gains under health reform and end Medicaid as we know it — even as other members of Congress, with the help of governors and insurance commissioners of both parties, are making progress in crafting bipartisan legislation to strengthen the individual market.

Block Grant No Replacement for ACA Coverage Provisions

Cassidy-Graham cuts health coverage in two ways: first, by undoing the ACA's major coverage expansions through a block grant, and second, by radically restructuring and cutting the entire Medicaid program. The bill would eliminate the ACA's Medicaid expansion and marketplace subsidies starting in 2020, offering in their place only a smaller, temporary block grant that states could use for health coverage or any other health care purposes, with no guarantee of coverage or financial assistance for individuals.

According to the bill's sponsors, this block grant would give states "flexibility," allowing them to maintain the coverage available under the ACA if they wanted to do so while enabling other states to experiment with alternative approaches. But in reality, states wouldn't be able to maintain their coverage gains under the ACA. Instead, Cassidy-Graham, like the earlier House and Senate repeal-and-replace bills, would cause many millions of people to lose coverage.

First and foremost, this is because the block grant funding would be insufficient to maintain coverage levels equivalent to the ACA. The block grant would provide *$243 billion less* between 2020 and 2026 than projected federal spending for the Medicaid expansion and marketplace subsidies under current law. In 2026, block grant funding would be at least $41 billion (17 percent) below projected levels under the ACA. These figures do not include the cuts resulting from the bill's Medicaid per capita cap, discussed below, which would cut Medicaid funding outside of the ACA's Medicaid expansion by an estimated $39 billion in 2026.

These estimates understate the actual cuts to federal funding for health coverage in another way as well. Under current law, federal funding for the Medicaid expansion and marketplace subsidies automatically adjusts to account for enrollment increases due to recessions or for higher costs due to public health emergencies, new breakthrough treatments, demographic changes, or other cost pressures. In contrast, the Cassidy-Graham block grant amounts would be fixed — they wouldn't adjust for the higher costs states would face due to these factors. Faced with a recession, for example, states would have to either dramatically increase their own spending on health care or, as is far more likely, deny help to people losing their jobs and their health insurance.

Like the earlier version of the Cassidy-Graham plan, the revised plan would disproportionately harm certain states. The block grant would not only cut overall funding for the Medicaid expansion and marketplace subsidies but also, starting in 2021, *redistribute* the reduced federal funding across states, based on their share of low-income residents rather than their actual spending needs. In

general, over time, the plan would punish states that have adopted the Medicaid expansion or been more successful at enrolling low- and moderate-income people in marketplace coverage under the ACA. It would impose less damaging cuts, or even raise funding initially, for states that have rejected the Medicaid expansion or enrolled few low-income residents in marketplace coverage. (These states would still see large cuts in the long run and during recessions or when faced with other anticipated increases in health care costs or need.)

In 2026, the 20 states facing the largest funding cuts in percentage terms would be Alaska, California, Connecticut, Delaware, the District of Columbia, Hawaii, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New York, North Dakota, Oregon, Rhode Island, Vermont, and Washington. These states' block grant funding would be anywhere from *35 percent to nearly 60 percent* below what they would receive in federal Medicaid expansion and/or marketplace subsidy funding under current law.

The Cassidy-Graham bill would lead to large coverage losses for another reason as well. Under current law, moderate-income consumers in the individual market are guaranteed tax credits to help them pay for meaningful coverage meeting certain standards, and low-income adults in expansion states are guaranteed the ability to enroll in Medicaid, which provides a comprehensive array of benefits and financial protection. Cassidy-Graham would eliminate these guarantees and allow states to spend their federal block grant on virtually any health care purpose, not just for health coverage.

Facing federal funding cuts and exposed to enormous risk, most if not all states would have to use the bill's so-called "flexibility" to eliminate or cut coverage and financial assistance for low- and moderate-income people. In particular, many states would likely do one or more of the following: cap enrollment; offer very limited benefits; charge unaffordable premiums, deductibles, or copayments; redirect federal funding from providing coverage to other purposes, like reimbursing hospitals for uncompensated care; and limit assistance to fixed dollar amounts that put coverage out of reach for most low- and moderate-income people. As a result, many millions of people would lose coverage.

Block Grant Funding Would End After 2026

The bill's block grant would not only be inadequate to replace the ACA's major coverage expansions (the Medicaid expansion and the marketplace subsidies) but would *disappear altogether* after 2026. The bill's sponsors have claimed that the rules that govern the budget reconciliation process, which allows the bill to pass the Senate with only 50 votes, necessitated that the proposed block grant be temporary. In reality, however, nothing in those rules prevents the bill from permanently funding its block grant. Furthermore, the expiration of the temporary block grant would create a funding cliff that Congress likely couldn't afford to fill. Even if there were significant political support for extending the inadequate block grant in the future, budget rules would very likely require offsets for the hundreds of billions of dollars in increased federal spending needed for each additional year.

The result is that, beginning in 2027, Cassidy-Graham would be virtually identical to a repeal-without-replace bill — except for its additional Medicaid cuts through the per capita cap, described below. CBO estimated that the repeal-without-replace approach would ultimately leave *32 million more people* uninsured. The Cassidy-Graham bill would presumably result in even deeper coverage losses than that in the second decade.

Like Prior Repeal Bills, Cassidy-Graham Imposes Damaging Cuts to Rest of Medicaid Outside of Expansion

Like prior House and Senate Republican repeal bills, the Graham-Cassidy bill would radically restructure and cut the rest of Medicaid, outside of the ACA's Medicaid expansion. It would end the federal-state financial partnership under which the federal government pays a fixed percentage of a state's Medicaid costs. It would instead impose a per capita cap, under which federal Medicaid funding would be capped at a set amount per beneficiary, irrespective of states' actual costs, and would grow each year more slowly than the projected growth in state Medicaid costs per beneficiary.

The result would be deep cuts to federal Medicaid spending for seniors, people with disabilities, families with children, and other adults (apart from those affected by the bill's elimination of the Medicaid expansion). Earlier CBO estimates suggest that Cassidy-Graham would cut the rest of Medicaid (outside the expansion) by $175 billion between 2020 and 2026, with the cuts reaching $39 billion by 2026 or 8 percent relative to current law.[1]

These cuts would grow in coming decades. That's because starting in 2025, the bill would *lower* the annual adjustment of per capita cap amounts. For example, the cap on Medicaid spending for children and non-disabled, non-elderly adults would rise each year by the general inflation rate, which is about 2.5 percentage points lower than projected increases in per-beneficiary costs for those groups. As CBO has previously found with the Senate Republican leadership bill (the Better Care Reconciliation Act), this would drive deeper federal Medicaid spending cuts over the long run as the "gap [between Medicaid spending under current law and under the per capita cap] would continue to widen because of the compounding effect of the differences in spending growth rates" between the per capita cap and states' actual Medicaid spending needs.[2]

The per capita cap would force states to make the same kinds of harsh choices in the rest of their Medicaid program that are imposed on them by the bill's other funding cuts. States would have to raise taxes, cut other budget priorities like education, or make increasingly severe cuts to eligibility, benefits, and provider payments. For example, many states would likely cut home- and community-based services, which allow people needing long-term services and supports to remain in their homes rather than move to a nursing home; these and other benefits that are "optional" to states under federal law would be at greatest risk.

Moreover, the gap between federal funding under the per capita cap and states' actual funding needs would grow even larger if Medicaid costs grow more quickly than expected (due to a public health emergency or a new drug) or grow in ways that the per capita cap doesn't account for (due to the aging of the population).

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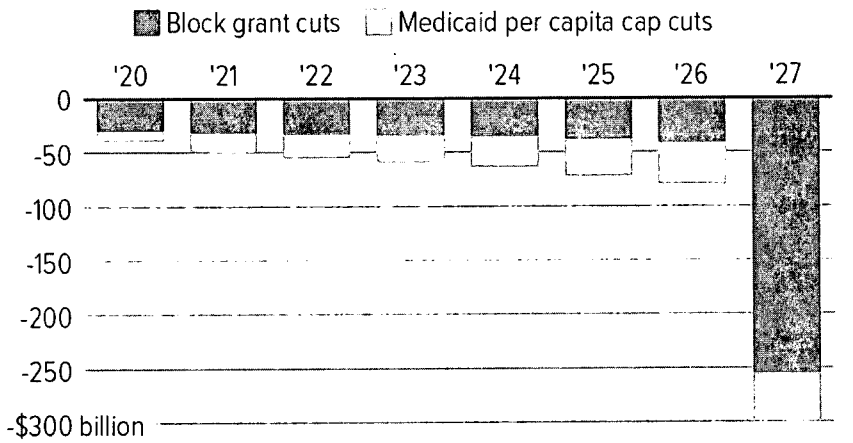
[1] CBPP calculations based on Congressional Budget Office estimates of July 20 version of Senate Republican leadership bill (Better Care Reconciliation Act), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.

[2] Congressional Budget Office, "Longer-Term Effects of the Better Care Reconciliation Act of 2017 on Medicaid Spending," June 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/52859-medicaid.pdf.

Notably, these per capita cap cuts would come on top of the cuts to Medicaid expansion funding and marketplace subsidies under the block grant discussed above. In 2026, for example, we estimate that the block grant and Medicaid per capita cap *combined* would result in at least a $80 billion federal funding cut. (See Figure 1.) Thirty-six states, including the District of Columbia, would face net cuts to Medicaid funding (not just for the expansion) and marketplace subsidies in that year. (See Appendix Table 1.) In 2027, when the block grant is eliminated entirely and the per capita cap cuts continue to grow, we estimate the combined federal funding cut would be $299 billion, relative to current law.[3]

FIGURE 1

Cassidy-Graham's Large Cuts to Federal Health Care Funding Grow Even Larger Starting in 2027



Note: The Cassidy-Graham proposal would eliminate the Affordable Care Act's (ACA) marketplace subsidies and enhanced matching funds for the ACA's Medicaid expansion, replacing them with an inadequate block grant that ends in 2026, and would cut funding for the rest of Medicaid by converting it to a per capita cap.

Source: CBPP calculations based on Congressional Budget Office estimates

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Plan Would Eliminate or Weaken Pre-Existing Condition Protections

Similar to the House-passed bill (the American Health Care Act), the Cassidy-Graham bill would provide states expansive waiver authority to eliminate or weaken the prohibition against insurance companies charging higher premiums based on their health status and the requirement that insurers cover the essential health benefits related to any health insurance plan that is in any way subsidized by the bill's block grant funding. States seeking waivers would only have to explain how they intend

[3] Edwin Park and Matt Broaddus, "Cassidy-Graham Plan's Damaging Cuts to Health Funding Would Grow Dramatically in 2027," Center on Budget and Policy Priorities, updated September 17, 2017, https://www.cbpp.org/research/health/cassidy-graham-plans-damaging-cuts-to-health-care-funding-would-grow-dramatically-in.

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.[4]

The block grant subsidy requirement, for example, could be satisfied by states simply using a small portion of their block grant funding to provide even tiny subsidies to all individual market plans. As a result, while insurers would still be required to offer coverage to people with pre-existing conditions, insurers could charge unaffordable premiums of thousands or tens of thousands of dollars per month, effectively resulting in a coverage denial. Insurers could also offer plans with large benefit gaps. For example, before the ACA introduced the requirement that all plans cover a defined set of basic services, 75 percent of individual market plans excluded maternity coverage, 45 percent excluded substance use treatment, and 38 percent excluded mental health care, according to analysis by the Kaiser Family Foundation.[5] This would leave many people — especially those with pre-existing conditions — without access to the health services they need.

The waiver authority included in the Cassidy-Graham bill is similar to the so-called "MacArthur amendment" waivers included in the House-passed bill.[6] Analyzing those waivers, the CBO concluded that 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]." And 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."[7]

Destabilizing Individual Market in Near Term, Risking Collapse in Long Run

Even as other members of Congress, including the chair and ranking member of the Senate Health, Education, Labor and Pensions (HELP) Committee, are working on bipartisan efforts to *strengthen* the individual market and the marketplaces, the Graham-Cassidy bill would disrupt the individual market in the short term. Like the Senate Republican leadership bill and the House-passed

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[4] Aviva Aron-Dine, "Cassidy-Graham's Waiver Authority Would Gut Protections for People with Pre-Existing Conditions," Center on Budget and Policy Priorities, September 15, 2017, https://www.cbpp.org/blog/cassidy-grahams-waiver-authority-would-gut-protections-for-people-with-pre-existing-conditions.

[5] Gary Claxton *et al.*, "Would States Eliminate Key Benefits if AHCA Waivers are Enacted?" Kaiser Family Foundation, June 14, 2017, http://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/.

[6] For more on the MacArthur Amendment, see Jacob Leibenluft, "MacArthur Amendment Would Mean Return to Pre-ACA Law for People with Pre-Existing Conditions," Center on Budget and Policy Priorities, April 27, 2017, https://www.cbpp.org/blog/macarthur-amendment-would-mean-return-to-pre-aca-law-for-people-with-pre-existing-conditions.

[7] Congressional Budget Office, "H.R. 1628: American Health Care Act of 2017," May 24, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

bill, it would immediately eliminate the individual mandate. That would raise the number of uninsured by 15 million relative to current law in 2018 and increase individual market premiums by 20 percent.

The bill's elimination of the ACA marketplace subsidies and start of a block grant in 2020 would cause massive additional disruption. With 50 states and the District of Columbia left to devise their own coverage programs — lacking guidance, standards, or administrative infrastructure — and to make substantial changes to their market rules as well, insurers would have no idea how the individual market would operate starting in 2020. It could be years before they had any clarity about the state of the market, including what their risk pools would look like. In the interim, insurers would most almost certainly impose large premium rate increases to account for uncertainty; some would likely exit the market altogether.

Then in 2027, when the block grant disappeared entirely, states would no longer be able to obtain waivers of the protections for people with pre-existing conditions. Insurers in all states would face a market without an individual mandate *or* any funding for subsidies to purchase coverage in the individual market yet be subject to the ACA's prohibition against denying coverage to people with pre-existing conditions or charging people higher premiums based on their health status. Many insurers would likely respond by withdrawing from the market, leaving a large share of the population living in states with no insurers, as CBO has warned about previous repeal-without-replace bills.

In both the near and long term, the disruption caused by Cassidy-Graham would thus result in large individual market coverage losses on top of those directly resulting from the bill's marketplace subsidy cuts.

Methods Note

We estimate each state's federal funding block grant amount in 2026 under the parameters of the Cassidy-Graham block grant formula, and compare the result to an estimate of the state's federal funding under current law for the Affordable Care Act (ACA) Medicaid expansion to low-income adults, marketplace subsidies, and/or the Basic Health Program (BHP).

To estimate states' Cassidy-Graham block grant amounts in 2026, we use the most recent population data for individuals with family income between 50 percent and 138 percent of the federal poverty line from the American Community Survey.

To estimate states' federal funding under current law, we start with the Congressional Budget Office's (CBO) March 2016 projections of national-level spending on the Medicaid expansion, marketplace subsidies, and the BHP in 2026. We apportion these amounts across the states based on the Centers for Medicare & Medicaid Services' most recent state-level spending data for the Medicaid expansion and marketplace subsidies.

Results of our analysis reflect two limitations. First, limited data availability requires that we apportion CBO's national-level estimate of cost-sharing reduction payments to states based on states' premium tax credit amounts rather than cost-sharing reduction amounts. Second, CBO's projection of Medicaid expansion spending in 2026 assumes that additional states beyond the current 31 states and the District of Columbia take up the option to expand Medicaid, but CBO does not project which specific states would do so.

Figures in Table 1 reflect the combined impact of the Cassidy-Graham block grant and the Cassidy-Graham Medicaid per capita cap. In its cost estimate for the Senate GOP leadership's health bill, the Better Care Reconciliation Act (BCRA), CBO estimates the federal Medicaid spending cut outside of the expansion due to the per capita cap. We interpolate based on other CBO per capita cap estimates to adjust the BCRA estimate to account for both Cassidy-Graham's changes to the per capita cap annual adjustment rate (relative to BCRA) and the plan's exclusion of certain low-population-density states from the per capita cap through 2026. We apportion this national cut estimate in 2026 to states based on the Kaiser Family Foundation's state-specific estimates of the federal funding impact of the BCRA per capita cap.

TABLE 1

Cassidy-Graham Block Grant and Medicaid Per Capita Cap Cut Federal Funding for Most States by 2026

State	Estimated federal funding change, in 2026 (in $millions)
United States	-$80,000
Alabama	1,713
Alaska	- 255
Arizona	- 1,600
Arkansas	- 1,102
California	- 27,823
Colorado	- 823
Connecticut	- 2,324
Delaware	- 724
District of Columbia	- 431
Florida	- 2,691
Georgia	1,685
Hawaii	- 659
Idaho	177
Illinois	- 1,420
Indiana	- 425
Iowa	- 525
Kansas	821
Kentucky	- 3,062
Louisiana	- 3,220
Maine	- 115
Maryland	- 2,162
Massachusetts	- 5,089
Michigan	- 3,041
Minnesota	- 2,747
Mississippi	1,441
Missouri	545
Montana	- 515
Nebraska	203
Nevada	- 639
New Hampshire	- 410
New Jersey	- 3,904
New Mexico	- 1,350
New York	- 18,905
North Carolina	- 1,099
North Dakota	- 211
Ohio	- 2,512
Oklahoma	1,118

TABLE 1

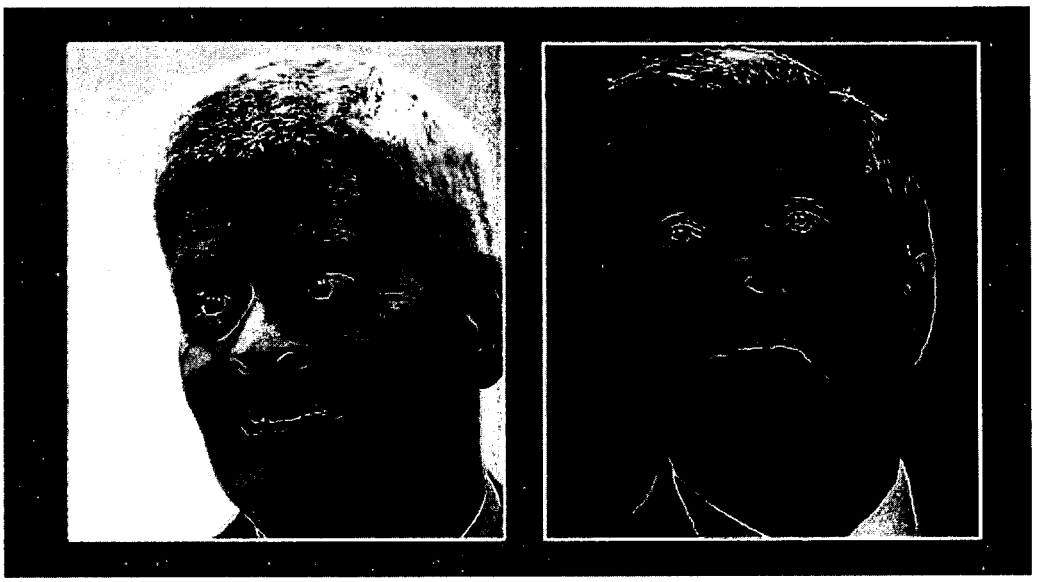
Cassidy-Graham Block Grant and Medicaid Per Capita Cap Cut Federal Funding for Most States by 2026

State	Estimated federal funding change, in 2026 (in $millions)
Oregon	- 3,641
Pennsylvania	- 850
Rhode Island	- 625
South Carolina	804
South Dakota	218
Tennessee	1,642
Texas	8,234
Utah	313
Vermont	- 561
Virginia	268
Washington	- 3,333
West Virginia	- 554
Wisconsin	252
Wyoming	-90

Source: CBPP analysis, see methods notes for details.

Last-ditch Obamacare repeal would be poison

The Editorial Board, USA TODAY Published 7:05 p.m. ET Sept. 20, 2017 | **Updated 1:43 p.m. ET Sept. 21, 2017**



The bill would end the Affordable Care Act's Medicaid expansion and institute a per-person spending cap for the program. Video provided by Newsy Newslook

Graham-Cassidy is another cynical effort that would deny health insurance to millions: Our view

Given up as a lost cause this summer, the Republican effort to repeal and replace Obamacare is back, this time in the form of a last-ditch effort led by GOP Sens. Lindsey Graham, Bill Cassidy, Dean Heller and Ron Johnson.

Like previous efforts, this measure would strip tens of millions of people of their health coverage. It would gut Medicaid, the program responsible for funding nearly half of baby deliveries and most of nursing home care. It would allow insurers in some states to deny coverage based on a previous medical condition. And it would allow insurers to skip coverage of essential services, including maternity care.

That's all bad enough, but the Graham-Cassidy measure adds a new level of cynicism. Unlike previous efforts, it would retain — at least for the next 10 years — some of the revenue now

helping low-income Americans buy private insurance. This money, however, would be redirected to states in form of block grants, with states that vote largely Republican faring far better than Democratic ones. In other words, it would punish those who vote against this ill-considered measure while rewarding those who vote for it.

SEN. JOHNSON: Let states tailor health care plans

This measure is destructive, not only to the systems that everyday Americans rely on for their health and well-being, but also to the institutions that make America a governable nation. No hearings have been held, and no Congressional Budget Office analysis has been completed.

Many of the plan's supporters don't seem to know, or even care, what's in it. All they care about is fulfilling promises to repeal Obamacare. They make the Affordable Care Act sound like some radical, left-wing experiment. It's not. It is a sensible, if imperfect, law that draws heavily on the HEART Act, a largely Republican plan proposed in the 1990s.

About 20 million Americans have gained coverage as the result of ACA's passage in 2010. About 32 million would lose coverage if the Graham-Cassidy measure became law, assuming that the CBO "scores" it like the previous measure to repeal the ACA, which fell one vote short in July.

Graham-Cassidy is terrifyingly close to passage in the Senate now. And Speaker Paul Ryan said Tuesday that it would pass the House if it got that far.

At the same time, it is something of a Hail Mary pass.

Several Republican senators had joined a bipartisan effort, which appears to have fallen apart for now, to shore up the shaky marketplaces in the ACA and don't relish going back to the divisive world of repeal.

Graham and Cassidy have just until the end of the fiscal year on Sept. 30 to get their repeal measure through using a special procedural tool that allows them to pass the bill with just a simple majority. They will have to flip one of the three GOP senators who voted no the last time, while not losing anyone else.

Americans can only hope that at least three of the 52 Republican senators will show some courage, and let this Hail Mary pass fall harmlessly to the ground.

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GRAHAM-CASSIDY: WHAT THE T1D COMMUNITY NEEDS TO KNOW + WHAT YOU CAN DO

9/20/17

OUR POSITION ON GRAHAM-CASSIDY

The latest healthcare legislation bill — introduced Sept. 13 by Senators Bill Cassidy (R-LA) and Lindsey Graham (R-SC) "Graham-Cassidy" is a threat to the Type 1 diabetes community in the United States. Every day we hear stories of hardship from the T1D community, especially around cost, access, and coverage. Graham-Cassidy's failure to protect people with pre-existing conditions is a failure to support the health of the T1D community.

We've said it before and we'll say it again ... Coverage matters. Access matters. People matter. Graham-Cassidy endangers access to affordable healthcare for millions of Americans — especially the most vulnerable.

Beyond Type 1 is not alone in this fight. 16 major health organizations jointly declared opposition to Graham-Cassidy, including JDRF and the ADA. We stand with those organizations and with the Type 1 community in opposition to this bill.

WHAT IS GRAHAM-CASSIDY, AND HOW WOULD IT IMPACT THE T1D COMMUNITY?

- Those pushing this bill are seeking a vote within days; after Sept. 30 the bill cannot be passed with a simple majority, and that change has resulted in a target vote before the end of September.
- Graham-Cassidy eliminates subsidized insurance coverage and Medicaid expansion (as well as other ACA programs).
-
- Instead, block grants, or lump sums of money, would be issued to states from the federal government. States that expanded Medicaid (i.e. California and Kentucky) stand to take the largest funding cut. States that did not expand Medicaid would likely receive more in federal funding (i.e. Texas and Georgia).
-
- States would no longer be required to use any federal funding to help cover low- and middle-income earners.
- States would be able to waive coverage of what are currently "essential benefits," including mental health, substance abuse treatment and maternity care.

- States would be able to waive the protection against charging higher premiums based on health status, including pre-existing conditions.

According to insurance expert, Tony Steuer, CLU, LA, CPFFE, "The congressional budget office has also stated they will not have sufficient time to review the Graham-Cassidy legislation and issue a 'score' indicating how many people might lose coverage and/or impact on premiums. This means that the Senate and potentially the House would be voting on one of the most significant pieces of legislation of our time without knowing the extent of the potential repercussions."

Want to learn more about the changes proposed by the Graham-Cassidy bill? This chart from NPR is a comprehensive resource that we recommend.

WHAT CAN YOU DO?

CONTACT YOUR SENATORS TODAY

Tell them why they should Vote NO on Graham-Cassidy. Tell them your personal story living with and paying for Type 1 diabetes. Call them often. Even if they have already come out in opposition to the bill, it's important to call to

voice your opinion and tell them why Graham-Cassidy would hurt you and your family and support their position.

Find your Senator's contact information here.

"Unworkable and Unfair": PHI Statement on Graham-Cassidy Proposal to Repeal ACA

September 19, 2017

STATEMENT FROM NORA CONNORS, DEPUTY DIRECTOR OF PUBLIC POLICY AND PARTNERSHIPS

The Public Health Institute is opposed to the latest version of Affordable Care Act repeal being proposed in the U.S. Senate.

The Graham-Cassidy proposal is just as bad as previous versions of ACA repeal—it would eliminate the Prevention and Public Health Fund, gut Medicaid funding, weaken current protections for people with pre-existing conditions and make meaningful coverage unaffordable for many.

Eliminating the Prevention and Public Health Fund would significantly hamper the ability of the Centers for Disease Control and Prevention (CDC) to address chronic disease, protect us from epidemics, keep us healthy and respond to emerging threats like opioid abuse. At a time when millions of Americans are responding to the aftermath of hurricanes and extreme weather it is foolish and shortsighted to slash essential funding for an agency responsible for disaster preparedness and emergency response.

This proposal is unworkable and unfair.

We call for a bipartisan approach that would realistically, affordably and equitably improve the health and well being of the American people.

September 19, 2017 / Latest News

Malloy, Inslee Statement on Graham-Cassidy Bill

Today, DGA Chair Gov. Dan Malloy (D-CT) and DGA Vice Chair Gov. Jay Inslee (D-WA) released the following joint statement on the Graham-Cassidy health care proposal:

"Congress is playing with fire by pushing an unvetted plan that could destroy state budgets and hike premiums for millions of Americans," said Governors Malloy and Inslee. "The Graham-Cassidy proposal is a multi-billion-dollar cost-shift to states. That would mean cuts in health care coverage and cuts to essential services like first responders and local school systems. And it would mean higher premiums, lost health coverage, and skyrocketing rates for people with pre-existing conditions.

"Democratic and Republican governors have already spoken out against this bill's attempts to shift the cost burden onto the states. Congress

should stop playing political games and should commit itself to working on bipartisan plans like the Alexander-Murray effort that would stabilize health care markets."

Governors from both parties are speaking out against the bill. Earlier today, a bipartisan group of governors sent a letter to Senators McConnell and Schumer outlining the problems with the proposal.

###

Graham-Cassidy is Terrible Legislation

WASHINGTON—Third Way released the following statement:

"When Republicans have nothing left to offer, they reach for their old stand-by: block grants. The Graham-Cassidy bill is terrible. This last-ditch effort to repeal and replace Obamacare is yet another effort to bring an unforced catastrophe to our health care system. It would replace federal funding for health coverage with a state-run system. It would cut funding for coverage in all states and punish states that have expanded Medicaid with even greater cuts. It uses state waivers to gut federal protections for coverage of pre-existing conditions, limits on insurance premiums for older and sicker Americans, and essential benefits like pregnancy coverage. In short, it would make health care less stable and far less secure.

"Instead of scrambling to come up with health policy on the fly, Congress should follow the lead of Senators Lamar Alexander and

Patty Murray and pass a bipartisan insurance stabilization package as **Third Way and others have proposed**."

Graham-Cassidy Healthcare Bill Introduced

Posted in Advocacy, Disability, Outreach, and Public Awareness

Graham-Cassidy Healthcare Bill Introduced

This Wednesday, Senators Lindsay Graham (R-SC) and Bill Cassidy (R-LA) introduced the Graham-Cassidy-Heller-Johnson (GCHJ) proposal (PDF), the Republicans' last-ditch effort to repeal and replace the Affordable Care Act (ACA) and make major cuts to Medicaid.

Like the previous bills we've seen, the GCHJ proposal would eliminate coverage and protections for millions while completely decimating Medicaid. The proposal would repeal the ACA individual and employer mandates, eliminate assistance that makes coverage affordable, revoke protections for people with pre-existing conditions, phase out Medicaid expansion, and dramatically cut Medicaid by imposing per capita caps. Just like the other bills, the GCHJ proposal will be devastating for people with disabilities.

NCIL is closely monitoring the progress of the GCHJ proposal, and we will be sending out a targeted action alert next week with more information for constituents of key Republican Senators. In the meantime, **call your Republican Senators NOW and urge them to oppose the GCHJ proposal!**

You can reach your Senators by calling the Capitol Switchboard at (202) 224-3121 or (202) 224-3091 (TTY). New tools are available at trumpcaretoolkit.org. You can also use Resistbot to have your texts turned into faxes, mail, or hand-delivered letters; use faxzero.com to fax your Senators for free; or contact them via social media. You can find social media contacts on Contacting Congress.

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September 22, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

Re: Access to Cochlear Implants under the Graham-Cassidy Health Care Bill

Dear Senator McConnell and Senator Schumer:

The American Cochlear Implant Alliance (ACI Alliance) does not support the Graham-Cassidy legislation (H.R. 1628), which would repeal and replace the Affordable Care Act (ACA). The American Cochlear Implant Alliance is a not-for-profit membership organization created for the purpose of eliminating barriers to cochlear implantation by sponsoring research, heightening awareness, and advocating for improved access to cochlear implants for patients of all ages across the U.S.

A cochlear implant is an electronic medical device designed to restore the ability for children and adults with moderate to profound hearing loss to perceive sounds and understand speech. The device is surgically implanted, and includes internal and external components that help amplify sound. Cochlear implants and the follow up habilitative and rehabilitative care that cochlear implant recipients receive are typically covered by public and private insurance, including Medicaid, under the "rehabilitative and habilitative services and devices" category of essential health benefits (EHBs), which were established by the ACA. In other words, many people gain access to cochlear implants and the ability to hear through the EHB protections provided by the ACA.

ACI Alliance is alarmed that the Graham-Cassidy bill will likely negatively impact access to cochlear implants for children and adults with hearing loss or impairment. Specifically, the Graham-Cassidy legislation proposes significant changes to private and public insurance programs that will undermine health insurance coverage and benefits for millions of Americans. The bill includes a provision that would allow states to apply for waivers exempting them from following important patient protections that are required by ACA, including age-related premium rating ratios and requirements for insurers to cover EHBs. We are deeply concerned that such waivers will limit access to rehabilitation and habilitation services and devices, including cochlear implants.

Additionally, the legislation's proposed changes to the Medicaid program – converting the entitlement program into a per capita cap and eliminating the expansion of Medicaid – will have significant and detrimental impacts on access to cochlear implants. More than 50 percent of pediatric cochlear implant procedures are covered by Medicaid. Significant

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reductions in Medicaid funding and eligibility would deeply impact the ability of many patients to obtain cochlear implants and the life-changing benefits they provide.

ACI Alliance urges the Senate not to pass the Graham-Cassidy legislation and urges bipartisan reforms to maintain and improve access to affordable, comprehensive care for all Americans, including individuals with hearing loss needing cochlear implants.

Sincerely,

Donna Sorkin
Executive Director
American Cochlear Implant Alliance

National
Multiple Sclerosis
Society

To: Senate Finance Committee

From: Bari Talente, Executive Vice President, Advocacy
National Multiple Sclerosis Society
bari.talente@nmss.org, 202-408-1500

Re: Statement for the Record for Hearing to Consider the Graham-Cassidy-Heller-Johnson Proposal, September 25, 2017

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.[i]

"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 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.[ii] 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 ok 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 wellbeing 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.*

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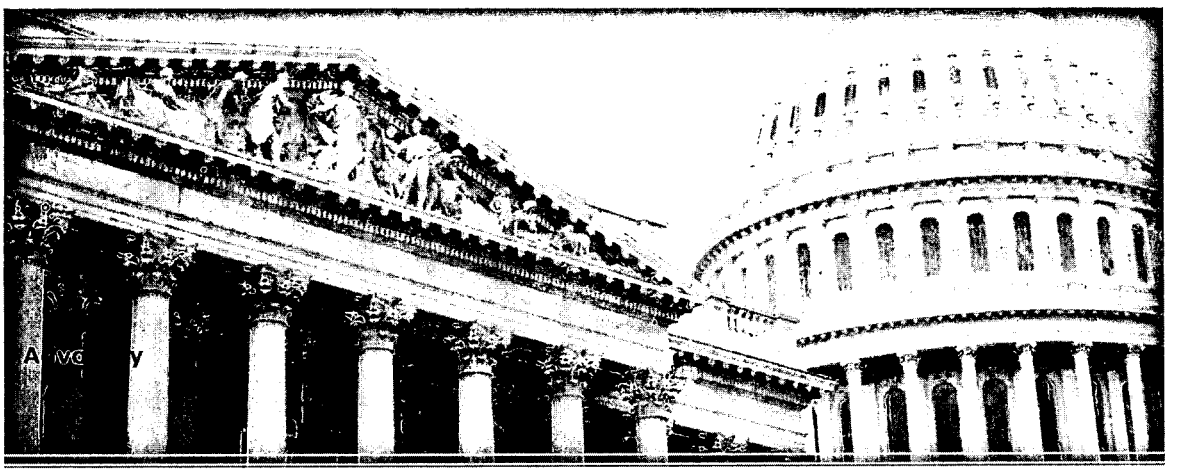
[i] Manatt Health, State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal, September 2017.

[ii] Ibid.



AHCA's over 13,500-strong membership is a powerful advocacy force for the long term and post-acute care profession. We're dedicated to giving care providers the information they need to advocate both on Capitol Hill and in their statehouses. With our tools, resources and how-to guides, it's easy speak out, stay informed and take action on issues affecting long term and post-acute care.

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Provider Tax Cuts Under Cassidy-Graham

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- Maryland
- Massachusetts
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- Mississippi
- Missouri
- Nevada
- New Hampshire
- New Jersey
- New York
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- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
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- Vermont
- Washington
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State Medicaid Cut Impact Information

Alaska Idaho Montana Rhode Island

Contact Information

AHCA Legislative Staff
advocacy@ahca.org
(202)898-2816

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Connecticut	Maryland	North Carolina	Vermont
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Update from Washington

Your Elected Officials Need to Hear from You!

The 116th Congress is full of challenges to tackle and now it is as necessary for the voice of long term care to be heard. Members of Congress value their constituents' opinions and it is critical that we offer them the opportunity to see first-hand the quality care that we provide.

We encourage you to reach out to your Member of Congress and invite them to tour your facility.

AHCA/NCAL staff stands ready to help you schedule these tours and provide you with valuable resources. Please contact Matt Smyth or Drew Thies for additional details and materials.

Host a Facility Tour
Curious about hosting a Member of Congress at your facility? We have tips and tools available to help you. Check out our "How To" Guide to Facility Tours for Elected Officials for tips on best practices including a sample agenda, invitations, and thank you letters.

Attend a Town Hall Meeting
While Members of Congress are at home for district work periods, many will host town hall meetings with their constituents. We encourage you to take advantage of this opportunity to meet with your elected officials, share your story, and advocate against additional cuts to skilled nursing facilities. For a schedule of town hall meetings in your area, please contact Drew Thies.

September 21, 2017

Senator Brown, my name is Gloria Aron and I live on the near west side of Cleveland. For over 30 years I have been a health care advocate and have worked to make sure that not only myself but all Ohioans are able to access affordable, quality health care.

I get my health care through Medicare and the sliding fee scale at MetroHealth. But, many of my fellow MetroHealth patients, my two granddaughters and my soon to be born greatgrandchild and many neighbors get their care because of Medicaid Expansion or Healthy Start (also a Medicaid program). Without Medicaid, all of these Ohioans would be using the emergency room for their care. My granddaughter Tiffany is currently in treatment for opioid addiction and is pregnant. She could lose access to treatment and prenatal care if the Graham-Cassidy Bill were to pass. This is an extremely serious problem not just for her but for thousands of other Ohioans.

Although MetroHealth would continue to see these patients through their sliding fee scale, the loss of Medicaid Expansion dollars would be devastating for them and other clinics and hospitals that serve the uninsured.

Finally, block granting Medicaid dollars to the States is not the answer. In the long run, this would decrease services to those who need it the most. These dollars would dwindle away to nothing over the years.

BPC Statement on Graham-Cassidy Amendment

Friday, September 22, 2017

Washington, D.C.– The following is a statement from the Bipartisan Policy Center's **Future of Health Care** policy experts in response to the current health care debate:

"Bipartisan, fully negotiated and analyzed reforms to our nation's health care system are essential if we are to ensure access to quality, affordable health care coverage for all Americans. Cooperation across party lines is critical to creating legislation that will be sustainable over the long term. It is regrettable that consideration of the Graham-Cassidy amendment is taking place entirely outside of a productive bipartisan process.

"During a time of intense partisanship in Washington, we have been encouraged by the collaboration led by Sens. Lamar Alexander (R-TN) and Patty Murray (D-WA,) the chairman and ranking chairman of the Senate Health, Education, Labor, and Pensions Committee, Sens. Susan Collins (R-ME) and Bill Nelson (D-FL), and others. Their efforts to develop short-term approaches to stabilizing markets and giving states more flexibility should be a first step toward a needed bipartisan process addressing additional aspects of our health care system, with the eventual goal of a broader political agreement around the system's fundamental design.

"Republicans and Democrats maintain substantive differences over the future of American health care. But we believe a determined bipartisan process can still produce substantive agreements on many critical issues because both parties want a system that delivers affordable, financially sustainable health care to all Americans.

"It is important for this Congress to embrace, as many previous congresses have, a bipartisan approach to important legislation. The failure to resolve policy differences between the parties in health care will only lead to further instability, as well as deepening political resentments, which would be detrimental to the well-being of the American public and to our democratic processes."

*This statement is from the BPC's Expert Panel on the **Future of Health Care**: former Senate Majority Leaders **Tom Daschle** and **Bill Frist**; BPC senior advisor and former acting administrator of the Centers for Medicare and Medicaid Services **Andy Slavitt**; and senior fellow, Project Hope and former administrator of the Health Care Financing Administration **Gail Wilensky**. They are collaborating with BPC's team of health policy experts which includes: **Sheila Burke**, BPC fellow and strategic advisor, Baker Donelson; **Jim Capretta**, resident fellow, Milton Friedman chair, American Enterprise Institute; **Chris Jennings**, BPC fellow and founder and president, Jennings Policy Strategies; **Cindy Mann**, partner, Manatt, Phelps & Phillips, LLP and former director of the Center for Medicaid; **Alice Rivlin**, senior fellow, Center for Health Policy, The Brookings Institution, and former director of the Office of Management and Budget; and **Avik Roy**, BPC senior advisor and co-founder and president, Foundation for Research on Equal Opportunity.*

KEYWORDS: HEALTH CARE, FUTURE OF HEALTH CARE INITIATIVE

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RICHARD STENSRUD
Executive Director

HELEN M. NINOS
Deputy Executive Director

September 22, 2017

The Honorable Senator Sherrod Brown
Senate Committee on Finance
Washington, D.C. 20510

Dear Senator Brown,

On behalf of the Board of Trustees of the School Employees Retirement System of Ohio (SERS) and our members and retirees, I am writing to express our strong support for the bipartisan approach to addressing changes in the American health care system that Governor Kasich and several other Governors have endorsed, and to also express SERS' strong concern regarding HR 1628 and the Graham-Cassidy-Heller-Johnson amendment.

Our Board would ask that you refrain from supporting this amendment until hearings are held allowing Congress to hear from experts in the field; the full CBO score is available; and you have all the information necessary to gauge the potentially profound consequences for all citizens, and especially our low-income SERS members and retirees who live in your state.

Pre-Existing Conditions Not Protected

Soaring health care expenses and prescription drug costs have strained the finances of our retired SERS members whose pensions average about $1,184 per month. They are not in a financial position to afford the premiums that insurers will undoubtedly charge when allowed to take pre-existing conditions into account, which will be permitted by this amendment.

Prior to the ACA, surveys of our members showed that about 25% of our non-Medicare retirees had no health insurance coverage at all because it was unaffordable. We do not want to return to those days.

Block Grants Likely to Impact Low-Income Retirees the Most

HR 1628 and this amendment propose to provide Ohio with approximately $9 billion less to spend on health care. This will leave our state with not enough to fund assistance for the individual market and Medicaid. Retirees are the most expensive demographic to insure, and they are likely to take the brunt of these cuts. Other states face similar cuts.

SERS Marketplace Wraparound Plan Will Be Forced to End

With the elimination of the subsidies in the individual insurance market, the SERS Marketplace Wraparound Plan that we created specifically to assist low-income retirees with their health care costs, will be forced to end.

As you will recall, the SERS Marketplace Wraparound Plan just opened in January 2017. It provides retirees under age 65 with the opportunity to choose coverage from any carrier in the Marketplace, receive a subsidy if they are eligible, and then SERS ***wraps*** additional benefits ***around*** their Marketplace coverage.

It provides cost-savings to retirees and saves the retirement system money on the most expensive retiree demographic to cover – pre-Medicare-eligible retirees. As you know, the Ohio retirement systems are challenged to continue to provide access to affordable coverage, so this program is a clear win-win. More than 500 SERS retirees have enrolled in the past eight months, and we anticipate many more retirees will enroll in 2018, absent significant market disruption.

We are concerned that the amendment will force us to end the program and upend this success.

Background on SERS Members and Retirees

SERS provides pensions and access to health care coverage for the people who served our schools. Our members are bus drivers, custodians, business officials, administrative assistants, food service providers, and educational aides – anyone who works for a public school in a nonteaching position.

In fiscal year 2016, SERS served 124,540 active, contributing members, and 76,280 benefit recipients. SERS paid out $1.3 billion in pensions and health care reimbursements, of which more than $1 billion was returned to the Ohio economy and every other states' economies.

In Conclusion

We appreciate the opportunity to work with you and your Washington staff to maintain access to affordable, comprehensive health care coverage for our retirees. If we can answer any questions, please feel free to call our federal legislative liaison, Carol Nolan Drake at (614) 581-2156, or email her at carol@carlowconsulting.com.

Sincerely,

Richard Stensrud

Richard Stensrud
Executive Director

September 19, 2017

Re: Graham-Cassidy

The Honorable Mitch McConnell

Majority Leader

U.S. Senate

Washington, DC 20510

The Honorable Chuck Schumer

Minority Leader

U.S. Senate

Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

The 70 undersigned organizations of the Save Medicaid in the Schools Coalition are concerned that the Graham-Cassidy bill jeopardizes healthcare for the nation's most vulnerable children: students with disabilities and students in poverty. Specifically, Graham-Cassidy reneges on Medicaid's 50+ year commitment to provide America's children with access to vital healthcare services that ensure they have adequate educational opportunities and can contribute to society by imposing a per-capita cap and shifting current and future costs to taxpayers in every state and Congressional district. While children currently comprise almost half of all Medicaid beneficiaries, less than one in five dollars is spent by Medicaid on children. Accordingly, a per-capita cap, even one that is based on different groups of beneficiaries, will disproportionately

harm children's access to care, including services received at school. Considering these unintended consequences, we urge a 'no" vote on Graham-Cassidy.

Medicaid is a cost-effective and efficient provider of essential health care services for children. School-based Medicaid programs serve as a lifeline to children who can't access critical health care and health services outside of their school. Under this bill, the bulk of the mandated costs of providing health care coverage would be shifted to the States even though health needs and costs of care for children will remain the same or increase. Like the Better Care Reconciliation Act, which is incorporated into Graham-Cassidy it is projected that the Medicaid funding shortfall in support of these mandated services will increase, placing states at greater risk year after year. The federal disinvestment in Medicaid imposed by Graham-Cassidy will force States and local communities to increase taxes and reduce or eliminate various programs and services, including other non-Medicaid services. The unintended consequences of Graham-Cassidy will force states to cut eligibility, services, and benefits for children.

The projected loss of hundreds of billions in federal Medicaid dollars will compel States to ration health care for children. Under the per-capita caps included in Graham-Cassidy, health care will be rationed and schools will be forced to compete with other critical health care providers— hospitals, physicians, and clinics— that serve Medicaid-eligible children. School-based health

services are mandated on the States and those mandates do not cease simply because Medicaid funds are capped by Graham-Cassidy. As with many other unfunded mandates, capping Medicaid merely shifts the financial burden of providing services to the States.

Medicaid Enables Schools to Provide Critical Health Care for Students

A school's primary responsibility is to provide students with a high-quality education. However, children cannot learn to their fullest potential with unmet health needs. As such, school district personnel regularly provide critical health services to ensure that all children are ready to learn and able to thrive alongside their peers. Schools deliver health services effectively and efficiently since school is where children spend most of their days. Increasing access to health care services through Medicaid improves health care and educational outcomes for students. Providing health and wellness services for students in poverty and services that benefit students with disabilities ultimately enables more children to become employable and attend higher-education.

Since 1988, Medicaid has permitted payment to schools for certain medically-necessary services provided to children under the Individuals with Disabilities Education Act (IDEA) through an individualized education program (IEP) or individualized family service program (IFSP). Schools are thus eligible to be reimbursed for direct medical services to Medicaid-eligible students with

an IEP or IFSP. In addition, districts can receive Medicaid reimbursements for providing Early Periodic Screening Diagnostic and Treatment Benefits (EPSDT), which provide Medicaid-eligible children under age 21 with a broad array of diagnosis and treatment services. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible before the problems become complex and treatment is more expensive.

School districts use their Medicaid reimbursement funds in a variety of ways to help support the learning and development of the children they serve. In a 2017 survey of school districts, district officials reported that two-thirds of Medicaid dollars are used to support the work of health professionals and other specialized instructional support personnel (e.g., speech-language pathologists, audiologists, occupational therapists, school psychologists, school social workers, and school nurses) who provide comprehensive health and mental health services to students. Districts also use these funds to expand the availability of a wide range of health and mental health services available to students in poverty, who are more likely to lack consistent access to healthcare professionals. Further, some districts depend on Medicaid reimbursements to purchase and update specialized equipment (e.g., walkers, wheelchairs, exercise equipment, special playground equipment, and equipment to assist with hearing and seeing) as well as assistive technology for students with disabilities to help them learn alongside their peers.

School districts would stand to lose much of their funding for Medicaid under GrahamCassidy. Schools currently receive roughly $4 billion in Medicaid reimbursements each year. Yet under this proposal, states would be incentivized to reduce spending on Medicaid and districts would be left with the same obligation to provide services for students with disabilities under IDEA, but no Medicaid dollars to provide medically-necessary services. Schools would also be unable to provide EPSDT to students, which would mean screenings and treatment that take place in school settings would have to be moved to physician offices or hospital emergency rooms, where some families may not visit regularly or where costs are much higher.

In addition, basic health screenings for vision, hearing, and mental health problems for students would no longer be possible, making these problems more difficult to address and expensive to treat. Moving health screenings out of schools also reduces access to early identification and treatment, which also leads to more costly treatment down the road. Efforts by schools to enroll eligible students in Medicaid, as required, would also decline.

The Consequences of Medicaid Per Capita Caps Will Potentially Be Devastating for Children

Significant reductions to Medicaid spending could have devastating effects on our nation's children, especially those with disabilities. Due to the underfunding of IDEA, districts rely on Medicaid reimbursements to ensure students with disabilities have access to the supports and

services they need to access a Free and Appropriate Public Education (FAPE) and Early Intervention services. Potential consequences of this critical loss of funds include:

- Fewer health services: Providing comprehensive physical and mental health services in schools improves accessibility for many children and youth, particularly in highneeds and hard-to-serve areas, such as rural and urban communities. In a 2017 survey of school district leaders, half of them indicated they recently took steps to increase Medicaid enrollment in their districts. Reduced funding for Medicaid would result in decreased access to critical health care for many children.

- Cuts to general education: Cuts in Medicaid funding would require districts to divert funds from other educational programs to provide the services as mandated under IDEA. These funding reductions could result in an elimination of program cuts of equivalent cost in "non-mandated" areas of regular education.

- Higher taxes: Many districts rely on Medicaid reimbursements to cover personnel costs for their special education programs. A loss in Medicaid dollars could lead to deficits in districts that require increases in property taxes or new levies to cover the costs of the special education programs.

- Job loss: Districts use Medicaid reimbursement to support the salaries and benefits of the staff performing eligible services. Sixty-eight percent of districts use Medicaid funding to pay for direct salaries for health professionals who provide services for students. Cuts to Medicaid funding would impact districts' ability to maintain employment for school nurses, physical and occupational therapists, speechlanguage pathologists, school social workers, school psychologists, and many other critical school personnel who ensure students with disabilities and those with a variety of educational needs are able to learn.

- Fewer critical supplies: Districts use Medicaid reimbursement for critical supplies such as wheelchairs, therapeutic bicycles, hydraulic changing tables, walkers, weighted vests, lifts, and student-specific items that are necessary for each child to access curriculum as closely as possible to their non-disabled peers. Replacing this equipment would be difficult if not impossible without Medicaid reimbursements.

- Fewer mental health supports: Seven out of ten students receiving mental health services receive these services at school. Cuts to Medicaid would further marginalize these critical services and leave students without access to care.

- Noncompliance with IDEA: Given the failure to commit federal resources to fully fund IDEA, Medicaid reimbursements serve as a critical funding stream to help schools provide the specialized instructional supports that students with disabilities need to be educated alongside their peers.

We urge you to carefully consider the important benefits that Medicaid provides to our nation's most vulnerable children. Schools are often the hub of the community, and converting Medicaid's financing structure to per-capita caps threatens to significantly reduce access to comprehensive health and mental and behavioral health care for children with disabilities and those living in poverty. We look forward to working with you to avert the harmful and unnecessary impacts Graham-Cassidy would impose on Medicaid, which has proven to benefit children in a highly effective and cost-effective manner.

If you have questions about the letter or wish to meet to discuss this issue further, please do not hesitate to reach out to the coalition co-chairs via email: John Hill

(john.hill@medicaidforeducation.org), Sasha Pudelski (spudelski@aasa.org), and Kelly

Vaillancourt Strobach (kvaillancourt@naspweb.org).

Sincerely,

AASA, The School Superintendents Association

Accelify

American Civil Liberties Union

American Dance Therapy Association

American Federation of School Administrators

American Federation of State, County and Municipal Employees

American Federation of Teachers

American Foundation for the Blind

American Occupational Therapy Association

American Psychological Association

American Speech-Language-Hearing Association

Association of Assistive Technology Act Programs

Association of Educational Service Agencies

Association of School Business Officials International (ASBO)

Association of University Centers on Disabilities

Autistic Self Advocacy Network

Autism Society of America

Center for American Progress

Center for Public Representation

Chiefs for Change

Clearinghouse on Women's Issues

Colorado School Medicaid Consortium

Consortium for Citizens with Disabilities

Conference of Educational Administrators of Schools and Programs for the Deaf

Council for Exceptional Children

Council of Administrators of Special Education

Council of Parent Attorneys and Advocates

Democrats for Education Reform

Disability Rights Education & Defense Fund

Division for Early Childhood of the Council for Exceptional Children (DEC)

First Focus Campaign for Children

Health and Education Alliance of Louisiana

Healthy Schools Campaign

Healthmaster Holdings LLC

Higher Education Consortium for Special Education

Judge David L. Bazelon Center for Mental Health Law

LEAnet, a national coalition of local education agencies

Learning Disabilities Association of America

Lutheran Services in America Disability Network

Michigan Association of Intermediate School Administrators

Michigan Association of School Administrators

National Association of Elementary School Principals

National Association of Pediatric Nurse Practitioners

National Association of Secondary School Principals

National Association of School Nurses

National Association of School Psychologists

National Association of Social Workers

National Association of State Boards of Education

National Association of State Directors of Special Education (NASDSE)

National Association of State Head Injury Administrators

National Black Justice Coalition

National Center for Learning Disabilities

National Association of Councils on Developmental Disabilities

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National Down Syndrome Congress

National Education Association

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National Respite Coalition

National Rural Education Advocacy Collaborative

National Rural Education Association

National School Boards Association

Paradigm Healthcare Services

School Social Work Association of America

School-Based Health Alliance

Share Our Strength

Society for Public Health Education

Teacher Education Division of the Council for Exceptional Children

The Arc of the United States

Union for Reform Judaism

United Way Worldwide

CC: Speaker Paul Ryan, Leader Nancy Pelosi

I am writing to convey to Senator Brown an electronic copy of testimony from my organization, Wisconsin Family Ties, regarding next Monday's Senate Committee on Finance hearing on the "Graham-Cassidy-Heller-Johnson" proposal. I have sent a copy via postal mail as the hearing instructions dictate, but given the unusually-tight timeline on this proposal, the electronic copy reproduced below will assure that our testimony is received in a timely manner. I appreciate the opportunity to offer our feedback; our strong recommendation is that the Senate Finance Committee vote AGAINST the proposal.

Sincerely, Joanne Juhnke

Testimony for the September 25 Hearing of the Senate Committee on Finance Regarding the "Graham-Cassidy-Heller-Johnson" proposal

Joanne Juhnke,

Policy Director

Wisconsin Family Ties

16 N. Carroll St., Suite 230

Madison, WI 53703 j

joanne@wifamilyties.org

(608)261-0532

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 5 children have a diagnosable mental health issue, and the prevalence of childhood severe emotional disturbance approaches one in ten.

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 3 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-HellerJohnson" 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 better 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 20172019 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, bi-partisan 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 Direct: 608.261.0532 | Mobile: 608.320.6165

Wisconsin Family Ties, Inc. |16 N. Carroll Street, Suite 230 | Madison, WI 53703 608.267.6800 | 800.422.7145 | wifamilyties.org

As you know, the Graham-Cassidy bill, crafted by a group of all-male politicians behind closed doors, has been denounced by Planned Parenthood and by a number of other health care groups, including the American Medical Association, American Cancer Society Cancer Action Network, the American Heart Association, and the March of Dimes.

And it's no surprise. In addition to the dangerous policies we've seen in previous versions of Obamacare repeal (including blocking people from accessing preventive care at Planned Parenthood, ending nationwide protections for maternity coverage, and imposing a nationwide ban on private insurance coverage for abortion), the Graham-Cassidy-Heller bill goes much further than any other piece of legislation we've seen. The bill restructures the Medicaid program in a way that would eliminate health care coverage for millions of people — affecting women and children the most. Thirteen million women stand to lose their maternity care. Those who don't lose their insurance will end up paying more in monthly premiums and out-of-pocket costs for less coverage. In fact, per Fitch Rating Agency, "the bill's repeal of certain provisions of the Affordable Care Act (ACA) are more disruptive for most states than prior Republican efforts."

This bill doesn't fix what's broken. Instead, it entirely does away with the health care system millions of people rely on. The legislation is built like a time bomb — every year, it will bring more bad news for women.

Simply put, this bill would mean Americans pay more and get less, and women would pay the biggest price of all.

We are encouraging pro-women's health members to engage constituents on the floor and on social media over the next several days to call out this bill as the worst version of Trumpcare and devastating for women's health.. We've provided social media samples below.

Additionally, please contact Karen Stone, Associate Director of Legislative Affairs at (202) 973-4834 or karen.stone@ppfa.org if you are interested in partnering with your local Planned Parenthood affiliate in the next few days on an event in your state.

Let's look at the specifics of the bill, and why the Graham-Cassidy-Heller bill is so bad:

1) BLOCKING CARE AT PLANNED PARENTHOOD. *Many Medicaid patients already have limited options for care such as birth control, cancer screenings, and regular checkups. Preventing them from coming to Planned Parenthood would leave many with nowhere to go for basic reproductive health care. The American Medical Association (AMA) said that parts of the bill that block access to care at Planned Parenthood health centers "violate longstanding AMA policy on patients' freedom to choose their providers and physicians' freedom to practice in the setting of their choice."*

- One in five women in America have relied on Planned Parenthood in her lifetime. More than half of Planned Parenthood's patients rely on Medicaid for care, and 56 percent of Planned Parenthood's health centers are in rural or otherwise medically underserved areas.
- Under this bill, all Medicaid patients would be prohibited from coming to Planned Parenthood health centers for care — leaving many women with nowhere to go for basic care such as cancer screenings, birth control, STD treatment, and more. We've seen what happens at the state level when policies like this are put in place, and they're devastating.

2) ENDING MEDICAID AS WE KNOW IT. *Millions of women will lose access to health insurance altogether because of the deep cuts to the Medicaid program —affecting one in five women of reproductive age.*

- Medicaid is the largest insurance program for women in this country. Women are the majority of Medicaid enrollees; in fact, two-thirds of adults with Medicaid coverage are women. Due to discriminatory systemic barriers, women of color disproportionately comprise the Medicaid population, with 30 percent of Black women and 24 percent of Hispanic women enrolled in Medicaid, compared to 14 percent of white women.
    - Medicaid covers more women's health services than any other health insurance program. Medicaid is the largest source of coverage for reproductive health care in the country, covering nearly half of all births in the United States and 75 percent of family planning services.
- The Graham-Cassidy-Heller bill will completely eviscerate Medicaid, and drastically reduce the amount of funding that goes toward the program. The Medicaid cuts come in three devastating phases:
    - Stopping Medicaid Expansion: Starting this month (September 2017), Medicaid expansion will be stopped in its tracks — states will no longer be able to expand coverage to people who need it. *States that expanded Medicaid cut the rate of uninsured women of reproductive age nearly in half between 2013 and 2015,* meaning an end to this program would take women backward.
    - Slash the Medicaid Program: Starting in 2020, all Medicaid funding will be cut drastically. In its place, the Graham-Cassidy-Heller bill would provide small, temporary pots of money for states to use for health coverage and other health care purposes. These pots of money would be fixed amounts, which means that funding would not adjust for the higher costs states will invariably face due to things like enrollment increases as a result of a recession, or higher costs due to public health emergencies (like Zika) or natural disasters. States would be forced to either dramatically increase their own spending or to deny healthcare coverage to people who are struggling to get by.

- Revoke Expanded Medicaid Coverage: By the end of 2026, Medicaid expansion will be completely shut down. The 11 million people who gained Medicaid coverage under the ACA would effectively be forced off of health coverage. For instance, before the ACA, a woman living in Ohio with HIV may not have qualified for Medicaid until she became sick enough to be considered disabled. The Medicaid expansion eliminated the requirements for low-income people to fit into certain categories, but under the Graham-Cassidy-Heller proposal, this woman would lose her coverage.

3) FORCING WOMEN TO CHOOSE BETWEEN BEING WITH THEIR NEWBORN OR KEEPING THEIR INSURANCE. *This cruel provision could force women back to work only 60 days after having a baby, or else they lose their health insurance.*

- For women who are actually able to keep their Medicaid coverage, starting just next month (October 2017), mothers of newborns may be forced to find a job within 60 days of giving birth or lose their health insurance.

4) WOMEN WILL PAY MORE FOR LESS. *Under this bill, women will lose critical nationwide coverage protections for maternity coverage, prescription drug coverage, and mental health services. Whether a woman has coverage for this services will depend on what state she lives in. And no matter where she lives, the cost of insurance will increase.*

- Maternity coverage could be gone for millions. States can immediately seek to waive nationwide protections for maternity care, prescription drug benefits, and mental health care.
  - Before the Affordable Care Act, millions of women didn't have insurance coverage for maternity care or other basic care. This bill again puts the maternity coverage of approximately 13 million women at risk. Without insurance, a vaginal birth can cost $30,000 and a C-section can cost $50,000 in out-of-pocket expenses.
- Increasing the Cost of Private Insurance. In addition to kicking millions of women off of Medicaid, the bill simultaneously makes it harder to afford private insurance. Beginning in 2020, the bill completely eliminates ACA tax credits to help people afford private insurance.
- Increased costs. Under the ACA, even as premiums have risen, enrollees were insulated from the rising costs. For instance, in 2016 and 2017, enrollees eligible for tax credits on average saw only a $1 to a $4 per month increase in monthly premiums. Eighty-five percent of people purchasing coverage on the marketplace receive a tax credit to purchase insurance. These millions of people would no longer be insulated from rising costs because the tax credits would be repealed. Studies show that women are more likely than men to forgo care because of cost.
  - The increased costs of care would disproportionately impact women, particularly women of color, given the inequities in earnings for women. This is particularly true

for the 15 million households — disproportionately led by Black and Latina women — where women are the head of households. People of color — even those who are insured — already report less confidence in being able to afford care.

- Women with pre-existing conditions, which includes pregnancy, will be charged more. Insurers get to unilaterally decide what is considered a pre-existing condition and thus, who they can charge more for coverage. Before the ACA, people who had a baby, a C-section, breast cancer, or even an eating disorder, anxiety, depression, or substance abuse were deemed to have a pre-existing condition. Sixty-five million women were considered to have a pre-existing condition.
    - While women can not be denied coverage based on pre-existing conditions, insurance companies will once again be permitted to charge them more for health care coverage. For many, the Cassidy-Graham-Heller proposal could mean that your health insurance isn't just more expensive, it's completely out of reach. Insurance companies could charge patients $28,660 more for having breast cancer, and $142,650 more for cancer that has metastasized. Just giving birth would allow insurers to charge a woman an additional $17,320 per year (compared to a similarly situated person who has not given birth), and it's important to remember: four out of five women will give birth in her lifetime.
    - People with serious illnesses will again face barriers to insurance coverage, life-saving treatments and care. For instance, people living with HIV have historically experienced barriers to accessing care in part due to discrimination by insurance companies who refused to cover them or their care, and today, the majority of people living with HIV do not have their HIV under control with treatment. The bill would mean that once again people living with HIV could be priced out of care. African-American and trans women are the women most likely to have HIV and would be the most impacted by exorbitant premium costs.
    - Black and Latina women face higher rates of many chronic illnesses, meaning these exorbitant costs will hurt the health and financial security of women of color the most. For instance, Black women are the group of people most likely to die from breast cancer. The ability to charge people more based on pre-existing conditions would permit insurers to charge a breast cancer survivor $28,660 more annually for insurance coverage. Without healthcare coverage, racial disparities in breast cancer rates could persist or even widen.

5) IMPOSING A NATIONAL BAN ON PRIVATE INSURANCE COVERAGE FOR ABORTION. The Graham-Cassidy-Heller bill will force private insurance plans to drop coverage of abortion almost immediately. In 2018, tax credits cannot be used to pay for a plan that include abortion coverage outside of the instance of rape, incest, or life endangerment.

- For the two-year period in which tax credits are still available to purchase health insurance coverage (the credits will be repealed in 2020), individuals will be prohibited from using their financial help to purchase a plan that covers abortion. At least 870,000 women will lose access to ACA marketplace insurance plans that cover abortion.

The Honorable Mitch McConnell
Senate Majority Leader
The Capitol S-230
Washington, DC 20510

The Honorable Chuck Schumer
Senate Democratic Leader
The Capitol S-221
Washington, DC 20510

Dear Leader McConnell and Leader Schumer:

As members of the National Health Collaborative on Violence and Abuse (NHCVA) and on behalf of the below signed national professional health associations, we are dedicated to reducing and addressing the health consequences of violence and abuse.

The vision of NHCVA is a healthier nation in which people live free from the pain and suffering of violence and abuse, and without fear of harm or retaliation. A community without violence and abuse is the foundation of hope for a more peaceful world. Children, adults and elders thrive best in respectful interpersonal relationships. NHCVA member organizations work together to advance health policy at the state and federal level to reach that goal and develop the capacity of health professionals and the infrastructure of health systems to prevent and address the harms of current or past exposure to violence and abuse.

The select organizational members of NHCVA below are writing to express opposition to the Graham-Cassidy amendment currently being considered in the Senate and to lay out principles for any health reform proposals. We understand that survivors of violence and abuse need comprehensive health insurance that they can afford for themselves and their children. Access to

health care, including behavioral and mental health services, is critical for survivors to heal and thrive, and to improving their health outcomes over a lifetime.

Over the past years, survivors of violence and abuse have seen a remarkable increase in their ability to afford health insurance and access critical health and behavioral health services. The Affordable Care Act (ACA) helped to make more coverage affordable and provided a guaranteed and expanded set of benefits that women and their families need. Women who have a pre-existing condition cannot be turned away from coverage – this includes prohibiting insurance discrimination against victims of domestic or sexual violence. Pregnant women now have guaranteed maternity benefits as part of their insurance package, and their newborns will get the screenings and care they need. For women who have stayed in unhealthy relationships for fear of losing their health insurance, there are options to access affordable health care not tied to their partner. In other words, affordable and comprehensive coverage is within reach for all women.

Coverage for children, including children who have been exposed to violence and abuse has also been strengthened. Children have seen unprecedented levels of enrollment in health insurance, and it is well documented that covering parents increases the likelihood that children will be insured. Strengthened benefit packages for children including access to behavioral and mental health services, and the strong emphasis on coordinated care and prevention mean that children can more seamlessly access the care they need to be healthy and thrive.

We support the package of "essential health benefits" because the mental health and substance use disorder treatments are critical – to all our patients but particularly survivors of abuse. The

essential health benefits also provide comprehensive coverage of maternity and pediatric benefits. Most notably, we support coverage of assessment and brief counseling for domestic and other interpersonal violence that currently must be offered in all new private insurance plans. We do not support new proposals to weaken waiver standards and puts at risk access to EHBs in all plans.

Recent efforts to repeal these existing health care protections have not recognized the unique situations in which survivors seek health insurance and health care. We are concerned that proposed changes make health insurance less affordable by reducing federal financial help and raising premiums and by changing standards about what services should be covered services. We are also concerned that proposed changes would eliminated coverage options for millions of families on Medicaid and caps the care that they can receive.

We have watched the health care debate unfold and are evaluating each proposal on its impact on the health and care of survivors. We urge policymakers to immediately stop consideration of policy efforts that will have the following impacts on survivors:

- Makes buying health insurance more expensive—and increases out of pocket expenses Survivors will pay more out of pocket for their premiums, and even more for a rich benefit package. For noncovered services, survivors will have to reach into their pockets and pay for care themselves.

- Eliminates coverage for many low-income survivors Survivors will lose coverage if policymakers eliminate the Medicaid expansion, which has helped millions of lowincome survivors access health care through their state Medicaid program.

- Keeps survivors from needed medical and behavioral health services Elimination of, or flexibility in, the Essential Health Benefits takes away the important guarantees that ALL health plans cover a comprehensive benefit package that includes medical and behavioral health services.

We also echo the sentiments and objectives set forth by the American Medical Association, The American Academy of Family Physicians, the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists and the American College of Physicians to maintain the following principles in any revisions to the ACA:

- Do not increase the number of uninsured: Individuals with health insurance coverage should not become uninsured because of any legislative or administrative short-term actions or inactions.

- Ensure a viable health care safety-net. There should be a viable and equitable safety-net health care program for low-income children, youth and adults including those enrolled in Medicaid.

- Ensure vital patient protections remain in the health insurance marketplace, including:

- Policies prohibiting health insurers from imposing annual and lifetime caps on benefits, and discriminating against those with pre-existing conditions, should be retained and made applicable to all insurers, public and private. • Insurance reforms that prevent discrimination against individuals in the insurance market must be preserved.
- All health insurance products should be required to cover evidence-based essential benefits including coverage, at no out-of-pockets cost to insured persons, to those preventive care and vaccines identified by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, the Women's Preventive Services Initiative, Bright Futures, and other designated evidence-based assessment entities.
- Premium assistance and cost-sharing reduction subsidies aimed at assisting qualifying individuals with the purchase of health care coverage and/or paying their deductibles and co-pays should be preserved; any proposals to alter such subsidies should provide, at minimum, comparable assistance especially for lower income persons who otherwise would be unable to afford coverage and services.
- The individual and small group markets should be protected.

Victims of violence frequently need medical and mental health services as they recover from violence and abuse—and this bill takes away coverage for these services for the lowest-income survivors. Among the benefits lost is the requirement that health plans pay for screening and brief counseling for domestic violence and interpersonal violence— ensuring that health care

providers can be reimbursed for their work. This service is currently required to be provided for free (with no copay or cost-sharing) to survivors.

The NHCVA urges the Senate to oppose the Graham-Cassidy amendment and instead encourages policymakers to focus on bipartisan efforts to improve market stability and affordability of comprehensive coverage. Thank you for the opportunity to share these concerns and recommendations. Please consider us a valuable resource as you move forward. We hope to partner with you to preserve the health care coverage gains achieved, and to continue to find ways to improve the quality of health care for all Americans.

Sincerely, Academy on Violence and Abuse American Academy of Neurology American Academy of Nursing American Association of Child and Adolescent Psychiatry American College of Physicians The American Congress of Obstetricians and Gynecologists American Medical Women's Association The Gay and Lesbian Medical Association Family Violence Prevention Caucus of the American Public Health Association Futures Without Violence International Association of Forensic Nurses National Association of Social Workers Nursing Network on Violence Against Women International

cc: U.S. Senate

September 18, 2017

The Honorable Lindsey Graham
290 Russell Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
520 Hart Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Dean Heller
324 Hart Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Ron Johnson
328 Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator Graham, Senator Cassidy, Senator Heller and Senator Johnson:

The undersigned organizations are writing to share our serious concerns with several of the health system reforms included in the Graham-Cassidy-Heller-Johnson (GCHJ) proposal. We are very concerned that the GCHJ's proposed changes to our health care system will result in reductions in health care coverage, particularly for individuals with substance use disorders and mental illness, and we cannot support the bill.

We collectively represent consumers, families, providers, health care and social service professionals, criminal justice professionals, advocates and allied organizations who are committed to meaningful and comprehensive policies to reduce the toll of substance use disorders and mental illness through prevention, treatment and recovery support services.

In the face of the opioid overdose and suicide epidemics, equitable access to a full continuum of mental health and substance use disorder treatment services, including medications to treat substance use disorders and mental illness, must be an essential component of health care coverage. It is also critical that substance use disorders and mental illness be covered on par with other medical conditions consistent with the *Mental Health Parity and Addiction Equity Act* (MHPAEA).

We recognize that the GCHJ would require coverage of mental health and substance use disorder treatment consistent with MHPAEA as part of the new Medicaid Flexibility Program. However, we do not support many of the other changes to the health care system in the proposal that would result in reduced access to substance use disorder and mental health treatment, including changes that would cap federal funding for Medicaid, end the Medicaid expansion, and eliminate mental health and substance use disorder benefit protections for Americans insured through the small group and individual markets. **We have serious concerns with provisions in the proposal that would allow states to easily waive Essential Health Benefit requirements, end Medicaid expansion and change Medicaid to a per-capita or block grant financing system.**

The Medicaid expansion in particular has led to significant increases in coverage and treatment access for persons with substance use disorders and mental illness. In states that expanded Medicaid, the share of people with substance use disorders or mental illness who were hospitalized but uninsured fell from about 20 percent in 2013 to 5 percent by mid-2015, and Medicaid expansion has been associated with an 18.3 percent reduction in the unmet need for substance use disorder treatment services among low-income adults.

Rolling back the Medicaid expansion and/or fundamentally changing Medicaid's financing structure to cap spending on health care services will certainly reduce access to evidence-based treatments and reverse much or all progress made on the opioid crisis last year. Capping federal Medicaid funding through per-capita caps or block grants would strain state budgets and likely force states to cut benefits, lower provider reimbursement rates, and/or limit access to care. These changes would be devastating to states grappling with the current opioid overdose and suicide epidemics. Moreover, the loss of Medicaid-covered mental health and substance

use disorder services for adults would result in more family disruption and out-of-home placements for children, significant trauma which has its own long-term health effects and a further burden on a child welfare system that is struggling to meet the current demand for foster home capacity.

The ACA's Medicaid expansion, Essential Health Benefit requirements for mental health and substance use disorder treatment coverage, and extension of parity protections to the individual and small group market have surely reduced the burden of the opioid misuse and overdose and suicide epidemics and saved lives. Substance use disorder and mental health treatment benefits must continue to be available to Americans enrolled in the individual, small and large group markets as well as Medicaid plans and that these benefits are compliant with the *Mental Health Parity and Addiction Equity Act*.

Finally, throughout this process, we implore you to keep in mind how Congressional decisions will affect the millions of Americans suffering from substance use disorders and mental illness who may lose their health care coverage entirely or see reductions in benefits that impede access to needed treatment.

Sincerely,

1. 10,000 beds
2. Acadia Healthcare
3. Adcare Educational Institute
4. Addiction Education Society
5. Addiction Haven
6. Addiction Resource Council
7. Addiction Services Council
8. Addiction Policy Forum
9. Addiction Treatment Center of New England
10. Addiction Connections Resource
11. Advocates for Recovery Colorado
12. Advocates, Inc.
13. Alabama Society of Addiction Medicine
14. Alano Club of Portland
15. Alcohol & Addictions Resource Center
16. Alcohol/Drug Council of North Carolina
17. Alliance for Strong Families and Communities
18. Alternatives Unlimited, Inc.
19. Amesbury Psychological Center, Inc.
20. American Correctional Association
21. American Federation of State, County and Municipal, Employees (AFSCME)
22. American Academy of Addiction Psychiatry
23. American Art Therapy Association
24. American Association for Marriage and Family Therapy
25. American Association for the Treatment of Opioid Dependence (AATOD)
26. American Association of Child & Adolescent Psychiatry
27. American Association on Health and Disability
28. American Dance Therapy Association
29. American Foundation for Suicide Prevention
30. American Group Psychotherapy Association
31. American Medical Student Association
32. American Mental Health Counselors Association
33. American Nurses Association
34. American Psychiatric Association
35. American Psychological Association
36. American Society of Addiction Medicine

37. Amida Care
38. A New PATH
39. Anthony's Act
40. Anxiety and Depression Association of America
41. Arc of South Norfolk, The
42. Arise & Flourish
43. Arizona's Children Association
44. Arizona Council of Human Service Providers
45. Arizona Society of Addiction Medicine
46. Arkansas Society of Addiction Medicine
47. Association for Ambulatory Behavioral Healthcare
48. Association for Behavioral Healthcare of Massachusetts
49. Association for Community Affiliated Plans (ACAP)
50. Association for Community Human Service Agencies
51. Association of Asian Pacific Community Health Organizations (AAPCHO)
52. Association of Community Mental Health Centers of Kansas, Inc.
53. Association of Flight Attendants – CWA, AFL-CIO
54. Association of Persons Affected by Addiction (APAA)
55. Association of Recovery Schools
56. Association of Recovery Community Organizations
57. Association of Women's Health, Obstetric and Neonatal Nurses
58. A Stepping Stone to Success
59. Atlantic Prevention Resources, Inc.
60. Avanti Wellness
61. Awakening Recovery
62. BAMSI
63. Bangor Area Recovery Network, Inc.
64. Bay Cove Human Services
65. Bay State Community Services, Inc.
66. Bazelon Center for Mental Health Law
67. Behavioral Health Network, Inc.
68. Better Life in Recovery
69. Bill Wilson Center
70. Boston Alcohol and Substance Abuse Programs, Inc.
71. Boston Healthcare for the Homeless
72. Boston Public Health Commission
73. BreakingTheCycles
74. Bridge of Central Massachusetts, Inc., The
75. Bridgewell
76. Brien Center for Mental Health and Substance Abuse Services, The
77. Brookline Community Mental Health Center
78. Bullhook Community Health Center, Inc.
79. Burke Recovery
80. CADA of Northwest Louisiana
81. California Association of Alcohol and Drug Program Executives (CAADPE)
82. California Consortium of Addiction Programs & Professionals
83. California Council of Community Behavioral Health Agencies
84. California Institute for Behavioral Health Solutions
85. California Society of Addiction Medicine
86. Cambridge Health Alliance
87. Camelot Care Centers, Inc.
88. Cape Cod Healthcare Centers for Behavioral Health
89. Capital Area Project Vox

90. Casa Esperanza
91. Casa Pacifica Centers for Children and Families
92. Catholic Charities Family Counseling and Guidance Center
93. Catholic Family Center
94. Center for Human Development
95. Center for Open Recovery
96. Center for Recovery and Wellness Resources
97. Central City Concern
98. Chautauqua Alcoholism and Substance Abuse Council
99. Chicago Recovering Communities Coalition (CRCC)
100. Child & Family Services, Inc.
101. Child and Family Services of New Hampshire
102. Children's Friend, Inc.
103. Children's Home Society of Washington
104. Children's Law Center
105. Children's Services of Roxbury
106. CleanSlate Centers
107. Clergy for a New Drug Policy
108. Clinical and Support Options, Inc.
109. Clinical Social Work Association
110. Coalition of Addiction Students and Professionals Pursuing Advocacy (CASPPA)
111. Colorado Society of Addiction Medicine
112. Community Catalyst
113. Communities for Recovery
114. Community Anti-Drug Coalitions of America (CADCA)
115. Community Counseling of Bristol County, Inc.
116. Community-Minded Enterprises
117. Community Oriented Correctional Health Services (COCHS)
118. Community Services Institute
119. Community Solutions
120. Community Substance Abuse Centers
121. Comrades of Hope
122. Connecticut Community for Addiction Recovery (CCAR)
123. Connecticut Society of Addiction Medicine
124. Counselors Obediently Preventing Substance Abuse (COPS)
125. Cover2Resources
126. Cutchins Programs for Children and Families
127. DarJune Recovery Support Services & Café
128. Dash for Recovery
129. Davis Direction Foundation - The Zone
130. DC Fights Back
131. DC Recovery Community Alliance
132. Delphi Behavioral Health Group/MHD
133. Desert Eagle Addiction Recovery
134. Detroit Recovery Project, Inc.
135. Dimock Community Health Center
136. Disability Rights Pennsylvania
137. Doctors for America
138. Doctors for Recovery
139. Dorchester Recovery Initiative
140. Drug and Alcohol Service Providers Organization of Pennsylvania (DASPOP)
141. Drug Policy Alliance
142. Drug Prevention Resources

143. East Bay Agency for Children
144. Easy Does It, Inc.
145. Eating Disorders Coalition
146. Edinburg Center, The
147. Eliot Community Human Services
148. El Paso Alliance
149. Engaged Recovery Community Services
150. Faces and Voices of Recovery
151. Facing Addiction
152. Family Advocates of Georgia, Inc
153. Family Focused Treatment Association
154. Family Service Association
155. Family Service of Greater Boston
156. FAVOR Greenville
157. FAVOR Low Country
158. FAVOR Mississippi Recovery Advocacy Project
159. FAVOR Pee Dee
160. FAVOR Tri-County
161. FED UP! Coalition
162. Fellowship Foundation Recovery Community Organization
163. Fenway Health
164. FHR
165. Florida Society of Addiction Medicine
166. Floridians for Recovery
167. Foundation for Recovery
168. Friends of Recovery - New York
169. FSA – Family Service Agency
170. Futures of Palm Beach
171. G III Associates
172. GAAMHA
173. Gandara Center
174. Georgia Council on Substance Abuse
175. Georgia Society of Addiction Medicine
176. Georgians for a Healthy Future
177. Global Alliance for Behavioral Health and Social Justice
178. Gosnold on Cape Cod
179. Gould Farm
180. Granite Pathways
181. Greater Macomb Project Vox
182. Greater Philadelphia Association for Recovery Education
183. Great South Bay Coalition
184. Greater Cincinnati Recovery Resource Collaborative (GCRRC)
185. Griffin Recovery Enterprises
186. Harm Reduction Coalition
187. Health Management Group, LTD
188. High Point Treatment Center
189. Hillview Mental Health Center, Inc.
190. HIV Medicine Association
191. Home for Little Wanderers, The
192. Hope2Gather Foundation
193. HOPE for New Hampshire Recovery
194. Hope House Addiction Services
195. Horizon Health Services

196. IC&RC
197. Indivisible St. Louis
198. Illinois Association for Behavioral Health
199. Illinois Association of Rehabilitation Facilities (IARF)
200. Indiana Society of Addiction Medicine
201. International Nurses Society on Addictions
202. Institute for Health and Recovery
203. Iowa Association of Community Providers
204. Iowa Behavioral Health Association
205. Italian Home for Children, Inc.
206. Jackson Area Recovery Community
207. Jewish Family and Children's Services (JF&CS)
208. Joint Coalition on Health
209. Jordan's Hope for Recovery
210. Judge Baker Children's Center
211. Juneau Recovery Community
212. Justice Resource Institute (JRI)
213. Ka Hale Pomaika'i
214. Kentucky Society of Addiction Medicine
215. KEY Program, Inc., The
216. Kyes 2 a 2nd Chance
217. Lahey Health Behavioral Services
218. Lakeshore Foundation
219. Latah Recovery Center
220. Legal Action Center
221. Lifehouse Recovery Connection
222. Lifeline Connections
223. Long Island Council on Alcoholism and Drug Dependence, Inc.
224. Long Island Recovery Association (LIRA)
225. Lost Dreams Awaken Center, Inc.
226. Lotus Peer Recovery/SoberKerrville
227. Lowell Community Health Center, Inc.
228. Lowell House, Inc.
229. LUK, Inc.
230. Madison County Council on Alcoholism & Substance Abuse
231. Magnolia Addiction Support
232. Maine Alliance for Addiction Recovery
233. Mariah's Mission Fund of the Mid-Shor Community Foundation
234. Mark Garwood SHARE Foundation
235. Martha's Vineyard Community Services
236. Maryland-DC Society of Addiction Medicine
237. Maryland House Detox
238. Maryland Recovery Organization Connecting Communities (M-ROCC)
239. Massachusetts Organization for Addiction Recovery (MOAR)
240. Massachusetts Society of Addiction Medicine
241. Maxed Out Drug Prevention
242. McShin Foundation
243. Mental Health Association
244. Message Carriers of Pennsylvania, Inc.
245. Messengers of Recovery Awareness
246. MHA of Greater Lowell
247. Michigan's Children
248. Michigan Recovery Voices

249. Michigan Society of Addiction Medicine
250. Middlesex Human Service Agency, Inc
251. Mid-Michigan Recovery Services, Inc.
252. Midwest Society of Addiction Medicine
253. Mi-HOPE - Michigan Heroin & Opiate Prevention and Education
254. Minnesota Association of Community Mental Health Programs (MACMHP)
255. Minnesota Recovery Connection
256. Minnesota Society of Addiction Medicine
257. Missouri Recovery Network
258. MOBER
259. Mountain View Prevention Services, Inc.
260. NAADAC – the Association for Addiction Professionals
261. National Alliance for Medication-Assisted Recovery (NAMA)
262. National Alliance for Recovery Residences
263. National Alliance on Mental Illness
264. National Alliance on Mental Illness – San Mateo County
265. National Alliance to Advance Adolescent Health
266. National Alliance to End Homelessness
267. National Association for Rural Mental Health
268. National Association of Addiction Treatment Providers
269. National Association of Clinical Nurse Specialists
270. National Association of Pediatric Nurse Practitioners
271. National Association of Social Workers (NASW)
272. National Association of State Mental Health Program Directors (NASMHPD)
273. National Association for Children's Behavioral Health
274. National Association for Rural Mental Health
275. National Association of County Behavioral Health and Developmental Disability Directors
276. National Association of County & City Health Officials
277. National Association of Social Workers (NASW)
278. National Black Justice Coalition
279. National Council for Behavioral Health
280. National Center on Addiction and Substance Abuse
281. National Council on Alcoholism and Drug Dependence
282. National Council on Alcoholism and Drug Dependence of E. San Gabriel & Pomona Valleys
283. National Council on Alcoholism and Drug Dependence--Greater Phoenix
284. National Council on Alcoholism and Drug Dependence – Maryland
285. National Council on Alcoholism and Drug Dependence – San Diego
286. National Council on Alcoholism and Drug Dependence of the San Fernando Valley
287. National Council on Alcoholism and Drug Abuse-St. Louis Area
288. National Disability Rights Network
289. National Federation of Families for Children's Mental Health
290. National Health Care for the Homeless Council
291. National League for Nursing
292. National Safety Council
293. National Viral Hepatitis Roundtable
294. Navigate Recovery Gwinnett
295. Nevada Society of Addiction Medicine
296. New Futures and New Futures Kids Count
297. New Jersey Association of Mental Health and Addiction Agencies, Inc.
298. New Jersey Society of Addiction Medicine
299. New Life Counseling & Wellness Center, Inc.
300. New Mexico Society of Addiction Medicine
301. New York Association of Psychiatric Rehabilitation Services

302. New York Society of Addiction Medicine
303. New York State Council for Behavioral Health
304. NFI Massachusetts, Inc.
305. NMSAS Recovery Center
306. No Health without Mental Health
307. North Charles, Inc.
308. North Cottage Program, Inc.
309. Northeast Center for Youth and Families, The
310. Northern New England Society of Addiction Medicine
311. Northern Ohio Recovery Association (NORA)
312. Northwest Indian Treatment Center
313. North Suffolk Mental Health Association, Inc.
314. Northern Rivers Family Services
315. North Carolina Society of Addiction Medicine (NCSAM)
316. O'Brien House
317. Ohio Recovery Housing
318. Ohio Society of Addiction Medicine (OHSAM)
319. Oklahoma Citizen Advocates for Recovery & Treatment Association (OCARTA)
320. Old Colony YMCA
321. Open Doorway of Cape Cod
322. Opportunity House, Inc
323. Oregon Recovery High School
324. Oregon Society of Addiction Medicine
325. Overcoming Addiction Radio
326. Parity Implementation Coalition
327. Partnership for Drug-Free Kids
328. Partners in Prevention/National Council on Alcoholism and Drug Dependence of Hudson County, Inc.
329. P.E.E.R Wellness Center, Inc.
330. PEER360 Recovery Alliance
331. Pennsylvania Recovery Organization - Achieving Community Together - (PRO-ACT)
332. Pennsylvania Recovery Organizations Alliance (PRO-A)
333. Pennsylvania Society of Addiction Medicine
334. People Advocating Recovery - PAR
335. Phoenix Houses of New England
336. Phoenix Multisport Boston
337. Pine Street Inn
338. Pivot, Alcohol and Substance Abuse Council of Jefferson County, Inc.
339. PLR Athens
340. Pretrial Justice Institute
341. Prevention Network OCAA
342. Psychiatric Rehabilitation Association
343. Putnam Family & Community Services, Inc.
344. RASE Project
345. REAL- Michigan (Recovery, Education, Advocacy & Leadership)
346. Recover Project/Western MA Training
347. Recovery Allies Of West Michigan
348. RecoveryATX
349. Recovery Café Seattle
350. Recovery Community Foundation of Forsyth
351. Recovery Communities of North Carolina
352. Recovery Community of Durham
353. Recovery Consultants of Atlanta

354. Recovery Data Solutions
355. Recovery - Friendly Taos County
356. Recovery Idaho, Inc.
357. Recovery is Happening
358. RecoveryNC (Governors Institute on Substance Abuse)
359. Recovery Point at HER Place
360. Recovery Point of Bluefield
361. Recovery Point of Charleston
362. Recovery Point of Huntington
363. Recovery Point of Parkersburg
364. Recovery Point of West Virginia
365. Recover Wyoming
366. reGROUP
367. Rhode Island Communities for Addiction Recovery Efforts (RICAREs)
368. Riverside Community Care
369. Robby's Voice
370. ROCovery Fitness
371. Rockland Council on Alcoholism and Other Drug Dependence, Inc.
372. Sandusky Artisans Recovery Community Center
373. Sandy Hook Promise
374. Serenity Sistas
375. ServiceNet
376. Shatterproof
377. SMART Recovery
378. S.O.A.R™ Yoga (Success Over Addiction and Relapse)
379. Solano Recovery Project
380. Solutions Recovery, Inc.
381. Sonoran Prevention Works
382. South Arkansas Regional Health Center, Inc
383. Sound Community Services, Inc.
384. South Middlesex Opportunity Council, Inc. (SMOC)
385. South Bay Community Services
386. South Carolina Society of Addiction Medicine
387. South Central Human Relations Center
388. South End Community Health Center
389. South Shore Mental Health
390. Southwest Washington Recovery Coalition
391. Spectrum Health Systems, Inc.
392. SpiritWorks Foundation
393. Springfield Recovery Community Center
394. Springs Recovery Connection
395. SSTAR
396. STEP Industries
397. Steppingstone, Incorporated
398. Steve Rummler Hope Network
399. Student Assistance Services Corp
400. Substance Use and Mental Health Leadership Council of Rhode Island
401. Technical Assistance Collaborative, Inc.
402. Tennessee Society of Addiction Medicine
403. Texas Society of Addiction Medicine
404. The Addict's Parents United (TAP United)
405. The Alliance
406. The Ammon Foundation

407. The Bridge Foundation
408. The Bridge Way School
409. The Campaign for Trauma-Informed Policy and Practice
410. The Chris Atwood Foundation
411. The Council on Alcohol and Drug Abuse
412. The Council on Alcohol & Drug Abuse for Greater New Orleans
413. The DOOR - DeKalb Open Opportunity for Recovery
414. The Global Alliance for Behavioral Health and Social Justice
415. The Kennedy Forum
416. The Ohana Center
417. The Peggie & Paul Shevlin Family Foundation
418. The Recovery Channel
419. The Rest of Your Life
420. The Trevor Project
421. The Village Family Services
422. The Village Project, Inc.
423. There Is No Hero In Heroin Foundation
424. Tia Hart Recovery Community Program
425. T.O.R.C.H Inc.
426. Toward Independent Living and Learning, TILL, Inc.
427. Transforming Youth Recovery
428. Treatment Communities of America
429. Trilogy Recovery Community
430. True Recovery, LLC
431. Trust for America's Health
432. Turning Point Center of Central Vermont
433. Two Guys and a Girl
434. UMass Memorial Community Healthlink, Inc.
435. United Methodist Church - General Board of Church and Society
436. Utah Support Advocates for Recovery Awareness (USARA)
437. Valley Hope
438. Veterans Inc.
439. Vermont Council of Developmental and Mental Health Services
440. Vermont Recovery Network
441. Victory Programs, Inc.
442. Vinfen
443. Virginia Association of Recovery Residences
444. Voice for Adoption
445. Voices of Hope for Cecil County
446. Voices of Recovery San Mateo County
447. Volunteers of America of Massachusetts, Inc.
448. WAI-IAM, Inc. and RISE Recovery Community
449. Walker, Inc.
450. Washtenaw Recovery Advocacy Project (WRAP)
451. Washington Federation of State Employees
452. Washington Recovery Alliance
453. Washington Society of Addiction Medicine
454. Watershed Treatment Programs
455. Wayside Youth & Family Support Network
456. WEConnect
457. Wellspring Recovery Services
458. West Virginia Society of Addiction Medicine
459. WholeLife Recovery Community/ Arizona Recovery Coalition

460. Wisconsin Recovery Community Organization (WIRCO)
461. Wisconsin Society of Addiction Medicine
462. Wisconsin Voices for Recovery
463. Wyoming County CARES
464. Yoga of Recovery
465. Young Invincibles
466. Young People in Recovery
467. Young People in Recovery – Los Angeles
468. Youth Opportunities Upheld, Inc.
469. Youth Villages

September 21, 2017

Re: Concerns with Proposals in the Graham-Cassidy Proposal

The Honorable Orin Hatch, Chairman, United States Senate Committee on Finance
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden, Ranking Member, United States Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden,

The National Association of School Psychologists is writing to express serious concerns that the Graham-Cassidy Proposal will jeopardize healthcare for the nation's most vulnerable children: students with disabilities and students in poverty. NASP represents over 24,000 school psychologists who work with students, parents, teachers, administrators, and communities to ensure students have the necessary supports needed to thrive at school, at home, and in life. Our members also provide a variety of school-based mental and physical health services—some of which are funded with Medicaid dollars—including prevention, early identification, and intervention services that remove barriers to learning and assist students in becoming effective learners and productive citizens. We serve all students in both general and special education settings.

We are concerned that restructuring Medicaid to a per capita cap system will undermine States' ability to provide America's neediest children access to vital healthcare necessary to ensure they are able to succeed in school and beyond. Medicaid is a cost-effective and efficient provider of essential health care services for children. School-based Medicaid programs in particular serve as a lifeline to children who can't access critical healthcare and services outside of their school.

Under this bill, the bulk of the costs for health care coverage would be shifted to the States even though health needs and costs of care for children will remain the same or increase. States and local communities will have to compensate for this federal disinvestment in our children's healthcare. If they cannot adequately make up the difference in federal funding, providers will be forced to cut eligibility, services, and benefits for children.

The proposals in the American Health Care Act, as passed by the House, will disproportionately harm children's access to care, including services received at school. We urge you to work with your colleagues to ensure our nation's most vulnerable children do not lose access to the vital comprehensive health care services they need in school and in the community. A recent report from the Center on Budget Policy Priorities outlines how Medicaid benefits children in the short term and helps them make long term economic gains as adults. Protecting this program is critical.

Schools Provide Critical Health Care for Students

A school's primary responsibility is to provide students with a high-quality education. Children cannot learn to their fullest potential with unmet health needs. As such, specialized instructional support personnel regularly provide critical health services to ensure all children are ready to learn and able to thrive alongside their peers. Schools deliver services effectively and efficiently since school is where children spend their days. Increasing access to healthcare services through Medicaid improves health care as well as educational outcomes for students. Providing health and wellness services for students in poverty and services that benefit students with disabilities ultimately enables more children to become employable and attend higher education.

Since 1988, Medicaid has permitted payment to schools for certain medically necessary services provided to children under the Individuals with Disabilities Education Act (IDEA) through an individualized education program (IEP) or individualized family service plan (IFSP). Schools are thus eligible to be reimbursed for direct medical services to Medicaid-eligible students with an IEP or IFSP. In addition, districts can receive Medicaid reimbursements for providing Early and Periodic, Screening, Diagnostic and Treatment benefits (EPSDT) for Medicaid-eligible children under age 21. The goal of EPSDT is to assure health problems are diagnosed and treated as early as possible before the problems become complex and treatment is more expensive.

School districts use Medicaid reimbursement funds in a variety of ways to help support the learning and development of the children they serve. In a 2017 survey of school districts, district officials reported that two-thirds of Medicaid dollars are used to support the work of school psychologists and other specialized instructional support personnel who provide comprehensive health and mental health services to students. Districts also use these funds to expand the availability of a wide range of health and mental health services to students in poverty, who are more likely to lack consistent access to healthcare professionals. Further, some districts depend on Medicaid reimbursement to purchase and update specialized equipment (e.g., walkers, wheelchairs, exercise equipment, special playground equipment, and equipment to assist with hearing and vision), as well as assistive technology for students with disabilities to assist them in learning.

School districts would stand to lose much of their funding for Medicaid under the current proposal. Schools currently receive roughly $4 billion in Medicaid reimbursements each year. Under the current proposal, States would no longer have to consider schools as eligible Medicaid providers, leaving districts with the same obligation to provide services for students with disabilities under IDEA, but no Medicaid dollars to provide medically-necessary services. Schools would be unable to provide EPSDT to students. Instead, screenings and treatment currently provided in school settings would have to be delivered in physicians' offices, which may be less accessible for families or in hospital emergency rooms where costs are much higher.

In summary, basic health screenings for vision, hearing, and mental health problems would no longer be possible, making these problems more difficult to address and more expensive to treat. Moving health screenings out of schools also reduces access to early identification and treatment, resulting in more costly treatment down the road.

The Consequences of Medicaid Per Capita Caps Will Potentially Be Devastating for Children

Significant reductions to Medicaid spending could have devastating effects on children, especially those with disabilities. Due to the underfunding of IDEA, districts rely on Medicaid reimbursements to ensure students with disabilities have access to the supports and services they need to access a free appropriate public education, as required by federal law. Potential consequences of this critical loss of funds include:

- **Fewer health services**: Providing comprehensive physical and mental health services in schools improves accessibility for many children and youth, particularly in high needs

and hard to serve areas such as rural and urban communities. In a 2017 survey of school district leaders, half indicated they have recently taken steps to increase Medicaid enrollment in their districts. Reduced funding for Medicaid would result in decreased access to critical healthcare for many children and youth.

- **Cuts to general education**: Cuts in Medicaid funding would require districts to divert funds from other educational programs to provide the services as required under IDEA. These funding reductions could result in program eliminations in other areas of the education system.

- **Job loss**: Districts use Medicaid reimbursement to support the salaries and benefits of the staff performing eligible services. Sixty-eight percent of districts use Medicaid funding to pay direct salaries for health professionals who provide services for students. Cuts to Medicaid funding would impact districts' ability to maintain employment for school nurses, physical and occupational therapists, speech-language pathologists, school social workers, school psychologists, and many other critical school personnel who ensure students with disabilities and other students with a variety of educational needs are able to learn.

- **Fewer critical supplies**: Districts use Medicaid reimbursement for critical supplies such as wheelchairs, therapeutic bicycles, hydraulic changing tables, walkers, lifts, and student-specific items that are necessary for each child to access curriculum as closely as possible to their non-disabled peers. Replacing this equipment would be difficult if not impossible without Medicaid reimbursement.

- **Fewer mental health supports**: Seven out of ten students receiving mental health services receive these services at school. Cuts to Medicaid would further marginalize these critical services and leave students without access to care.

- **Noncompliance with IDEA**: Given the failure to commit federal resources to fully fund the IDEA, Medicaid reimbursement serves as a critical funding stream to help school provide the specialized instructional supports students with disabilities need to be educated with their peers.

As the Senate begins to consider alternatives to the polices set forth by the Patient Protection and Affordable Care Act, we urge you to carefully consider the important benefits that Medicaid, as it is currently structured, provides to our nation's most vulnerable children. Schools are often the hub of the community, and converting Medicaid to a per capita cap system threatens to significantly reduce access to comprehensive physical, mental and behavioral health care for children with disabilities and those living in poverty.

We look forward to working with you to prevent unwarranted changes to this highly effective and beneficial program. Further, we wish to express our opposition to efforts to remove mandatory coverage for the 10 categories of Essential Health Benefits, specifically mental and behavioral health care from public and private health care plans. We have a mental and behavioral health care crisis in this country, with many children and youth lacking adequate access to high quality and affordable care. Allowing states and insurance companies to deny coverage or charge exorbitant co-pays for these services will only increase barriers to care and

exacerbate the difficulty in effectively preventing and treating mental and behavioral health among our nation's children and youth. We urge you to reject any proposal that seeks to deny or reduce access to mental and behavioral health care.

If you have questions about this information or wish to meet to discuss this issue further, please do not hesitate to reach out to Kelly Vaillancourt Strobach, NASP Director of Government Relations (kvaillancourt@naspweb.org). Thank you for all you do for our nation's children and youth.

Sincerely,

Susan Gorin, CAE

Executive Director

MOLINA HEALTHCARE

September 21, 2017

The Honorable Mitch McConnell
Senate Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Senate Minority Leader
United States Senate
Washington, DC 20510

Re: Graham-Cassidy-Heller-Johnson Amendment

Dear Majority Leader McConnell and Minority Leader Schumer:

Molina Healthcare has been serving the poor and underserved who are insured through government-sponsored healthcare programs for close to four decades, engaging in Medicaid markets in thirty states and Puerto Rico. We currently operate in the Health Insurance Marketplaces in nine different states. In addition, Molina Healthcare has more Medicare Medicaid Program (MMP) dual eligibles enrolled in our MMP plans than any other insurer in the country. We have been serving the neediest members of the Medicare Advantage program through our D-SNP product for close to a decade. Today, we are one of the ten largest health insurers in the country, serving more than four and a half million low-income members in 12 states and Puerto Rico.

Molina has extensive experience optimizing the value provided by these programs while generating additional improvements in patient outcomes and healthcare costs. It is this experience which informs the concerns Molina Healthcare has about the impact of the proposed Graham-Cassidy-Heller-Johnson (GCHJ) legislation on our nation's healthcare system and our most vulnerable populations.

Medicaid

We have significant reservations about the overall changes to existing Medicaid funding mechanisms included in GCHJ. As we have stated in previous correspondence, one of our biggest concerns is with the proposed use of the CPI-U Medical and CPI-U indices as the inflation factors in determining the annual growth of per capita caps funding amounts for the various Medicaid population segments.

We believe these flawed metrics will create an immense gap between *actual* healthcare costs and Medicaid funding – leaving states with insufficient resources to serve current and future beneficiaries. Further, they do not take into account demands that could arise from various contingencies such as an economic downturn, a health epidemic like Zika or the Bird Flu, ongoing opioid and drug addiction problems, or the introduction of costly new pharmaceutical treatments.

Finally, funding cuts of this magnitude will generate unavoidable adverse socioeconomic impacts. According to independent analyses, they could lead to the loss of at least 1 million jobs as providers downsize and will do lasting damage to our strained healthcare system, particularly the safety net in rural areas, thereby dramatically lowering quality of life and access to care for low-income populations.

Medicaid Expansion and the Individual Market

One of our core principles for any future healthcare reform efforts is that low-income populations that have gained coverage under the Affordable Care Act (ACA) should be protected in the design of a replacement for the ACA. Twenty-four million people have gained coverage since 2014 through the Medicaid expansion and

MOLINA HEALTHCARE

the individual Marketplaces. These gains are worth protecting, which is why GCHJ's proposed changes to these programs, as currently structured, are so concerning to us.

Between now and 2019, GCHJ's repeal of the individual mandate will create the classic conditions for adverse selection. The stabilization funds GCHJ appropriates for this period are far less than what prior healthcare reform efforts provided for the same purpose; moreover, the legislation does nothing to address the current issues such as uncertainty around cost sharing reduction (CSR) funding that are destabilizing the individual market.

GCHJ's proposed block grants for the combined Medicaid expansion and Marketplace populations for the period 2020-2026 are about 20% less than projected funding under current law for these programs and represent a risky redistribution of dollars from expansion states to non-expansion states. As a result, GCHJ may produce incremental gains in coverage in non-expansion states at the expense of significant coverage losses in the expansion states that have produced the bulk of the decline in uninsured rates since 2014.

We are also extremely concerned by the "funding cliff" that will occur in 2027 when the block grant funds would expire and require additional congressional appropriation to move forward. This would lead to a roughly $200 billion annual contraction in Federal financial support for healthcare markets in the states.

Finally, the legislation's provisions which exempt states from the ACA's individual market reforms also risk disrupting coverage for millions of Americans leaving many, especially those with pre-existing conditions, without access to the health services they need.

In summary, the proposed changes to the healthcare system will perpetuate volatility in state finances and health insurance markets for the foreseeable future and will act as a deterrent for insurers and providers who need some measure of stability in order to make the capital and operational investments necessary for providing coverage to Americans, and will likely curtail their participation in these programs.

Molina recognizes the need to improve and change many aspects of the ACA, but the GCHJ, in its current form, does not solve many of the problems that exist in our current healthcare system and creates a host of new problems that threaten those who need assistance the most. As a result of the issues outlined above, Molina Healthcare cannot support this legislation in its current form.

We hope the Senate will reconsider its current approach to healthcare reform and consider bipartisan efforts to reform the healthcare system. We will continue to stand ready to partner with the Federal and State governments as a resource whose input can assist in the development and implementation of policy measures that advance the goal of quality, affordable health coverage for all.

Sincerely,

Joseph White
Interim Chief Executive Officer

Jimmy Kimmel Statement on Graham Cassidy:

I know you guys are gonna find this hard to believe, but a few months ago, after my son had open-heart surgery, which was something I spoke about on the air, a politician, a senator named Bill Cassidy from Louisiana, was on my show, and he wasn't very honest. It *seemed* like he was being honest. He got a lot of credit and attention for coming off like a rare, reasonable voice in the Republican Party when it came to health care, for coming up with something he called—and I didn't name it this, *he* named it this—the "Jimmy Kimmel test." Which was, in a nutshell, no family should be denied medical care, emergency or otherwise, because they can't afford it. He agreed to that. He said he would only support a health care bill that made sure a child like mine would get the health coverage he needs, no matter how much money his parents make. And that did not have annual or lifetime caps. These insurance companies, they want caps to limit how much they can pay out. So, for instance, if your son has to have three open-heart surgeries, it can cost hundreds of thousands of dollars apiece, if he hits his lifetime cap of, let's say, a million dollars, the rest of his life, he's on his own. Now, our current plan protects Americans from these caps and prevents insurance providers from jacking up the rates for people who have preexisting conditions of all types. And Senator Cassidy said his plan would do that too. He said all of this on television, many times.

CLIP: Senator Cassidy: As you present that, I ask, "Does it pass the Jimmy Kimmel test? Would a child born with a congenital health disease be able to get everything she or he would need in that first year of life. I want it to pass the Jimmy Kimmel test.

Jimmy Kimmel: So last week, Bill Cassidy and Senator Lindsey Graham proposed a new bill, the Graham-Cassidy Bill, and this new bill actually does pass the Jimmy Kimmel test, but a different Jimmy Kimmel test. With this one, your child with a preexisting condition will get the care he needs if—and only if—his father is Jimmy Kimmel. Otherwise, you might be screwed. Now, I don't know what happened to Bill Cassidy, but when he was on this publicity tour, he listed his demands for a health care bill very clearly. These were his words. He said he wants:

1. Coverage for all
2. No discrimination based on pre-existing conditions
3. Lower premiums for middle-class families
4. No lifetime caps

And guess what? The new bill does none of those things. Coverage for all? No. In fact, it'll take about 30 million Americans off insurance. Pre-existing conditions? No. If the bill passes, individual states can let insurance companies charge you more if you have a pre-existing condition. You'll find that little loophole later in the document, after it says they can't. They can, and they will. But will it lower premiums? Well, in fact, for lots of people, the bill will result in higher premiums. And as far as no lifetime caps go, the states can decide on that too, which means there will be lifetime caps in many states. So not only did Bill Cassidy fail the Jimmy Kimmel test, he failed the Bill Cassidy test. He failed his own test. And you don't see that happen very much. This bill that he came up with is actually worse than the one that—thank God—Republicans like Susan Collins

and Lisa Murkowski and John McCain torpedoed over the summer. And I hope they have the courage and good sense to do that with this one.

Because these other guys, who claim they want Americans to have better health care, even though eight years ago they didn't want anyone to have health care at all, they're trying to sneak this scam of a bill they cooked up in without an analysis from the bipartisan Congressional Budget Office. They don't even want you to see it. They're having one hearing—I read the hearings are being held in the Homeland Security Committee, which has nothing to do with health care, and the chairman agreed to allow two witnesses—Bill Cassidy and Lindsey Graham—to speak.

So listen. Health care is complicated. It's boring. I don't want to talk about it. The details are confusing. And that's what these guys are relying on. They're counting on you to be so overwhelmed with all the information, you just trust them to take care of you. But they're not taking care of you, they're taking care of the people who give them money, like insurance companies. And we're all just looking at our Instagram accounts and liking things while they're voting on whether people can afford to keep their children alive or not. Most of the congresspeople who vote on this bill probably won't even read it. And they want us to do the same thing. They want us to treat it like an iTunes service agreement. And this guy, Bill Cassidy, just lied right to my face.

CLIP: Jimmy Kimmel: Do you believe that every American, regardless of income, should be able to get regular checkups, maternity care, etcetera, all of those things that people who have health care get and need?

Bill Cassidy: Yep.

Jimmy Kimmel: So "Yep," is Washington for "Nope," I guess. And I never imagined I would get involved in something like this, this is not my area of expertise. My area of expertise is eating pizza, and that's really about it. But we can't let them do this to our children, our senior citizens, and our veterans, or to any of us.

And by the way, before you post a nasty Facebook message saying I'm politicizing my son's health problems, I want you to know, I *am* politicizing my son's health problems, because I have to. My family has health insurance. We don't have to worry about this. But other people do, so you can shove your disgusting comments where your doctor won't be giving you a prostate exam once they take your health care benefits away.

It's truly, it's unbelievable. Somehow Japan and England and Canada and Germany and France, they all figured health care out. And don't say they have terrible health care, because it's just not true. This is a bad bill. But don't take my word for it. Here are just some of the organizations that oppose this Graham-Cassidy bill.

- The American Cancer Society
- The American Diabetes Association
- The American Heart Association
- The American Lung Association
- The Arthritis Foundation
- The Cystic Fibrosis Foundation
- The ALS Association
- The March of Dimes
- The National Multiple Sclerosis Society
- Children's Hospital of Los Angeles

Basically, any group you've ever given money to thinks this is a bad idea. Do you trust them? Or do you trust him? (**Kimmel gestures at a photo of Senator Cassidy**) Ok? So if this bill isn't good enough for you, call your congressperson. That's the number, it will go to your congressperson, whoever he or she is: 202-224-3121. You have to do this, you can't just click like on this video. Tell them this bill doesn't pass *your* test.

And Senator Cassidy, you were on my show, you seem like you're a decent guy. But here's the thing: Nobody outside of your buddies in Congress wants this bill. Only 12% of Americans supported the last one, and this one is worse. Right now, there's a bipartisan group of senators working to improve the health care system we have. We want quality, affordable health care. Dozens of other countries figured it out. So instead of jamming this horrible bill down our throats, go pitch in and be a part of that, I'm sure they could use a guy with your medical background.

And if not, *stop using my name*, okay? Because I don't want my name on it. There's a new Jimmy Kimmel test for you: it's called a lie detector test. You're welcome to stop by the studio and take it any time.

Trust for America's Health
Preventing Epidemics. Protecting People.

September 20, 2017

Dear Abigail:

The Graham-Cassidy amendment (#1030) to the American Health Care Act (H poses numerous threats to the health and well-being of Americans, including t the Prevention and Public Health Fund beginning in FY19.

The Prevention Fund makes up more than 12 percent of the Centers for Disease and Prevention's (CDC) budget in FY17, and its repeal would create a massive at CDC. In addition, the Prevention Fund makes several key investments to all the Prevention Fund is repealed, states stand to lose more than $3 billion over five years alone. Trust for America's Health published an analysis on the impa potential loss of the Prevention Fund, including state-specific information list

Alabama	Kentucky	North Dakota
Alaska	Louisiana	Ohio
Arizona	Maine	Oklahoma
Arkansas	Maryland	Oregon
California	Massachusetts	Pennsylvania
Colorado	Michigan	Rhode Island
Connecticut	Minnesota	South Carolina
Delaware	Mississippi	South Dakota

District of Columbia	Missouri	Tennessee
Florida	Montana	Texas
Georgia	Nebraska	Utah
Hawaii	Nevada	Vermont
Idaho	New Hampshire	Virginia
Illinois	New Jersey	Washington
Indiana	New Mexico	West Virginia
Iowa	New York	Wisconsin
Kansas	North Carolina	Wyoming

We urge you not to repeal the Prevention Fund without a plan in place to safeguard funding for public health. Thank you for your consideration. For more information, please do not hesitate to contact me at bsalay@tfah.org.

Sincerely,
Becky Salay
Director of Government Relations

Trust for America's Health Trust for America's Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. www.healthyamericans.org

New Health Care Repeal bill threatens Medicaid and IHSS

IHSS provider Rose Montano and her daughter Nicolette

Earlier this year UDW and working people across the country stood up and successfully stopped multiple health care repeal bills. We protected IHSS and Medicaid from cuts that would harm our clients and loved ones. The message sent to Congress was millions of voices strong: **Protect Medicaid**. Don't cut our care.

Now they need to hear our voices again. Congress is working to pass a federal budget and a new health care repeal legislation that would make even worse cuts to Medicaid and home care in California. The new legislation is being rushed through Congress to beat a September 30 deadline. **We must stop it before then.**

The new proposal, known as Graham-Cassidy, will make devastating cuts to the overall Medicaid program which partially funds IHSS. In addition, the proposal will allow states to get rid of important consumer protections and essential health benefits and undermine or eliminate protections for people with pre-existing conditions. All of this adds up to potentially devastating impacts for disability services and home care in our state.

California stands to lose $35 billion per year, even more than under previous ACA repeal proposals, because Graham-Cassidy deliberately shifts resources from large, densely-populated states that embraced and implemented the ACA, to smaller, more sparsely-populated states that did not. States like California, New York, Maryland, and Massachusetts that were successful in enrolling millions of people in the marketplace and on Medicaid would face disproportionately larger cuts – intentionally and explicitly. For more information on the threats posed by Graham-Cassidy, click here.

UNITED STEELWORKERS

UNITY AND STRENGTH FOR WORKERS

Leo W. Gerard
International President

September 21, 2017

VIA EMAIL
United States Senate
Washington, D.C. 20510

Dear Senator:

On behalf of the 1.2 million active and retired members of the United Steelworkers union (USW), **I strongly urge you to oppose the last-minute Graham-Cassidy proposal** to repeal the Affordable Care Act (ACA) and radically restructure Medicaid. As with prior votes to repeal the ACA this year, this agreement will adversely affect every American's health insurance benefits including workplace plans, Medicare, Medicaid, and the individual market. Estimates conclude that tens of millions of Americans will be uninsured under these proposed policies.

Most of our members are covered under employer-negotiated insurance plans. However, the Graham-Cassidy proposal **removes the employer-mandate** included in the Affordable Care Act. This dramatically changes the incentive and landscape for employer-sponsored insurance, which threatens the system that provides insurance for millions of hard-working Americans.

The Graham-Cassidy proposal would eliminate the individual mandate and convert the marketplace tax credits and Medicaid expansions into block grants while also imposing per capita caps for the traditional Medicaid program. This will put enormous strain on state budgets and undoubtedly lead to increased costs to Americans in the form of premiums, deductibles, and other cost-sharing. These cuts will also hurt those who rely on Medicaid, like the elderly, people with disabilities, and millions of children.

Additionally, this proposal will remove safeguards for Americans that guarantee essential health benefits and protect those with pre-existing conditions. By putting these decisions in the hands of states, Senators Graham and Cassidy would render these protections meaningless and put health care out of financial reach for many working Americans and their families, like the Link family. We urge you to watch the video story of Ryan and Nathan Link, an Ohio father and young son with a rare genetic disorder that mutates the tumor-blocking genes. The video is at https://youtu.be/4J_wpOxm6hY

This proposal is not about good health care policy. It is about politics. Multiple hearings were not held, and no effort has been made to move this bill through regular order to receive public input. Senators are not even seeking provisions to provide emergency funding to deal with the opioid crisis, as they have in past iterations of ACA repeal.

The framework of this proposal does not reduce costs or make it easier for Americans to get health insurance and access to quality care—in fact, this bill would make those problems worse. It is a last ditch, partisan effort to repeal the ACA. We urge the Senate to reject this bill and work towards a bipartisan proposal to stabilize the health insurance marketplace and reduce costs to American families.

The Graham-Cassidy proposal is a harmful piece of legislation that does not solve the problems in our current health insurance system and will cause millions to lose insurance coverage. **The United Steelworkers <u>strongly</u> opposes it and we urge you to vote "NO" on this harmful legislation.**

Sincerely,

Leo W. Gerard
International President

LWG/cdk

VoteVets.org
Country. Service. Action.

Hon. Lindsay Graham
United States Senate
290 Russell Senate Office Building
Washington, DC 20510

Hon. Bill Cassidy
United States Senate
520 Hart Senate Office Building
Washington, D.C. 20510

September 20, 2017

Dear Senator Graham and Senator Cassidy,

America's veterans make tremendous sacrifices to defend our nation. They deserve the best access to health care and at the lowest cost. However, we are writing to express our alarm and concern with the current "Graham-Cassidy" proposal and the devastating consequences it will have on America's veterans. By dramatically cutting the Medicaid program and repealing Medicaid expansion, the Graham-Cassidy proposal breaks America's promise to provide health care to America's veterans.

Instead of expanding coverage and lowering costs, this proposal will strip critically-needed health care coverage away from veterans who rely on the Medicaid program. In fact, one in ten veterans rely on Medicaid as a source of health coverage. These 1.75 million Americans – many of whom have disabilities and chronic health conditions as a result of their service – count on Medicaid for comprehensive, affordable health care. The Medicaid expansion has provided health care coverage to 340,000 veterans nationwide in states that chose to expand Medicaid. Thanks to the expansion of Medicaid, the uninsured rate among veterans is down 42 percent. The Graham-Cassidy proposal undermines all of these coverage gains.

We urge you in the strongest possible language to stop consideration of the current Graham-Cassidy proposal and return to bipartisan solutions to serve America's veterans. The heroic Americans who defend our nation should not be subject to attacks on their health care. Graham-Cassidy breaks our nation's promises to veterans.

Sincerely,

Jonathan Soltz
Chairman

March 7, 2017

Dear Members of Congress,

We, the undersigned faith organizations and members of the Washington Interreligious Staff Community (WISC), write to urge that any change, repeal, or repair of the Patient Protection and Affordable Care Act (ACA) include comprehensive health care legislation in a single bill that meets our ten priorities for a faithful health care system.

While we come from different faith traditions, these priorities arise from a shared commitment to a faith-inspired moral vision of a health care system that offers health, wholeness, and human dignity for all. The scriptures of the Abrahamic traditions of Christians, Jews, and Muslims, as well as the sacred teachings of other faiths, understand that addressing the general welfare of the nation includes giving particular attention to people experiencing poverty or sickness. For their sake and for the common good, we must continue to make progress toward a U.S. health care system that is inclusive, equitable, affordable, accountable, and accessible for all. Rooted in faith, we ask that health reform:

1. Uphold the purpose of Medicaid by refraining from structural changes to how the program is funded. Changing the funding structure to a block grant or per capita cap would impose rigid limits on the amount of federal money available to states for Medicaid, endangering the health and well-being of children, older adults, people with disabilities, and their families.
2. Preserve the funding for Medicaid expansion and expand the program in all states.
3. Preserve the coverage gains made by the ACA and further decrease the number of Americans without health insurance.
4. Ensure that reasonable revenue is in the federal budget to pay for health care for all.

5. Ensure that insurance premiums and cost sharing are truly affordable to all. Policies to improve affordability must prioritize those with the greatest need, not those with the means to put money in a health savings account or wait for tax deductions.

6. Maintain health services and benefits currently provided by the ACA including access to essential medicines, mental health services, preventive services, pre-natal services, and other key services necessary to maintain health.

7. Maintain guaranteed issue for those with pre-existing conditions. Do not quarantine the millions of Americans with pre-existing conditions in unaffordable high risk insurance pools.

8. Prevent insurance companies from discriminating against women, the elderly, and people in poverty.

9. Create effective mechanisms of accountability for insurance companies and not allow them to have annual or lifetime caps on expenditures.

10. Continue to allow children under the age of 26 to be covered by their parents' insurance.

We must point out that the proposals and talking points to date fall far short of these priorities. Failure to meet these criteria will result in grave consequences for our communities, especially the most vulnerable in our society. The Congressional Budget Office estimated that repealing the ACA without a replacement ready would cause 32 million more people to go uninsured, with premiums doubling by 2026.[1] Piecemeal replacement ideas have been proposed that might mitigate the harm for some, but for many these tax credits, health savings accounts, and state innovation grants will be no substitute for quality, affordable insurance coverage.

Before committees markup legislation to repeal parts of the ACA, the millions of people who could be affected deserve proof of a comprehensive replacement plan that would protect their access to coverage. Changes to the ACA or Medicaid will impact the health of millions of Americans.

Therefore, it is imperative that any proposal be deliberated through a transparent process that includes public hearings and analysis from non-partisan experts such as the Congressional Budget Office before any vote takes place.

Proposals to cut Medicaid funding by radically changing the funding structure into a block grant or per capita cap are particularly concerning to people of faith. These reforms would threaten Medicaid and endanger the millions of senior citizens, people with disabilities, people with long-term care needs, people experiencing poverty, and children who benefit from Medicaid. States would face impossible budget decisions, jobs will be lost, and the program will be less responsive to the needs of the people. Rationing care for those who need it most while giving large tax breaks to the wealthiest families is not just bad policy for a healthy, thriving nation; it also directly contradicts the values of our faith traditions.

We see this moment as a decision point for the kind of country and society we want to be. Are we a society which leaves people experiencing hard times out in the cold, or are we our sisters' and brothers' keepers? Beyond these abstract moral consequences, however, we know that ACA repeal would have very real, life-or-death consequences for people experiencing illness and poverty in our nation. Stories of constituents and members of our faith communities remind us that lives are at stake. **We must NOT return to a health system where**

- the 27% of people under the age of 65 with pre-existing conditions are uninsurable,
- essential health services like pre-natal care are difficult to find and prohibitively expensive,
- half the population can be charged more for health insurance on the basis of their gender,
- health is a privilege for the few rather than a right bestowed upon all by a loving Creator.

We urge you to reject any proposals that do not meet our faith-inspired criteria. Legislation must meet these ten priorities to extend coverage and make health care more affordable and accessible. Millions of Americans and their communities of faith are counting on you to advance a moral vision of health, wholeness, and human dignity for all.

Sincerely,

Adorers of the Blood of Christ, US Region

Alliance of Baptists

American Muslim Health Professionals

Angels Everywhere

Auburn Seminary

Bread for the World

Church of the Brethren Benefit Trust

Congregation of Notre Dame Justice and Peace Office of the American Provinces

Congregation of Our Lady of Charity of the Good Shepherd, US Provinces

Disciples Center for Public Witness

Ecumenical Poverty Initiative

Evangelical Lutheran Church in America

Franciscan Action Network

Franciscan Peace Center

Friends Committee on National Legislation

Islamic Society of North America

Ladysmith Servite Sisters

Leadership Conference of Women Religious

Leadership of the Sisters of Charity, BVM

Leadership Team of the Felician Sisters of North America

Medical Mission Sisters

Mennonite Central Committee U.S. Washington Office

Methodist Federation for Social Action

National Advocacy Center of the Sisters of the Good Shepherd

National Council of Churches

National Council of Jewish Women

NETWORK Lobby for Catholic Social Justice

Office of Social Justice: Christian Reformed Church

Our Lady of Victory Missionary Sisters

Pax Christi USA

Presbyterian Church U.S.A.

Reformed Church in America

Religious Institute

Sisters of Charity, BVM

Sisters of Mercy of the Americas' Institute Justice Team

Sisters of St. Joseph of Carondelet

Sisters of the Holy Cross

Sisters of the Humility of Mary

Society of St. Vincent de Paul, Council of the United States

Stuart Center for Mission, Educational Leadership and Technology

Union for Reform Judaism

Unitarian Universalist Association

Unitarian Universalist Women's Federation

United Church of Christ, Justice & Witness Ministries

United Methodist Church - General Board of Church and Society

Western Methodist Justice Movement

Women of Reform Judaism

CC: Members of the U.S. House of Representatives

Members of the U.S. Senate

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[1] Congressional Budget Office, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums* (January 2017), https://www.cbo.gov/publication/52371.

Graham-Cassidy Would Decimate Young Adults' Health Care

September 20, 2017

Last week, a group of Senate Republicans unveiled their latest attempt to repeal the Affordable Care Act and strip millions of Americans of their health care coverage. Graham-Cassidy, named after its primary sponsors in the Senate, is even worse than its predecessor repeal plans and would devastate young adults' health care. Young Invincibles urges members to vote NO on the Graham-Cassidy amendment.

How Graham-Cassidy Hurts Young Adults:

- **Graham-Cassidy slashes federal health care funding.** New Census numbers reveal that more than 9.3 million young adults have gained coverage since passage of the Affordable Care Act (ACA) — thanks in large part to new federal funding for health care dedicated to premium tax credits for low- and middle-income consumers and Medicaid expansion. And millions more could be eligible for coverage if all states expanded their Medicaid programs. Graham-Cassidy would cut federal health care funding by 34 percent between 2020 and 2026; in 2027, all federal funding for Medicaid expansion and financial assistance through the marketplaces would be eliminated entirely. Another analysis of the amendment by Avalere Health finds that federal health care spending would fall by $4 trillion over the next two decades.
- **It would end Medicaid as we know it.** The Medicaid program is a critical lifeline for young families, as it covers care for half of all births and more than a third of all

children. Graham-Cassidy would end the Medicaid program as we know it by converting the program's guaranteed funding to a limited,per capita cap funding model. This would force states to cut millions from their Medicaid coverage, cut access to essential services, raise taxes, and/or lower provider reimbursement rates. Furthermore, this fundamental change would hamstring states in being able to respond to public health emergencies like a Zika outbreak or natural disasters similar to those that have recently ravaged states like Texas, Florida, and Georgia.

- **It guts protections for people with pre-existing conditions.** Prior to the ACA, more than a third of young adults had conditions that exposed them to being denied coverage by insurers. The ACA not only banned insurers from denying coverage to people with pre-existing conditions, but it also prevented them from charging people with pre-existing conditions more for coverage. Graham-Cassidy would allow states to waive these protections and subject people with pre-existing conditions to higher costs for their coverage. For example, if you have asthma, you could face a premium surcharge of $4,340. Consumers who are pregnant or have metastatic cancer could face even higher surcharges of $17,320 and $142,650 respectively.
- **It would end the ACA's Essential Health Benefits.** Graham-Cassidy would also allow states to waive the ACA's Essential Health Benefits (EHBs) that ensure policies cover basic health care services like maternity and newborn care, mental health and substance use disorder services, and preventive services. These services are both highly valued and utilized by young people. Waiving these benefits opens the back door to allowing states to discriminate against people who need health care services by forcing them to pay more out of pocket for the health care services they need. Eliminating EHBs could also allow

insurers to impose more annual and lifetime limits on coverage and shifting costs to consumers.

- **The amendment defunds Planned Parenthood.** Millions of young people rely on Planned Parenthood to access basic health care services like preventive care, including immunizations, cancer screenings, and contraception. Graham-Cassidy would single out Planned Parenthood by prohibiting it from receiving Medicaid reimbursement dollars for administering care. Defunding Planned Parenthood could lead to more unintended pregnancies, higher maternal mortality rates, and missed diagnoses that could help catch and treat diseases before they become more serious.

Why the Senate Must Abandon Graham-Cassidy NOW:

- **No CBO score, no vote.** The Senate will not have a CBO score outlining the amendment's full impact before members are being asked to vote. It is reckless for the Senate to vote on legislation that will reorder the health care system without a comprehensive analysis of how the bill will impact Americans' access to health coverage, consumers' premiums and out-of-pocket costs, and protections for people with pre-existing conditions.
- **Funding for essential health programs could lapse.** Congress has until September 30, 2017 to reauthorize funding for several crucial health programs, including the Children's Health Insurance Program (CHIP), Community Health Centers, and Medicare programs that support rural hospitals and patients. However, if Congress prioritizes passing its partisan Graham-Cassidy amendment over these essential programs, funding for these programs will lapse. As a former Senate staffer and professor at Georgetown Center for Children and Families put it: "There are only [now 10] days left in September, and there

are even fewer legislative days. The Senate will have a short week this week and next to observe Rosh Hashanah and Yom Kippur, limiting the total number of legislative days between now and the end of September to six at the most... it is highly unlikely if not impossible to move forward on two completely different paths [repeal and reauthorizing CHIP] and come to any productive resolution in the span of six legislative days."

- **Give bipartisan efforts in the Senate a chance.** Earlier this month, the Senate Health, Education, Labor & Pensions (HELP) Committee held bipartisan hearings on ways to reduce insurance premiums and stabilize the health insurance markets. At these hearings, liberal and conservative experts alike called on Congress to make Cost-Sharing Reduction (CSR) payments to insurers that help reduce out-of-pocket costs for low- and middle-income consumers and prevent a 20 percent spike in premiums next year. This week, Democratic and Republican Governors wrote a joint letter pleading with the US Senate not to consider Graham-Cassidy and give a chance to the bipartisan efforts in the Senate to stabilize the individual insurance market. They wrote: "legislation should receive consideration under regular order, including hearings in health committees and input from the appropriate health-related parties."

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Reid Setzer
Government Affairs Director
YOUNG INVINCIBLES
1411 K St., Suite 400
Washington, DC 20005
Tel 609-379-0123 (Mobile)
@younginvincible

September 18, 2017

The Honorable Mitch McConnell The Honorable Charles Schumer
Senate Majority Leader Senate Minority Leader
United States Senate United States Senate
Washington, DC 20510 Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

Prevention Institute—a national nonprofit organization dedicated to fostering health, safety, and equity by taking action to build resilience and to prevent problems *in the first place*—wishes to express our strong opposition to the Graham-Cassidy 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 the Senate to heed the voices of the American public and those from the public health and healthcare community by pursuing bipartisan strategies that will strengthen—rather than undermine—access to high quality, affordable healthcare and a robust public health infrastructure.

Our strength and vitality as a nation depends on the health and resilience of our communities. Eliminating the Prevention Fund would halt and potentially reverse life-saving gains made by communities across the country in tobacco use prevention, healthy eating, active living, and immunizations, among other local efforts to improve community health and wellbeing and address the leading causes of illness and injury. Eliminating the Prevention Fund would cut the Centers for Disease Control and Prevention's (CDC) budget by 12 percent, crippling their efforts to maintain the public's health, and slash $15.1 billion in current and future public health funding (FY19-FY28).

We cannot afford to unravel the progress we've made as a country to expand healthcare coverage and invest in community health and wellbeing. More than 580 organizations have already expressed their opposition to repealing the Prevention Fund. We urge you to oppose this legislation and all future attempts to repeal the ACA and eliminate the Prevention and Public Health Fund.

All the best,

Sana Chehimi, MPH
Director, Prevention Institute
Putting **prevention** and **equity** at the center of **community well-being**
1301 Connecticut Ave NW #200
Washington, DC 20036
Direct: (510) 681-3534

CC: Members of the United States Senate

POCIL statement on Graham-Cassidy-Heller-Johnson ACA repeal plan

Protect Our Care Illinois calls on all members of the Senate to immediately reject the Graham-Cassidy-Heller-Johnson ACA Repeal plan introduced today. This latest ACA repeal bill is a huge step backwards just at a time when Congress was beginning to look for bipartisan solutions to help all Americans have access to affordable health care coverage. These four Senators are moving in opposition to the will of the American people and in contravention of the advice of their fellow Republican governors and colleagues who have been testifying and participating on the Senate HELP Committee this week to stabilize insurance markets and protect coverage gains.

The news this week that the uninsured rates across the country continue to fall is encouraging but we must remain vigilant and not again entertain dangerous proposals such as this one that would eliminate the ACA tax credits and end the Medicaid Expansion (shown to be the primary coverage vehicle impacting the uninsured rate). It would also drastically limit Medicaid funding for seniors, children and people with disabilities. Now is the time to work together – not to go back to partisan, unpopular and dangerous proposals to end coverage that is working and needs to be supported not destroyed.

Senate Will Vote NEXT WEEK to Repeal the Affordable Care Act

As you've likely read, the Senate is once again trying to pass legislation that would dramatically alter the Affordable Care Act and cause tremendous harm to people with disabilities on Medicaid.

The Senate is rushing to pass the Graham-Cassidy (H.R. 1628) proposal NEXT WEEK. Because of a previous agreement, the Senate would need just 50 votes to pass the bill before September 30, but would require 60 votes beginning on October 1. Therefore, it's vital that we tell the Senate TODAY to stop this devastating legislation.

Among other things, the bill would:

Cut protections for people with preexisting conditions (including most disabilities). Under Graham-Cassidy, insurers could not refuse to cover someone because of a preexisting condition, but they would be able to make coverage so expensive that many individuals simply couldn't afford it.

Drastically reduce federal funding for health care. Graham-Cassidy would eliminate both the employer and the individual mandate, though states would have a system to reinstate them. Graham-Cassidy would also eliminate federal funding for ACA marketplace subsidies and the Medicaid expansion, replacing it

with one block grant to the states – a block grant that would gradually reduce, then effectively end federal funding of Medicaid by 2026.

Cut Medicaid Even Further. Graham-Cassidy contains language from the Senate's previous repeal bills: a per capita cap on federal funding for Medicaid. While the federal government currently pays a percentage of a state's Medicaid costs, starting in 2020 it would pay a fixed amount for each Medicaid enrollee, regardless of what it actually costs to cover them.

Leave Millions Uninsured. While it's unclear how many the proposal would leave uninsured (the Congressional Budget Office is unable to "score" the bill prior to the Senate's September 30 deadline for passage), but it's clear that, given it's similarity to previous repeal attempts, it would do just as much damage.

People with disabilities account for 15 percent of total Medicaid enrollment and 42 percent of program spending due to their greater health needs and more intensive care requirements. And Medicaid has resulted in years of slow but steady progress in expanding access to community life for people with disabilities. Slashing Medicaid funding would torpedo this progress.

The entire disability population is at risk , which is why we need our advocates to share their concerns and perspectives with legislators by explaining how Medicaid cuts would have a devastating impact to the health, independence and quality of life of individuals with disabilities.

Please send a message to your Senators TODAY urging them to vote against any bill that doesn't protect people with disabilities. Simply add your information at the right to send your message. The process will take only a few minutes, but it will have a life-saving impact.

Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

September 22, 2017

Commentary: Cassidy-Graham Would Create Huge Funding Inequities Across States

By Judith Solomon

In pitching their bill to repeal the Affordable Care Act (ACA) as an effort to "equalize" treatment among states, Senators Bill Cassidy and Lindsey Graham repeatedly note that California, Maryland, Massachusetts, and New York receive a combined 37 percent of federal funding for the ACA's Medicaid expansion and marketplace subsidies.[1] They claim that that this means the ACA treats other states unfairly and that their plan, which would replace funding for the expansion and subsidies with a temporary block grant and impose a per capita cap on Medicaid as a whole, would do better. They're flatly wrong on both counts.

Those four states account for 37 percent of the *funding* for the Medicaid expansion and marketplace subsidies because they account for 32 percent of the *people* enrolled in the expansion or receiving subsidies and because they have higher-than-average health care costs.

It's Cassidy-Graham that would create huge inequities and turn federal support for health coverage into a zero-sum game. Under the ACA, states that haven't adopted the Medicaid expansion could decide at any time to do so (as Louisiana did in 2016), drawing down additional federal funds to cover more low-income people without affecting other states. Cassidy-Graham, in contrast, would raise funding for non-expansion states by imposing huge funding cuts — and thereby forcing coverage losses — on expansion states.

Cassidy-Graham's notion of equity has two big problems:

1. It Confuses Equal Dollar Funding Across States With Equitable Treatment of Vulnerable People in Different States

Equalizing funding based on the number of state residents with incomes between 50 and 138 percent of the poverty line, as Cassidy-Graham purports to do, doesn't lead to equitable outcomes. That's because states differ widely in living costs, medical care costs, competition among insurers and health care providers, extent of job-based coverage, urban or rural status, and policies over how

[1] "Graham-Cassidy-Heller-Johnson: Frequently Asked Questions," https://www.cassidy.senate.gov/imo/media/doc/GCH%20FAQs%20Final.pdf.

to provide coverage and in what amount (including the decision whether to expand Medicaid). And states hit hard by the opioid epidemic face higher health care costs as a result.

Senators Cassidy and Graham repeatedly claim their bill would allow states to respond to "the unique health care needs of the patients in each state."[2] Actually, the *current* system does just that. It allows states to respond to residents' needs by raising federal Medicaid funding and marketplace subsidies when need rises, as in a recession or natural disaster. Cassidy-Graham's block grant, with its fixed and arbitrary state allotments that would end after 2026, would not.

2. It Uses "Equity" as an Excuse for Cuts

Cassidy-Graham would cut funding by $243 billion between 2020 and 2026, compared to what states would need to maintain the Medicaid expansion and marketplace subsidies under current law. And it would distribute that money *without regard to a state's current coverage levels and spending*, deeply cutting funding to states that have expanded Medicaid and raising funding to states that haven't. States like Florida and North Carolina, which have enrolled large numbers of people in the marketplace but haven't expanded Medicaid, would also be hurt disproportionately.

Cassidy and Graham claim the block grant would give states "flexibility," allowing them either to maintain the coverage available under the ACA or try alternative approaches.[3] But for most states, any "flexibility" under Cassidy-Graham would be unwelcome flexibility to cut coverage. Every expansion state would see a cut in 2026 due to the block grant and per capita cap.[4] Meanwhile, all but four non-expansion states (Florida, Maine, North Carolina, and Wyoming) would see net increases in federal funding. *All* states would see large, net federal funding cuts starting in 2027, when the block grant disappeared entirely and the cuts under the per capita cap continued growing.[5]

States couldn't use the block grant to continue the Medicaid expansion because Cassidy-Graham repeals the statutory authority for expansion.[6] Instead, states would have to figure out how to continue coverage for the expansion population — and continue marketplace subsidies — with less money. They likely couldn't raise their own spending enough to offset the lost federal funds, so large coverage losses are likely. And by prohibiting states from using Medicaid — which is more efficient

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[2] "Read About Graham-Cassidy-Heller-Johnson," https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson.

[3] "Senators Introduce Graham-Cassidy-Heller-Johnson," September 13, 2017, https://www.cassidy.senate.gov/newsroom/press-releases/senators-introduce-graham-cassidy-heller-johnson.

[4] Jacob Leibenluft *et al.*, "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market," Center on Budget and Policy Priorities, revised September 20, 2017, https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.

[5] Edwin Park and Matt Broaddus, "Cassidy-Graham Plan's Damaging Cuts to Health Care Funding Would Grow Dramatically in 2027," Center on Budget and Policy Priorities, revised September 20, 2017, https://www.cbpp.org/research/health/cassidy-graham-plans-damaging-cuts-to-health-care-funding-would-grow-dramatically-in.

[6] Jessica Schubel, "Cassidy-Graham Would End Medicaid Expansion in 2020, Leave Millions of Low-Income Adults Uninsured," Center on Budget and Policy Priorities, September 19, 2017, https://www.cbpp.org/blog/cassidy-graham-would-end-medicaid-expansion-in-2020-leave-millions-of-low-income-adults.

and less expensive than private coverage — to maintain the Medicaid expansion, Cassidy-Graham would raise per beneficiary costs.

Moreover, since the block grant wouldn't grow to reflect increased need, states would likely end up capping enrollment for any coverage program they created.

Cassidy-Graham does provide a great deal of flexibility to most *non*-expansion states. They'd get more federal funding, with no strings and little accountability, and they wouldn't have to use it to provide coverage at all. Many of the states that would see big funding increases have large numbers of poor residents in a "coverage gap," with incomes too high for Medicaid but too low to qualify for marketplace subsidies, because the state didn't expand Medicaid. To the extent they now get less money per low-income individual than expansion states, it's because the state *chose* not to expand. There's no reason to believe these states would use newly available block grant funds to cover uninsured adults they *could have* covered through Medicaid under current law when they could instead use the funds to replace other state spending or for other health-related purposes. Moreover, all states would think twice before creating new programs they might not be able to sustain after 2026, when the block grant would disappear.

Sandusky County Citizens for Affordable Healthcare Statement on Graham-Cassidy:

I can think of no morally defensible reason why Republicans in the U.S. Senate are persisting in their tone-deaf efforts to repeal the Affordable Care Act and replace it with a cruel and senseless bill that would undermine the ACA's protections and force massive cuts in the funding that's available for health care programs across the country.

Consumer groups, governors, health care providers and even insurance companies are adamantly opposed to the GOP measure. In fact, the only ones who seem to favor it are Republican politicians – many of whom freely admit they haven't even read the so-called Cassidy-Graham bill. Yet those pols are so desperate to deliver on their rabid campaign pledges to "repeal and replace Obamacare" that they're willing to race ahead and vote for something, ANYTHING, to accomplish that, even if it means devastating consequences for tens of millions of Americans, many of them right here in Ohio.

But I guess those consequences don't matter much as long as those distinguished politicians can say they repealed Obamacare – even if they end up replacing it with a steaming pile of ... block grants.

Mike Kelly

(Mike Kelly of Fremont is a member of the Sandusky County Citizens for Affordable Healthcare.)

SGIM
Society of General Internal Medicine
Creating Value for Patients

September XX, 2017

The Honorable Mitch McConnell
Majority Leader
U. S. Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
U. S. Senate
Washington, DC 20510

Dear Senate Leaders:

On behalf of the Society of General Internal Medicine, I am writing to express our deep concerns with the latest attempt to repeal and replace the Affordable Care Act (ACA), the Graham-Cassidy bill, that is about to be voted on by the Senate.

SGIM is a national medical society whose mission is to lead excellence, change and innovation in clinical care, education and research in general internal medicine. As physicians, educators and researchers, we take seriously our responsibilities as stewards of the public's health. As such, we have grave concerns with the Graham-Cassidy proposal or any similar legislation that fails to meet the basic thresholds of insurance coverage, including:

1. Ensuring that access to healthcare is a fundamental right ofall Americans;
2. Guaranteeing that any changes to the Affordable Care Act (ACA) maintain or increase the number of Americans with health insurance;
3. Ensuring that Medicaid remains available to any individual who currently meets eligibility criteria and that cost-sharing in Medicaid does not increase;
4. Continuing access to evidence-based, affordable preventive services and immunizations, including full coverage of services rated A or B by the U.S. Preventive Services Task Force, with no cost-sharing;
5. Providing access to mental health and addiction treatment services, consistent with those afforded by the ACA; and
6. Preserving the patient protections contained in the ACA, including prohibitions against preexisting conditions exclusions and the retroactive denial of coverage as well as eliminating lifetime and annual coverage limits.

1500 King Street • Suite 303 • Alexandria • VA 22314
Tel. 202.887.5150 • 800.822 3060 • Fax: 202.887 5405
Web: http://www.sgim.org

SGIM
Society of General Internal Medicine
Creating Value for Patients

As currently written, the Graham-Cassidy legislation fails to meet the core principles outlined above, weakening rather than strengthening the health of the nation and adversely affecting our patients in many serious ways.

We strongly urge you to adopt health care legislation that will decrease the number of uninsured Americans and will ensure that all Americans will be able to receive affordable care, like that currently being developed by Senators Lamar Alexander and Patty Murray, to stabilize the individual insurance market.

Sincerely,

Thomas H Gallagher

Thomas H. Gallagher, MD
President, Society of General Internal Medicine

1500 King Street • Suite 303 • Alexandria • VA 22314
Tel. 202.887.5150 • 800.822.3060 • Fax 202.887 5405
Web. http://www.sgim.org

STATEMENT FROM GOVERNOR SANDOVAL ON GRAHAM-CASSIDY-HELLER AMENDMENT

Contact

Mari N. St. Martin
Communications Director
(775) 684-5670

CARSON CITY, NV - September 19, 2017

Governor Brian Sandoval today issued the following statement on the Graham-Cassidy-Heller amendment.

"I know that Senator Heller is working in the best interest of the state and I appreciate the intended flexibility created in the Graham-Cassidy-Heller amendment which would distribute healthcare funding via block grants. State experts will continue to work with our federal partners, specifically with Senator Heller's office, on ideas to improve Nevada's healthcare market. I continue to believe the framework authored by bipartisan Governors is the best path to improve our healthcare system but will continue to work with Senator Heller on healthcare solutions for the state of Nevada."

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Statement from People for Peace and Justice Sandusky County.

People for Peace and Justice Sandusky County supports healthcare for all people who live in our country. We urge the Senate to reject the Graham-Cassidy bill, because it will harm many of our fellow Ohioans.

We are concerned for Mark who lives in Fremont and works full time as a security guard checking the trucks in and out of the guard house at a local plant. He is paid so little that he could not afford healthcare until he was able to get Medicaid under Ohio's Medicaid expansion program. He is alive today, because of Medicaid. Earlier this summer, he developed an auto-immune disorder that attacked his platelets and left him in danger of bleeding to death. Luckily he was able to get the same treatment at University of Toledo Medical Center that any U.S. Senator would get. And it saved his life! Under Graham-Cassidy, not only would he be at risk of losing his Medicaid, but his pre-existing condition could make his insurance rates skyrocket totally out of his reach.

We are concerned for Paulette, a widow who lives in Medina. At the age of 62 she retired from the factory. Her employers expected her to do the same lifting and work at the same speed as she did when she first entered that factory at the age of 30. Yet her body was wracked with arthritis after so many years of strenuous work. Because of the ACA and its cost sharing program, she could afford healthcare after her retirement. She has not been sleeping well after she learned Congress might take her healthcare away. Graham-Cassidy will put healthcare out of her reach.

Then there's Kate, a single mom from Sandusky County who struggles with an opioid addiction and works hard to be a good mom to her 5 year old son. The addiction is tough, but at least Medicaid provides her with the healthcare to help her beat this addiction. Her whole family is worried sick about what will happen to her under Graham-Cassidy. Does the U.S. Senate even think about what will happen to people like her?

Will the U.S. Senate take healthcare away from these people that we care about? Will senators tell us they can't afford to help these deserving people at the same time that they throw money at warmaking with great abandon and propose huge tax cuts for the rich in discredited supply side schemes?

Ohioans have found out what humane healthcare looks like, and we won't accept less. People for Peace and Justice Sandusky County asks the U.S. Senate to reject Graham-Cassidy and turn its attention to providing real healthcare for all.

Statement from Project Peace in Ohio:

In the name of Project Peace--Imagining a World without War, I write to ask you to please oppose the healthcare bill --Graham-Cassidy.

From every person I know with Project Peace---about 400 people ---there is no one who would vote to put this bill into place. To reject healthcare for 32,000,000 people is abominable.

I trust you will follow your conscience.

much good to you.

sr. Paulette Schroeder, osf/Tiffin, OH

Statement from Robert Wood Johnson Foundation President and CEO Richard Besser, MD, on Potential Impact of the Graham-Cassidy-Heller-Johnson Legislation September 21, 2017

The following statement is in response to the Senate's most recent proposed legislation to repeal the Affordable Care Act. The Robert Wood Johnson Foundation has worked for more than 40 years to ensure that everyone in America has access to affordable, high-quality health care.

"We believe that everyone in America should have access to high-quality, affordable, comprehensive health care. The United States Senate may consider legislation as early as next week that could result in dramatic damage to the nation's health care safety net. This is simply bad for health.

While the Congressional Budget Office has not fully analyzed the Graham-Cassidy-Heller-Johnson bill, we believe that the caps on benefits, and significant reductions in funding for Medicaid benefits and insurance subsidies proposed in the new legislation will likely result in millions of people in America losing access to affordable coverage. Medicaid is one of the most important ways that our country keeps health care affordable

and accessible for approximately 69 million Americans, including children, pregnant women, low-income and elderly adults, and people with disabilities.

Further, this proposal could eliminate important protections for those with pre-existing health conditions, and weaken the requirement that insurers cover essential health benefits like emergency services, maternal and newborn care, and pediatric care. Finally, the proposed caps to the Medicaid program could also erode care for the disabled, frail elderly and children, along with low-income adults.

This is not the right future for our country.

We support a bipartisan approach to finding solutions that will ensure everyone in America has a fair and just opportunity to access affordable care. As always, the Robert Wood Johnson Foundation stands ready to work with others to help achieve that goal."

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

For Immediate Release: September 18, 2017
Contacts: Office of the Governor: Brian Coy, (804) 225-4260, Brian.Coy@governor.virginia.gov

Governor McAuliffe Statement on Proposed Cassidy-Graham Health Care Legislation

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RICHMOND – Governor Terry McAuliffe released the following statement today in response to the health care legislation introduced by Senators Cassidy and Graham:

"The Senate Republican's latest effort to repeal the Affordable Care Act would have the exact same disastrous consequences for Virginia's families as the previous versions that they tried to ram through earlier this year. This legislation, like the earlier iterations, was not designed to make health care better. It is nothing more than a tax cut for the rich and a poorly disguised cost shift from the federal government to the states and families.

"Once again, middle-class families, seniors, and women suffer the most as premiums will skyrocket and Medicaid will be slashed. This bill re-introduces policies that gut protections for individuals with pre-existing conditions and no longer requires insurers to provide essential service coverage. And it goes further by slashing funding to states for marketplace tax credits and cost-sharing reductions on the way to zeroing them out completely after 2026.

"This backdoor effort to force through legislation without waiting for a CBO score or even holding as much as a single hearing is totally unacceptable. Our estimates is that this will be a $1.2 Billion cut to Virginia's Medicaid program. I urge the Senate Republicans to stop undermining our economy and health care system and instead to work together in a transparent and bipartisan manner to fix the existing issues with the ACA."

AHCA®
AMERICAN HEALTH CARE ASSOCIATION

NCAL®
NATIONAL CENTER FOR ASSISTED LIVING

For Immediate Release
September 19, 2017

Contact: AHCAPressOffice@ahca.org
(202) 898-2814

Long Term Care Profession Urges Senate to Oppose Graham-Cassidy Repeal and Replace Bill

Washington, D.C. — The American Health Care Association/National Center for Assisted Living (AHCA/NCAL) President and CEO Mark Parkinson today issued the following statement regarding the Graham-Cassidy Bill to repeal and replace the Affordable Care Act (ACA):

"The latest effort to repeal and replace the Affordable Care Act once again tries to solve the complicated question of health care reform by slashing hundreds of billions of dollars from the Medicaid program that funds essential care for the aged and disabled.

"The Medicaid cuts proposed in the Graham-Cassidy Bill –including a reduction in provider assessments that alone will result in billions of dollars less to long term care each year – are catastrophic. Reducing provider taxes will devastate state budgets, amounting to an average additional cut of nearly $200,000 per center each year.

"Medicaid already underfunds nursing center care by $7 billion annually. Skilled nursing centers across the country operate on razor thin margins. According to the Medicare Payment Advisory Commission (MedPAC), total skilled nursing center margins are currently positive at 1.6%, while non-Medicare margins (e.g., Medicaid and commercial) are -2.0%. When combined with these Medicaid provisions, the Graham-Cassidy bill would force many nursing centers to close their doors.

"Drastic cuts to Medicaid also threaten access to home and community-based services, such as assisted living care. States may be forced to scale back these Medicaid waiver programs that offer the older adults and people with disabilities long term care in the setting best suited for their needs.

"There is no question that this bill will undermine care for vulnerable seniors and individuals with disabilities who rely on Medicaid for their daily long term care. Most of the one million people who reside in nursing centers rely on Medicaid, as well as tens of thousands of seniors in America's assisted living communities.

"As Baby Boomers increasingly need long term services and supports in coming years, our seniors deserve better than an unstable and underfunded safety net. We urge Senators to oppose this legislation and protect Medicaid access for seniors and people with disabilities."

-30-

ABOUT AHCA/NCAL

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,500 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day. For more information, please visit www.ahca.org or www.ncal.org.

The Ohio Council
Of Behavioral Health & Family Services Providers

35 E. Gay Street, Suite 401
Columbus, OH 43215
614-228-0747 • www.TheOhioCouncil.org

September 21, 2017

Lori Criss, CEO of the Ohio Council of Behavioral Health & Family Services Providers (The Ohio Council) issued the following statement opposing the Graham-Cassidy ACA repeal and replace effort and urging Senator Rob Portman to oppose it in the United States Senate.

The Graham-Cassidy ACA repeal and replace bill would have a devastating impact on Ohio's Medicaid program and the people who rely on it for access to health care and treatment for addiction and mental illness.

This proposal would block grant and cap federal funding, radically altering the Medicaid financing process, causing Ohio to end Medicaid expansion and lose $9 billion in the middle of Ohio's opioid crisis – this is unconscionable.

Simply adding opioid treatment grant funding to the bill is insufficient and misguided, and not a substitute for comprehensive health coverage. Grant funding is limited in scope, quantity and duration; when it runs out, so does the treatment. By relying on a woefully inadequate grant fund to replace lost Medicaid health coverage, Graham-Cassidy will cripple states in their efforts to fight the opioid epidemic.

Indeed, the Graham-Cassidy repeal and replace plan would likely force Ohio to cut benefits and restrict access to critical behavioral health and addiction services – reversing much of the progress Ohio has made in fighting the opiate crisis.

The Ohio Council calls on Senator Portman to oppose the Graham-Cassidy proposal and stand by his past statements that health care reform demands a deliberative and thoughtful process and that no bill should be passed without public hearings and careful examination.

We understand that changes need to be made to the current health care system and support efforts to strategically address those areas that are not working as intended – however, the Graham-Cassidy proposal is not the answer.

Senator Portman must vote no on Graham-Cassidy if it is brought to the Senate floor for a vote.

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The Ohio Council of Behavioral Health & Family Services Providers is a statewide trade and advocacy association that represents over 150 private organizations that provide alcohol and other drug addiction, mental health, and family services.

CAMPAIGN for TOBACCO-FREE Kids

1400 EYE STREET, N.W. • SUITE 1200 • WASHINGTON, DC 20005
PHONE (202) 296-5469 • FAX (202) 296-5427

September 21, 2017

United States Senate
Washington, DC 20510

Dear Senator:

We are writing to express our strong opposition to the Graham-Cassidy amendment to H.R. 1628, the budget reconciliation bill. By repealing provisions of the Affordable Care Act that have helped improve health and access to health care, the Graham-Cassidy amendment would set back progress the nation has made in reducing tobacco use and preventing deadly and costly diseases caused by tobacco use. It would, among other things, repeal funding for disease-prevention programs and likely cause tens of millions to lose health insurance coverage, including for preventive health services.

Many of the costly chronic diseases that burden our health care system are preventable. Implementing evidence-based preventive measures can reduce disease, save lives, and help rein in health care costs. Tobacco use, for example, is the leading preventable cause of death in the United States, responsible for more than 480,000 deaths each year. It is also responsible for about $170 billion in health care costs each year, with more than 60 percent of these costs paid by government programs such as Medicare and Medicaid. Implementation of evidence-based policies and programs has dramatically reduced tobacco use and the toll it takes on America's health. Since 1990, for example, about 1.3 million tobacco-related cancer deaths have been prevented because of declines in smoking.

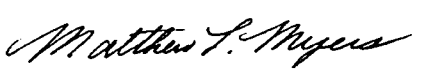
The Graham-Cassidy amendment threatens the progress that the nation has made in reducing tobacco use. The amendment would repeal the Prevention and Public Health Fund, which supports key initiatives to reduce tobacco use and other leading causes of death and disease in the U.S. Currently, about 60 percent of the funding for CDC's Office on Smoking and Health comes from the Prevention Fund. Repealing it would likely mean eliminating programs that we know are working, such as the CDC's Tips from Former Smokers (Tips) media campaign, which has motivated about five million smokers to try to quit and helped 500,000 smokers to quit successfully since its launch in 2012. Repeal of the Prevention Fund would also likely mean significant reductions in funding for state tobacco prevention programs and state quitlines, which provide tobacco cessation services and have been found to double or triple success rates in quitting compared to smokers who try to quit on their own.

The Graham-Cassidy amendment would increase the number of Americans who are without health insurance coverage, including life-saving preventive health services, likely by tens of millions. It would

also enable states to waive current requirements that insurers cover tobacco cessation services and other clinical prevention services. Nearly 70 percent of adult smokers want to quit, and smokers who use tobacco cessation services (e.g., counseling and FDA-approved medications) improve their chances of quitting successfully. But loss of health insurance and fewer covered services for those remaining insured would mean reduced access to tobacco cessation services and, ultimately, more tobacco-caused disease and premature death. People enrolled in Medicaid, who smoke at more than twice the rate of those with private health insurance (27.8 percent compared to 11.1 percent), would be disproportionately affected by the loss of coverage.

The Graham-Cassidy amendment would be a giant step backward for disease prevention and public health. We cannot afford to undermine successful efforts to reduce tobacco use and other causes of poor health. It would lead to more lost lives and higher health care spending. We urge you to oppose this bill.

Sincerely,



Matthew L. Myers
President
Campaign for Tobacco-Free Kids

September 20, 2017

The Honorable Sherrod Brown
United States Senate
713 Hart Senate Office Building
Washington, DC 20510-3505

Dear Senator Brown,

On behalf of the 150,000 registered nurse members of National Nurses United, the largest nurses' union in the United States, we urge you to oppose the Cassidy-Graham amendment to the American Health Care Act if it comes to a vote on the Senate floor.

Registered nurses care for Americans in their most difficult hours. More than any other profession, we see the personal effects of a flawed healthcare system in our hospitals every single day. Our primary responsibility is to protect the health and wellbeing of our patients by providing safe, therapeutic care at the bedside.

This amendment poses a mortal threat to the health and well-being of millions of our patients, and to the health security of our country.

This bill is even more extreme than previous attempts at repealing and replacing the Affordable Care Act. The Cassidy-Graham plan would repeal the Affordable Care Act without any meaningful attempt at replacement. Indeed, the amendment redirects the ACA's funding into a block grant program to states that would disappear entirely after 2026. While the CBO has not scored this amendment yet, it has previously estimated that such a repeal-without-replace approach would ultimately leave 32 million more people uninsured. We can expect that number to increase due to the plan's additional cuts to Medicaid.

There is not a single aspect of this legislation that will benefit our patients who already lack the comprehensive health care services that they need. Specifically, the legislation would:

- Eliminate the ACA's marketplace subsidies, which currently help 9 million people afford coverage. While earlier Republican bills made it more difficult for Americans to qualify for individual insurance subsidies, this plan eliminates *any* assistance for low- and middle-income families on the insurance markets.

- End the ACA's Medicaid expansion program, which extended coverage to 11 million low-income adults. As a result, millions of low-income Americans who depend on assistance through Medicaid expansion will lose health insurance.

- Replace the ACA's Medicaid expansion and individual insurance subsidies with a block grant program to states. These grants would:
    - Cut $239 billion in federal health spending between 2020 and 2026. The Center for Budget and Policy Priorities estimates that by 2026, the Cassidy-Graham plan would spend $83 billion less than the ACA would have spent, based on current projected funding. Because block grants would likely grow more slowly than the cost of insurance or medical care, states would see a 34 percent cut in funding, forcing them to scale back health coverage.
    - Dramatically redistribute funding across states. As a result, Medicaid expansion states would see deep cuts to federal funding of healthcare.
    - Unfairly shift the burden of costs to the states. Because block grants are fixed, states are responsible for balancing the provision of health coverage against unexpected budget pressures such as recessions, natural disasters, public health emergencies, prescription drug price spikes, and other cost pressures outside of states' control.
    - Disappear after 2026. The amendment includes the provision of block grants only through 2026, after which date tens of millions of low- and middle-income families who gain coverage through the ACA will lose health care coverage.

- Cap and cut Medicaid for seniors, people with disabilities, and families with children. In addition to the elimination of Medicaid expansion, this plan would institute per capita caps on federal Medicaid subsidies, which would grow each year more slowly than the

projected growth in state Medicaid costs per beneficiary. This would result in dramatic cuts to the program by about $175 billion between 2020 and 2026, which would reduce coverage for the most vulnerable, shift care from clinics to emergency rooms, and increase system costs for the chronically ill as they defer treatments because of cost.

- Allow individual states to opt out of regulations that require insurance companies to cover essential health benefits including maternity care, mental health, substance abuse treatment, and hospitalization. These services should be guaranteed as a basic right for all people— but this bill will mean that millions of Americans will lose access to these essential health services.

- Allow states to grant insurers the ability to deny coverage of costs associated with certain conditions, which will increase out-of-pocket costs for people with pre-existing conditions.

- Eliminate the Prevention and Public Health Fund after 2018, which will worsen the health of our communities, spread infectious disease, and increase overall health care costs.

- Defund Planned Parenthood for at least one year, which will worsen women's health, and create burdens for women, families and society from unsafe pregnancies, cancer prevention, and other health conditions that Planned Parenthood clinics will no longer be able to treat.

- Eliminate the definition of "essential benefits" – a move that makes all patients vulnerable to the distortions and marketing games of insurance companies.

- Eliminate the individual mandate, which will result in higher health insurance premiums, deductibles and copays for people with health problems that buy insurance.

- Allow insurers to charge seniors five times the amount of a younger person. This revision will prove to be deadly for our nation's seniors, and it reveals the extent to which this reform will benefit the profit margins of insurance companies, at the expense of patients' lives.

Our experience at the bedside, coupled with analysis from health policy researchers, confirm our conclusion that this bill does not address the primary concerns of our patients: getting the quality, therapeutic care they need when they need it. Indeed, there is literally nothing in this legislation that provides our patients with the care they need.

Over many years, with the notable exception of the passage of Medicare in 1965, the United States has built a patchwork health system around private insurance access for those with financial resources, rather than genuine access to health care. In order to effectively address the health system problems in this country, legislators must move beyond a private health insurance industry-dominated system. Health policy research, and the experience of every other wealthy nation, shows that a single-payer health care system is the most successful model to use. In the United States, Medicare is an example of how successful such a system can be. If the goal of our health system is to provide quality care for all Americans at the lowest cost possible, then we must transition to single payer— also known as Medicare For All.This is why our union wholeheartedly supports the Medicare-For-All Act, S. 1804, introduced by Senator Bernie Sanders and 16 Senate cosponsors.

The principal effect of the Cassidy-Graham amendment, on the other hand, will be the loss of existing health coverage for tens of millions of people without any restraints on healthcare industry pricing practices. This legislation will result in overwhelming health insecurity for the American people.

On behalf of registered nurses across the country, we urge the rejection of this flawed, and deadly, proposal. We urge you to instead support guaranteed healthcare for all, through an

improved, expanded Medicare for All program embodied in S. 1804.

Sincerely,

Deborah Burger, RN
President, NNU

Jean Ross, RN
President, NNU

Sep. 19, 2017

TOPIC: Advocacy, Featured News, Get Involved, Patients & Members, Press Releases

NORD Issues Statement Opposing the "Graham-Cassidy" ACA Replacement Plan

Posted by Christina Jensen

The National Organization for Rare Disorders (NORD), the leading independent nonprofit organization representing the 30 million Americans with rare diseases, issued the following statement opposing the "Graham-Cassidy" plan to repeal and replace the Affordable Care Act (ACA):

"The Senate is currently considering a proposal put forward by Senators Graham, Cassidy, Heller, and Johnson that would repeal and replace the Affordable Care Act (ACA). If passed, this plan (known as 'Graham-Cassidy') has the potential to jeopardize access to care for millions of individuals with rare diseases.

Once more we used our Principles for Health Coverage Reform published in February to evaluate this proposal. In doing so, we found that not only does this plan contain the same concerning aspects of the *American Health Care Act (AHCA)* and the *Better Care Reconciliation Act (BCRA)*, but it also contains additional provisions that would further allow insurers to discriminate against individuals with pre-existing conditions.

Therefore, we strongly oppose this legislation, and urge Senators to join us in opposition.

First, this legislation fails to meet several of our principles by allowing states who participate within the 'Graham-Cassidy' plan to opt out of key insurance market protections for individuals with pre-existing conditions. By allowing states to opt out of the Essential Health Benefits (EHB) requirements, this plan would bring back annual and lifetime limits, limitless out-of-pocket costs, and wholly inadequate coverage.

In addition, 'Graham-Cassidy' would also allow states to opt out of community rating requirements, thus once again permitting insurers to discriminate against individuals with pre-existing conditions. By allowing insurers to charge premiums based upon health status, 'Graham-Cassidy' would effectively price individuals with a rare disease out of the private insurance market.

Second, 'Graham-Cassidy' will cut hundreds of billions of dollars of Federal funding from the Medicaid program by instituting per capita caps. Medicaid is a critical lifeline to millions of individuals with rare diseases across the United States. Rare disease patients of all ages will be devastated, as states will likely be forced to cut eligibility, coverage, and services across the entire Medicaid population to compensate for the lost funding.

Furthermore, Federal Medicaid funding, once capped, and other Federal health funding will be block granted to states. As enumerated within our Principles, 'block granting or instituting per-capita caps can disincentivize states from covering high cost patients, adding orphan drugs to state formularies,

or covering expensive but medically necessary inpatient care, outpatient care, habilitative services, and rehabilitative services.'

The block grant formula within 'Graham-Cassidy' also is particularly disadvantageous to individuals with rare diseases living in states that provide more comprehensive coverage to Medicaid enrollees. States in the Northeast and on the West Coast could experience a particularly impactful cut in Federal Medicaid and health spending assistance.

Third, 'Graham-Cassidy' fails to meet our principle on, 'maintain(ing) long-term coverage for rare disease patients in states that chose to expand eligibility under the ACA-funded Medicaid expansion.' 'Graham-Cassidy' would phase out Medicaid expansion starting in 2020 and concluding in 2024, likely leaving many individuals with rare diseases without health insurance.

Simply put, 'Graham-Cassidy' includes most of the same problematic proposals from the AHCA and BCRA, in addition to several new provisions that jeopardize access to care for rare disease patients even further.

Instead of pursuing this legislation, we urge Senators to support the bi-partisan efforts ongoing within the Senate Health, Education, Labor, and Pensions (HELP) Committee. This effort holds the promise of stabilizing the private insurance market and expanding insurance options for individuals with rare diseases. We were pleased to offer our recommendations to the HELP Committee in August, and we will continue to collaboratively support their efforts.

As the voice for the 30 million Americans with rare diseases, we are ready to work with Congress to address the issues outlined above. However, as passage of the bill in its current form would very likely result in millions of individuals with rare diseases losing healthcare coverage, access to orphan therapies and specialists, and protections against discriminatory insurance practices, we will continue to lead the rare disease community in opposition to the 'Graham-Cassidy' legislation.

We urge both Republican and Democratic Senators to stand up for the rare disease community and reject the 'Graham-Cassidy' proposal as written."

Pulmonary Hypertension Association

Take Action: Speak Out Against Graham-Cassidy Healthcare Proposal

Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) introduced new legislation in mid-September to repeal and replace the Affordable Care Act (ACA). The Graham-Cassidy proposal is more far-reaching than other recent Senate proposals and could be devastating to people living with PH and other chronic health conditions. Specifically, the new proposal would:

- Allow insurance companies to charge individuals with pre-existing health conditions more
- Allow states to more easily opt out of requiring quality health insurance options and comprehensive benefits
- Dramatically reduce the federal commitment to Medicaid expansion

The proposal has quickly gained support and could be voted on next week. Contact your senators today and ask them to oppose the Graham-Cassidy repeal and replace proposal. Act now!

Planned Parenthood Blasts Cassidy-Graham-Heller Proposal

For Immediate Release: Sept. 13, 2017

Share This

Worst ACA Repeal Bill Yet; Proposes to Defund Planned Parenthood

Washington, DC – Planned Parenthood Federation of America strongly opposes the latest version of Trumpcare. The Graham-Cassidy-Heller-Johnson proposal is the worst ACA repeal proposal yet. Americans have repeatedly rejected every other version of Trumpcare.

The Graham-Cassidy-Heller proposal includes a provision that would block millions of people from going to Planned Parenthood for preventive care, including birth control, cancer screenings, and STD testing and treatment.

The Graham-Cassidy-Heller proposal also fails the "Jimmy Kimmel test" that Sen. Cassidy himself set as a baseline. In June, Jimmy Kimmel tweeted a reminder to Sen. Cassidy that "No family should be denied medical care, emerg or otherwise, because they can't afford it." By gutting Medicaid, the Graham-Cassidy-Heller proposal would put health care out of reach for millions of families.

Statement by Dawn Laguens, executive vice president at Planned Parenthood Federation of America:

The Graham-Cassidy-Heller proposal is the worst ACA repeal bill yet, and it is especially terrible for women.

"The Graham-Cassidy-Heller proposal would disproportionately impact low-income women and women of color.

"It blocks women from getting preventive care at Planned Parenthood. It slashes Medicaid, which 1 in 5 women of reproductive age rely on for care, including birth control and cancer screenings. It guts Essential Health Benefit protections, including maternity coverage and prescription drugs. Thirteen million women could lose coverage to maternity care under this bill. And it raises premiums on millions more by eliminating tax credits.

"With this latest version of Trumpcare, Americans will pay more and get less, but women will pay the biggest price of all.

"Graham-Cassidy-Heller, like every other version of Trumpcare, makes it harder to prevent unintended pregnancy, harder to have a healthy pregnancy, and harder to raise a family.

"Slashing Medicaid, ending maternity care, and blocking millions from getting preventive care at Planned Parenthood would result in more undetected cancers and more unintended pregnancies.

"At every step of trying to repeal the ACA, Republican leaders have chipped away at women's health and rights. The Graham-Cassidy-Heller proposal is just most of the same.

"Congress should listen to the American people, reject efforts to take away care, and focus on bipartisan fixes to expand access to care.

###

Planned Parenthood is the nation's leading provider and advocate of high-quality, affordable health care for women, men, and young people, as well as the nation's largest provider of sex education. With more than 600 health centers across the country, Planned Parenthood affiliates serve all patients with care and compassion, with respect and without judgment. Through health centers, programs in schools and communities, and online resources, Planned Parenthood is a trusted source of reliable health information that allows people to make informed health decisions. We do all this because we care passionately about helping people lead healthier lives.

President Obama statement on Graham-Cassidy bill:

" When I see those people trying to undo that hard-won progress, for the 50 th or 60 th time, with a bill that will raise costs, reduce coverage, and roll back protections for older Americans and people with pre-existing conditions ... it's aggravating, " Obama said Wednesday during a keynote speech at Goalkeepers, an event hosted by the Bill and Melinda Gates Foundation. He noted that there is no " demonstrable economic, actuarial, or even human rationale for pushing such a bill."

"The legislation that we passed was full of things that needed to be fixed," Obama said. "It was not perfect; it was better."

'Graham-Cassidy-Heller-Johnson: Another Health Care Repeal Bill That Would Devastate Women and Families'

Statement of Debra L. Ness, President, National Partnership for Women & Families

WASHINGTON, D.C. — September 13, 2017 —
"The repeal bill Senators Lindsey Graham, Bill Cassidy, Dean Heller and Ron Johnson introduced today is yet another assault on the health care women and families rely on. This bill would cause tens of millions of people to lose their insurance coverage. It would cause costs to skyrocket. It would end Medicaid as we know it and repeal the Medicaid expansion. It would allow states to waive key consumer protections and guarantees of coverage for maternity care and other essential health benefits. And it would block millions of people from getting preventive care – including birth control and screenings for cancer and sexually transmitted infections – at the Planned Parenthood health clinics they rely on for quality care.

The block grants the Graham-Cassidy-Heller-Johnson bill proposes are designed to mask deep cuts that would make health coverage less comprehensive and less affordable for millions. But we are not fooled.

It's 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. This bill would devastate women and families. It very definitely is not what the country wants or needs."

CONTACT

Lauren Sogor (202) 986-2600 **lsogor@nationalpartnership.org**
The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at ***www.NationalPartnership.org****.*

NATIONAL COALITION ON HEALTH CARE

Working Together for an Affordable Future

PRESS STATEMENT

September 21, 2017

Contact: **Terri G. Pollock**
National Coalition on Health Care (NCHC)
tpollock@nchc.org
202-638-7151, ext. 108

Graham-Cassidy Shifts Costs to States, Consumers, and Employers while Neglecting Urgent Health Priorities

Statement by National Coalition on Health Care President and CEO John Rother on the Graham-Cassidy-Heller-Johnson (GCHJ) ACA repeal proposal in light of yesterday's analysis by the independent, nonpartisan research firm Avalere

"There's urgent bipartisan work to be done right now to keep health care affordable, but this proposal just shifts more costs onto consumers, employers, and states.

"The nation needs serious, long-term solutions that actually curb the growing cost of health care and prescription drugs. But instead, this proposal merely shifts $215 billion over ten years from the federal government onto state governments and their taxpayers, according to Avalere's analysis. The magnitude of that cost-shift swells to more than $4 trillion over the next two decades. *Every state but Mississippi will see double digit reductions in federal support* for health care, compared to current law.

"States need a reliable federal partnership in order to care for a growing population of high-cost, high-need beneficiaries on Original Medicaid - special needs children, low-income seniors, the disabled, the homeless, and the addicted. But instead, this proposal's caps would impose $164 billion in Original Medicaid cuts *across all fifty states* - hamstringing state innovations that keep seniors in their homes and coordinate care for dual eligibles.

"Consumers need competitive private insurance markets with stable premiums and out of pocket costs. But instead, this proposal's repeal of tax credits and the individual mandate would further spike non-group premiums across all fifty states. The resulting instability would precipitate a chain of events - millions going without coverage, fewer receiving primary care and preventive services, and more hospitals and ERs swamped with uncompensated care. Ultimately, taxpayers, the 170 million Americans with job-based insurance, and their employers would be forced to pick up the bill.

"Right now, Congress ought to be working on bipartisan legislation to meet this month's deadlines to fund the Children's Health Insurance Program, physician loan repayment programs, and Community Health Centers. But instead, this last ditch partisan campaign to advance Graham-Cassidy is sidelining those efforts - jeopardizing health coverage for children and undermining the providers on the front line in the fight against chronic disease.

"In the strongest possible terms, NCHC implores the House and Senate to return to the search for common ground approaches to our health care affordability challenges."

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The National Coalition on Health Care (NCHC), the oldest and most diverse group working to achieve comprehensive health system reform, is a 501(c)(3) organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers and groups representing consumers, patients, women, minorities and persons with disabilities. Member organizations collectively represent – as employees, members, or congregants – over 150 million Americans.

Some members of NCHC do not, or cannot, take positions either on specific legislation, strategies or on any policies outside their respective mission areas. However, all that can, do endorse broad policy positions in support of comprehensive health system change.

Senate Health Care Reform Talking Points

September 18, 2017

Background:

On September 13, Senators Lindsey Graham (R-SC), Bill Cassidy (R-LA), Dean Heller (R-NV), and Ron Johnson (R-WI) released a new plan to repeal and replace the Affordable Care Act (ACA). This proposal is commonly referred to as Graham-Cassidy, and it must be considered by the Senate by September 30 in order to meet technical Senate rules for a 50 vote threshold.

The bill contains many of the same harmful provisions that the patient advocacy community has opposed this year throughout the repeal process.

Overarching message:

The Senate must vote "no" on Graham-Cassidy. It will lead to unaffordable insurance for people with chronic conditions and coverage that will be inadequate to meet their health care needs. Senators should instead support the efforts of Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), who are attempting to work on a bipartisan basis to stabilize the market and create long-term solutions for the health care system.

What is in Graham-Cassidy?

- **Graham-Cassidy will have a devastating impact on people with chronic conditions.**
- **People with chronic conditions will pay more for less benefit. This is unacceptable.**
- Graham-Cassidy repeals the Medicaid expansion, premium tax credits, and cost-sharing reduction (CSR) payments, and redistributes the money to the states in block grants to operate their health care programs.
    - The premium tax credits, CSRs, and Medicaid expansion are all intended to help people afford their health care.
    - The funding included in Graham-Cassidy would expire in 2026 without additional Congressional action.

- Graham-Cassidy also allows states to opt out of important protections that exist to protect people with chronic conditions.
    - States could waive community rating, which ensures that everyone pays the same premium, regardless of health status.
    - States could waive the essential health benefits requirements.
- In states that waive these requirements, people with chronic conditions may:
    - Pay higher premiums
    - Have greater difficulty finding plans that cover all of their needed medicines and services
    - Have no limit to their out-of-pocket expenses
    - Be subject to lifetime and annual limits on their coverage

- **Graham-Cassidy contains the same harmful cuts to the Medicaid program as previous ACA repeal bills. These proposed cuts to Medicaid will harm the nation's poorest and sickest populations.**
    - By Congress reducing hundreds of billions of dollars in Medicaid payments to the states, states could cut enrollment, limit benefits, or reduce payment rates to providers and plans.
    - This could mean that fewer low-income patients have access to health insurance through Medicaid or to additional benefits offered by Medicaid.

What about bipartisan efforts?

- While the Senate considers Graham-Cassidy, there is a better option: a bipartisan stabilization effort being led by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), who have held a series of hearings to explore options to stabilize the existing markets.
- The NHC has released a set of proposals for Congress to consider as a way forward. The proposals are:
    - Assure Funding for Cost Sharing Reductions
    - Establish a Stability Fund
    - Support Navigator Programs
    - Maintain Financial Assistance
    - Strengthen Outreach
    - Monitor and Address Bare or Limited-Choice Counties
- More detail on these proposals can be found here.

NNEDV
NATIONAL NETWORK TO END DOMESTIC VIOLENCE

FUTURES WITHOUT VIOLENCE®

NATIONAL COALITION AGAINST DOMESTIC VIOLENCE
NCADV

Dear Senator,

Domestic and sexual violence survivors and child victims of abuse need affordable and accessible health care. They need health care immediately after an assault and for long-term physical and mental health problems caused by an attack, abuse in childhood, or by a partner's ongoing violence. As leaders of three national organizations working to end domestic violence in the United States, we write today to urge you to **reject the Graham-Cassidy amendment**.

The Graham-Cassidy amendment is a dramatic step backwards in health care for survivors of violence. This legislation would keep survivors from needed medical and behavioral health services, make buying insurance more expensive by increasing premiums and out-of-pocket expenses, and eliminate coverage for many low-income survivors. Additionally, the bill ends the Medicaid expansion which has helped **millions of low-income** survivors access health care through their state Medicaid program. In Alaska, domestic violence advocates report that 90% of women who enter shelters to leave an abusive relationship qualify for Medicaid. These provisions are essential to ensuring that all survivors have unfettered access to quality health care.

We strongly oppose this and any other legislation that would eliminate the nationwide guarantee of coverage for essential health benefits and protections for those with pre-existing conditions. No survivor should find themselves without this basic coverage in a time of crisis. Further, before the Affordable Care Act (ACA), survivors of sexual assault and domestic violence were considered to have pre-existing conditions *because of their victimization*, and were routinely denied coverage or faced unaffordable premiums and other out-of-pocket expenditures. Coverage of emergency services, mental health services, and women's preventive services including screening and counseling for domestic violence are of vital importance to survivors.

Survivors of domestic and sexual violence and childhood trauma have a lot at stake in this debate. We are counting on you to stand with victims and survivors by voting NO on the Graham-Cassidy amendment. We stand ready to work with you on bipartisan solutions that protect and strengthen the care that millions of women and their families need.

For additional information, please contact Kiersten Stewart at Futures Without Violence, 202-595-7383 or Michelle Mitchell with the National Network to End Domestic Violence at 202-543-5566.

Sincerely,

Esta Soler
President
Futures Without Violence

Kim Gandy
President & CEO
NNEDV

Ruth Glenn
Executive Director
NCADV

National Committee to Preserve
Social Security & Medicare™
Trusted • Independent • Effective

September 20, 2017

United States Senate
Washington, DC 20510

Dear Senator:

On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I write to urge you to vote against the legislation drafted by Senators Lindsey Graham and Bill Cassidy to repeal the Affordable Care Act (ACA).

Like the House-passed American Health Care Act, the Graham-Cassidy bill would leave millions of Americans uninsured and would be particularly harmful to older and disabled Americans.

Americans have a right to know what this bill will do to them. Regretfully, the Majority Leadership is rushing the Senate to blindly consider Graham-Cassidy without a full Congressional Budget Office (CBO) score. CBO previously estimated that repeal-without-replace would cause 32 million people to lose health coverage. Senate consideration of any bill that would change the accessibility and affordability of essential health care for millions of Americans without a complete analysis would be the height of legislative malpractice.

This bill is particularly objectionable because it would:

- Jeopardize long-term care and other supportive services by restructuring Medicaid into per capita caps or block grants. Middle class Americans often rely on Medicaid for long-term services and supports when they exhaust their savings. Nearly two-thirds of all nursing home residents' care is financed in part by Medicaid. In addition, Medicaid provides home and community-based services that allow seniors to stay in their homes.

- End Medicaid expansion, which will take away health coverage from 11 million Americans, including low-income older adults under the age of 65.

- Drive up seniors' out-of-pocket costs by repealing the ACA's tax credit and cost-sharing subsidies.

- Allow insurance carriers to:

  - ✓ Charge certain enrollees with pre-existing conditions thousands of dollars more than healthier individuals. This proposal would be particularly harmful to the 40 percent of enrollees age 50 to 64 who have one or more pre-existing condition.

- ✓ Pick and choose which essential health benefits – such as prescription drugs, chronic disease management and maternity care – their plans will cover. Without the essential benefits requirement, health plans may not cover chemotherapy for cancer patients or insulin for diabetics. In a health insurance market without risk sharing, comprehensive coverage would be unaffordable because most plan enrollees would have pre-existing conditions.

The National Committee believes this legislation is so deeply flawed that Congress should instead turn to Senate Committee on Health, Education, Labor and Pensions Chairman Lamar Alexander and Ranking Member Patty Murray's bipartisan effort to strengthen the ACA's individual health insurance market reforms. In that spirit, we believe Congress should prioritize lowering costs for all Americans regardless of health status and age and protecting existing programs like Medicaid and Medicare.

But first, we urge you to vote against the Graham-Cassidy bill because it would put seniors and people with disabilities at significant risk of ending up uninsured and losing access to needed care.

Sincerely,

Max Richtman

Max Richtman
President and CEO

September 20, 2017

The Honorable Sherrod Brown
United States Senate
713 Hart Senate Office Building
Washington, DC 20510-3505

Dear Senator Brown:

On behalf of our three million members and the 50 million students they serve, NEA strongly urges you to **VOTE NO** on the Graham-Cassidy "replacement" for the Affordable Care Act (ACA). Developed in secret to circumvent regular order, this bill will deprive millions of children of the health care they need to learn, thrive, and grow into productive citizens; it also threatens to undermine the ongoing bipartisan effort to reauthorize funding for the Children's Health Insurance Program (CHIP), which expires September 30, and threatens to destabilize the individual health care marketplace. Votes on this issue may be included in NEA's Report Card for the 115th Congress.

Specifically, we are concerned that this legislation would:

- **Radically restructure and deeply cut Medicaid.** Federal support for Medicaid — the source of health coverage for 40 percent of all children and 60 percent of children with disabilities — would decline dramatically. Instead of basing that support on actual Medicaid costs, states would get a limited amount for each beneficiary (also called a per capita cap). To compensate for the loss of federal support, states are likely to divert money from education to health care as well as limit the number of Medicaid beneficiaries, the scope of Medicaid benefits, or both.

- **Hit the students most in need the hardest.** Slashing federal support for Medicaid would threaten services essential for students to learn and thrive, especially those with disabilities and special needs. Medicaid reimburses schools

for mental health care, vision and hearing screenings, diabetes and asthma management, wheelchairs, hearing aids, and more. That support is substantial — $4 billion a year, according to the Centers for Medicare and Medicaid.

- **Create severe financial hardship for low-income people.** Federal funding for the ACA subsidies that help make health coverage affordable would be limited and folded into block grants. After a decade, the subsidies would vanish, leaving many low-income people unable to afford health coverage or treatment for chronic diseases like diabetes. Premature deaths could rise.

- **Punish states that expanded Medicaid.** States that participated in the ACA's Medicaid expansion would lose funding while those that did not participate gain funding. By 2026, 20 states — including Alaska, Kentucky, Louisiana, Montana, New Hampshire, and North Dakota — would face funding cuts ranging from 35 percent to nearly 60 percent, according to the Center on Budget and Policy Priorities.

- **Jeopardize coverage for people with pre-existing conditions.** States would be allowed to waive the ACA's essential health benefit requirements, so insurance companies could charge people with pre-existing conditions many times more than they charge healthy people. They could also exclude essential benefits — like mental health care, prescription drugs, and treatment for substance abuse — and impose annual or lifetime dollar-based limits, shifting tremendous financial and health risks to working families.

- **Raise taxes on working families while providing tax breaks for corporations and wealthy people.** Tax breaks included in the bill benefit corporations and allow wealthy people to shelter even more money in tax-free health savings accounts. Yet a 40 percent excise tax on "high-cost" employer-sponsored coverage would take effect in 2020 — a back-door pay cut for millions of working families.

- **Weaken both the individual insurance market and employment-based coverage.** The bill eliminates financial penalties for individuals not buying — and large employers not providing — health coverage. Some employers may gut their health plans or stop offering coverage altogether, since they would no longer be penalized for doing so.

We strongly urge you to VOTE NO. Like the "replacements" for the ACA previously rejected by the Senate, the Graham-Cassidy bill reneges on the promise to deliver better, less costly health coverage for all Americans.

Sincerely,

Marc Egan
Director of Government Relations
National Education Association

September 20, 2017

The Honorable Sherrod Brown
United States Senate
713 Hart Senate Office Building
Washington, DC 20510-3505

Dear Senator Brown:

On behalf of our three million members and the 50 million students they serve, NEA strongly urges you to **VOTE NO** on the Graham-Cassidy "replacement" for the Affordable Care Act (ACA). Developed in secret to circumvent regular order, this bill will deprive millions of children of the health care they need to learn, thrive, and grow into productive citizens; it also threatens to undermine the ongoing bipartisan effort to reauthorize funding for the Children's Health Insurance Program (CHIP), which expires September 30, and threatens to destabilize the individual health care marketplace. Votes on this issue may be included in NEA's Report Card for the 115th Congress.

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Sincerely,

Marc Egan
Director of Government Relations
National Education Association

Gov. Martinez gives thumbs-down to latest GOP health care bill

By Dan Boyd / Journal Capitol Bureau Chief

Wednesday, September 20th, 2017 at 6:15pm

Gov. Susana Martinez

SANTA FE — Gov. Susana Martinez has waded into the debate on the latest Republican-backed Obamacare repeal plan — and she's not sold on the bill's merits.

"While it's encouraging that Congress is working on a healthcare solution, the governor is concerned this bill could hurt New Mexico and still needs some work," Martinez spokesman Joseph Cueto told the Journal.

A bill written by GOP Sens. Lindsey Graham of South Carolina and Bill Cassidy of Louisiana is the latest effort to undo Obamacare, and could reportedly be voted on by the U.S. Senate next week.

Among other provisions, the Graham-Cassidy bill would convert federal health insurance funding into block grants for states and do away with coverage mandates.

Several previous GOP-backed attempts to repeal Obamacare have stalled due to Republican defections and staunch Democratic opposition.

While Martinez has roundly criticized Obamacare in recent statements, the governor has taken a cautious approach to the federal health care debate surrounding the law's fate.

That's likely because any loss of federal dollars — the federal government currently pays 95 percent of the cost of those receiving benefits under Medicaid expansion — could hit New Mexico particularly hard.

Martinez, a two-term Republican, decided in 2013 to accept federal funding to expand New Mexico's Medicaid rolls. More than 40 percent of the state's population — or about 900,000 low-income adults, children and disabled individuals — is currently covered by the joint federal-state health care program.

In the statement released today, the Governor's Office said New Mexicans deserve a health care system that works.

"She believes we need a bipartisan approach that focuses on the insurance market to make health care affordable," Cueto said.

Meanwhile, Martinez's stance on the Graham-Cassidy bill also aligns her — at least for now — with the state's two Democratic U.S. senators, Tom Udall and Martin Heinrich.

Group of Republican Senators Launch Another Attack on the Affordable Care Act

on **September 13, 2017**

Bill Pushed by Sens. Graham, Cassidy, Heller and Johnson Would Also Impose Draconian Cuts on Medicaid

Washington - Despite claims of a bipartisan health care bill, Republican Sens. Lindsey Graham (R-S.C.), Bill Cassidy (R-La.), Dean Heller (R-Nev.) and Ron Johnson (R-Wis.) today unveiled a measure that contains most, if not all, of the austere provisions that were housed in previous bills to repeal the landmark Affordable Care Act (ACA).

The new measure, for example, would eliminate the ACA's key premium tax credits and cost sharing reductions, and the ACA's integral individual and employer mandates, which ensure robust market participation needed to assure that those with pre-existing conditions are able to access quality health care. The Graham-Cassidy proposal would also end Medicaid expansion by providing a time-limited block grant that would expire in 2026, leaving states with no federal assistance to provide health care for the 11 million low-income individuals and families who have benefited from Medicaid's expansion. On top of that, the Graham-Cassidy measure imposes a Medicaid per capita cap that was a part of the Senate's so-called Better Care Reconciliation Act (BCRA). The nonpartisan Congressional Budget Office estimated that the Medicaid per capita cap would quickly result in hundreds of billions of dollars cut from Medicaid ever year. In a cynical effort to win votes in the Senate, the new proposal shifts funding from densely populated states, such as California that expanded Medicaid, to smaller, sparsely populated states that refused to expand Medicaid.

National Health Law Program (NHeLP) Executive Director Elizabeth G. Taylor said the Graham-Cassidy proposal is an unfortunate and needlessly partisan attempt to rollback health care gains for previously uninsured people, especially for the nation's vulnerable populations.

"Senator Cassidy claims this new bill allows states to keep the Affordable Care Act if they wish; that is a remarkably dubious claim," Taylor said. "There is no way for states to operate the ACA without its tax credits and its mechanism to ensure that people with

pre-existing conditions can access affordable care. This is another effort to repeal the ACA and radically gut Medicaid. It is stunning that after the failed attempts to ram a partisan repeal bill through Congress, there are still senators trying to destroy our health care system for political gains. Instead, they should be joining bi-partisan efforts to make the system stronger. Republican Senator Lamar Alexander, for example, joined with Democratic Senator Patty Murray to conduct hearings on how to stabilize the ACA marketplaces so that insurers have confidence enough to stay in them, something governors and health insurers nationwide are pleading with lawmakers and the president to take positive action on. Graham-Cassidy is a bill we have seen before, and it is worse the second time around."

NHeLP Managing Attorney of the D.C. office Mara Youdelman described the new proposal as the most cynical approach yet and the most mean-spirited.

"People are calling for bipartisan action to improve the ACA, and how that message could be missed by this group of senators is beyond me and likely a lot of others," Youdelman said. "There is no appetite for austere policy that caps and cuts Medicaid, which is exactly what the Graham-Cassidy bill proposes. These proposals should be relegated to the dustbin of history. Let us move to meaningful, forward-looking discussion on how to make the ACA stronger. The evidence is that the ACA is improving lives, so Graham-Cassidy makes no sense."

Youdelman added that the senators' bill also includes "ending Medicaid expansion with a block grant, and the same per capita caps on Medicaid that the CBO score said would end the funding structure of Medicaid as we know it. This would lead to rising uninsured rates and greater health care costs for all of us. Some commentators have noted that the Graham-Cassidy bill is arguably the most radical repeal version yet."

Please contact NHeLP's Director of Communications Jeremy Leaming for further comment on Graham-Cassidy ACA repeal bill.

NHMA
National Hispanic Medical Association

September 21, 2017

Senate Speaker McConnell
317 Russell Senate Office Building
Washington, DC 20510

Senate Minority Leader Schumer
322 Hart Senate Office Building
Washington, DC 20510

Dear Speaker McConnell and Senator Schumer:

The National Hispanic Medical Association (NHMA) mission is to empower Hispanic physicians to work with our public and private partners to improve the health of Hispanic and other underserved populations. The NHMA is **opposed to the Graham Cassidy Bill that will continue to decrease access to health care in our communities through its call to Repeal and Replace the Affordable Care Act (ACA).**

The ACA was signed into law by President Obama in 2010 and has resulted in 30 million newly insured Americans. Our most vulnerable populations who are working poor have been the most to gain with new access to health care services and improved quality lives.

The Graham Cassidy Bill, on the other hand, **will decrease this trend by decreasing access to health care.** It would eliminate the Federal insurance exchange, subsidies and tax credits that help low and middle income persons and small businesses pay for health insurance, essential benefits (mental health, women's health, oral health, prevention), pre-existing conditions protections, and individual and employer mandates and penalties if they fail to obtain health insurance. According to the CBO, deleting the mandates will cause 16 million to lose insurance coverage. Lastly, this bill would fundamentally restructure the Medicaid program – ending expansion and cap funding overall and the funds would be redistributed to the States to equalize payments and cause greater losses of coverage in CA, NY and other states with large Hispanic populations. Medicaid funding would also be barred from Planned Parenthood.

We support bipartisan ACA improvement that continues subsidies to middle class families and small employers for health care insurance, cost-sharing for insurance companies to support middle class families, and taxes on stakeholders – wealthy individuals, corporations, medical device and pharmaceutical companies. We support continued value-based care efforts to provide quality care and patient-centered care, (culturally-competent and linguistically appropriate), diversity health professions education recruitment, retention, faculty, leadership training, clinics, SCHIP, health disparities research and the leadership needed with the Offices of Minority Health at the US Department of Health and Human Services.

In summary, the National Hispanic Medical Association urges the Senate to vote NO on the Graham Cassidy bill because it will lead to decreased health and increased premature death across America.

Sincerely,

Elena Rios

President & CEO

CC: Senate Offices

NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health

September 18, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

The National Association of County and City Health Officials (NACCHO) opposes the current version of the proposal to replace the Affordable Care Act being circulated by Senators Lindsey Graham (R-SC) and Bill Cassidy, MD (R-LA). As the voice of local health departments that protect the public across our nation, NACCHO respectfully requests your continued support for vital public health programs currently funded through the Prevention and Public Health Fund (PPHF). NACCHO and local health departments are concerned that long-standing public health programs are in jeopardy due to elimination of the PPHF in FY2019 in this proposal.

The potential loss of hundreds of millions of dollars for public health would have repercussions in communities across the country, hampering efforts to respond to food borne outbreaks, prevent emerging infectious diseases like Ebola and Zika, and respond to natural disasters and other emergencies. Among the programs at risk at the Centers for Disease Control and Prevention (CDC) are the 317 Immunization Program, Epidemiology and Laboratory Capacity Grants, Childhood Lead Poisoning Prevention Program, Heart Disease and Stroke Prevention program, and Diabetes Prevention program, among others. The PPHF provides vital resources to governmental public health at the federal, state, and local levels, and its elimination will serve to further erode our public health system.

Public health leaders are also concerned that the Graham-Cassidy proposal would block grant many of the current ACA protections, which provide access to primary and emergency care to millions of Americans. Erosion of the essential benefits package would jeopardize access to primary prevention services, including immunizations, mammograms and other health screening tests. A full package of prevention services is necessary to make sure that diseases are prevented effectively and skyrocketing health care costs are reined in by keeping people as healthy as possible.

NACCHO urges you to sustain current investments in public health and prevention. To rein in costs and save lives, our nation needs a strong public health system with the capacity to promote health, prevent illness, and treat disease.

Sincerely,

Laura A. Hanen

Laura Hanen, MPP
Interim Executive Director & Chief of Government Affairs

Graham-Cassidy-Heller-Johnson Bill 'Reckless and Harmful'

Statement from Kristin Rowe-Finkbeiner, executive director and CEO of MomsRising, a national online and on-the-ground organization of more than 1 million mothers and their families:

"In yet another partisan, secretive attempt to repeal the Affordable Care Act, Senators Lindsey Graham, Bill Cassidy, Dean Heller and Ron Johnson today introduced a bill that would strip Medicaid funding, weaken protections for those with pre-existing conditions and lead to massive numbers of people losing the coverage they need. This bill is just as bad as – if not worse than – any of the repeal bills that came before, and threatens the bipartisan efforts to improve health care for millions that began last week. It is reckless and harmful, and its passage would devastate our families and our economy. Low-income women, families, people with disabilities, the elderly, and those who live in rural and medically underserved communities would suffer the most, with a compounding impact in Black, Latinx, Asian, Native American, and LGBTQ+ communities.

"Like its predecessors in the House and Senate, the Graham-Cassidy bill would make health insurance less affordable, less accessible and less comprehensive. It would reduce federal funding for the subsidies that help people afford insurance; let states obtain waivers to allow insurers to impose lifetime and annual caps and exclude essential health benefits – such as maternity care coverage and mental health care – from their plans; and embrace the same Medicaid cuts as the Senate's failed health care repeal bill, gutting coverage for seniors, kids with disabilities and other vulnerable populations and effectively eliminating Medicaid expansion over ten years.

"For months, MomsRising members across the country have been speaking out in support of the Affordable Care Act and in opposition to any plan that would make our country less healthy and less prosperous. We urge the Senate to reject the Graham-Cassidy bill or any attempt to undermine the consumer protections of the Affordable Care Act, and instead work across the

aisle to stabilize the insurance markets and improve the health care system our families rely on. It's the right choice for our families, businesses, communities and economy."

# # # #

MomsRising.org is an on-the-ground and online grassroots organization of more than a million people who are working to increase family economic security, decrease discrimination against women and moms, and to build a nation where businesses and families can thrive. Established in 2006, MomsRising and its members are organizing and speaking out to improve public policy and to change the national dialogue on issues that are critically important to America's families, including criminal justice reform, immigration policy reform, and gun safety. MomsRising is working for paid family and medical leave, affordable, high quality childcare and early learning, and for an end to the wage and hiring discrimination which penalizes women— particularly moms and women of color— and so many others. MomsRising advocates for access to healthy food for all kids, health care for all, earned sick days, and breastfeeding rights so that all children can have a healthy start. MomsRising maintains a Spanish language website: MamásConPoder.org. Sign up online at www.MomsRising.org — and follow us on our blog, and on Twitter and Facebook.

September 20, 2017

Dear Senator Brown,

On behalf of The Michael J. Fox Foundation for Parkinson's Research (MJFF), I write to express serious concerns regarding key provisions of the Graham-Cassidy-Heller-Johnson (GCHJ) healthcare proposal and its impact on people with Parkinson's disease (PD). **I strongly urge you to oppose this damaging proposal and, instead, work towards a new, bipartisan approach to healthcare reform that stabilizes markets, addresses problems in current law, and truly meets the needs of patients.**

It is estimated that between 750,000 and 1 million people in the United States have Parkinson's disease, with an annual economic burden of between $19.8 and $26.4 billion. As the world's largest nonprofit funder of PD research, MJFF is dedicated to accelerating a cure for Parkinson's and developing improved therapies for those living with the disease today. In providing more than $750 million in research to date, the Foundation has fundamentally altered the trajectory of progress toward a cure.

As you carefully weigh your decision regarding the Graham-Cassidy-Heller-Johnson healthcare proposal, please consider the detrimental impact of the legislation on the most vulnerable Americans. Of particular concern to the Parkinson's community are the proposal's modifications regarding:

- **Pre-existing condition discrimination/Waivers to essential health benefits.** The GCHJ 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 and subject them to increased costs, as well as annual and lifetime caps. Chronic disease management is part of what is considered an essential health benefit. 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 individuals' 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 PD.

- **Discrimination based on health status.** Currently, the Affordable Care Act prohibits the use of actual or expected health status when setting group premiums. This practice, known as Community Rating, protects individuals with pre-existing conditions by ensuring that premiums offered by insurance providers are the same for all individuals within a specified geographic territory. The GCHJ 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 and price these individuals out of the market.

Repeal of Medicaid Expansion. The GCHJ 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. 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. 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. In addition, the GCHJ healthcare proposal allows states to require beneficiaries to re-certify their eligibility for Medicaid every six months. 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.

As you consider the Graham-Cassidy-Heller-Johnson healthcare proposal, I urge you to reconsider many of these problematic provisions. Our shared goal of better health care coverage at lower costs for all Americans is ultimately attainable, but the GCHJ proposal does not take us in that direction. Rather, it would move us to a system with lower quality

coverage options and no guarantee that every American has access to affordable healthcare insurance. **On behalf of the 750,000 to 1 million Americans with Parkinson's disease, I strongly urge you to oppose this damaging proposal, and again, encourage you to work in a bipartisan manner to develop reforms to our healthcare system based on regular order; expert analysis; and patient, caregiver, provider and industry input, that truly meets the needs of the patient.**

I am happy to be a resource to you as you move forward with health reform legislation in the Senate. Please feel free to contact me at tthompson@michaeljfox.org or by phone at 202-638-7250.

Sincerely,

Ted Thompson, JD

Senior Vice President of Public Policy

Mental Health Liaison Group

September 19, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

On behalf of the Mental Health Liaison Group (MHLG), the undersigned organizations are writing today to express our strong opposition to a new Graham-Cassidy-Heller-Johnson (GCHJ) proposal aimed at repealing and replacing major portions of our current health care system. The GCHJ proposal fails to protect the health care coverage and consumer protections available under current law, particularly for individuals with substance use disorders and mental illness. Additionally, it would create a health care system built on state-by-state variability that would exacerbate inequities in coverage and most likely place millions of vulnerable individuals at risk of losing their health care coverage.

MHLG is a coalition of national organizations representing mental health and substance use disorder (MH/SUD) consumers, providers, family members, payers, and other MH/SUD stakeholders. Together, on behalf of the millions of Americans living with MH/SUD, their families, and communities, we advocate for public policies and funding to improve access to high-quality care.

We recognize that the GCHJ proposal would require coverage of mental health and substance use disorder treatment consistent with Health Parity and Addiction Equity Act (MHPAEA) as part of the new Medicaid Flexibility Program. However, we do not support many of the other changes to the health care system in the proposal that would result in reduced access to substance use disorder and mental health treatment, including changes that would cap federal funding for Medicaid, end the Medicaid expansion, and eliminate mental health and substance use disorder benefit protections for Americans insured through the small group and individual markets. We have serious concerns with provisions in the proposal that would allow states to easily waive Essential Health Benefit requirements, end Medicaid expansion and change Medicaid to a per-capita or block grant financing system.

The ACA's Medicaid expansion, Essential Health Benefit requirements for mental health and substance use disorder treatment coverage, and extension of parity protections to the individual and small group market have surely reduced the burden of the opioid misuse and overdose and suicide epidemics and saved lives. Substance use disorder and mental health treatment benefits must continue to be available to Americans enrolled in the individual, small and large group markets as well as Medicaid plans and that these benefits are compliant with the Mental Health Parity and Addiction Equity Act.

Further, we are very concerned about rushing through any legislation to repeal and replace the ACA, including the GCHJ proposal, through the current budget reconciliation authorization, which is set to expire on October 1. Instead, we call on the United States Senate to set aside the GCHJ

proposal and turn its focus to bipartisan efforts to stabilize the health insurance marketplaces, create competition among insurers, and lower the costs of health care.

We urge your support of the bipartisan policies being developed by the Senate HELP Committee through regular order, and stand ready to work with you and the full Senate to secure passage of legislation that would build upon the successes we have made in extending health care coverage to millions of previously uninsured individuals.

Sincerely,

American Art Therapy Association
American Association of Child & Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association for Geriatric Psychiatry
American Association for Psychoanalysis in Clinical Social Work
American Association on Health and Disability
American Dance Therapy Association
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Mental Health Counselors Association (AMHCA)
American Nurses Association
American Psychiatric Association
American Psychoanalytic Association (APsaA)
American Psychological Association
American Society of Addiction Medicine
Anxiety and Depression Association
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health Law
Campaign for Trauma-Informed Policy and Practice
Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD)
Clinical Social Work Association
Clinical Social Work Guild 49-OPEIU
Confederation of Independent Psychoanalytic Societies
Depression and Bipolar Support Alliance
Eating Disorders Coalition
EMDR International Association
Global Alliance for Behavioral Health and Social Justice
International Certification & Reciprocity Consortium (IC&RC)
The Jewish Federations of North America
Mental Health America
National Association for Children's Behavioral Health
The National Association of County Behavioral Health and Developmental Disability Directors
The National Association for Rural Mental Health (NARMH)
National Association of Social Workers
National Association of State Mental Health Program Directors (NASMHPD)
National Alliance on the Mental Illness (NAMI)
The National Alliance to Advance Adolescent Health
National Council for Behavioral Health
National Disability Rights Network
National Eating Disorders Association
National Federation of Families for Children's Mental Health
National Health Care for the Homeless Council
National League for Nursing

National Multiple Sclerosis Society
National Register of Health Service Psychologists
No Health Without Mental Health (NHMH)
Psychiatric Rehabilitation Association and Foundation
Residential Eating Disorder Consortium
Sandy Hook Promise
School Social Work Association of America
Treatment Communities of America
Trinity Health of Livonia, Michigan
Young Invincibles

MEDICARE RIGHTS CENTER

Center for Medicare Advocacy

MedicareAdvocacy.org

September 19, 2017

The Honorable Mitch McConnell
Leader, U.S. Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader, U.S. Senate
Washington, DC 20510

Dear Leader McConnell and Minority Leader Schumer:

On behalf of the Medicare Rights Center and the Center for Medicare Advocacy, we are writing to express our staunch opposition to the recently unveiled substitute to H.R.1628, commonly referred to as the "Graham-Cassidy" bill. Our organizations share a commitment to promoting access to affordable, high-quality health care for older adults, people with disabilities, and their families.

We are deeply concerned that the latest amendment to H.R.1628, like its predecessors, puts the availability of affordable health coverage and care for older Americans and people with disabilities at risk. As with previous versions of H.R. 1628—the American Health Care Act and the Better Care Reconciliation Act—the Graham-Cassidy bill would dramatically diminish the benefits that near retirees and people with disabilities receive from the coverage expansions and consumer protections advanced through the Affordable Care Act (ACA).

The Graham-Cassidy bill would replace both expansion Medicaid and subsidies that support ACA Marketplace enrollees with a block grant to states. Analyses find that these changes would result in a significant cost shift to states, cutting federal funding by hundreds of billions of dollars over the next decade.[1] The proposed block grants also redistribute funds between states—providing more funding for those states that did not expand Medicaid under the ACA and making deeper cuts to those states that did expand coverage. Further, because a block grant provides a fixed amount of funding for states each year, the proposal leaves states vulnerable to unexpected costs from recessions, natural disasters, public health emergencies, or prescription drug price spikes.

Near retirees and people with disabilities gained needed health coverage from the ACA, including through expansion Medicaid and the Marketplaces. Nearly 3.3 million people between ages 55 and 64 have coverage through the Marketplaces, representing the largest share of enrollees nationwide—26%.[2] Over 1.5 million people with disabilities are in the Medicare two-year waiting period at any time and frequently turn to

[1] Edwin Park & Matt Broaddus, "Cassidy-Graham Plan's Damaging Cuts to Health Care Funding Would Grow Dramatically in 2027," Center on Budget and Policy Priorities (September 15, 2017), *available at* https://www.cbpp.org/research/health/cassidy-graham-plans-damaging-cuts-to-health-care-funding-would-grow-dramatically-in.

[2] ASPE Issue Brief, "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report For the period: November 1, 2015—February 1, 2016" (March 11, 2016), *available at* https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.

expansion Medicaid or the Marketplaces for coverage before their Medicare takes effect.[3] We are deeply concerned the combined effect of the Graham-Cassidy bill's changes to the Medicaid expansion and individual market coverage will cause older Americans and people with disabilities to pay significantly more for health insurance or force them to go without coverage altogether.

We also strongly oppose the Medicaid per-capita caps included in the Graham-Cassidy bill. Eleven million people with Medicare rely on Medicaid to cover vital long-term home health care and nursing home services, to help afford their Medicare premiums and cost-sharing, and more.[4] Federal cuts to Medicaid brought about by per-capita caps would drive states to make hard choices, likely leading states to scale back benefits, impose waiting lists, implement unaffordable financial obligations, or otherwise restrict access to needed care for older adults and people with disabilities.

In addition to the content of these bills, we are dismayed with the secretive and rushed manner in which each iteration of H.R.1628 has been written and advanced. It is especially concerning that a preliminary Congressional Budget Office score on the Graham-Cassidy legislation will not include analyses on potential coverage and premium impacts.[5] This vital information is needed to allow members of Congress and the public to evaluate the bill and its effects on families' access to coverage and care well in advance of a vote in the Senate.

Historically, the Senate has developed health care proposals through transparent means, including public hearings, open comment periods on discussion drafts, multi-stakeholder meetings, and more. Proposals to fundamentally restructure the ACA and Medicaid should be treated no differently. We strongly urge the Senate leadership to focus instead on the dialogue arising in the Committee on Health, Education, Labor & Pensions that aims to stabilize the individual insurance market through bipartisan solutions.

Our organizations stand ready to work with you to identify bipartisan opportunities to strengthen the ACA, Medicaid, and Medicare and ensure access to affordable health care for older adults and people with disabilities. If you have questions, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961 and David Lipschutz, Senior Policy Attorney, at dlipschutz@medicareadvocacy.org or 202-293-5760. Thank you.

Sincerely,

Joe Baker
President
Medicare Rights Center

Judith Stein
Executive Director
Center for Medicare Advocacy

[3] *See* Social Security Administration, "Selected Data from Social Security's Disability Program" (last accessed March 7, 2017), *available at* https://www.ssa.gov/oact/STATS/dibStat.html.

[4] Centers for Medicare & Medicaid Services, "Analytic Reports and Data Resources" (last accessed March 7, 2017), *available at* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html.

[5] Statement by Deborah Kilroe and Leigh Angres, "CBO aims to provide preliminary assessment of Graham-Cassidy bill by early next week," (September 18, 2017), available at: https://www.cbo.gov/publication/53116

CC: The Honorable Orrin Hatch, Chairman, Committee on Finance
The Honorable Ron Wyden, Ranking Member, Committee on Finance
The Honorable Lamar Alexander, Chairman, Committee on Health, Education, Labor & Pensions
The Honorable Patty Murray, Ranking Member, Committee on Health, Education, Labor & Pensions
The Honorable Susan Collins, Chairman, Senate Special Committee on Aging
The Honorable Bob Casey, Ranking Member, Senate Special Committee on Aging

Jeff M. Myers
President and CEO

Medicaid Health Plans of America

September 21, 2017

The Honorable Bill Cassidy
United States Senate
Washington, D.C. 20510

Dear Senator Cassidy,

As you know from our discussions with you and your staff, MHPA and our member plans are committed to exploring ways to guarantee that Medicaid is on firm financial footing to ensure its long-term viability for beneficiaries that count on this extremely important program and for the taxpayers who provide the resources to pay for these much-needed services. We have been open to discussing alternative financing models as well as structural reforms which, if implemented, would drive better care for Medicaid enrollees while bending the cost curve. While we understand and accept the limitations that are placed on you and your colleagues using a reconciliation-driven model, we are alarmed at both the size of the federal funding reductions you are proposing and its timing, as well as the impact that moving to a block grant mechanism would have on the overall integrity of the Medicaid program.

In our view, the Cassidy/Graham proposal would reduce federal participation in Medicaid to such an extent that it would create significant challenges for the states to adequately fund services to beneficiaries. Indeed, according to an independent analysis from Avalere Health consulting, the Cassidy/Graham bill might reduce federal support for the program even more than what was proposed by the ***Better Care Reconciliation Act*** (BCRA), which the Senate wisely rejected. One of the first principles that MHPA has consistently reiterated to policymakers is the need to provide adequate funding and a reasonable timeframe for any financing changes to ensure program stability. In our view Cassidy/Graham fails that test.

The transition from the current funding mechanism to a fundamentally different design must allow sufficient time for states, MCOs and provider networks to adapt. A transition period should be no less than three years, and preferably five, to curtail disruptions and the increase in associated expenses. Graham/Cassidy specifies that the *per capita* funding mechanism will go into effect in 2020. This timeframe is far too short. State procurement processes, contracting and negotiating terms for new program changes for a complex program like Medicaid averages two years. With state legislative and budget approvals also required, a minimum of three years is essential.

In the Graham/Cassidy proposal, the *per capita* model, unlike the block grants which are discussed below, ties each state's allocation to a per-person capitated rate within four different populations and, going forward, sets up a funding structure based on national trends and costs per population. While this mitigates some of the shortcomings of a block grant, the inadequate annual update factor and the absence of rebasing in the current *per capita* model make it

suboptimal and can be viewed only as a starting point to a true discussion on comprehensive Medicaid reform.

Furthermore, the removal of enhanced Federal Medicaid Assistance Program funds (FMAP) for the expansion population by placing the funds into the so-called "Market Based Healthcare Grant Program" penalizes those states that expanded the program to the near poor by simultaneously reducing funding and combining it into a block grant. MHPA supported (and continues to support) the expansion provisions because they encouraged states to provide care in an integrated, capitated fashion instead of a fragmented and inefficient charity care model that drives high costs to the states and the federal government paid for via disproportionate share hospital (DSH) and supplemental payments.

We have also consistently reminded policymakers that the block grant mechanism ignores the complexity and purpose of the Medicaid program. While we support additional "state flexibility" in designing Medicaid services to address the needs of their citizens, MHPA does not believe that the funding or design of a block grant will ensure that enrollees get the services they need in an actuarially sound manner over time. Block grants do not accommodate the counter cyclical nature of Medicaid and the inability of States to shoulder increased financial stress during economic downturns. They do not take into account changes in population health, demographics, and unanticipated events (like hurricanes or public health emergencies like the opioid addiction crisis). Block grants are simply not a suitable mechanism for Medicaid.

We know and appreciate your interest in finding ways to address the challenges that Medicaid faces; unfortunately, in our view, significant reductions in funding over a short period of time combined with a fundamental restructuring of the federal commitment to our nation's poor will dramatically destabilize the program. As you and your colleagues consider redesigning the federal and state partnership implicit in this program, we would strongly encourage you to consider the views of the plans that provide the care to nearly three fourths of beneficiaries. We are committed to doing all that we can to provide ideas that make the program more robust and address well founded concerns about Medicaid's cost growth, and we look forward to continuing to work with you and other members of the U.S. Senate who share this commitment.

Best regards,

Jeff M. Myers

1150 18th Street NW Suite 1010 Washington, DC 20036
TEL (202) 857-5720 FAX (202) 857-5731 jmyers@mhpa.org www.mhpa.org

I'm reaching out to express ProMedica's opposition to the legislation proposed by Senators Graham and Cassidy that would repeal and replace the ACA, and to thank Senator Brown for his opposition, as well. Under this bill, millions would lose insurance and, by 2026, estimates are that Ohio would see annual funding cuts of $2,512,000,000. Additionally, one of our greatest concerns about the legislation is that it would significantly impact the most vulnerable populations that ProMedica serves by permanently eliminating the federal match for the Medicaid-expansion population at the end of December 2019 and replacing the program with inadequate block grant funding. Other top concerns include:

- Eliminating the ACA's marketplace subsidies and converting the traditional federal-state Medicaid partnership to a per-capita cap;
- **The bill would result in the loss of coverage for Ohioans**. Almost 1 million Ohioans secured health care coverage through the ACA, with about 725,000 covered through the state's Medicaid expansion and another 250,000 on the individual market
- These funding reductions are unsustainable for many Ohio hospitals. Nearly 20 percent of facilities in the state operate with negative margins and one in four operate below a two percent margin; and
- Providing states with the ability to eliminate pre-existing condition protections by eliminating essential benefits and by allowing insurers to charge higher rates to those with preexisting conditions.

We appreciate you sharing our concerns with Senator Brown and conveying our thanks for him joining us in opposing this legislation. We remain committed to working with him to help

develop a healthcare delivery model that meets the needs of those we serve and ensures timely, quality and cost-efficient care.

Please let me know if you have any questions. Thank you.

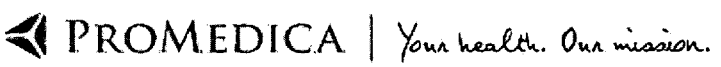
Barb

Barbara J. Petee
Chief Advocacy and Government Relations Officer

ProMedica
MSC – S39000
100 Madison Avenue
Toledo, Ohio 43604

567-585-3894

barb.petee@promedica.org



CITY OF YOUNGSTOWN

MAYOR JOHN A. McNALLY

OFFICE OF THE MAYOR

CITY HALL • 26 S. PHELPS STREET • YOUNGSTOWN, OHIO 44503

PHONE: (330) 742-8701 • FAX: (330) 743-1335

September 20, 2017

The Honorable Sherrod Brown
U.S. Senator
713 Hart Senate Office Building
Washington, DC 20510

Dear Senator Brown:

I am happy that to date you have not indicated any level of support for the current Graham-Cassidy legislation.

When I wrote to you on July 17th, I pointed out that the BCRA would decimate our behavioral health system with deep Medicaid cuts, eliminate life-saving drug/alcohol treatments and would help weaken state initiatives to address the nationwide opioid epidemic. Thank you for not supporting the BCRA legislation.

Senator, the Graham-Cassidy legislation is no better. The Graham-Cassidy legislation permits redistribution of ACA financing for subsidized private health insurance and Medicaid expansions into State block grants. Under this scenario, Ohio would lose millions in funding. As Sarah Kliff wrote in her *Vox* article today, "No other [health] bills contemplated simply taking away money from Ohio, which expanded Medicaid, and sending it to Virginia, which didn't."

In addition, states could seek federal waivers allowing for modifications to market safeguards for consumers. Such waivers would gut the coverage provided for essential health benefit provisions and pre-existing condition language. As Blue Cross/Blue Shield Association said this morning in a letter voicing its opposition:

> "We share the significant concerns of many health care organizations about this proposed Graham-Cassidy bill. This bill contains provisions that would allow states to waive key consumer protections, as well as undermine safeguards for those with pre-existing medical conditions. This legislation reduces funding for many states significantly and would increase uncertainty in the marketplace, making coverage more expensive and jeopardizing Americans' choice of health plans. Legislation must also ensure adequate funds for Medicaid to protect those most vulnerable."

Finally, on an issue very important to you and the State of Ohio, the $100 million in funding for opioid treatment assistance included in the BCRA appears to have disappeared in this legislation and the federal waiver option could drastically reduce mental health and substance abuse treatment available to Ohio residents. Please do not give up on the importance of opioid treatment dollars to our state!

Thank you for your continued efforts to improve health care access for our Ohio residents. I encourage you to continue to oppose any healthcare legislation that rolls back Medicaid expansion in Ohio, reduces mental health and substance abuse coverage or weakens coverage for pre-existing conditions and essential health benefits.

Sincerely yours,

John A. McNally
Mayor

cc: Sarah Lowry

National League
for **Nursing**

September 20, 2017

Dear Senator:

As the oldest nursing organization in the United States, the National League for Nursing (NLN) is writing to inform you of our opposition to the health system reforms included in the Graham-Cassidy-Heller-Johnson (GCHJ) proposal. The NLN promotes excellence in nursing education to build a strong and diverse nursing workforce to advance the health of the nation and the global community. The League represents more than 1,200 nursing schools, 40,000 members, and 25 regional constituent leagues.

The ***GCHJ proposal*** not only goes against the League's mission, but also goes against our core values of caring, integrity, diversity, and excellence. Nursing brings a steadfast commitment to patient care, and the unique ability to partner with the other health professions to ensure quality, safety and access to care for all of our nation's patients in all settings where care is delivered. Unfortunately, the most vulnerable will be ill served by the ***GCHJ proposal*** and the NLN cannot in good conscience support this legislation. We encourage Congress to focus on bipartisan efforts to stabilize the health care system through regular order rather than rushing a repeal and replace proposal of our complicated health care system through the current budget reconciliation authorization.

Fundamental to the nursing profession and the NLN is the principle that all individuals have equitable access to comprehensive health and wellness care across the lifespan of patients and caregivers. This includes all care for health conditions regardless of pre-existing condition status, behavioral health, and substance abuse disorders. We recognize that the GCHJ proposal would require coverage of mental health and substance use disorder treatment consistent with the ***Mental Health Parity and Addiction Equity Act (MHPAEA)*** as part of the new Medicaid Flexibility Program. However, we do not support many of the other changes to the health care system in the proposal that would result in reduced access to substance use disorder and mental health treatment, including changes that would cap federal funding for Medicaid, end the Medicaid expansion, and eliminate mental health and substance use disorder benefit protections for Americans insured through the small group and individual markets.

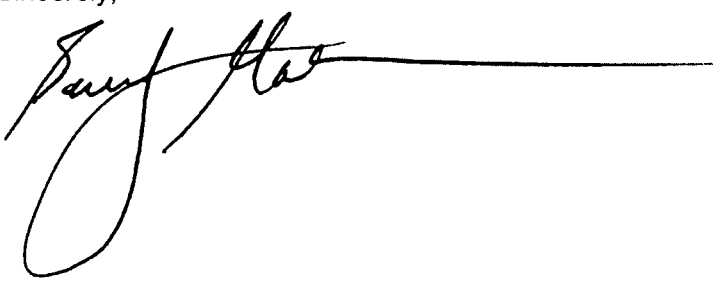
We have serious concerns with provisions in the proposal that would allow states to easily waive essential health benefit requirements, end Medicaid expansion and change Medicaid to a per-capita or block grant financing system. Capping federal Medicaid funding through per-capita caps or block grants would strain state budgets and likely force states to cut benefits and/or limit access to care particularly for the most vulnerable. These changes would be devastating to states grappling with the current opioid epidemics. This is unacceptable to the NLN as it is not aligned with our core values and mission.

If the NLN is to abide by our core values—caring, integrity, diversity, and excellence—and fulfill our mission to advance the health of the nation, we cannot support the GCHJ proposal. As the voice for nursing education, it is imperative that we speak out on the

National League
for **Nursing**

negative health effects this bill would have on all communities. This proposal would hollow out or terminate coverage for tens of millions of Americans and especially impact those who need it most.

Sincerely,



Beverly Malone, PhD, RN, FAAN
Chief Executive Officer

Statement from Linda Rosenberg, President and CEO, National Council for Behavioral Health on Graham-Cassidy-Heller-Johnson Bill

CONTACT:

Aaron Cohen, (301) 633-6773

aaroncohenpr@gmail.com

Statement from Linda Rosenberg, President and CEO, National Council for Behavioral Health on Graham-Cassidy-Heller-Johnson Bill

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 Pension 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 illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council helped introduce Mental Health First Aid USA and more than 1 million Americans have been trained.*

ACA Update | September 15, 2017: Cassidy-Graham Repeal Plan Is Devastating for Patients—and Is Gaining Support in the Senate

September 15, 2017 | *In Cancer News, Cancer Policy Blog* | *Add Comment*

Prior to the Affordable Care Act (ACA), cancer survivors were at the mercy of the health care system, often forced to pay exorbitant premiums or simply denied coverage altogether. Today, America's 16 million cancer survivors benefit from the ACA's patient protections that are critical to providing them with quality, affordable, and accessible health care coverage. NCCS is actively engaged in advocating to ensure this unprecedented access for cancer patients and providers continues.

We have been monitoring and reporting on the proposed Cassidy-Graham repeal bill for several weeks, and now its threat is imminent. Yesterday, Senators Cassidy (R-LA) and Graham (R-SC) unveiled their health care plan at a press conference on Capitol Hill. Indications are that the sponsors of the bill are only a couple of votes away and this has moved up on the priority list for Senate Republican leadership to get done in September.

The bill not only gets rid of the ACA exchanges and block grants the law's funding, but it also eliminates the Medicaid expansion and key patient protections, all of which have been critical for cancer survivors across the U.S. and is necessary for their access to affordable and comprehensive health care. We cannot let the Senate pass this terrible bill that would leave millions without health insurance. The Senate has started to work in a bipartisan fashion to stabilize the ACA markets, and this bill undermines those productive efforts. Senator McCain (R-AZ), whose dramatic vote against so-called "skinny" repeal killed the crusade in July, has spoken positively about the bill, giving

supporters of the bill further hope that repeal can be achieved. Vox reports that while it will be difficult to get the 50 votes necessary for this bill, it is certainly possible.

As the Center for Budget and Policy Priorities reports, the bill would permit states to access waivers that would allow insurers to charge people with cancer more for their health care, a discriminatory practice that was made illegal under the ACA. **Cancer survivors cannot go back to the days when insurers could deny or charge exorbitant premiums to those who have pre-existing conditions.** Another concerning piece to the Cassidy-Graham bill is the fact that the funding for the health care block grants face a cliff in year 2026, meaning every dollar disappears thereafter.

This legislation is not only dangerous and irresponsible, but it would be devastating for patients who would be left with expensive health plans that did not cover prescription drugs, chemo therapy, or other critical services. This is unacceptable and **NOW** is the time to call the NCCS hotline at (844) 257-6227 and ask your Senators to say NO to the Cassidy-Graham repeal bill. We need a bipartisan and transparent process to strengthen the ACA and help provide critical long-term stability.

For more information on how you can get involved, check out our #ProtectOurCare page »

Follow NCCS on Twitter to stay updated on developments: @CancerAdvocacy.

Dear Abigail,

The National Advocacy Center of the Sisters of the Good Shepherd urges the Senator to vote against the Cassidy-Graham bill and the effort to repeal the Affordable Care Act (ACA). The plan would completely eliminate the ACA's expansion of Medicaid, which has extended coverage to 11 million low-income adults.

The bill would also completely eliminate the ACA's marketplace subsidies, which currently help almost 9 million people afford coverage. Unlike under earlier Republican bills, which substituted highly inadequate tax credits, moderate-income working people buying individual market coverage would no longer be guaranteed *any* assistance.

In addition, the bill would dramatically redistribute funding across states, meaning that many states – especially Medicaid expansion states and states with high marketplace costs – would see far deeper cuts. The legislation would end completely after 2026 – as if the need to help low- and moderate-income people afford coverage would just disappear overnight.

Because a block grant provides a fixed amount of funding for states each year, the proposal also leave states on the hook for any and all unexpected costs from recessions, natural disasters, public health emergencies, or prescription drug price spikes. 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.

For all these reasons, we urge you to vote against the Cassidy-Graham. Thank you for your consideration of our request. We look forward to your reply,

Sincerely,

Larry Couch

Lawrence Couch, Director
National Advocacy Center of the Sisters of the Good Shepherd
504 Hexton Hill Road
Silver Spring, MD 20904
FB: goodshepherdnationaladvocacycenter
Twitter: @NAC4Justice
www.gsadvocacy.org
301-622-6838 (o)
240-463-0660 (c)

National Association for the Support of Long Term Care
Insight . Advocacy . Action

National Association for the Support of Long Term Care

September 20, 2017

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
United States Senate

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
United States Senate

Dear Chairman Hatch, Ranking Member Wyden, and Members of the Senate Finance Committee:

I write on behalf of the Board of Directors of the National Association for the Support of Long Term Care (NASL), a trade association representing suppliers of ancillary services and providers to the long-term and post-acute care (LTPAC) sector. NASL members include therapy companies that employ more than 300,000 physical therapists, occupational therapists, and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare and Medicaid beneficiaries in nursing facilities as well as in other long-term and post-acute care settings. NASL members also include vendors of health information technology (IT) that develop and distribute full clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers. In addition, NASL members include providers of clinical laboratory services, portable x-ray/EKG and other diagnostic equipment for the LTPAC sector.

In providing services to Medicaid and Medicare beneficiaries in various long term and post-acute care settings, we understand how these very vulnerable individuals depend on these programs for long term services and supports that enable them to recover from an illness, maintain or improve function, remain in the community, and live a higher quality of life. We have grave concerns regarding the recently released "Graham-Cassidy-Heller-Johnson" (GCHJ) amendment to the American Health Care Act (H.R. 1628), introduced by Sens. Lindsey Graham (R-SC), Bill Cassidy (R-LA), Dean Heller (R-NV) and Ron Johnson (R-WI). This amendment repeals and replaces key aspects of the Affordable Care Act beginning in FY2020, including transforming Medicaid funding to states into a per capita cap, or block grant. We believe that this amendment would significantly restrict the resources available to state Medicaid programs to spend on care for the aged, blind, and people with disabilities.

Additionally, these drastic cuts to the Medicaid program threaten access to long term care services and supports, such as home and community-based services and assisted living care. States may be forced to scale back Medicaid programs that have been developed to offer the elderly and people with disabilities care in the setting best suited for their needs.

1050 17th Street, NW
Suite 500
Washington, DC 20036-5558

202-803-2385
www.NASL.org
@NASLdc

Every day NASL member companies provide care and services to our most vulnerable Medicaid beneficiaries who reside in long term care facilities and other settings. NASL has serious concerns that the GCHJ amendment will undermine the crucial services provided to this population and degrade their ability to access the services that they need. For these reasons, NASL opposes the GCHJ amendment.

Sincerely,

Cynthia K. Morton, MPA
NASL Executive Vice President

National Association of State Directors of Special Education, Inc.
225 Reinekers Lane, Suite 420, Alexandria, VA 22314
Tel: 703/519-3800 Fax: 703/519-3808 www.nasdse.org

September 20, 2017

Re: Graham-Cassidy

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, D.C. 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

The National Association of State Directors of Special Education (NASDSE) writes to express concerns regarding the Graham-Cassidy bill and proposed changes to Medicaid funding or structure. Specifically, we are concerned about the impact on students who rely on school based Medicaid services.

NASDSE is the national nonprofit organization that represents the state directors of special education, the IDEA Part B data managers and the IDEA 619 coordinators in the states, the District of Columbia, the federal territories, the Freely Associated States and the Department of Defense Education Agency.

Schools are a critical component of the health care safety net for children and Medicaid plays a significant role in funding medically necessary services for children. Districts can be reimbursed for providing Early Periodic Screening Diagnosis & Treatment (EPSDT), which ensures that eligible children under age 21 have access to a system that leads to appropriate diagnosis and treatment when necessary.

In regards to special education, Medicaid permits payments to schools for certain medically necessary services provided to children under the Individuals with Disabilities Education Act (IDEA). These dollars pay for wheelchairs, walkers, lifts and other therapeutic equipment for qualified students with disabilities. According to National Alliance for Medicaid in Education, 46% of all Medicaid beneficiaries are children. However, only 1% of total Medicaid funding flows to schools. NASDSE considers this a worthwhile investment in students.

Medicaid also covers services provided by specialized instructional support personnel including speech therapists and physical therapists. These services MUST be provided by schools under the IDEA. Consequently, if Medicaid is cut local school districts will have to pick up the costs. Because new children are identified for services every day, a per capita cap will have a significant impact on local community budgets.

Changing the funding or structure of Medicaid would have devastating effects for students with disabilities and could result in:

- Reduced eligibility, coverage of fewer services or lower payments to providers,

- Cuts to general education – Cuts to Medicaid will necessitate utilizing funds from other sources to provide services mandated under IDEA.
- Job loss – Districts use Medicaid reimbursement to support the salaries and benefits of the staff performing eligible services. A 2017 AASA survey found 68% of districts use Medicaid funding to pay direct salaries for health professionals.
- Higher taxes – A loss in Medicaid reimbursement could lead to deficits in districts that require increases in property taxes or new levis to cover the costs.
- And non-compliance with IDEA - Federal resources were never realized to fully fund IDEA as promised. Consequently the Medicaid dollars are a critical funding stream to ensure districts can provide the specialized instructional supports that students with disabilities need to be educated alongside their peers.

These issues must be fully deliberated before making life changing decisions that will impact the academic success of America's students.

Thank you for the opportunity to provide comments. Please feel free to contact NASDSE's Director of Government Relations, Valerie Williams at Valerie.Williams@nasdse.org if you have any questions about our comments.

Sincerely,

Theron (Bill) East, Jr.
Executive Director

STATEMENT

NAMD
National Association of
Medicaid Directors

FOR IMMEDIATE RELEASE
September 21, 2017

contact: Matt Salo
matt.salo@medicaiddirectors.org

NAMD Statement on Graham-Cassidy

The Board of Directors of the National Association of Medicaid Directors (NAMD) urges Congress to carefully consider the significant challenges posed by the Graham-Cassidy legislation. State Medicaid Directors are strong proponents of state innovation in the drive towards health care system transformation. Our members are committed to ensuring that the programs we operate improve health outcomes while also being fiscally responsible to state and federal taxpayers. In order to succeed, however, these efforts must be undertaken in a thoughtful, deliberative, and responsible way. We are concerned that this legislation would undermine these efforts in many states and fail to deliver on our collective goal of an improved health care system.

1. Graham-Cassidy would completely restructure the Medicaid program's financing, which by itself is three percent of the nation's Gross Domestic Product and 25 percent of the average state budget. Like BCRA, the legislation would convert the traditional Medicaid program into a per-capita cap financing system. All states will be impacted by this change, regardless of their decisions to leverage the Medicaid expansion option under the ACA. It would also incorporate Medicaid expansion funding and other ACA health funds into a block grant, made available to all states. How these block grants will be utilized, what programs they may fund, and the overall impact they will have on state budgets, operations, and citizens are all uncertain. 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. While the block grant portion is intended to create maximum flexibility, the legislation does not provide clear and powerful statutory reforms within the underlying Medicaid program commensurate with proposed funding reductions of the per capita cap.

2. The Graham-Cassidy legislation would require states to operationalize the block grant component by January 1, 2020. The scope of this work, and the resources required to support state planning and implementation activities, cannot be overstated. States will need to develop overall strategies, invest in infrastructure development, systems changes, provider and managed care plan contracting, and perform a host of other activities. The vast majority of states will not be able to do so within the two-year timeframe envisioned here, especially considering the apparent lack of federal funding in the bill to support these critical activities.

NAMD
National Association of Medicaid Directors

3. Any effort of this magnitude needs thorough discussion, examination and analysis, and should not be rushed through without proper deliberation. The legislative proposal would not even have a full CBO score until after its scheduled passage, which should be the bare minimum required for beginning consideration. With only a few legislative days left for the entire process to conclude, there clearly is not sufficient time for policymakers, Governors, Medicaid Directors, or other critical stakeholders to engage in the thoughtful deliberation necessary to ensure successful long-term reforms.

For these reasons, we encourage Congress to revisit the topic of comprehensive Medicaid reform when it can be addressed with the careful consideration merited by such a complex undertaking – as we articulated in our June 26 statement on BCRA.

# # #

Gov. Edwards releases statement on Graham-Cassidy health care amendment

BATON ROUGE, LA. (KLFY) – ***The following is a news release from the office of Governor John Bel Edwards:***

Today, Louisiana Gov. John Bel Edwards released the following statement on the Graham-Cassidy health care amendment. Gov. Edwards also joined a bipartisan group of governors, including Governors John R. Kasich (R-Ohio), Steve Bullock (D-Mont.), Phil Scott (R-Vt.), John Hickenlooper (D-Colo.), Charles Baker (R-Mass.), Tom Wolf (D-Pa.), Bill Walker (I-Alaska), Brian Sandoval (R-Nev.), Charles Baker (R-Mass.), and Terry McAuliffe (D-Va.), in asking congressional leaders to not consider the latest health care proposal, but instead, follow the lead of Chairman Lamar Alexander and Ranking Member Patty Murray of the Senate's Health, Education, Labor and Pensions (HELP) Committee in promoting a bipartisan solution that includes input from governors.

"First, I want to thank Dr. Cassidy for taking the time to sit down privately with me to discuss his health care proposal. While we may not always agree on policy, I want to commend him for making a tireless effort to reform our nation's health care system and for his willingness to incorporate some of the ideas that we've presented to him.

"However, after a careful review of this legislation, I cannot support the Graham-Cassidy Amendment. My primary objection relates to the elimination of the Medicaid expansion program in 2020. Right now, more than 430,000 working poor people in Louisiana have access to health insurance because we chose to bring our federal tax dollars back home. We're saving lives, money, and investing in our people to ensure they are able to receive quality healthcare. Importantly, Louisiana's uninsured rate has dropped to nearly 10 percent. Undoing this progress would negatively impact our citizens and our economy.

"I am working with Republican and Democratic governors from across the country to promote a solution that makes health insurance more stable and affordable. We all agree that any plan must go through regular order and receive proper analysis from the Congressional Budget Office. Rushing a piece of legislation of this significance through the process without proper vetting, thorough hearings or robust debate will leave us with unintended consequences that can be avoided. Congress should take the time to get this process and policy right because it is the American people's lives, well-being and tax dollars that hang in the balance. The people of Louisiana deserve nothing less, and I am willing to work with Dr. Cassidy on an acceptable, bipartisan solution to our nation's health care problems."

The text of the letter from the governors is below and available by clicking here:

Dear Majority Leader McConnell and Minority Leader Schumer:

As you continue to consider changes to the American health care system, we ask you to not consider the Graham-Cassidy-Heller-Johnson amendment and renew support for bipartisan efforts to make health care more available and affordable for all Americans. Only open, bipartisan approaches can achieve true, lasting reforms.

Chairman Lamar Alexander and Ranking Member Patty Murray have held bipartisan hearings in the Senate's Health, Education, Labor and Pensions (HELP) Committee, and have negotiated in good faith to stabilize the individual market. At the committee's recent hearing with Governors, there was broad bipartisan agreement about many of the initial steps that need to be taken to make individual health insurance more stable and affordable. We are hopeful that the HELP committee, through an open process, can develop bipartisan legislation and we believe their efforts deserve support.

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 health committees and input from the appropriate health-related parties. Improvements to our health insurance markets should control costs, stabilize

the market, and positively impact coverage and care of millions of Americans, including many who are dealing with mental illness, chronic health problems, and drug addiction.

We look forward to continuing to work with you to improve the American health care system.

POSTED ONSEPTEMBER 20, 2017

Our letter to U.S. Senators regarding Graham-Cassidy

Below is a copy of the letter that we have been delivering to U.S. Senators regarding our opposition to the Graham-Cassidy bill:

September 18, 2017

Dear Senator,

Little Lobbyists is an organization of families with one thing in common: we all have medically complex children requiring significant medical care. **Our mission is to advocate on behalf of the millions of such children across the country to ensure that their stories are heard and their access to quality health care is protected.** We have visited your office previously and hand-delivered the stories of medically complex children in your state whose health and future would have been jeopardized by the legislation under consideration at the time.

We write again because **the pending Cassidy-Graham health care bill poses similar danger to the millions of medically complex children in this country, thousands of whom live in your state.** We ask that you stand up to protect our children, and demand that Congress do the same.

Our current health care laws can and must be improved, about this there is no debate. However, the Cassidy-Graham bill departs from recent good faith, bipartisan efforts and attempts a massive upheaval of our health care system without input from policy experts or those who would be most affected by its provisions. In particular, **the**

Cassidy-Graham bill undermines three protections in current law that are vital to the health and well-being of medically complex children and their families:

- **Decreased Medicaid funding through "per capita caps" and "block grants".** Private insurance frequently does not cover home/community-based care (such as private duty nursing) and therapeutic care. Medicaid fills this gap, which allows medically complex children not only to live at home, but to thrive. **Cassidy-Graham's upheaval of Medicaid will cut billions of dollars nationally from the program relative to current law, with no guarantees that the funds must be spent on the same population.** Under such funding restrictions, optional Medicaid programs, such as the Katie Beckett Medicaid waiver program created by Ronald Reagan to help families care for their medically complex children at home, will likely be among the first eliminated. In short, under Cassidy-Graham, the vital safety net that Medicaid provides our children is slowly pulled away, with families like ours left to worry constantly whether it will be there when they need it.

- **Eliminating the ban on annual/lifetime limits.** Many of our children accumulated millions of dollars in medical bills in their infancy before they ever left the hospital. Under the ACA, insurance companies were prohibited from kicking our children off of insurance plans when their care reached a certain dollar amount. Cassidy-Graham would allow states the ability to waive these protections. **This means that parents across the nation sitting bedside in Neonatal Intensive Care Units will once again have to worry not only about whether their child will survive, but also whether the hospital stay will leave them bankrupt.**

- **Eliminating the ACA's pre-existing condition protections.** Medically complex children are frequently born with multiple pre-existing conditions. **Protections against discrimination on the basis of these conditions give us the security that our children will not one day be denied affordable insurance because of conditions they were born with. That security is stolen by the Graham-Cassidy bill**, giving states broad authority to waive these protections. This is contrary to the Republican Party's own platform, which provides that "individuals with preexisting conditions who maintain continuous coverage should be protected from discrimination."

We have heard politicians over the past few days tell us that the Cassidy-Graham bill will increase "flexibility" and "choice" for Americans. That is flatly untrue for our families. Rather, the bill's provisions will fundamentally disrupt the safety net that our families depend on, likely leaving us only one unthinkable choice: incur debt far beyond our means, or forego medical care that will keep our children alive and able to achieve their God-given potential.

As we said at the outset, our nation's health care laws can and must be fixed. **But it is unjust, immoral, and contrary to any reasonable meaning of "pro-life" to pass a health care law that makes it harder for medically complex children to access the care they need to survive and thrive.** Our children have done nothing wrong. They do not lack personal responsibility; indeed, they show more strength, bravery, 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. Work with us to ensure their access to health care is not diminished. We will make ourselves available anytime of any day to discuss our concerns with you in person, and to assist in any way we can toward the goal of a health care system that works better for all Americans.

Sincerely,

Elena Hung

Michelle Morrison

Co-Founders, Little Lobbyists

View this email in your browser

Lutheran Services in America

CEO UPDATE

September 21, 2017

Dear ,

From advocacy to events—as fall arrives we are preparing for a busy season.

A New Threat to Medicaid

Medicaid is critically important to the vast majority of our members. The program provides funding to support two-thirds of seniors in nursing homes, health care for 39 percent of American children and services and supports to over 10 million people with disabilities.

A new effort to repeal and replace the Affordable Care Act (ACA) is moving quickly in the Senate. The new legislation, known as the "Graham-Cassidy" amendment, would, among other provisions, convert ACA spending to block grants and federal Medicaid spending to a per capita cap.

Although the legislation is proceeding forward without a full analysis by the Congressional Budget Office, independent analysts predict that the proposed the cuts and caps to Medicaid would be as severe, if not more so, than those proposed in previous legislation. Therefore we are reactivating our advocacy campaign to #SaveMedicaid. We urge you to call your Senators and ask them to vote no on the legislation. Instructions and a call script are here.

Telling the Lutheran Social Ministry Story

On October 31 we will celebrate the 500th anniversary of the Reformation. This is a time to reflect on our history and heritage and to tell our story—the story of Lutheran social ministry—to a broader audience. This is a story that many of you have asked for our assistance in telling and we are pleased to offer several materials to do just that.

Thanks to a generous grant from the ELCA we produced a brochure and companion video that tell the story of Lutheran social ministry. We explore its origins in the Reformation and theological context and describe how Lutheran social ministry took root in the United States and grew into the organizations that comprise the Lutheran Services in America network today.

In addition to these materials we also produced a toolkit that will help you tell your story and the story of Lutheran social ministry to audiences ranging from your boards of directors to prospective clients.

Join us at the LSA Reception at the LeadingAge Annual Meeting and Expo

We invite those of you planning to attend the LeadingAge Annual Meeting and Expo to join us at an LSA reception from 5:30 to 7:00 pm on October 29 in the Canal Room of the Hilton New Orleans Riverside (the LeadingAge conference headquarters). Please share this invitation with any of your staff attending the conference. To RSVP click **here**.

Engage with Fellow CEOs at CEO Academy

Finally, we are excited to welcome you back to the Safety Harbor Resort and Spa for the **2018 CEO Academy** on January 28-31. In these rapidly changing and increasingly complex times, we designed a **program** that allows chief executives to rethink their approach, build value and develop the strategies to carry their organizations forward. In this one-of-a-kind environment, we bring together the CEOs of Lutheran social ministry organizations with the **country's foremost experts** on leadership and nonprofits to engage with their peers and chart the course for success. Click **here** to register for CEO Academy.

As always, please reach out to me with any questions, comments or concerns.

Blessings,

Charlotte Valenzuela

Charlotte Haberaecker
President & CEO
Lutheran Services in America, Inc.

Lutheran
Services
in America

100 Maryland Avenue, NE
Suite 500
Washington, DC 20002

Main: 202-499-5836
Toll-free: 800-664-3848
Fax: 202-544-0890
lsa@lutheranservices.org

One of America's Most Influential Health Care CEOs Just Trashed the Graham Cassidy Obamacare Bill

Sy Mukherjee
Sep 20, 2017

Bernard Tyson, chairman and CEO of the sprawling Kaiser Permanente nonprofit health system—which combines health plans, hospitals, and an affiliated physician group into one consortium—doesn't have anything nice to say about the Graham Cassidy health care bill to repeal Obamacare. A GOP Senate health care vote on the Graham Cassidy legislation could come as early as next week, and Republicans may be just one vote shy of being able to pass it.

"At Kaiser Permanente, we believe that changes to our nation's health care laws should increase access to high-quality, affordable care and coverage for as many people as possible. The Graham-Cassidy bill does not meet any of those tests," wrote Tyson in a statement.

Graham Cassidy would fundamentally transform the American health system by giving states broad authority to gut Obamacare's consumer protections and placing caps on how much money is spent on the massive Medicaid program for poor Americans. States would either have a per-person cap on federal Medicaid funding—which would likely lead to stricter eligibility requirements or curtailed benefits—or be given the option for a "block grant," or a set amount of money that it receives to pay for people on Medicaid.

Initial analyses have suggested that deep funding cuts imposed by the Graham Cassidy health care bill would likely push costs onto patients by slashing Obamacare's provisions to help people pay premiums and their out-of-pocket medical costs—and that it would especially burden sick people, who could be charged more for being in poor health (a practice banned by Obamacare).

Tyson echoed those arguments in his missive. "The block grant proposal in the bill would erode coverage of needed medical services and pose major issues for state budgets. Repealing the individual mandate without alternative incentives for enrollment will lead to fewer people enrolled and higher premiums," he said. Doctor and hospital groups like the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) have similarly denounced the legislation.

Tyson was recently honored as one of *TIME*'s 100 most influential people of 2017. As Kaiser Permanente CEO, he oversees a system that serves some 11.8 million Americans.

This post has been updated to reflect Kaiser's most recent membership number.

Justice in Aging's Statement on Graham-Cassidy Proposal

By Emma AyersSeptember 15, 2017Newsroom

This week, Senators Graham and Cassidy released yet another ACA repeal and replace bill that would have devastating consequences for the health and well-being of older Americans. Like the other harmful proposals that consumers, advocates, and the majority of Americans soundly rejected (and also all failed in the Senate), Graham-Cassidy would strip coverage from millions, gut the Medicaid program, and undermine the ACA's most popular consumer protections.

By terminating Medicaid expansion and imposing per capita caps and block grants, this proposal would cut Medicaid funding by hundreds of billions over the next decade. **Millions of older adults and people with disabilities who rely on Medicaid to live in their homes and communities would be at risk of losing coverage as states are forced to cut services.**

Graham-Cassidy would wreak havoc in the individual health insurance market as well, hitting older adults and people with limited income the hardest. The proposal eliminates the premium tax credits and cost-sharing reductions that make coverage affordable. On top of that, **states would have the option to waive many of the ACA's most vital consumer protections** and allow insurers to charge people more based on health status and cover fewer benefits. **Older adults would face unaffordable premiums** in a market that divides the young and healthy from those who have pre-existing conditions. Many of those who could afford the premiums would be underinsured facing bare-bones coverage and skyrocketing deductibles.

We commend the Senators who have begun to work in a bipartisan manner to ensure that older Americans have affordable access to the coverage and care they need in 2018 and beyond. We call on them and their colleagues to **reject this proposal and move forward to improve the health and well-being of all Americans**.

Jewish Federation
OF CLEVELAND

September 19, 2017

Senator Sherrod Brown
713 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Brown:

The Jewish Federation of Cleveland is deeply troubled by the recently released legislation offered by Senators Cassidy and Graham to cap Medicaid and end the state Medicaid Expansion. The Congressional Budget Office (CBO) score of the Senate Republican leadership's defeated "Better Care Reconciliation Act", which also proposed to cap Medicaid and phase out the expansion, predicted a loss in coverage for 22 million people and a $772 billion reduction in federal funding for the Medicaid program. With these projections for devastating cuts in coverage and funding, the Senate should not move forward with this bill or similar efforts to cap or block grant Medicaid and end the state Medicaid expansion.

Instead, the Senate needs to start again -- working in a bipartisan and open process -- towards reform that maintains coverage standards, and sustains a strong and secure safety net. We are committed to working with you to develop a new framework of policies to improve Medicaid quality, efficiency, and sustainability.

A per capita cap and/or a block grant for Medicaid would restructure its long-standing and fundamental federal-state financing partnership and would lead to devastating federal funding cuts to the program over time. Medicaid is a vital program for the Jewish federations in Ohio and particularly for our communal health and long-term care partner agencies, such as Menorah Park, Montefiore, Jewish Family Services Association and Bellefaire JCB. This critical federal-state safety net allows our providers to continue caring for the most vulnerable populations in our communities, such as low-income children, pregnant women, older adults, and people with disabilities. Converting Medicaid to a per capita cap and/or a block grant not only would adversely impact the many people living in our community who depend heavily on Medicaid coverage, but also our providers who serve them.

For providers affiliated with our Jewish community, Medicaid is the major source of funding for health care, home and community-based services, and long-term care

Jewish Federation of Cleveland
Jack, Joseph and Morton Mandel Building
25701 Science Park Drive
Cleveland, Ohio 44122

Phone 216-593-2900
Fax 216-593-2901
www.jewishcleveland.org
info@jcfcleve.org

proposals projected a 26% reduction in the federal Medicaid contribution by 2026, and 35% over twenty years. **We still believe that under this proposal Medicaid will not be sufficiently flexible to address key factors affecting Medicaid spending, such as disasters, economic downturns, unexpected**

health care cost increases, and demographic changes like the rapidly aging baby boomer generation. It makes no sense to undermine the only long-term care option available to most Americans just as our country undergoes a transformational demographic shift to an aging nation.

Such a drastic reduction in the federal share of Medicaid will shift substantial costs to state and local governments, our providers, and our patients, thus exacerbating the existing strain on the program. We fear that states will be left with no choice but to sharply cut Medicaid enrollment, eligibility for Medicaid, benefits, and payment rates.

States will not be able to innovate their way out of cuts of this magnitude, and philanthropies, such as Jewish federations, will not be able to make up the difference. Many people who now qualify for Medicaid could end up uninsured, including low-income children, pregnant women, older adults, and people with disabilities who are in the workforce.

Ultimately, we believe these proposals would lead to the denial of critical health care, home and community-based services, and long-term care services for millions of vulnerable Americans.

We are deeply concerned that some of the legislation's unintended consequences will be:

- People in need of Medicaid and who are currently eligible will become uninsured;

- Our state will be forced to cut back on crucial Medicaid services, such as home and community-based services;

- People who are capable of living in our communities with proper home and community-based services will be forced to live in nursing homes, thus undermining the laudable and cost effective trend of moving people with disabilities and older adults out of institutions if they prefer;

- Health care providers and entities that care for vulnerable populations will suffer significant financial strain, forcing them to cut services, lay off staff or close their doors thereby causing additional job losses and further harming state economies.

We urge you to vote "NO" on the Graham-Cassidy proposal because it caps Medicaid and ends the state Medicaid expansion. We stand ready to work with

you in tandem with our Jewish communal health and long-term care providers to promote more targeted ways to reduce Medicaid spending and improve the quality of care.

Sincerely,

Amy R. Kaplan

Amy R. Kaplan
Assistant Vice President, External Affairs

Internists oppose Graham-Cassidy proposal

Legislation would cause an unacceptable increase in the number of uninsured patients

AMERICAN COLLEGE OF PHYSICIANS

Share

Print E-Mail

Washington, Sept. 13, 2017, -- The American College of Physicians (ACP) sent a letter to Senators Lindsey Graham and Bill Cassidy, sharing ACP's opposition to their bill to "repeal and replace" the Affordable Care Act's Medicaid expansion, premium and cost-sharing subsidies with block grants to states to develop their own plans to provide health care coverage to their residents. ACP also sent a separate letter to Senate Majority Leader Mitch McConnell and Minority Leader Charles Schumer, urging the Senate to set the Graham-Cassidy bill aside and instead advance bipartisan improvements to current law through a more deliberative process of regular order that allows for hearings, amendments, independent expert review, and input by those directly affected.

The letters, from Jack Ende, MD, MACP, president of ACP tell the senators that, "substantial cuts to Medicaid authorized by this legislation would cause a significant increase in the number of uninsured patients and that it would undermine essential benefits provided for patients insured under current law." 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. The letters stressed ACP's concern that the Graham-Cassidy legislation falls well short of meeting the criteria that ACP established to ensure that the health of patients is improved rather than harmed by changes to current law.

The letters detail ACP's areas of concern in four areas:

- Eliminating the enhanced federal match provided under the ACA for Medicaid expansion, capping and cutting the federal contribution to Medicaid, replacing guaranteed federal

funding with optional block grants, and allowing states to impose work requirements under Medicaid that would cause millions of the most vulnerable to lose coverage.

- Replacing the ACA's premium tax credits and cost-sharing subsidies with a discretionary formula would result in less funding than currently in place for individuals to purchase health insurance in the individual market. ACP is also concerned 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.
- Allowing waivers for state innovation and essential health benefits would weaken consumer protections such as essential health benefits guaranteed under current law.
- Eliminating the requirement that individuals buy insurance would allow individuals to wait until they are ill to purchase insurance; insurers would then need to increase premiums to compensate for the resulting sicker risk pool. Congress should not enact any legislation to weaken or repeal the individual insurance requirement absent an alternative that will be equally or more effective.

"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 ACA in a budget reconciliation bill. Rather than continue with an effort to repeal and replace the ACA, ACP urges you to set aside this legislation and instead, focus on bipartisan efforts to stabilize the health insurance marketplaces, create competition among insurers, and lower the costs of health care for all Americans," Dr. Ende concluded. "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 independent analysis by the Congressional Budget Office (CBO), independent experts, and the clinicians and patients directly affected by the proposed changes."

the MAIN STREET alliance

September 18, 2017

Members of the United States Senate
U.S. Senate
Washington, DC 20002

Dear Senators,

Re: The Graham-Cassidy Health Amendment to H.R. 1628

Main Street Alliance, a network of small business owners throughout the country, strongly urges you to oppose the Graham-Cassidy Health Amendment to H.R. 1628. This latest ACA repeal proposal by Senators Graham, Cassidy, Heller, Johnson and Blunt will significantly harm small business owners and their employees, damage local economies, and decimate state budgets.

Millions of small business owners, their employees, and their families rely on the Affordable Care Act (ACA) for access to healthcare critical to their survival. The Graham-Cassidy ACA repeal would strip them of their health coverage. The proposal would eliminate Medicaid expansion under the ACA, which has extended coverage to 11 million low-income adults, including 6.1 million small business employees. It would also eliminate ACA marketplace subsidies, which currently help almost 9 million low- and moderate-income working people afford healthcare coverage. More than 4 million small business owners and employees gained access to affordable coverage under the ACA, and many could lose health coverage as a result of the loss in marketplace subsidies.

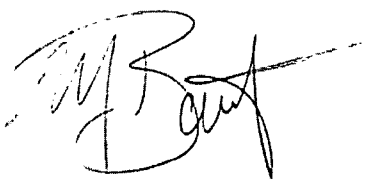
Healthcare costs would skyrocket under the Graham-Cassidy repeal, devastating local economies and small businesses who depend on consumer demand from customers in their communities. The proposal would cut $239 billion in Medicaid expansion and marketplace subsidies funding, and gut an additional $175 billion from Medicaid, devastating working people, seniors, people with disabilities, and families with children. The removal of the ACA'S protections for people with pre-existing conditions, coupled with these draconian spending cuts, would force vulnerable and working families to pay more for vital healthcare services, resulting in a reduction in their disposal income and the amount of money they can spend on goods and services. Small business owners would see a decline in customers.

The cuts to Medicaid and the ACA would siphon at least $414 billion out of state economies from 2020 to 2026, and at least $299 billion in 2027 alone. Because a block grant

provides a fixed amount of funding for states each year, the proposal would also leave states on the hook for any and all unexpected healthcare costs from recessions, natural disasters, public health emergencies, or prescription drug price spikes, and unaccounted costs like the aging of the population. In order to cover the loss in federal healthcare funding, states will be forced to spend less on education, training and employment programs, and public infrastructure projects.

The impact of the Graham-Cassidy amendment on small businesses will be felt in the loss of critical healthcare coverage, reduced business, and contracted state budgets. We urge you to protect Main Street small businesses owners, working families, communities, and economies, and to oppose the Graham-Cassidy Health Amendment to H.R. 1628. Reject any plan to repeal the Affordable Care Act and dismantle our current healthcare system.

Signed,



Amanda Ballantyne
National Director
Main Street Alliance

September 20, 2017

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

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

Re: Opposition to Graham-Cassidy Proposal

Dear Leader McConnell and Minority Leader Schumer:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments.

Together, EDPMA's members deliver (or directly support) health care for about half of the 141 million patients that visit U.S. emergency departments each year. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn. We are writing to

urge you not to hold a vote on the healthcare proposal from Senators Cassidy, Graham, Heller, and Johnson to repeal and replace the Affordable Care Act (ACA).

Further, if it is brought to the floor for a vote, we urge you to oppose it. Current Medicaid Patients Must Be Adequately Insured for Emergency Care in the Future Emergency departments are the nation's health safety net. Federal law – through the Emergency Medical Treatment & Labor Act (EMTALA) - requires hospitals and physicians to evaluate and stabilize everyone visiting the emergency department, no matter the ability to pay. So, even though emergency physicians are only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients.

The Congressional Budget Office has not had an opportunity to estimate the number of children and adults who will lose health care coverage under the Cassidy-Graham proposal. However, because the proposal includes many provisions that were in earlier versions of repeal and replace legislation, tens of millions are expected to lose coverage. Many who support deep cuts to Medicaid argue that individuals would still be able to receive EMTALA-mandated care in the emergency department. However, a shift to more uncompensated EMTALA care would seriously jeopardize the nation's health safety net.

The demand for care in the nation's emergency departments would skyrocket while significantly fewer physicians would be attracted to a specialty that is not fairly compensated. This, in turn, would significantly threaten access to care for everyone.

Therefore, as you consider shifting current Medicaid patients into a less robust Medicaid program, into a different program altogether, or off the rolls, we urge you to ensure that these patients continue, at minimum, to be fully insured for emergency care so EMTALA-mandated care is compensated care. As part of this request, we ask you to ensure that the prudent layperson standard (PLP) is incorporated and reiterated in all Medicaid plans. The PLP is the well-established standard, reiterated in the Balance Budget Act of 1997, which requires plans to reimburse for emergency care when a prudent layperson believes he or she may be experiencing an emergency, including when he or she is experiencing severe pain. Plans may not require preauthorization in these circumstances. And the final determination on reimbursement should take into account the presenting symptoms rather than the final diagnosis. Emergency Care Must Be Covered as an Essential Health Benefit The Emergency Department is not only the safety net for Medicaid patients and the uninsured, it is also the safety net for patients covered by private insurance. The rise in narrow networks and ever increasing deductibles are contributing to an epidemic of "medical homeless," leaving the emergency department (ED) as the only option for many insured patients.

We oppose provisions in the Graham-Cassidy proposal that make it easier for states to waive the requirement that policies cover essential health benefits (EHB) such as emergency care. Requiring private insurers to cover EMTALA-mandated care is especially important because, as noted above, emergency physicians already provide a significant and disproportionate amount of uncompensated and undercompensated care. If emergency care is so essential that it is mandated, it also should be essential enough to be covered care.

Furthermore, consistent with the importance of covering emergency care as an essential health benefit, the PLP standard discussed in the previous section should be incorporated into and reiterated in all private insurance plans.

We also oppose provisions in the Graham-Cassidy proposal that allow states to waive the ACA prohibition against increasing premiums due to preexisting conditions.

It's Time to Shrink the Surprise Gap in Private Insurance If you do not bring the Graham-Cassidy proposal up for a vote at this time, there will be more time to consider important amendments that address the current problem of the surprise gap in insurance. Unfortunately, under current law, private insurance "coverage" of emergency care is often a misnomer. Insurers often are unwilling to negotiate fair

and sustainable reimbursement rates that reflect the true cost of providing EMTALA-mandated care.

So, some patients visiting the emergency department will be treated by an out-of-network emergency physician and be financially responsible for a large portion of those charges through their deductible. This is especially true as more insurers offer high deductible plans. This surprise gap in insurance – which is often a very large gap - is a serious problem for many patients. It is time to shrink this gap by requiring insurers to contribute to the cost of emergency care. When implementing the ACA, the Department of Health and Human Services, the Department of Labor, and the Treasury Department stated that "it would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to [an emergency] provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts."

Thus, "a plan or issuer must pay a reasonable amount for emergency services by some objective standard." Unfortunately, the Obama Administration's proposed standard – known as the greatest-of-three rule – is vague and unenforceable. Although it was well intentioned and also references usual and customary charges, it nonetheless allows insurers to determine reimbursement levels unilaterally and in relative isolation, and pay at levels that have little or no connection to the market rate. And the process is not transparent, so patients and providers are not able to identify or prove noncompliance.

We propose improving this standard so insurers are more clearly required to reimburse for out-of-network emergency care, at minimum, in an amount equal to the usual and customary charge. The usual and customary charge should be defined by referencing an independent (unbiased) transparent charge database, like FAIR Health.

We urge you to establish the standard adopted in the state of Connecticut which requires insurers to pay, at minimum, the 80th percentile of an independent, nonprofit, transparent charge database.

With these changes, the payment standard would be an objective standard and would:

- protect patients from the growing surprise gap in insurance,
- ensure that physicians are reimbursed for EMTALA-mandated care, a
- avoid setting reimbursement rates that are disconnected from the fair market, and
- establish transparent standards that are easy to comply with and enforce.

The EDPMA appreciates the opportunity to share our concerns and provide potential solutions. Please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

Andrea Brault, MD, FACEP, MMM,

Chair of the Board Emergency Department Practice Management Association

(EDPMA)

cc: U.S. Senate

GOP strains to find votes for ACA repeal

- By Erin Granger, egranger@newsminer.com
- Sep 19, 2017 Updated 12 hrs ago
- (0)

Josh Martinez

FAIRBANKS — Time growing short, President Donald Trump and Republican Senate leaders dove into a frantic hunt for votes Tuesday in a last-ditch effort to repeal and replace the Affordable Care Act within the next 10 days. The pressure was intense, the outcome uncertain in a Capitol newly engulfed in drama over health care.

The bill, introduced by Sens. Lindsey Graham, R-S.C, and Bill Cassidy, R-La, last week, has gained the support of the president, Vice President Mike Pence and several prominent GOP senators, but has Alaska Gov. Bill Walker on edge about a potential risk to Medicaid funding, upon which Alaska relies heavily.

Pence says the Trump administration is "all in" on the repeal effort after he and Graham flew back to Washington from the United Nations to push the bill.

They spoke by phone to Trump and House Speaker Paul Ryan about the plan. Pence also called West Virginia Sen. Joe Manchin, a Democrat, about the proposal. Walker also received a call but was unable to be reached for comment on the conversation.

The Alaska governor has expressed deep concern about the bill's plan to slash federal funding for a Medicaid expansion that has provided additional care to 36,000 Alaskans in recent years.

In addition to ending the ACA's Medicaid expansion, this new bill would create a per-capita cap on Medicaid funding, remove protections for those with pre-existing conditions, allow states to impose work requirements as a condition of Medicaid coverage and create a funding cliff that eliminates the guarantee of coverage in 2026.

"That coverage must be protected," Walker said.

Walker joined nine other governors from across the country Tuesday in a continued push for the U.S. Senate to slow the repeal of the Affordable Care Act and to address health care costs in a comprehensive and bipartisan approach.

"Alaskans pay more for health care than do most Americans," Walker said. "Before any changes to existing law are made, Alaska must have a clear understanding of how the proposed changes impact Alaskans."

Alaska Republican Sen. Lisa Murkowski told reporters Monday she has not yet taken a stance on the Graham/Cassidy health care bill because she hasn't seen hard statistics regarding how the bill would affect Alaska.

The Congressional Budget Office said it will release a "preliminary assessment" of the bill next week to provide some information on potential effects. However, the CBO said it may still be "several weeks" before they have concrete numbers on who would lose insurance under this bill and how it could affect premiums.

This time frame would fall after Sept. 30, the date by which Republicans must vote on the bill in order to avoid a Democratic filibuster.

"I will use the governor's words," Murkowski told CNN, referring to Alaska Gov. Bill Walker. "He said, 'I understand that a block grant gives me increased flexibility, but if I don't have the dollars to help implement the flexibility, that doesn't help us much.' So, we are both trying to figure out how those dollars fall."

Alaska Republican Sen. Dan Sullivan has yet to take a stance on the most recent repeal attempt and is still reviewing the legislation, according to his office.

Collins' plan

As the Graham-Cassidy bill pushes forward, Sen. Susan Collins took to the Senate floor Tuesday afternoon to introduce a separate health care bill focusing almost entirely on

reinsurance. Collins called the bill the Lower Premiums through Reinsurance Act of 2017.

The Maine Republican teamed up with Murkowski in July to defeat the first attempts to repeal the ACA and is now using Alaska as inspiration for her new health care plan.

Collins said she believes the 1332 waiver, which was approved for Alaska last year, can effectively help other states in shrinking the need for that level of federal funding.

"This bill would provide states with the flexibility and support that they need to create state-based reinsurance programs for their individual state-based markets in order to lower premiums while ensuring continued coverage for people with pre-existing conditions," Collins said.

Over the past two weeks, the Senate Health, Education, Labor and Pensions committee has completed a round of hearings on the issue of high cost health care. Both Collins and Murkowski sit on the Senate HELP committee.

"[We] looked at the steps we could take in the near term to stabilize the individual market and help to bring down rates," Collins said. "Reinsurance was frequently mentioned as an option that Congress should consider and adopt."

Insurance commissioners from five states, including Alaska, spoke in favor of reinsurance, as did all five governors who testified before the committee, Collins said. Alaska's Insurance Commissioner, Lori Wing-Heier, was among the first to give testimony before the HELP committee. Wing-Heier was unable to be reached for comment.

"As Alaska's insurance commissioner told the HELP committee, next year her state will be able to fund its $55 million reinsurance program with just $6.6 million of its own money," Collins said. "The remaining $48.4 million will be provided in federal flow through funding that matches the savings from the federal government resulting from the reinsurance program."

The bill would appropriate $2.25 billion a year in 2018 and 2019, which should be sufficient to leverage $15 billion in total reinsurance funding annually, based on the ratio in Alaska's recently approved waiver, Collins said.

Although Murkowski was unavailable for comment on Collins' new plan, the Alaska senator in the past has spoken highly of the state's 1332 waiver.

"Alaska's the only state that to this point in time has been granted a 1332," Murkowski said in an editorial board meeting with the Fairbanks Daily News-Miner. "It is one of the

reasons that we are seeing Premera come back with recommended decreases instead of increases."

Murkowski said it was good to see progress as Alaska has some of the highest health care costs in the country.

"Alaska has, throughout this debate, been held out as the poster child for highest cost," Murkowski said. "So to be able to look to a specific state and see that a provision under the ACA has given the state the flexibility that we felt would be helpful, we are seeing a little demonstrative progress."

Collins said she feels like reinsurance is one of the country's best options of lowering the cost of health care and maintaining coverage.

"While Alaska's reinsurance program differs from Maine's in some respects, the success of both models shows the promise, proves the promise, of invisible reinsurance pools," Collins said.

Contact staff writer Erin Granger at 459-7544. Follow her on Twitter: @FDNMPolitics.

The Associated Press contributed to this report.

FAIRBANKS—Gov. Bill Walker joined nine other governors from across the country Tuesday in a continued push for the U.S. Senate to slow the process of repealing the Affordable Care Act and to address the issue of health care costs in a comprehensive and bipartisan approach.

The 10 governors have sent a second letter to congressional leadership expressing their concerns about the seemingly rushed process. The first letter was sent in late August.

Walker emphasized the need to allow states' to have input on the issue.

"Alaskans pay more for health care than do most Americans," Walker said. "Before any changes to existing law are made, Alaska must have a clear understanding of how the proposed changes impact Alaskans."

As part of the Medicaid expansion implemented through the Affordable Care Act, more than 36,000 Alaskans have access to affordable health care, according to Walker.

Walker noted that through the state's 1332 reinsurance waiver, health care premiums are expected to drop 20 percent in the state next year.

"That coverage must be protected, which is why I joined a bipartisan group of governors in a continued push for Congress to follow a thorough process," Walker said. "Health

care should not be a partisan issue. Building a Stronger Alaska begins with healthy Alaskans."

The second letter from the group of governors urges the Senate to consider health care legislation through the committee process. The previous GOP effort to undo the Affordable Care Act circumvented the Senate's committees.

"Legislation should receive consideration under regular order, including hearings in health committees and input from the appropriate health-related parties," the letter reads. "Improvements to our health insurance markets should control costs, stabilize the market, and positively impact coverage and care of millions of Americans, including many who are dealing with mental illness, chronic health problems, and drug addiction."

Contact staff writer Erin Granger at 459-7544. Follow her on Twitter: @FDNMPolitics

September 15, 2017

Dear Senator:

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 commented on 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, 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 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 GCHJ's cap – like the structure in previous bills – makes cuts worse after it reduces the growth rate in 2025.

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 35%

cut by 2036, 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 four-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 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, 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 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 highrisk pools. The CBO estimated that ACA repeal without a replacement would cause 32 million people to lose insurance. GCHJ 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 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 longterm 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
- 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

Dear Senator,

I am writing to you today on behalf of the Cooley's Anemia Foundation (CAF), which is dedicated to serving people afflicted with various forms of thalassemia, most notably the major form of this chronic, genetic blood disease, Cooley's Anemia/thalassemia major. Founded over 60 years ago, CAF's mission is to advance the treatment and cure for this fatal blood disease, to enhance the quality of life of patients and to educate the medical profession, trait carriers and the public about Cooley's Anemia/thalassemia major.

Today, I am writing to express the Foundation's sincere concern about the impact of the changes to patient coverage proposed in the Graham-Cassidy bill. We are extremely concerned that these efforts will have a devastating impact on our community. Additionally, we are alarmed at proposed changes to Medicaid, which many thalassemia patients rely on to access the regular and specialized care that they require. We also remain extremely troubled by legislation which will inevitably create additional costs for patients with preexisting conditions.

Thalassemia is the name for a group of blood disorders. There is a wide spectrum of severity for patients with thalassemia, ranging from mild to extremely severe, though many patients must receive regular blood transfusions to make up for the body's

inability to effectively produce hemoglobin. These regular blood transfusions cause a number of health concerns and risks for patients due to the resultant excess of iron. Patients with thalassemia face a number of issues related both to the management of their disease and as a response to the regular blood transfusions which are necessary for many patients. Thalassemia care often exceeds $20,000 per month.

Most patients are simply not able to cover the exorbitant costs associated with their care. Many of our patients utilize Medicaid to afford the exorbitant costs of their care and treatment. Without it, many would be uninsured or under-insured and unable to pay for the cost of their care, or the care of their children. For our patients, Medicaid is literally life-saving.

On behalf of our community, we urge you to reject all efforts to repeal the Affordable Care Act and the inevitable consequences that will enormously hurt the sickest among us. We are happy to serve as a resource in any capacity to help you work to make life better for the children and families trying to navigate this complex and life-threatening disease.

Sincerely,

Craig Butler National Executive Director, the Cooley's Anemia Foundation

September 19, 2017

Dear Senator:

Easterseals strongly opposes the Graham-Cassidy legislation for its Medicaid provision that will limit access to essential home and community-based services and supports for children and adults with disabilities. The Graham-Cassidy legislation (Sec. 124) removes the federal funding guarantee that currently exists in Medicaid and replaces it with a restrictive cap based on a funding formula rather than the actual needs of individuals with disabilities.

The Congressional Budget Office examined the Medicaid per capita cap proposal and concluded that capping federal Medicaid funding will force states to eliminate optional home and community-based services, restrict eligibility, or cut provider rates—unless new state resources are added to make up the funding shortfall left by a Medicaid cap. The troubling GrahamCassidy Medicaid cap proposal will make it much harder for a child or adult with disabilities to access the Medicaid services they need to maintain their health and independence.

Easterseals urges the Senate to reject the Graham-Cassidy legislation for its harmful provision to cap, cut and restrict access to needed Medicaid home and community services. Instead, Easterseals urges the Senate to continue the bipartisan health care reform work being led by Senators Alexander and Murray to help stabilize health care markets and to improve access to and affordable coverage of quality health care.

Thank you for considering our views.

Sincerely,

Katy Beh Neas Executive Vice President, Public Affairs

Office of Public Affairs
1425 K Street NW, Suite 200, Washington, DC 20005
P 202.347.3066
www.easterseals.com

AMERICAN SOCIETY OF HEMATOLOGY

2021 L Street, NW, Suite 900, Washington, DC 20036 ph 202.776.0544 fax 202.776.0545 e-mail ASH@hematology.org

September 20, 2017

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

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

Dear Majority Leader McConnell and Minority Leader Schumer:

I am writing on behalf of the American Society of Hematology (ASH) to express the Society's concerns with the Cassidy-Graham-Heller-Johnson Amendment to H.R. 1628, the American Health Care Act. This legislation would reduce access to comprehensive coverage for the patients that our members serve, patients with rare debilitating chronic diseases such as hemophilia or sickle cell disease, and patients with blood cancers such as acute myeloid leukemia (AML) or multiple myeloma. The Society urges the Senate to preserve access to affordable, high quality health care for all Americans and to focus their efforts on stabilizing the individual insurance market.

ASH represents over 17,000 clinicians and scientists worldwide who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell anemia, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists were pioneers in demonstrating the potential of treating various hematologic diseases through the transplantation of bone marrow stem cells, and we continue to be innovators in the fields of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. ASH membership is comprised of basic, translational, and clinical scientists, as well as physicians who are providing care to patients in diverse settings including teaching and community hospitals, as well as private practices.

Throughout Congress' efforts to repeal and replace the Affordable Care Act (ACA), ASH has continued to advocate for access to affordable, high quality health care for all Americans and has opposed changes that will undermine the patient protections to ensure that patients with costly hematologic disorders can get the specialized care they require. Once again, ASH urges caution as Congress considers changes to the ACA. The Graham-Cassidy Amendment does not differ from the alternatives already considered by Congress, and it will invalidate the patient protections established by the ACA.

The Society is very supportive of the private insurance reforms that now prohibit health plans from discriminating against patients with pre-existing conditions or imposing limits on annual and lifetime benefits. The public and private insurance reforms that are currently in place have been especially impactful for individuals with blood diseases and disorders. For example, the patient who has a blood cancer such as multiple myeloma and relies on a combination of expensive therapies could reach their annual cap within a few months; meanwhile, the patient living with a blood disorder that has high

treatment costs such as hemophilia could reach their lifetime cap within a few years. Additionally, ASH wants to guarantee that individuals eligible for Medicaid do not lose their ability to acquire affordable health care coverage and essential health benefits. This is critical for patients with sickle cell disease, an inherited chronic disorder affecting nearly 100,000 Americans who often experience lifelong complications including stroke, acute chest syndrome (a condition that lowers the level of oxygen in the blood), organ damage, and other disabilities.

Importantly, the Graham-Cassidy Amendment undermines these protections since it allows the states to remove the essential health benefits (EHB) requirement, which will undermine the ACA's patient protections. The provisions to repeal the ACA cost-sharing reductions and Medicaid expansion, as well as the move to block grants and per-capita caps, are particularly concerning as they threaten to reduce access to affordable, high-quality care for millions of Americans. By moving Medicaid to a per-capita allotment, states would have greater difficulty in responding to fluctuations in the price and demand for health care services. Additionally, ASH is concerned about any proposed elimination of the Public Health and Prevention Fund, which has supported many critical projects at the Centers for Disease Control and Prevention (CDC) including investments in immunizations and health-care associated infections. Currently the Fund comprises approximately 12 percent of CDC's budget and should be preserved.

Changes implemented through the ACA benefited many of the patients that our members serve. We remain committed to protecting access to affordable, high-quality, care for all patients with hematologic diseases and disorders. Again, ASH cannot support the Cassidy-Graham-Heller-Johnson Amendment to H.R. 1628, the American Health Care Act, because it would undermine patient access to care. ASH looks forward to working with you to address the challenges and opportunities impacting hematology practice, as well as issues impacting hematology patients. Please feel free to contact either myself or Leslie Brady (lbrady@hematology.org, 202-292-0264) if you have any questions or would like any additional information about hematology.

Sincerely,

Kenneth C Anderson

Kenneth C. Anderson, MD
President

Cc: United States Senate

People with Hemophilia and Other Bleeding Disorders Urge their Senators to Reject Dangerous Graham-Cassidy-Heller-Johnson Health Reform Legislation

The Senate is expected to consider the Graham-Cassidy-Heller-Johnson bill, a final partisan attempt to repeal the Affordable Care Act (ACA). While some provisions differ from other ACA repeal proposals considered by Congress this year, it is the same in the most fundamental ways: **the bill jeopardizes access to public and private insurance coverage for individuals with pre-existing conditions and would be just as harmful as the earlier proposals defeated in the Senate.** We are very concerned that people with chronic health conditions will either lose coverage entirely or pay more for inadequate coverage if they maintain it.

As a result of its damaging impact, The National Hemophilia Foundation, Hemophilia Federation of America, Coalition for Hemophilia B, and Hemophilia Alliance – which represent people with hemophilia, von Willebrand Disease, and other bleeding disorders and the hemophilia treatment centers (HTCs) that care for them – are united in their opposition to Graham-Cassidy-Heller-Johnson and urge the Senate to reject this harmful proposal. In particular, we are concerned that:

- **Graham-Cassidy will jeopardize access to private insurance plans:** The bill allows states to waive insurance rules to allow plans to charge people with pre-existing conditions and to change the essential health benefits (EHBs) requirements, which undermines the ban on lifetime and annual limits that applies only to EHBs. Patient protections are meaningless if insurance companies can charge individuals pre-existing conditions exorbitant rates and remove services for expensive conditions.
- **Graham-Cassidy will also lead to significant coverage losses for individuals on Medicaid:** The bill's repeal of the Medicaid expansion and significant cuts to Medicaid financing will jeopardize coverage for the approximately 30% of the bleeding disorders community – thousands of individuals – who are insured by the program.

People with hemophilia and other bleeding disorders live with a painful, lifelong, chronic condition that requires expensive medication and specialized care provided by HTCs and other specialists. Without access to comprehensive insurance, our community members will suffer. **The bleeding disorders community urges Senators to vote no on the Graham-Cassidy-Heller-Johnson legislation.**

HFA Hemophilia Federation of America

National Hemophilia Foundation *for all bleeding disorders*

The Coalition for Hemophilia B

The Hemophilia Alliance

Revised Cassidy-Graham ACA Repeal Plan
Statement of HIVMA Chair Wendy Armstrong, MD:
The HIV Medicine Association strongly urges our senators to reject the Cassidy-Graham bill, the latest proposal to repeal the Affordable Care Act, which would undo critical health reforms that have benefited millions of Americans, including many persons living with HIV. Instead, we appeal to senators to support the current bi-partisan and transparent process initiated to strengthen the individual market and lower coverage costs.

Last week the U.S. Census Bureau released the latest data confirming that, in 2016, the uninsured rate in the U.S. dropped to an historic low of 10.1 percent for those under 65 years of age. This latest repeal effort would reverse these coverage gains by ending the Medicaid expansion, capping and cutting Medicaid funding, block granting and cutting funding for premiums subsidies and allowing states to waive critical protections for individuals with pre-existing conditions, as well as other harmful provisions. Shifting the financial risk to states to administer the Medicaid program and the Marketplace plans in conjunction with allowing states to set coverage rules will exacerbate existing health disparities across the U.S. that are already acute for individuals with HIV in the southeastern states where the death rates are three times higher than in some other states.
The health of our patients with HIV and millions of others with chronic conditions depends on having consistent access to reliable, affordable, comprehensive healthcare coverage. This bill would fundamentally restructure and limit federal support for the Medicaid program, a critical safety net for many and an important source of support for more than 40% of individuals with HIV in care. Those with HIV can live long, healthy and productive lives with access to the appropriate health care and treatment; and when effectively treated, their risk of transmitting the virus is nearly zero.

Senators Cassidy and Graham's proposal, like the ACA repeal proposals before it, would put the health and lives of tens of thousands of persons living with HIV at risk. We appeal once more to our senators to stop once and for all efforts to repeal the ACA and turn to improving rather than dismantling critical health coverage reforms. Bipartisan efforts are already underway to develop legislation that will stabilize and improve the individual health insurance market. That is what a majority of Americans want and individual health, public health and the stability of our country depends on it.

Our concerns around the proposed "Graham-Cassidy" plan are similar to the concerns we stated previously in the year in regards to other nonpartisan proposals. Specifically, with this bill we are concerned it would:

- Cut and cap the traditional Medicaid program that covers long-term services and supports for seniors and people with disabilities beginning in 2020, cutting $175 billion between 2020 and 2026.

- End Medicaid expansion beginning in 2020, and replace that funding with a block grant to all states ending in 2026, cutting $239 billion in federal support.
    - Some of the 19 non-expansion states would get additional funds during the life of the block grant.
    - The 31 Medicaid expansion states like Ohio, however, would see their funds cut substantially.
    - Ohioans and health care providers would be hurt by this proposal. Many Ohioans would lose coverage and providers would fail receive reimbursement for services.
    - In the ACA provisions, health care providers took cuts in reimbursement with a stipulation that the number of uninsured American's would drop as the number of insured rose and reimbursement for services would then cover the costs of cuts.

Of critical importance, the permanent change to a per capita cap formula ends the federal guarantee of paying for Medicaid's health and long-term care costs.

- Federal support would no longer increase to account for economic downturns, new treatments, increasing prescription drug prices, the aging of the older adult population from the "young-old" to the "old-old," or other considerations.

- This would put enormous pressure on state budgets, forcing states to consider raising taxes, cutting spending on other essential programs, or reducing Medicaid enrollment.

We believe It is crucial that Senate Leaders not bring this bill before the Senate. To move forward, America and Ohio need a bipartisan bill that focuses on improving the health of its citizens and appropriately supports the financial underpinnings of the health care system.

We are asking Senator Brown strongly oppose support for this legislation.

With Gratitude,

Jeff

Jeff Lycan, President
Hospice Alliance of Ohio
jlycan@hospicealliianceofohio.org
614-530-8854

HOSPICE ALLIANCE OF OHIO

HUMAN SERVICE CHAMBER
OF FRANKLIN COUNTY
1515 INDIANOLA AVENUE
COLUMBUS, OH 43201

September 21, 2017

To Senator Rob Portman and Senator Sherrod Brown,

The State of Ohio stands to lose $9 billion in federal funding through 2026 if the Graham-Cassidy legislation were to become law, an ominous figure among many others that have unified the healthcare industry, the insurance industry, and a bipartisan group of 10 governors—including Ohio's John Kasich—in opposing this attempt to reshape our healthcare system.

We are eager for bipartisan solutions to make our healthcare system better, not worse. The partisan Graham-Cassidy bill would achieve the latter. This is why we stand against this legislation with industry experts and state executives—and the 809,000 Ohioans that would lose care.

The Human Service Chamber of Franklin County, which represents nearly 60 social service agencies working in housing, healthcare, food insecurity, education, immigration and more, joins that coalition in opposing Graham-Cassidy. The nonprofit sector in our county generates $6 billion in business activity and employs more than 50,000 people; this community knows that at a time when health crises such as the opioid epidemic are worsening dramatically, enormous cuts in healthcare expenditures would have an incalculably negative effect on our friends and neighbors across our community and our country.

The American Medical Association, the American Heart Association, the American Psychiatric Association, the National Council for Behavioral Health, the American Cancer Society Cancer Action Network, the American Diabetes Association, the American Lung Association, the March of Dimes, along with the two major insurance trade groups, the Blue Cross Blue Shield Association and America's Health Insurance Plans—they *all* oppose this legislation, as do five Democratic governors, four Republican governors, and one Independent governor.

Here are three critical reasons why.

- An independent analysis finds that Graham-Cassidy would reduce federal funding to Ohio by $9 billion through 2026, another $19 billion in 2027, and $161 billion over two decades, affecting children with disabilities, nursing home care, and mental health care.
- The legislation would cut coverage for a whopping 32 million Americans, 15 million of them losing that coverage in 2018 because Graham-Cassidy would end Medicaid expansion and tax credits for the Affordable Care Act's marketplace.
- Graham-Cassidy would allow insurance companies to discriminate against people with pre-existing conditions. States could decide to charge people with pre-existing conditions more for the care they require.

The Human Service Chamber of Franklin County urges you to stand with your constituents by working toward bipartisan healthcare reform. That effort must begin by opposing this bill.

Signed,

The Human Service Chamber of Franklin County

TELEPHONE 614.429.4238
TWITTER @ONEVOICEHSC
EMAIL MCOREY@HUMANSERVICECHAMBER.ORG
WEBSITE WWW.HUMANSERVICECHAMBER.ORG

HUMAN SERVICE CHAMBER OF FRANKLIN COUNTY
One voice. One community.

INTERNATIONAL FEDERATION OF PROFESSIONAL & TECHNICAL ENGINEERS
AFL-CIO & CLC

501 3rd Street, NW, Suite 701, Washington, DC 20001
202-239-4880 • FAX 202-239-4881 • www.ifpte.org

GREGORY J. JUNEMANN
President

PAUL SHEARON
Secretary-Treasurer

September 21, 2017

Dear Senator,

On behalf of the many working families we represent, the International Federation of Professional and Technical Engineers (IFPTE), urges you to oppose the latest Graham/Cassidy Affordable Care Act (ACA) repeal bill if it comes before the Senate for a vote next week.

Like other recent attempts to abandon millions of Americans, this latest ACA repeal legislation would still end Medicaid as we know it by morphing it from a federally-funded defined benefit program, administered by the States to meet the needs of their most vulnerable citizens, into a block grant system designed to shift Medicaid resources from States that accepted the ACA Medicaid expansion to those states that refused the expansion to the great detriment of its citizens. The bill also calls for a per-capita cap that would limit individual Medicaid coverage for our most vulnerable citizens, and it would end the block grant program altogether after 2026. Overall, this cruel bill will result in drastic reductions, and eventually an end in medical and long-term care coverage for tens of millions of Americans, their children, and their parents.

Amazingly, the Senate plans to take up this bill next week, without hearings to evaluate the damage it will do, and even without a proper score from the Congressional Budget Office (CBO). The American public and their lawmakers who will be voting will not be aware as to how many Americans will lose their health coverage, so passage would show utter contempt for the millions who stand to lose their lifeline to medical care. We should not lose sight of the fact that the last legislative attempt to repeal to the ACA would have resulted in lost coverage for 22 million people. Given the construction of the current bill, it is hard to see where that number will drastically improve, if at all. After all, the elimination of the individual mandate called for in the bill would completely sabotage the underlying ACA premise of shared risk and itself would result in 15 million losing coverage – a number that would only grow when you consider the devastating cuts to Medicaid, the eventual end to subsidies, and the complete elimination of the block grant funding after 2026. Based on past scores, well over 32 million people could lose coverage under this legislation.[1]

This bill would also make things worse by all but destroying the guarantee of affordable coverage for those Americans with pre-existing conditions by allowing States to opt-out of the key ACA protection against charging higher premiums to those with health problems. It is the height of dishonesty to argue that high-risk pools will provide an acceptable alternative to the ACA for the millions of Americans with pre-existing conditions; they would ultimately find their coverage completely unaffordable just as they need it the most.

Like previous attempts to repeal the ACA, the Graham/Cassidy bill would leave tens of millions of Americans without health coverage, would end the Medicaid program as we know it, and would lead to the loss of countless jobs for those dedicated souls providing and supporting medical care for their neighbors.

In lieu of this bill, Congress should instead move forward with hearings and bipartisan legislation to reform the weaknesses of Obamacare consistent with the recent bipartisan effort by Senators Alexander and Murray to bring stability to the individual market. Americans are looking for legislation to remedy the ACA's shortcomings while preserving its lifesaving expansion of access to healthcare for tens of millions of citizens who were previously forgotten.

IFPTE urges you to oppose this bill.

Sincerely,

Gregory J. Junemann,
President

[1] 9/20/2017, Center on Budget and Policy Priorities, Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market

Graham-Cassidy Proposal: Gigantic Block Grants and Huge Health Care Cuts

By:
Stan Dorn,
Eliot Fishman

Senators Graham (R-SC) and Cassidy (R-LA) have proposed a gigantic new block grant that would dramatically cut funding both for Medicaid expansion and for financial assistance that helps low-wage workers and moderate-income families buy private insurance.[1]

Cosponsored by Senator Heller (R-NV), the Graham-Cassidy plan brings back troubling features of health care repeal bills that the Senate rejected on a bipartisan basis: major cuts to the underlying Medicaid program and the revocation of key protections for people with preexisting conditions.

Congress should reject this or any other partisan proposal that takes health insurance away from tens of millions of Americans. Instead, lawmakers should focus on bipartisan approaches to stabilizing health insurance marketplaces.[2]

What's in the Graham-Cassidy proposal?

Their plan has three main elements.

1. **A new block grant that would slash federal funding currently slated for Medicaid expansion and for financial assistance with marketplace coverage.** After making huge cuts, the block grant would entirely end after 2026, leaving millions stranded without any federal help.

2. **Large Medicaid cutbacks like those in health care repeal proposals already rejected by the Senate on a bipartisan basis.** The underlying Medicaid program would be cut and restructured, posing serious risks to seniors, children with special health care needs, and others among the more than 70 million Americans who get their health coverage through Medicaid.[3]

3. **Elimination of consumer safeguards--a step similarly copied from health care repeal proposals already rejected by Senators from both parties.** State waivers would

effectively end important national standards for private coverage, taking away essential benefits from people with preexisting conditions.

What's wrong with block grants?

Block grants do not respond to changing circumstances. Each state gets a set amount of federal funding, which changes based only on population growth and inflation, rather than need. This creates serious problems.

States are forced to cut health care or other critical services during economic downturns, precisely when people need help the most

Under current law, when the next economic downturn hits, and more people qualify for help after losing employment and earnings, federal funding for Medicaid and marketplace subsidies automatically keeps pace. With a block grant, by contrast, no additional funding responds to increased need.

During the Great Recession, millions of Americans lost both earnings and coverage from employers, turning to Medicaid for help. With Congress increasing rather than capping available resources, federal Medicaid funding rose from 2008 to 2011 by 45 percent in Alaska, 89 percent in Arizona, 29 percent in Maine, 42 percent in Nevada, and 34 percent in West Virginia.[4] If the ACA's Medicaid expansion had been in place, these states would have benefited even more, since expansion coverage more than triples Medicaid's responsiveness to economic downturn.[5]

By contrast, the Graham-Cassidy block grant would have limited total federal funding growth to 2.1 percent per year or less, totaling a maximum 6.4 percent increase from 2008 to 2011.[6] If this proposal had been law, states would have faced a grim choice: deny health coverage precisely when residents most needed help; or preserve health coverage by raising taxes or cutting other state priorities, like education, social services, and infrastructure. States would face the same grim choice during future recessions if this bill becomes law.

Block grants prevent states from responding to unexpected health care needs

States often encounter significant, unexpected health care cost increases. They can result from epidemics of infectious disease; new and costly prescription drugs or medical technology; emerging health problems, like the opioid epidemic; or catastrophic weather events, like

Hurricane Harvey. Under current law, federal Medicaid funding and federal financial assistance for marketplace coverage automatically rise to share the cost of these unpredicted events.

Block grants would end that federal-state partnership, which has been at Medicaid's core since the program's inception. Instead, each state would be left on its own to shoulder the cost of unexpected health care problems. States that are experiencing hard times economically or that have a limited tax base would find themselves unable to respond, leaving residents without the help they need to cope with new and emerging health care challenges.

By making federal funding rigid rather than responsive to economic conditions, block grants kill jobs during recession

Today, federal funding for Medicaid and private insurance automatically rises if the economy declines and more people qualify for help. Additional federal dollars are spent on doctors, hospitals, and nurses, who buy other goods and services. The proposed Graham-Cassidy block grant would end this responsiveness, eliminating crucial support that limits economic damage in hard times.

The impact of such "automatic stabilizers" has been studied with unemployment insurance (UI), which, like Medicaid and ACA assistance for private insurance, automatically injects money into the economy during economic downturn. In the average quarter of the Great Recession, UI saved 1.6 million jobs and boosted gross domestic product by $123 billion, according to rigorous research.[7]

For 2020, UI benefits are projected to total $38.9 billion, or less than one-fourth the $166 billion in health care funding that the Graham-Cassidy plan would convert into a rigid block grant.[8] Health programs differ from UI in many important ways. However, their vastly greater size, compared to UI, suggests that the Graham-Cassidy proposal would substantially reduce the automatic infusion of federal dollars when economic contraction hits. The result: millions more Americans could lose their jobs.

Block grants let states divert federal resources away from needy residents and toward fiscal chicanery

Historically, block grants have let states redirect federal dollars away from services for needy residents.[9] The Graham-Cassidy plan fits squarely within that troubling tradition, authorizing the use of block-grant funds to "provide payments for health care providers for the provision of health care services." This remarkably broad language could provide opportunities to divert

federal dollars away from helping low- and moderate-income consumers obtain health insurance.

Uniquely troubling features of the Graham-Cassidy block grant

- It would cut $375 billion from Medicaid expansion and financial assistance for marketplace health coverage. The amount being cut would rise from 16 percent in 2020 to 34 percent in 2026.
- It would end all funding after 2026, leaving 29 million Americans stranded, without any known source of health insurance.
- It would arbitrarily redistribute federal money from some states to others. The proposal's convoluted formula would lower funding for nearly all states by 2026, but California, Connecticut, Delaware, D.C., Florida, Massachusetts, New Jersey, New York, North Carolina, and Virginia would experience particularly immediate and severe cuts.[10]
- It would replace not just Medicaid but also financial assistance with marketplace coverage for low-wage and moderate-income families. For the first time, states would become accountable for serving millions of privately insured residents who, until now, have been exclusively the federal government's financial responsibility.
- Unlike previous Republican proposals, the Graham-Cassidy plan would mandate block grants for all states, rather than give states a choice. Senators Graham and Cassidy would force every state to accept their block grant—even if a state objects that the block grant would do serious harm within its borders.

The Graham-Cassidy plan lets insurers deny essential services to people who need health care, including those with preexisting conditions

Like previously rejected partisan proposals to repeal health care coverage under the ACA, Graham-Cassidy would let states weaken standards that now require insurance companies to cover essential benefits, such as maternity care, treatment of mental health and substance use disorders, and prescription drugs—essential services that most individual market plans denied before the ACA.

The nonpartisan Congressional Budget Office (CBO) estimated that roughly half of the country's population lives in states that would eliminate benefit requirements.[11] According to CBO, people who live in those states "would experience substantial increases in out-of-pocket spending on health care or would choose to forgo the services. ...In particular, out-of-pocket spending on maternity care and mental health and substance abuse services could increase by thousands of

dollars in a given year" for people who need such care. States could also repeal other protections for people with preexisting conditions.

The Graham-Cassidy plan cuts and fundamentally restructures the underlying Medicaid program

Like earlier health care repeal bills rejected by bipartisan Senate majorities, this new plan would make major cuts to the traditional Medicaid program, which serves seniors, children, people with disabilities, parents, and pregnant women. The Graham-Cassidy proposal would limit federal per capita funding and give states the option to turn the entire Medicaid program into a block grant.

Reductions would total at least $41 billion a year by 2026,[12] with additional cuts if particular states experience faster-than-expected increases in health care costs. Other changes to the broad Medicaid program would eliminate federal funding for Planned Parenthood clinics, cut payment for hospital care, and let states impose new paperwork requirements that cause eligible consumers to lose health insurance.

Conclusion

The Graham-Cassidy proposal represents another extreme and partisan attempt to take health insurance away from tens of millions of Americans in working families. Rather than continue down a road that the American people and senators in both parties have already rejected,[13] Congress should focus its attention on bipartisan strategies to stabilize and strengthen the individual health insurance market.

September 21, 2017

Dear Senator,

I write on behalf of nearly 200,000 members of National Farmers Union (NFU) who are engaged in all forms of family farming and ranching. NFU's member-driven policy "affirms the right of all Americans to have access to affordable, quality health care." The Graham-Cassidy bill does not address the barriers that farmers and ranchers face in accessing health coverage, and it would only make matters worse.

We urge you to vote no on the legislation. NFU will be monitoring each Senator's vote and will include it in our Congressional scorecard.

The cost of healthcare has long been a primary concern of farmers and ranchers. American farmers are much older, more injury-prone, and endure higher levels of stress than workers in other industries. A recent USDA-funded study found that nearly three out of four farmers and ranchers report health insurance is an important risk management strategy for their operation. Without affordable access to quality coverage, farmers' and ranchers' personal health would be at risk, and so would the financial viability of their operations.

The Graham-Cassidy plan would eliminate tax credits, cost-sharing reductions, and subsidies for out of pocket costs. Each of these provisions is critical to making healthcare more affordable for family farmers and ranchers. Allowing insurance companies to charge older customers five times as much as younger customers would also be particularly troublesome for farmers, who average 58 years of age.

NFU is extremely concerned about the bill's effects on the non-group marketplace. The plan would create even more uncertainty in the marketplace, forcing insurance companies to raise premiums. The loss of marketplace subsidies in 2020 would exacerbate the problem, leaving the

marketplace far more unstable than it is currently. States would then be left with the challenge of devising their own marketstabilizing plans in the face of annual budget decreases.

The Graham-Cassidy bill would make it easier to deny farming and ranching families important protections and services. Two-thirds of farmers and ranchers report having a preexisting condition. The current requirement for insurance plans to cover 10 essential health benefits categories is particularly crucial for making prescription drugs, preventive services, and rehabilitative services affordable for family farmers and ranchers. The current prohibitions on lifetime and annual limits are also important protections for individuals with preexisting conditions. The Graham-Cassidy bill's amendments to the 1332 waiver would have disproportionate impacts on family farmers and ranchers.

NFU is strongly opposed to a per capita cap or block grant of Medicaid funding. Medicaid enrollment is higher in rural communities than in urban areas, and rural hospitals are more dependent on Medicaid payments than their urban counterparts. The correlation between a strong Medicaid program and the success of rural hospitals has become evident over the last six years. Over 70% of the 82 rural hospitals that have closed over the last six years are located in states that opted not to expand Medicaid. The cap to Medicaid funding would endanger rural hospitals even further.

Finally, NFU believes the lack of transparency in this process is unacceptable. The Graham-Cassidy plan would have far-reaching impacts on farmers, ranchers, and all Americans. Yet, there have been no hearings on this bill, and there will be no opportunity for a mark-up. The CBO stated their assessment of the bill will be extremely narrow, providing no clarity on how the bill will impact health insurance coverage or premiums. This process has robbed farmers and ranchers the opportunity to make their voices heard.

The Graham-Cassidy bill would harm farmers' and ranchers' access to quality, affordable health coverage. NFU urges you to vote no on the legislation and to begin a bipartisan approach to improving our nation's healthcare system.

Sincerely,

Roger Johnson President

Federation of American Hospitals released statements this morning opposing the latest repeal plan.

"The Graham-Cassidy proposal could disrupt access to health care for millions of the more than 70 million Americans who depend on Medicaid and the marketplaces for their health coverage," FAH chief executive Chip Kahn said in a statement

Cuomo says Congress could 'decimate' state health system

09/19/2017 07:52 PM EDT

Gov. Andrew Cuomo said Tuesday that the viability of New York's health care system, a $200 billion industry, is in jeopardy as Congress once again debates repealing the Affordable Care Act while cuts to the Disproportionate Share Hospital program are set to take effect.

"If either of those two contingencies happen, all bets are going to be off," Cuomo said during a press conference in Manhattan. "You'll have 12 holes in the dyke and you have 10 fingers. We would have to reconstruct the entire health care system."

Sitting in his midtown office, flanked by representatives from hospital trade groups and labor unions, the governor outlined a series of devastating scenarios that could unfold if the ACA is repealed and the DSH cuts are allowed to take effect:

— 2.7 million New Yorkers will be at risk of losing health insurance.

— 1.2 million New York jobs will be at risk.

— The federal government could defund Planned Parenthood.

— Billions of dollars in bonds issued by the state will be at risk of default as hospitals lose their revenue source and ability to repay loans.

"It is not too strong to say this would decimate the public hospitals and safety net hospitals in New York," Cuomo said. "Between the repeal of Obamacare and the DSH cuts, this is a devastating one-two punch to the state of New York."

A new Republican plan to repeal and replace Obamacare, which is gaining momentum in the U.S. Senate, would block-grant health care funding to states. That funding would then be cut over time and zeroed out in a decade.

The Center for Budget and Policy Priorities estimates the cuts will cost New York $18.9 billion.

"The destruction of the health care system is at hand," said Ken Raske, president of Greater New York Hospital Association. "It's like a ticking time bomb."

Proponents of the repeal bill argue that block-granting the money would give the states far more flexibility to administer the Medicaid program as governors see fit, an argument Cuomo quickly dismissed.

"I would not trade $19 billion for the flexibility," Cuomo said. "Because if they cut $19 billion, if I was as flexible as a Gumby doll, we could not fund our health care system."

New York's two senators, Chuck Schumer and Kirsten Gillibrand, have pledged to fight Republican efforts to repeal Obamacare, but they are in the minority and there is a limit to what they can do, Cuomo acknowledged.

The Senate, under reconciliation rules, has until Sept. 30 to pass its version of an Obamacare repeal-and-replace bill with only 51 votes. The bill would then move to House for an up-or-down vote. No changes would be allowed.

In the House, seven of the nine New York Republicans voted for the American Health Care Act, a version of Obamacare repeal that failed in the Senate but one that also would have cut billions from the state's Medicaid program.

"I don't know what they are thinking," Cuomo said of those seven members of Congress. "They were sent there to represent the people of their district. I don't know what action they are contemplating that does anything other than hurt the people of their district. ... Why they would want to cut assistance to their home state, disproportionately to their own state, defies comprehension. ... There is no way they can defend this when they come back home."

Reps. Tom Reed, Pete King and John J. Faso, all of whom voted for the American Health Care Act, have publicly stated their reservations about the Senate's latest efforts and the proposal's effects on New York.

Cuomo said the only reason he could fathom a New York Republican voting for the latest ACA replacement bill is to finance tax cuts for the wealthy.

"They need to find revenues to finance their tax cuts, and the place they always look to finance tax cuts for the richest is from the health system," Cuomo said.

It would be a cruel irony, Cuomo added, "that they are going to finance tax cuts for the richest by eliminating health care for the poorest."

Cuomo also implored Congress to postpone or repeal the Disproportionate Share Hospital payment cuts that take effect in 12 days.

As POLITICO New York reported last week, New York stands to lose $329 million in federal payments, according to a proposed rule from the Centers for Medicare and Medicaid Services. That's 16 percent of New York's total allotment and the largest cut, in terms of dollars, of any state.

The Medicaid DSH program is meant to help hospitals cover the uninsured and underinsured. The cuts to the federal program, which are supposed to total $43 billion between 2018 and 2025, and begin with $2 billion next year, help pay for the Affordable Care Act.

Under current state law, NYC Health + Hospitals, which treats 425,000 uninsured patients per year, would bear almost the entire burden of cuts to DSH funding in New York. The public hospital system estimates it could lose more than $300 million in federal funding next year because state law allows Health + Hospitals to dip into the DSH pot only after all other hospitals have taken their share.

"Without DSH funding, NYC Health + Hospital's essential mission to provide care for all, including the uninsured and underinsured, would be seriously threatened," a spokesman for the system said. "While the proposed cuts are not new, we will continue to make our case in Washington and Albany that these cutbacks have to be reduced and delayed."

Raske said last week that the cuts would be so devastating that he would ask the state to backfill the federal government.

Cuomo said on Tuesday that was impossible. The state, he noted, is already facing a $4 billion budget deficit. Even if the state could find $329 million to supplement next year's payment, the cuts in the out years would prove far too much for the state to bear.

"There is no way the state could pick up this cost," Cuomo said. "It is mathematically impossible. ... You don't have a lot of flexibility when you come in broke."

Hogan opposes latest version of Obamacare repeal bill

Michael DresserContact Reporter The Baltimore Sun

Gov. Larry Hogan urged Congress Tuesday to reject the latest version of a SenateRepublican plan to repeal Obamacare, saying it would cost Maryland $2 billion a year.

Hogan, a Republican, has so far opposed all of the measures supported by President Donald J. Trump to scrap the Affordable Care Act. The new version, known as Graham-Cassidy, faces a potentially close vote in the Senate before the end of September.

The governor released a statement emphasizing that the current law needs to be fixed, but he rejected the repeal measure sponsored by Republican Sens. Lindsey Graham of South Carolina and Bill Cassidy of Louisiana.

"Unfortunately, the Graham-Cassidy bill is not a solution that works for Maryland. It will cost our state over $2 billion annually while directly jeopardizing the health care of our citizens," Hogan said. "We need common sense, bipartisan solutions that will stabilize markets and actually expand affordable coverage."

Hogan called on congressional Republicans and Democrats to negotiate a deal to shore up the Affordable Care Act.

Hogan is not the only GOP governor to come out against Graham-Cassidy, which critics have called little different from a previous Republican bill that failed by one vote in the Senate in July. Four Republican governors joined with five Democrats and one independent in writing a letter to Congress opposing the legislation. They are Charlie Baker of Massachusetts, John Kasich of Ohio, Brian Sandovalof Nevada and Phil Scott of Vermont. Hogan issued his statement separately from the others.

Graham-Cassidy would replace the Obamacare Medicaid expansion that was embraced by Maryland, Massachusetts and other states with block grants that are expected to provide fewer dollars per patient. It would also eliminate the mandates for individuals to purchase health care insurance and for large employers to offer health care plans.

The measure has yet to be scored by the Congressional Budget Office for its likely effects on the number of Americans insured. Previous versions of an Obamacare repeal failed after the CBO estimated millions would lose coverage. Some proponents are pushing for a vote on Graham-Cassidy even without a score.

If Graham-Cassidy passes in the Senate, it would still have to go back to the House for a vote before it could go to Trump's desk.

News Release

For Immediate Release
September 18, 2017

Contact:
Governor Sununu Press Office
(603) 271-2121
Sununu.Press@nh.gov

Governor Chris Sununu Statement on Graham-Cassidy

Concord, NH – Today, Governor Chris Sununu issued the following statement regarding the Graham-Cassidy healthcare bill:

"While I continue to strongly believe that Obamacare must be reformed, it must be replaced with something that works for New Hampshire. The Graham-Cassidy healthcare plan has some laudable aspects, including offering more flexibility to states in managing Medicaid. Unfortunately, under this plan, New Hampshire could possibly lose over a $1 billion in Medicaid funding between 2020-2026. While innovative, consumer-driven programs that eliminate waste and provide flexibility is the direction our nation's health care must go, it is not practical for New Hampshire to craft a system with over $1 billion in cuts to federal funding. New Hampshire is proud of its tradition of not having an income tax or sales tax and remains vigilant against down-shifting of costs onto states that become general fund liabilities. As such, I cannot support this plan as it is currently drafted. It is my hope that Congress will continue to improve this plan to earn

New Hampshire's support. If given the opportunity, we stand ready to roll up our sleeves and craft a fiscally responsible system that works for all Granite Staters and does not ask us to subsidize the health care costs of other states."

GOVERNOR BULLOCK JOINS REPUBLICAN AND DEMOCRATIC GOVERNORS TO DEMAND CONGRESS REJECT LAST-DITCH EFFORT TO RIP HEALTHCARE FROM

BULLOCK ON CASSIDY-GRAHAM AMENDMENT: "WE NEED TO FIX HEALTHCARE, NOT DESTROY IT"

Governor Steve Bullock today joined a bipartisan group of governors urging Congress to reject the Graham-Cassidy-Heller-Johnson amendment and instead continue to pursue an open and transparent process to find bipartisan solutions on healthcare reform that include both Republican and Democratic governors.

"This last-ditch effort to rip healthcare from thousands of Montanans and millions of Americans is insulting to all of the folks trying to work across the aisle to find meaningful solutions," said Governor Bullock. **"We need to fix healthcare, not destroy it."**

In the joint letter, Governor Bullock (D-MT), Governor Hickenlooper (D-CO), Governor Kasich (R-OH), Governor Walker (I-AK), Governor Wolf (D-PA), Governor McAuliffe (D-VA), Governor Bel Edwards (D-LA), Governor Sandoval (R-NV), Governor Baker (R-MA), and Governor Scott (R-VT) wrote, **"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 health committees and input from the appropriate health-related parties. Improvements to our health insurance markets should control costs, stabilize the market, and positively impact coverage and care of millions of Americans, including many who are dealing with mental illness, chronic health problems, and drug addiction."**

Two weeks ago Governor Bullock testified in front of the U.S. Senate Committee on Health, Education, Labor & Pensions and urged the committee to focus on the immediate steps Congress can take to stabilize premiums and help individuals in the insurance market.

Governor Bullock has consistently urged Congress to work with Republican and Democratic governors to find bipartisan solutions to fix America's healthcare system. Last month, Bullock joined 4 other Democratic governors, 5 Republican governors, and 1 Independent to pursue an open, bipartisan process. Last month he joined a similar bipartisan group of governors to suggest a set of guiding principles to address rising healthcare costs and restore stability to insurance markets.

Bullock has publically criticized the secretive, one-party process to repeal and replace the Affordable Care Act as "exactly what's wrong with Washington, D.C" and blasted previous House and Senate proposals that would have damaging impacts on Montanans "half-baked and heartless."

Bullock worked with Republican and Democratic legislators to pass the Health and Economic Livelihood Partnership (HELP) Act, an innovative approach to Medicaid expansion. This has led to a dramatic drop in the number of Montanans without insurance. Nearly 80,000 Montanans have gained access to healthcare and the uninsured rate in Montana has dropped from a staggering 20% in 2013 to 7% in 2016.

Print

SEPTEMBER 6, 2017

Press Release: Health Care for America Now on McCain's Health Care Repeal Flip

For Immediate Release: September 6, 2017

Contact: Morgan Williams Grogan, morgan.williams@berlinrosen.com, 202-836-9890

Health Care for America Now on McCain's Health Care Repeal Flip

Washington, DC – Health Care for America Now (HCAN) co-directors Ethan Rome and Margarida Jorge released the following statement in response to Senator John McCain's (R-AZ) announcement of support for the Affordable Care Act (ACA) repeal legislation put forth by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA):

"The Graham-Cassidy repeal bill is as bad or worse than every other GOP repeal bill and Senator John McCain's flip-flop is an outrage. This isn't even a sheep in wolf's clothing. Just like every other repeal bill Republicans have attempted to jam through Congress this year, this proposal will wreck America's health care and blow up state budgets. You can't block grant the health care of millions of Americans and call that a health plan.

"This plan would have the same life-threatening and devastating consequences as the GOP repeal bill that Senator McCain voted against and that Americans have

overwhelmingly rejected. Under the Graham-Cassidy bill, millions of Americans will lose care and millions more will lose critical consumer protections.

"Instead of offering up more of the same, Congress should work to strengthen our health care markets and increase access to affordable care, as the U.S. Senate Committee on Health, Education, Labor and Pensions has started to do with its hearings this week and next."

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Health Care for America Now (HCAN) is the national grassroots coalition that ran a $60 million five-and-a-half year campaign from 2008-2013 to pass, protect, and promote the Affordable Care Act (ACA) and protect Medicare and Medicaid. HCAN has come back together to fight the Republicans' all-out effort to take away America's health care and put people at the mercy of the health insurance companies again.

September 19, 2017

For Immediate Release:

Statement by HANYS President Bea Grause on the Graham-Cassidy ACA Repeal Bill

ALBANY, N.Y. — HANYS and a broad coalition of partners—including consumers, workers, insurers, and providers—sent a joint letter today today urging the New York State Congressional Delegation to voice opposition to the Cassidy-Graham Affordable Care Act (ACA) repeal bill that could be approved by the U.S. Senate in coming days and sent to the House for a vote. This highly redistributive bill would result in devastating funding cuts to New York's healthcare system, restricting access to comprehensive healthcare coverage and necessary services.

By eliminating the ACA's tax credits and Medicaid expansion, shifting a lesser amount of funding into per capita block grants to states, Cassidy-Graham would result in New York State receiving $18.9 billion less in federal funding through 2026, without any assurances that even those meager block grant funding levels would continue beyond 2026.

The partisan politics of redistribution are at the core of this harsh bill, purposefully shifting federal funds away from New York State and other states that expanded Medicaid and to those states that have refused to expand their programs.

Protections for patients would no longer be guaranteed under this bill, as it would allow states to waive protections for individuals with pre-existing conditions and would jettison requirements that plans provide comprehensive coverage.

HANYS and our coalition partners urge the Delegation to reject the Cassidy-Graham bill and any other partisan approaches to healthcare that undermine expansion of comprehensive healthcare coverage and access to care.

HANYS also continues to press for bipartisan action in Washington to address other key priorities for hospitals and health systems and their patients. These include stopping the Medicaid Disproportionate Share Hospital (DSH) cuts that would devastate coverage for the most needy, reauthorizing the Medicare Dependent Hospital and Medicaid Low Volume Hospital programs, extending the Children's Health Insurance Program (CHIP), and stabilizing the health insurance exchanges, including continuing payment of Cost Sharing Reductions. HANYS is also working to address regulatory proposals that threaten the 340B drug cost savings program and hospital outpatient off-campus clinic Medicare reimbursement.

The Healthcare Association of New York State (HANYS) is the statewide hospital and continuing care association in New York State, representing hundreds of non-profit and public hospitals, nursing homes, home care agencies, and other healthcare organizations

Dear Colleagues:

We are writing once again to urge you to **reject yet another attempt to repeal major pillars of the Affordable Care Act (ACA) and overhaul the Medicaid program**. Every version of such legislation proposed so far—including the most recent one, the Graham-Cassidy-Heller-Johnson (GCHJ) proposal—would have severe negative consequences for reproductive health.

The ACA has greatly benefited U.S. women and families by increasing insurance rates nationwide and establishing important protections for contraception, maternity care and access to reproductive health providers. Conversely, the GCHJ proposal, like the prior House and Senate ones, would have harmful consequences for women and their families, including by drastically scaling back Medicaid and subsidized private coverage, barring Medicaid reimbursement to Planned Parenthood health centers, severely restricting private insurance coverage of abortion, allowing states to undermine protections for maternity care, and more. The Congressional Budget Office (CBO) is not being given the time it needs to make a proper assessment of this bill—something that should be a prerequisite before voting on any major piece of legislation—yet it is clear that GCHJ would lead to many millions more uninsured people in this country and would devastate both Medicaid and the individual insurance market.

More evidence and resources from the Guttmacher Institute are linked to below. If you have further questions or need more information, do not hesitate to contact me.

Best,

Heather Boonstra
Director of Public Policy
Guttmacher Institute

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The ACA has had particular benefits for U.S. women. The major coverage provisions of the ACA went into effect at the beginning of 2014 and had an impact on insurance coverage across the country for women of reproductive age (15–44). Nationally, the proportion of women aged 15–44 who were uninsured dropped by 36% between 2013 and 2015, after the ACA's coverage expansions had taken root. The change was driven by substantial gains in both Medicaid coverage and private insurance, but was especially pronounced in states that had expanded Medicaid under the ACA.

The ACA also 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. Privately insured women have experienced notable declines in out-of-pocket costs for contraception, an impact that has become more pronounced over time.

- **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.

- **Access to providers:** Safety-net health centers that provide family planning services have become an increasingly valued part of the health care system, delivering high-quality care to insured and uninsured individuals alike.

Conversely, the Graham-Cassidy-Heller-Johnson (GCHJ) proposal would have harmful consequences for women and their families. Like previous proposals in the House and Senate, the CGHJ proposal:

- Excludes Planned Parenthood health centers from Medicaid and other federal programs, jeopardizing women's access to high-quality contraceptive and related care nationwide.

- Drastically limits Medicaid coverage—the source of coverage for basic sexual and reproductive health services for 74 million U.S. residents, including 13 million women of reproductive age.

- Would likely result in more than 20 million people losing coverage (based on CBO estimates for previous, similar proposals), including coverage of the full range of contraceptive methods and counseling without additional cost-sharing.

- Allows states to eliminate the requirement that marketplace and other private health plans must cover 10 essential health benefits, including maternity care, and to undermine other important protections for patients, including those with preexisting medical conditions.

- Seeks to eliminate private insurance coverage of abortion, coverage that is already difficult for many women to obtain.

Moreover, GCHJ goes beyond previous House and Senate proposals through its harmful block grant provision, which 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. The block grant provision 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.

For all these reasons, the Guttmacher Institute strongly opposes GCHJ and urges you to oppose it.

Governor Wolf Opposes Graham-Cassidy; Urges Bipartisan Stabilization Progress

September 19, 2017

Harrisburg, PA – Today, Governor Wolf joined a group of bipartisan governors on a letter to U.S. Senate leadership opposing the Graham-Cassidy amendment. The governors asked that the Senate reject the proposed amendment and focus on bipartisan efforts already underway to stabilize health insurance markets and address affordability for consumers.

"Providing and protecting health care for all Americans should be a bipartisan effort," said Governor Wolf. "I am proud to join fellow governors in calling for Senate leadership to improve and stabilize our health insurance markets through bipartisan supported legislation. We must continue to work on protecting the gains we made in Pennsylvania and many other states that have allowed Americans to access affordable health care. For Washington to disrupt this process now and proceed out of regular order, the faith of the American people in the federal government would be further eroded."

Governor Wolf was joined by Governors Hickenlooper (Colorado), Kasich (Ohio), Walker (Alaska), Bullock (Montana), McAuliffe (Virginia), Edwards (Louisiana), Sandoval (Nevada), Baker (Massachusetts), and Scott (Vermont).

Read full text of the letter below. You can also view the letter on Scribd and as a PDF.

Dear Majority Leader McConnell and Minority Leader Schumer:

As you continue to consider changes to the American health care system, we ask you to not consider the Graham-Cassidy-Heller-Johnson amendment and renew support for bipartisan

efforts to make health care more available and affordable for all Americans. Only open, bipartisan approaches can achieve true, lasting reforms.

Chairman Alexander and Ranking Member Murray have held bipartisan hearings in the Senate's Health, Education, Labor and Pensions (HELP) Committee and have negotiated in good faith to stabilize the individual market. At the committee's recent hearing with Governors, there was broad bipartisan agreement about many of the initial steps that need to be taken to make individual health insurance more stable and affordable. We are hopeful that the HELP committee, through an open process, can develop bipartisan legislation and believe their efforts deserve support.

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 health committees and input from the appropriate health-related parties. Improvements to our health insurance markets should control costs, stabilize the market, and positively impact coverage and care of millions of Americans, including many who are dealing with mental illness, chronic health problems, and drug addiction.

We look forward to continuing to work with you to improve the American health care system.

Governor John Kasich (R-OH): "Somehow, they keep missing the point. A partisan push, without even one single committee hearing, isn't how to move [forward] on health care. Graham/Cassidy/Heller/Johnson eliminates the guardrails that protect some of the most vulnerable among us."

BIG CITIES HEALTH COALITION

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SOUTHERN NV (LAS VEGAS)
TARRANT COUNTY (FORT WORTH)
WASHINGTON, D.C.

September 18, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

The Big Cities Health Coalition (BCHC) opposes the current version of the proposal to replace the Affordable Care Act being circulated by Senators Lindsey Graham (R-SC) and Bill Cassidy, MD (R-LA). The long-standing public health programs that are currently in jeopardy due to elimination of the Prevention and Public Health Fund (PPHF) in this proposal would be devastating for our 28 large, urban health departments – and to the nation as a whole.

BCHC is a forum for the leaders of America's largest metropolitan health departments to exchange strategies and jointly address issues to promote and protect the health and safety of their residents. Collectively, BCHC member jurisdictions directly impact more than 54 million people, or one in six Americans.

Among the programs at risk at the CDC are the 317 Immunization Program, Epidemiology and Laboratory Capacity Grants, Childhood Lead Poisoning Prevention Program, and a host of chronic disease programs. The PPHF provides vital resources to governmental public health at all levels, and its elimination will further erode our fragile health system.

Eliminating public health programs that are now funded by the ACA would seriously undermine the ability of cities and counties to protect and promote health. The loss of hundreds of millions of dollars would hamper efforts to respond to food borne illness outbreaks, prevent emerging infectious diseases like Ebola and Zika, and respond to natural disasters like Hurricanes Irma and Harvey.

Further, we are also concerned that the Graham-Cassidy proposal would block grant many of the current ACA protections, which provide access to primary and emergency care to millions of Americans. Erosion of the essential benefits package would jeopardize access to primary prevention services, including immunizations, mammograms, and other health screening tests.

Our nation needs a strong public health system with the capacity to promote health, prevent illness, and treat disease. Our members urge you to sustain current investments in public health and prevention by rejecting the Graham-Cassidy proposal.

Sincerely,

Chrissie Juliano, MPP
Director, Big Cities Health Coalition

through a wide variety of services affecting a large segment of the population, including acute care, long-term care and home health, mental health, and substance abuse services, as well as neo-natal programs and maternity care. The program covers nearly 50 percent of all U.S. births and helps reduce unemployment and homelessness by stabilizing individuals' health. Additionally, Medicaid provides states the ability to design the program to fit their state's needs, enables innovation and also holds states financially accountable for their proportional share of the costs of the program.

Again, we urge you to oppose the Graham-Cassidy-Heller-Johnson legislation and instead to focus on bipartisan reform efforts to strengthen and expand the health insurance coverage gains already achieved, and improve the stability and affordability of the insurance market.

While the ACA is not a perfect law, and should be improved where necessary, no attempt to do so should leave behind millions of people who have obtained meaningful, affordable insurance that was not possible before the ACA. We stand ready to work with all members of Congress to improve the availability, affordability, coverage and quality of our health care system. But above all, we urge you always to keep in mind the many millions of vulnerable individuals and families who will be affected by such changes to our health care system.

Sincerely,

Sister Carol Keehan

Sr. Carol Keehan, DC
President and CEO

CHA
Catholic Health Association
of the United States

A Passionate Voice for Compassionate Care

September 19, 2017

United States Senate
Washington, DC 20510

Dear Senator,

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations, **I strongly urge you to reject the Graham-Cassidy-Heller-Johnson legislation and instead support bipartisan efforts to improve our health care system** focusing on insurance market stabilization, affordability, and coverage access and expansion.

The Graham-Cassidy legislation would eliminate the ACA Medicaid expansion coverage, premium tax credits and cost-sharing subsidies after 2019 and replace them with a seven-year block grant to states. **This new block grant is estimated to provide $95 billion less to states from 2020 to 2026 than under current law, after which the grants end.** The loss of funding to states in 2027 alone is over $231 billion. **The result will be unbearable cost shifting to patients, health providers and states, causing loss of coverage for tens of millions of individuals and families.** States that have expanded Medicaid or have high Marketplace costs or enrollment will face the deepest cuts under the state block grant, as funding would no longer be tied to actual coverage costs or the number of individuals enrolled in coverage.

Among other provisions, we are opposed to the broad waiver authority given to states, which could undermine key consumer protections such as restrictions on premium variation; essential health benefit requirements; minimum medical loss ratios; caps on annual and lifetime out-of-pocket charges; and protections keeping those with pre-existing conditions from being charged higher premiums. **We also are strongly opposed to this legislation's complete restructuring and deep funding reductions—estimated to be $164 billion in cuts through 2027—to the traditional Medicaid program. Capping federal Medicaid funding, either with per capita caps or block grants, fundamentally undermines the health care safety net and our ability to serve beneficiaries.** As several of our nation's governors have stated, such proposals simply shift the cost burden onto local and state governments, individual beneficiaries and health providers. None of these could possibly make up for the huge loses in federal funding, in turn causing millions of vulnerable, low-income income individuals and families to lose coverage. Medicaid is already a lean program, with spending per beneficiary considerably lower than private insurance and growth in spending per beneficiary slower than private insurance.

As you know, Medicaid is the foundation of our nation's safety net and provides necessary health care services to low-income children, pregnant women, individuals, seniors, disabled and medically complex individuals in our country. Medicaid provides essential support

STATEMENT BY U.S. CONFERENCE OF MAYORS PRESIDENT AND NEW ORLEANS MAYOR MITCH LANDRIEU ON THE GRAHAM-CASSIDY ACA REPEAL AND REPLACE PLAN

Share

September 19, 2017 18:46 ET | **Source:** The U.S. Conference of Mayors

Washington, D.C, Sept. 19, 2017 (GLOBE NEWSWIRE) -- As the Senate tries to advance its latest health care repeal plan, the U.S. Conference of Mayors President and New Orleans Mayor Mitch Landrieu released the following statement:

"The Graham-Cassidy ACA repeal and replace plan is a bad pill for the American healthcare system. The Senate leadership has once again engaged in exactly the back door, secretive dealings Senator McCain warned about when he voted 'no' on their last attempt to repeal the ACA. In this case, we fear Senate Republicans have produced a bill that would have the same, if not a deeper and more devastating, impact to the nation's healthcare system and on millions of families across the country.

"We say 'fear' because we won't know exactly how many people will be left uninsured by this bill because the Congressional Budget Office (CBO) will be unable to render a full analysis of the bill before the September 30 Senate deadline.

"What we do know is like earlier attempts, this bill would force Americans in cities big and small to pay more for less care and would end Medicaid expansion, which has been a lifeline for children, seniors, people with disabilities and substance use disorders. This proposal would let Washington walk away, and saddle state and local governments with the skyrocketing healthcare costs – forcing them to cover fewer people, reduce care, or make up the cost by cutting other needed programs.

"For mayors across the country, this bill is a nonstarter. We again urge Washington to start over, abandon these dangerous proposals and work with mayors and governors who are closest to the people to craft fixes to the current system and ensure access to affordable healthcare."

###

The U.S. Conference of Mayors is the official nonpartisan organization of cities with populations of 30,000 or more. There are nearly 1,400 such cities in the country today, and each city is represented in the Conference by its chief elected official, the mayor. Like us on Facebook at facebook.com/usmayors, or follow us on Twitter at twitter.com/usmayors

September 20, 2017

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

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

Re: Opposition to Graham-Cassidy Proposal

Dear Leader McConnell and Minority Leader Schumer: The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, costeffective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 141 million patients that visit U.S. emergency departments each year. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn. We are writing to urge you not to hold a vote on the healthcare proposal from Senators Cassidy, Graham, Heller, and Johnson to repeal and replace the Affordable Care Act (ACA). Further, if it is brought to the floor for a vote, we urge you to oppose it. Current Medicaid Patients Must Be Adequately Insured for Emergency Care in the Future Emergency departments are the nation's health safety net. Federal law – through the Emergency Medical Treatment & Labor Act (EMTALA) - requires hospitals and physicians to evaluate and stabilize everyone visiting the emergency department, no matter the ability to pay. So, even though emergency physicians are

only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients.

The Congressional Budget Office has not had an opportunity to estimate the number of children and adults who will lose health care coverage under the Cassidy-Graham proposal. However, because the proposal includes many provisions that were in earlier versions of repeal and replace legislation, tens of millions are expected to lose coverage. Many who support deep cuts to Medicaid argue that individuals would still be able to receive EMTALA-mandated care in the emergency department. However, a shift to more uncompensated EMTALA care would

seriously jeopardize the nation's health safety net. The demand for care in the nation's emergency departments would skyrocket while significantly fewer physicians would be attracted to a specialty that is not fairly compensated. This, in turn, would significantly threaten access to care for everyone.

Therefore, as you consider shifting current Medicaid patients into a less robust Medicaid program, into a different program altogether, or off the rolls, we urge you to ensure that these patients continue, at minimum, to be fully insured for emergency care so EMTALA-mandated care is compensated care. As part of this request, we ask you to ensure that the prudent layperson standard (PLP) is incorporated and reiterated in all Medicaid plans. The PLP is the well-established standard, reiterated in the Balance Budget Act of 1997, which requires plans to reimburse for emergency care when a prudent layperson believes he or she may be experiencing an emergency, including when he or she is experiencing severe pain. Plans may not require

preauthorization in these circumstances. And the final determination on reimbursement should take into account the presenting symptoms rather than the final diagnosis.

Emergency Care Must Be Covered as an Essential Health Benefit The Emergency Department is not only the safety net for Medicaid patients and the uninsured, it is also the safety net for patients covered by private insurance. The rise in narrow networks and ever increasing deductibles are contributing to an epidemic of "medical homeless," leaving the emergency department (ED) as the only option for many insured patients.

We oppose provisions in the Graham-Cassidy proposal that make it easier for states to waive the requirement that policies cover essential health benefits (EHB) such as emergency care. Requiring private insurers to cover EMTALA-mandated care is especially important because, as noted above, emergency physicians already provide a significant and disproportionate amount of uncompensated and undercompensated care. If emergency care is so essential that it is mandated, it also should be essential enough to be covered care.

Furthermore, consistent with the importance of covering emergency care as an essential health benefit, the PLP standard discussed in the previous section should be incorporated into and reiterated in all private insurance plans.

We also oppose provisions in the Graham-Cassidy proposal that allow states to waive the ACA prohibition against increasing premiums due to preexisting conditions.

It's Time to Shrink the Surprise Gap in Private Insurance If you do not bring the Graham-Cassidy proposal up for a vote at this time, there will be more time to consider important amendments that address the current problem of the surprise gap in insurance. Unfortunately, under current law, private insurance "coverage" of emergency care is often a misnomer. Insurers often are unwilling to negotiate fair and sustainable reimbursement rates that reflect the true cost of providing EMTALA-mandated care. So, some patients visiting the

emergency department will be treated by an out-of-network emergency physician and be financially responsible for a large portion of those charges through their deductible. This is especially true as more insurers offer high deductible plans. This surprise gap in insurance – which is often a very large gap - is a serious problem for many patients. It is time to shrink this gap by requiring insurers to contribute to the cost of emergency care. When implementing the ACA, the Department of Health and Human Services, the Department of Labor, and the Treasury Department stated that "it would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to [an emergency] provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts." Thus, "a plan or issuer must pay a reasonable amount for emergency services by some objective standard." Unfortunately, the Obama Administration's proposed standard – known as the greatest-of-three rule – is vague and unenforceable. Although it was well-intentioned and also references usual and customary charges, it nonetheless allows insurers to determine reimbursement levels unilaterally and in relative isolation, and pay at levels that have little or no connection to the market rate. And the process is not transparent, so patients and providers are not able to identify or prove noncompliance. We propose improving this standard so insurers are more clearly

required to reimburse for outof-network emergency care, at minimum, in an amount equal to the usual and customary charge. The usual and customary charge should be defined by referencing an independent (unbiased) transparent charge database, like FAIR Health. We urge you to establish the standard adopted in the state of Connecticut which requires insurers to pay, at minimum, the 80th percentile of an independent, nonprofit, transparent charge database. With these changes, the payment standard would be an objective standard and would: * protect patients from the growing surprise gap in insurance, * ensure that physicians are reimbursed for EMTALA-mandated care, * avoid setting reimbursement rates that are disconnected from the fair market, and * establish transparent standards that are easy to comply with and enforce.

The EDPMA appreciates the opportunity to share our concerns and provide potential solutions. Please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance. Sincerely,

Andrea Brault, MD, FACEP, MMM, Chair of the Board Emergency Department Practice Management Association (EDPMA)

Endocrine Society Opposes Graham-Cassidy

- SEP 2017

In a letter to Senate Majority Leader Mitch McConnell (R-KY) and Senate Minority Leader Chuck Schumer (D-NY), the Endocrine Society is calling for a bipartisan effort to focus on market stabilization as opposed to the recent proposal to end the Affordable Care Act brought by Republican senators Lindsay Graham (R-SC) and Bill Cassidy (R-LA).

Authored by Endocrine Society CEO Barbara Byrd Keenan, the letter states that this new proposal would negatively impact patients' access to adequate and affordable health coverage, preventive services, and patient-centered care.

Here is the rest of the letter in full:

"Our members care for people with complex, chronic diseases, such as diabetes, obesity, osteoporosis, infertility, rare cancers and thyroid conditions. These diseases affect growing numbers of people, placing stress on the health care system. Our more than 18,000 members care for patients and are dedicated to advancing hormone research and excellence in the clinical practice of endocrinology. We promote policies to help ensure that all individuals with endocrine diseases have access to high quality, specialized care and adequate, affordable health insurance.

Affordable, adequate care is vital to the patients we represent. This legislation fails to provide Americans with what they need to maintain their health. It would limit funding for the Medicaid program, roll back important essential health benefit protections, and potentially allow annual and lifetime caps on coverage, endangering access to critical care for millions of Americans. In addition, it also fails to achieve the other principles our Society has identified for health reform legislation: inclusion of preventive health benefits and maintenance of the Prevention and Public Health Fund; creation of new care models focused on providing coordinated care for people who are treated by multiple health care providers; and protection of women's health, including ensuring that all women have continued access to necessary health care services, contraception, and preventive screenings.

Instead of this legislation, we urge you to continue the bipartisan effort led by Chairman Lamar Alexander and Ranking Member Patty Murray in the Senate Health, Education, Labor and Pensions (HELP) Committee and by Chairman Orrin Hatch and Ranking Member Ron Wyden in the Senate Finance Committee focused on market stabilization and other critical issues.

We urge you to continue bipartisan efforts rather than advancing a proposal that would weaken access to the care Americans need and deserve, and we would like to work with both sides of the aisle to ensure that the needs of endocrine patients are fully considered as policies affecting access to health insurance and the healthcare system are considered."

Dear Senator Brown,

The Council for Exceptional Children (CEC) is concerned that the Graham-Cassidy bill jeopardizes healthcare for the nation's most vulnerable children: children and youth with disabilities and those in poverty. Specifically, Graham-Cassidy reneges on Medicaid's 50+ year commitment to provide America's children with access to vital healthcare services that ensure they have adequate developmental and educational opportunities and can contribute to society by imposing a per-capita cap and shifting current and future costs to taxpayers in every state and Congressional district. While children currently comprise almost half of all Medicaid beneficiaries, less than one in five dollars is spent by Medicaid on children. Accordingly, a per-capita cap, even one that is based on different groups of beneficiaries, will disproportionately harm children's access to care, including services received at school and early intervention programs. **Considering these unintended consequences, CEC urges a 'no" vote on Graham-Cassidy.**

Medicaid is a cost-effective and efficient provider of essential health care services for children. School-based and early intervention Medicaid programs serve as a lifeline to children who can't access critical health care and health services outside of their school or early intervention program. Under this bill, the bulk of the mandated costs of providing health care coverage would be shifted to the States even though health needs and costs of care for children will remain the same or increase. Like the Better Care Reconciliation Act, which is incorporated into Graham-Cassidy it is projected that the Medicaid funding shortfall in support of these mandated services will increase, placing states at greater risk year after year. The federal disinvestment in Medicaid imposed by Graham-Cassidy will force States and local communities to increase taxes and

reduce or eliminate various programs and services, including other non-Medicaid services. The unintended consequences of Graham-Cassidy will force states to cut eligibility, services, and benefits for children.

The projected loss of hundreds of billions in federal Medicaid dollars will compel States to ration health care for children. Under the per-capita caps included in Graham-Cassidy , health care will be rationed and schools and early intervention programs will be forced to compete with other critical health care providers—hospitals, physicians, and clinics— that serve Medicaid-eligible children. School and early intervention based health services are mandated on the States and those mandates do not cease simply because Medicaid funds are capped by Graham-Cassidy. As with many other unfunded mandates, capping Medicaid merely shifts the financial burden of providing services to the States.

Medicaid Enables Schools to Provide Critical Health Care for Children and Youth

A school's primary responsibility is to provide students with a high-quality education. However, children cannot learn to their fullest potential with unmet health needs. As such, school district personnel regularly provide critical health services to ensure that all children are ready to learn and able to thrive alongside their peers. Schools deliver health services effectively and efficiently since school is where children spend most of their days. Increasing access to health care services through Medicaid improves health care and educational outcomes for students. Providing health and wellness services for students in poverty and services that benefit students with disabilities ultimately enables more children to become employable and attend higher-education.

Since 1988, Medicaid has permitted payment to schools and early intervention programs for certain medically-necessary services provided to children under the Individuals with Disabilities Education Act (IDEA) through an individualized education program (IEP) or individualized family service program (IFSP). Programs are thus eligible to be reimbursed for direct medical services to Medicaid-eligible children with an IEP or IFSP. In addition, programs can receive Medicaid reimbursements for providing Early Periodic Screening Diagnostic and Treatment Benefits (EPSDT), which provide Medicaid-eligible children under age 21 with a broad array of diagnosis and treatment services. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible before the problems become complex and treatment is more expensive.

School districts use their Medicaid reimbursement funds in a variety of ways to help support the learning and development of the children they serve. In a 2017 survey of school districts, district officials reported that two-thirds of Medicaid dollars are used to support the work of health professionals and other specialized instructional support personnel (e.g., speech-language pathologists, audiologists, occupational therapists, school psychologists, school social workers, and school nurses) who provide comprehensive health and mental health services to students. Districts also use these funds to expand the availability of a wide range of health and mental health services available to students in poverty, who are more likely to lack consistent access to healthcare professionals. Further, some districts depend on Medicaid reimbursements to purchase and update specialized equipment (e.g., walkers, wheelchairs, exercise equipment, special playground equipment, and equipment to assist with hearing and seeing) as well as assistive technology for students with disabilities to help them learn alongside their peers.

School districts and early intervention programs would stand to lose much of their funding for Medicaid under the Graham-Cassidy. Programs currently receive roughly $4 billion in Medicaid reimbursements each year. Yet under this proposal, states would no longer have to consider schools as eligible Medicaid providers, which would mean that districts would have the same obligation to provide services for students with disabilities under IDEA, but no Medicaid dollars to provide medically-necessary services. Schools would be unable to provide EPSDT to students, which would mean screenings and treatment that take place in school settings would have to be moved to physician offices or hospital emergency rooms, where some families may not visit regularly or where costs are much higher.

In addition, basic health screenings for vision, hearing, and mental health problems for children would no longer be possible, making these problems more difficult to address and expensive to treat. Moving health screenings out of schools and early intervention programs also reduces access to early identification and treatment, which also leads to more costly treatment down the road. Efforts by schools and early intervention programs to enroll eligible children in Medicaid, as required, would also decline.

The Consequences of Medicaid Per Capita Caps Will Potentially Be Devastating for Children:

Significant reductions to Medicaid spending could have devastating effects on our nation's children, especially those with disabilities. Due to the underfunding of IDEA, districts rely on Medicaid reimbursements to ensure students with disabilities have access to the supports and

services they need to access a Free and Appropriate Public Education (FAPE) and Early Intervention services. Potential consequences of this critical loss of funds include:

- Fewer health services: Providing comprehensive physical and mental health services in schools and early intervention programs improves accessibility for many children and youth, particularly in high-needs and hard-to-serve areas, such as rural and urban communities. In a 2017 survey of school district leaders, half of them indicated they recently took steps to increase Medicaid enrollment in their districts. Reduced funding for Medicaid would result in decreased access to critical health care for many children.
- Cuts to general education: Cuts in Medicaid funding would require districts to divert funds from other educational programs to provide the services as mandated under IDEA. These funding reductions could result in an elimination of program cuts of equivalent cost in "non-mandated" areas of regular education.
- Higher taxes: Many districts and early intervention programs rely on Medicaid reimbursements to cover personnel costs for their special education and early intervention programs. A loss in Medicaid dollars could lead to deficits in programs that require increases in property taxes or new levies to cover the costs of the programs.
- Job loss: Districts and early intervention programs use Medicaid reimbursement to support the salaries and benefits of the staff performing eligible services. Sixty-eight percent of districts use Medicaid funding to pay for direct salaries for health professionals who provide services for students. Cuts to Medicaid funding would impact districts' ability to maintain employment for school nurses, physical and occupational therapists, speech-language pathologists, school social workers, school psychologists, and many other critical school personnel who ensure students with disabilities and those with a variety of educational needs are able to learn.

- Fewer critical supplies: Districts and early intervention programs use Medicaid reimbursement for critical supplies such as wheelchairs, therapeutic bicycles, hydraulic changing tables, walkers, weighted vests, lifts, and student-specific items that are necessary for each child to access curriculum as closely as possible to their non-disabled peers. Replacing this equipment would be difficult if not impossible without Medicaid reimbursements.
- Fewer mental health supports: Seven out of ten students receiving mental health services receive these services at school. Cuts to Medicaid would further marginalize these critical services and leave students without access to care.

CEC urges you to carefully consider the important benefits that Medicaid provides to our nation's most vulnerable children. Schools and early intervention programs are often the hub of the community, and converting Medicaid's financing structure to per-capita caps threatens to significantly reduce access to comprehensive health and mental and behavioral health care for children with disabilities and those living in poverty. CEC looks forward to working with you to avert the harmful and unnecessary impacts Graham-Cassidy would impose on Medicaid, which has proven to benefit children in a highly effective and cost-effective manner.

If you have questions about the letter or wish to meet to discuss this issue further, please do not hesitate to reach out to me at debz@cec.sped.org.

Sincerely,

Deborah A. Ziegler

Director, Policy and Advocacy

BlueCross BlueShield Association

Statement

Blue Cross Blue Shield Association
1310 G Street, N.W.
Washington, D.C. 20005-3001
www.BCBS.com

For Immediate Release:
September 20, 2017

Contact:
Eric Lail
202.626.8625
eric.lail@bcbsa.com

Blue Cross Blue Shield Association Statement on the Graham-Cassidy Health Care Reform Proposal

WASHINGTON – The Blue Cross Blue Shield Association issued the following statement today in response to the health care reform bill proposed by Senators Lindsey Graham (R-SC), Bill Cassidy (R-LA), Dean Heller (R-NV) and Ron Johnson (R-WI).

"Blue Cross and Blue Shield companies are committed to ensuring that all Americans have access to health insurance coverage and the peace of mind that comes with it. The current market is not working, and we will continue to work with lawmakers on a bipartisan basis to improve the individual insurance marketplace with the goal of making coverage more affordable and accessible for all.

Although we support providing states with greater flexibility in shaping health care options for their residents, we share the significant concerns of many health care organizations about the proposed Graham-Cassidy bill. The bill contains provisions that would allow states to waive key consumer protections, as well as undermine safeguards for those with pre-existing medical conditions. The legislation reduces funding for many states significantly and would increase uncertainty in the marketplace, making coverage more expensive and jeopardizing Americans' choice of health plans. Legislation must also ensure adequate funding for Medicaid to protect the most vulnerable.

We will continue to work with lawmakers on solutions to improve Americans' health care and assure that people can access the coverage and care they need."

About Blue Cross Blue Shield Association

The Blue Cross and Blue Shield Association 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. BCBSA provides health care insights through The Health of America Report series and the national BCBS Health Index. For more information on BCBSA and its member companies, please visit bcbs.com. We also encourage you to connect with us on Facebook, check out our videos on YouTube, follow us on Twitter and check out The BCBS Blog.

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Bennet Statement on Graham-Cassidy Bill

Washington, D.C. - Colorado U.S. Senator Michael Bennet today issued the following statement regarding the Graham-Cassidy bill to repeal and replace the Affordable Care Act:

"I can't decide whether this is Groundhog Day or the definition of insanity: every attempt is worse than the last. This latest version cuts nearly $1 billion in funding to Colorado, sets up a nonsensical cliff in coverage, and puts patient protections at risk. The bipartisan process in our committee was making progress. Why would we abandon it now? This is exactly why Coloradans have lost so much faith in Washington."

Bennet is a member of the Senate Committee on Health, Education, Labor, and Pensions.

Blue Cross Blue Shield Of Massachusetts Releases Statement On Proposed Graham-Cassidy Health Care Legislation

MASSACHUSETTS

NEWS PROVIDED BY
Blue Cross Blue Shield of Massachusetts
Sep 19, 2017, 15:08 ET

BOSTON, Sept. 19, 2017 /PRNewswire-USNewswire/ -- In response to legislation proposed by Senators Bill Cassidy (R-LA) and Lindsey Graham (R-SC), Andrew Dreyfus, President & CEO of Blue Cross Blue Shield of Massachusetts, released the following statement:

"As the Senate continues its efforts on health care reform, we have serious concerns about the proposed Graham-Cassidy legislation, which calls for significant cuts to Medicaid and contains provisions that would allow states to remove protections for those with pre-existing conditions.

The bill would destabilize state insurance markets and undermine the ability to provide quality, affordable coverage and care to everyone, regardless of condition. As a nation, we've reached a historically high insured rate among our citizens – this bill has the potential to jeopardize these meaningful gains in coverage.

This legislation would also affect Massachusetts disproportionately, by significantly reducing critical federal funding to support the Commonwealth's continued commitment to universal health care coverage. By some estimates, our state's federal funding could be cut by more than $5 billion by 2026. The targeting of specific states puts politics over policy at the expense of those most in need of care.

We urge our elected leaders to continue working in a bipartisan spirit toward legislation that promotes access to high-quality, affordable care."

About Blue Cross Blue Shield of Massachusetts

Blue Cross Blue Shield of Massachusetts (bluecrossma.com) is a community-focused, tax-paying, not–for–profit health plan headquartered in Boston. We're the trusted health plan for more than 25,000 Massachusetts employers and are committed to working with others in a spirit of shared responsibility to make quality health care affordable. Consistent with our corporate promise to always put our 2.8 million members first, we're rated among the nation's best health plans for member satisfaction and quality. Connect with us on Facebook, Twitter, YouTube, and LinkedIn.

Senator Brown:

As the Aging & Disability Resource Network for the 8-county region in SE Ohio including Athens, Hocking, Meigs, Monroe, Morgan, Noble, Perry & Washington Counties, Buckeye Hills Regional Council is concerned about the Graham-Cassidy bill and how it may Impact Medicaid in Ohio. Buckeye Hills administers the Ohio PASSPORT and Assisted Living program Waivers serving seniors and those with disabilities at home, where they prefer to be.

Our care managers work with the family, physician and home health workers to customize a care plan that includes home delivered meals, personal care, chore service, emergency response systems, home medical equipment, transportation, and other such services. Last year, 1,280 individuals were served. Clients received $13,288,025 in services from 142 providers.

The average yearly PASSPORT plan cost in the Buckeye Hills region was $13,794 (an average monthly plan cost of $1,262.) According to the Administration on Aging, average nursing home costs in our region are $40,841-$43,472 annually. Thanks to the Ohio aging network's success administering the PASSPORT program, older and disabled adults avoid or delay admission to more expensive and restrictive nursing homes.

Our national association of area agencies on aging indicates that the Graham-Cassidy bill may fundamentally restructure the Medicaid program giving states the flexibility to cut

services – such as eliminating options to provide long-term services and supports (LTSS) at home and in the community.

We trust that you will monitor the bill's ability to limit much-needed home and community-based services for Ohio's elders and those with disabilities. We invite you to join us for a home visit with an Ohio PASSPORT consumer, at your convenience so that you may fully see the depth and breadth of services provided through this successful waiver program.

Below is a link to a recent PASSPORT Medicaid waiver consumer story that shares how the program supports independence at home and saves Ohio's taxpayers.
http://buckeyehills.org/2017/08/18/passport-program-supports-independence-at-home/

Thank you for your continued advocacy for Ohio's aging and disabled constituents.

Gwynn Stewart
Communications Director

BUCKEYE • HILLS
regional council

1400 Pike Street | Marietta, OH 45750
1.800.331.2644 x2100
o: 740.376.1030 f: 740.472-1258

STATEMENT: CAP Slams Latest Senate Republican Effort to Repeal the ACA

- **Date:** September 13, 2017
- **Contact:** Devon Kearns
- **Email:** dkearns@americanprogress.org

Washington, D.C. — **Topher Spiro**, vice president for Health Policy at the Center for American Progress, released the below statement following the introduction of a bill by Sens. Lindsey Graham (R-SC) and Bill Cassidy (R-LA) to repeal the Affordable Care Act (ACA).

The Graham-Cassidy bill is one of the most devastating proposals put forth by congressional Republican leaders yet, threatening to overhaul the Medicaid program as we know it and leave millions uninsured. This proposal would eliminate protections that help millions of Americans obtain the care they need, repeal the Medicaid expansion, and place caps on the rest of Medicaid, leaving states on the hook for any and all unexpected costs from recessions, natural disasters, public health emergencies, or prescription drug price spikes.

At a time when our leaders should be focusing on a bipartisan solution to stabilize health care markets, as well as ensuring that millions devastated by natural disasters in the southern part of our country can rebuild, some congressional Republicans are instead trying to jeopardize Americans' health and well-being.

It's time to abandon partisan attempts to repeal the ACA once and for all. We should have an immediate goal to address threats to the ACA's marketplaces. Efforts led by Sens. Patty Murray (D-WA) and Lamar Alexander (R-TN) present a real and rare opportunity to work on a bipartisan basis to obtain these fixes to stabilize the markets and lower premiums. Congress should embrace it.

The Graham-Cassidy bill is not a viable path forward and the American people will reject it with breathtaking resolve the way they have every attempt to undermine their ability to access care.

For more information or to speak with an expert, please contact Devon Kearns at 202.741.6290 or dkearns@americanprogressaction.org.

Center for Disability Rights Statement:

Take action today and over the next few days to stop the Graham-Cassidy repeal proposal from gaining any more traction in the Senate!

This effort will derail any bi-partisan action on cost sharing reductions and could lead to the decimation of Medicaid and the Affordable Care Act (ACA). The Republicans have only two weeks before their ability to pass an ACA repeal with 51 votes expires on September 30. Reports are they are getting close to the needed number of votes- even though the public is more opposed to ACA repeal than ever. This vote has moved up on the list of Republican priorities and must move up on ours!

We need everyone to call offices asking Members to reject Graham-Cassidy and remind them that it still does all the bad things that the other repeal bills did:

- Ends Medicaid As We Know It
- Punishes people with Pre-Existing Conditions
- Eliminates subsidies that help moderate income people afford coverage forcing millions into the ranks of the uninsured.

Council *of the* Great City Schools®
1331 Pennsylvania Avenue, NW, Suite 1100N, Washington, DC 20004
(202) 393-2427 (202) 393-2400 (fax) www.cgcs.org

Council *of the* Great City Schools®

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San Antonio
San Diego
San Francisco
Seattle
Shelby County
St. Louis
St. Paul
Toledo
Tulsa
Washington, D.C.
Wichita

September 20, 2017

United States Senate
Washington, DC 20510

Dear Senator:

The Council of the Great City Schools, the coalition of the nation's largest central city school districts, opposes the Graham-Cassidy block grant proposal to the FY17 healthcare reconciliation bill (H.R. 1628). The Council's opposition to this healthcare block grant is based on the massive Medicaid reductions caused by rolling-back Medicaid expansions in the Affordable Care Act (ACA) and cutting funds to the traditional Medicaid program compared to current law.

The proposed Medicaid funding reductions under the Graham-Cassidy bill are expected to limit Medicaid-funded health services for school-age children, particularly students with disabilities, and reduce or eliminate Medicaid reimbursements for school-based health services in many states. Even without an updated CBO analysis, it is clear that state and local budgets would be severely affected by the proposed legislation, including resources for the nation's urban public schools.

The nation's urban public schools know that block grants traditionally have been used as a legislative device to reduce long-term federal financial commitments under the pretext of providing increased flexibility in setting social policy priorities. The pending legislation would produce a sea change in the financial structure of the Medicaid program by shifting from the guaranteed federal matching reimbursements for a set of eligible medical services to a finite per-capita grant for each state. This change would place substantially increased financial burdens on state and local governments, including school districts. Tying per-capita Medicaid state grants to an inflationary index that is lower than the actual increase in healthcare costs will create further shortfalls in federal Medicaid funding. The classic false promise of allowing recipients "to do more with less" is particularly disingenuous in the context of ever-increasing healthcare costs, including those incurred by schools.

In opposing the Graham-Cassidy legislation, the Council also knows that the proposal would have substantial implications for our students' families and low-income communities, because it allows for reductions in essential insurance benefits, revises provisions on pre-existing conditions, and redistributes federal health subsidies in a way that would create short-term State "winners" and "losers."

The nation's large urban school districts join with most of the medical community and much of the nation in opposing the pending health care reconciliation legislation, including the new Graham-Cassidy proposal. The Council urges a NO vote on the Senate version of H.R. 1628. The Council recommends returning to the traditional legislative process and a deliberative approach to fixing the federal health care law.

Sincerely,

Michael Casserly
Executive Director

PRESS RELEASE | **September 18, 2017**

CHA Statement on Graham-Cassidy Repeal Bill

Gina Drioane | (202) 753-5372

Washington, D.C. – The nation's children's hospitals stand in strong opposition to the most recent legislative proposal introduced by Sens. Lindsay Graham, R-S.C., Bill Cassidy, R-La., Dean Heller, R-Nev., and Ron Johnson, R-Wis. Their legislation would slash funding for Medicaid, the nation's largest health care program for children, by one-third, reducing access and coverage for more than 30 million children in the program. Furthermore, the legislation weakens important consumer safeguards, and as a result, millions of children in working families would no longer be assured that their private insurance covers the most basic of services without annual and lifetime limits and regardless of any underlying medical condition. This bill would have devastating consequences for children and families.

The Medicaid provisions in the Graham-Cassidy-Heller-Johnson bill closely mirror those included in the Better Care Reconciliation Act (BCRA) that was already rejected by the Senate. Under current law, Medicaid guarantees meaningful coverage for eligible populations, and flexes up and down based on shifts in the economy and labor force. By converting Medicaid into a capped program that limits funding to states, the bill removes the certainty states count on to be able to provide health care coverage to their most vulnerable children, including those impacted by natural disasters and public health emergencies. Previous analysis of the impact of similar proposals considered this year by Congress estimates the cut to Medicaid for children at more than $40 billion by 2026.

On behalf of America's children's hospitals, Children's Hospital Association (CHA) urges Congress to constructively focus on ensuring health care for America's children by protecting Medicaid funding for children and passing a long-term extension of the bipartisan Children's Health Insurance Program (CHIP) before funding runs out at the end of September. Together, CHIP and Medicaid provide health care coverage to nearly 40 million kids nationwide. Thanks to these public programs, children in the United States are experiencing the highest rate of health care coverage on record at 95 percent.

Tags Medicaid

About the Children's Hospital Association

The Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

"on Monday, Baker's office said in a statement that the Republican-led Senate legislation "would be damaging to the people of Massachusetts and cost the state billions of dollars in lost federal revenue."

- Governor Charlie Baker of Massachusetts

Action Alert: Take Action to Defeat Another Zombie Healthcare Bill in Congress!

September 14, 2017

get back on track to a bipartisan process with public input to create a health system that works for all Americans

Below please find an Action Alert from Access Living's Director of Advocacy, Amber Smock. The alert calls on members of the community to mobilize against the Graham-Cassidy-Heller amendment.

Dear Access Living friends and allies,

Over the last several months, many of you have worked hard to help Congress understand how terrible cuts to Medicaid, as well as essential health benefits in insurance, would be. You helped stop a major budget bill that would do these back on July 27. Now, leaders in the U.S. Senate are proposing a new last-ditch amendment, called the Graham-Cassidy-Heller amendment, that would bring back the threat of Medicaid block grants and elimination of essential health benefits. They want to try to pass this by end of day September 30, the last day under which they could pass this type of bill under rules that allow passage with a simple majority. We need your help to ask Congress to DROP the partisan efforts to repeal and replace Obamacare, and instead, get back on track to a bipartisan process with public input to create a health system that works for all Americans.

TAKE ACTION: The quick link to send an email to your members of Congress is here .

What's the Graham-Cassidy-Heller amendment? Here's a link to a longer explanation , but in short the main pieces of concern are as follows. Block grants or per capita caps to Medicaid would devastate the Medicaid system. Allowing the elimination of essential health benefits would devastate needed supports like rehab therapy, mental health supports, and ER visits. Shortening the Medicaid waiver approval process would decimate stakeholder input to craft a good system. This amendment is not only a last-ditch effort, but it's the worst version of an Obamacare repeal/replace yet. If allowed to pass Congress, this would be terrible for our community.

We at Access Living call upon YOU to contact your Congressmen and urge them to OPPOSE the Graham-Cassidy-Heller amendment and to SUPPORT creating a bipartisan process with public input to create the healthcare system that will actually serve all of us.

Please share this alert widely!

Amber Smock
Director of Advocacy, Access Living

Academy Letter Opposing Cassidy-Graham Proposal

September 15, 2017

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

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

Dear Majority Leader McConnell and Minority Leader Schumer:

The Academy of Nutrition and Dietetics, the nation's largest organization of food and nutrition professionals representing registered dietitian nutritionists (RDNs), nutrition and dietetics technician, registered (NDTRs), and other nutrition professionals, knows that nutrition services save money, improve chronic disease outcomes and save lives. For that reason, the Academy continues to strongly oppose the American Health Care Act (H.R. 1628), as amended by the Graham-Cassidy proposal on September 13, 2017.

As it stands, the Senate discussion draft would eliminate investments in prevention and public health, reverse advancements made in disease prevention and chronic care management, and according to nonpartisan analysis of the underlying bill, would result in the loss of health care coverage for at least 22 million Americans.[1]

The Academy opposes the repeal of the Prevention and Public Health Fund, which would remove vital resources that are effective in improving health across the country. The Prevention Fund provides critical support for nutrition interventions led by nutrition

professionals to improve community health, and these jobs will be gone without this critical investment.

The Academy also opposes the provisions that would allow states to block grant or utilize per capita caps for Medicaid spending, drastically reducing access to preventive services and to home and community-based services (HCBS). This reduction in Medicaid spending will result in fewer opportunities for patients to have access to vital nutrition services provided by registered dietitian nutritionists for disease prevention and treatment.

Additionally, allowing states to opt out of requiring that health plans cover the Essential Health Benefits would reduce access to these cost-saving services; allow insurers to charge people higher premiums based on pre-existing conditions like nutrition-related diseases, including diabetes and heart disease; and increase out-of-pocket costs for vulnerable older adults.

Finally, the Graham-Cassidy amendment to H.R. 1628 fails to meet the Academy's five tenets of health care:

- The health of all Americans should improve as a result of our health policy choices. Sufficient resources must be made available to ensure optimal health.
- Access to quality health care is a right that must be extended to all Americans.
- Nutrition services, from pre-conception through end of life, are an essential component of comprehensive health care.
- Stable, sufficient and reliable funding is necessary for our health care system to provide everyone access to a core package of benefits.
- Health care must be patient-centered.

For these reasons, the Academy of Nutrition and Dietetics strongly urges the Senate to oppose passage of the current version of the bill.

The Academy urges the Senate to continue the bipartisan work of the Senate Health, Education, Labor and Pensions Committee to draft common-sense reforms that would

improve access to quality and affordable health care for all Americans. The Academy continues to offer to work with you to improve the nutrition and health of the country.

Sincerely,

Donna S. Martin, EdS, RDN, LD, SNS, FAND
President, 2017-2018

Sixteen Patient and Provider Groups Oppose Graham/Cassidy Bill

WASHINGTON, D.C., September 18, 2017 — Sixteen patient and provider groups oppose the proposal put forward by Senators Lindsey Graham (R-S.C.), Bill Cassidy (R-La.), Dean Heller (R-Nev.), and Ron Johnson (R-Wis.) that will negatively impact patients' access to adequate and affordable health coverage and care.

This bill would limit funding for the Medicaid program, roll back important essential health benefit protections, and potentially open the door to annual and lifetime caps on coverage, endangering access to critical care for millions of Americans. Our organizations urge senators to oppose this legislation.

Affordable, adequate care is vital to the patients we represent. This legislation fails to provide Americans with what they need to maintain their health. In fact, much of the proposal just repackages the problematic provisions of the Better Care Reconciliation Act (BCRA), which we opposed. Fortunately, the BCRA was voted down by Congress earlier this year.

Our organizations, instead, strongly support the bipartisan hearings spearheaded by Chairman Lamar Alexander (R-Tenn.) and Ranking Member Patty Murray (D-Wash.) in the Senate Health, Education, Labor and Pensions (HELP) Committee, and by Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-Ore.) in the Senate Finance Committee. These hearings, focused on market stabilization and other critical issues, represent a modest, yet promising first step towards addressing our nation's health care challenges. Bipartisan agreement on the

Children's Health Insurance Program also represents a welcome return to regular order, and we applaud the committees for undertaking this critical work.

We urge Congress to continue this important bipartisan effort rather than advancing proposals that would weaken access to the care Americans need and deserve. We stand ready to work with both sides of the aisle to build long-lasting bipartisan solutions both now and in the future.

Signers:
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

COALITION FOR HEALTHY COMMUNITIES

ADVOCATING FOR QUALITY MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

September 19, 2017

Honorable Rob Portman
United States Senate
448 Russell Senate Office Building
Washington, DC 20510

Dear Senator Portman,

We the undersigned members of the Coalition for Healthy Communities (CHC) ***write to urge you to oppose the Graham-Cassidy-Heller-Johnson (GCHJ) legislative proposal*** to "repeal and replace" the Affordable Care Act (ACA). If enacted, this proposal would have a devastating impact on Ohio's Medicaid program and the people who rely on it for access to health care, including treatment for addiction and mental illness.

The CHC agrees with your past statements that health care reform demands a deliberative and thoughtful process and that no bill should pass without public hearings, careful examination and further discussion. As we understand it, the GCHJ proposal will not even have a CBO score that shows the full impact of the legislation.

We understand the current health care system needs further reforms. However, the GCHJ proposal is not the answer, as it would significantly reduce citizens' access to behavioral health care in Ohio and across the nation. The CHC has serious concerns with any legislative proposal that would block grant and cap federal funding for Medicaid, end the Medicaid expansion, and allow states to easily waive the Essential Health Benefit requirements. Moreover, it appears that the GCHJ proposal would radically change the Medicaid financing process, causing Ohio to lose billions while other states gain more funds. This will place tremendous strain on Ohio's budget and likely force Ohio to cut benefits and restrict access to critical behavioral health and addiction services – reversing much of the progress Ohio has made in fighting the opiate crisis and addressing the mental health needs of Ohioans suffering from the most serious mental health conditions.

1225 Dublin Road, Suite 125, Columbus, Ohio 43215 614-224-2700

As an alternative to the misguided GCHJ proposal, the CHC encourages you to support the ongoing bipartisan efforts of the Senate Health, Education, Labor and Pension Committee to stabilize the health insurance market and create a better health care system for Ohioans.

Thank you for your time and consideration.

Sincerely,

Terry Russell,
CHC Co-Chair
Executive Director
NAMI Ohio

Marcie Seidel,
CHC Co-Chair
Executive Director
Prevention Action Alliance

COALITION FOR HEALTHY COMMUNITIES

ADVOCATING FOR QUALITY MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

Membership

National Alliance on Mental Illness of Ohio
Prevention Action Alliance
Ohio Association of County Behavioral Health Authorities
Ohio Council of Behavioral Health & Family Services Providers
Ohio Psychiatric Physicians Association
Ohio Psychological Association
Universal Health Care Action Network of Ohio
Mental Health & Addiction Advocacy Coalition
National Association of Social Workers
Ohio Association of Child Caring Agencies
Multiethnic Advocates for Cultural Competence
Ohio Citizen Advocates for Addiction Recovery
Ohio Counseling Association
Ohio Empowerment Coalition
Mental Health America Franklin County
Ohio Suicide Prevention Foundation
Buckeye Art Therapy Association

1225 Dublin Road, Suite 125, Columbus, Ohio 43215 614-224-2700

AMERICAN PUBLIC HEALTH ASSOCIATION
For science. For action. For health.

Sept. 18, 2017

United States Senate
Washington, DC 20510

Dear Senator:

On behalf of the American Public Health Association, a diverse community of public health professionals who champion the health of all people and communities, I write to express our strong opposition to the Graham-Cassidy bill and any other legislation that would repeal or weaken the Affordable Care Act. Similar to other proposals that we ardently opposed, the Graham-Cassidy plan would have the same damaging consequences for the health of Americans, especially the most vulnerable. Instead, we ask that you continue to build on the balanced, bipartisan efforts already underway to stabilize the individual market and put forward additional legislation to strengthen the health care system.

Much like previous proposals to repeal or weaken the ACA, the Graham-Cassidy plan would take health insurance coverage away from millions of people, eliminate critical public health funding, devastate the Medicaid program, increase out-of-pocket costs and weaken or eliminate protections for people living with pre-existing conditions. Millions of Americans losing health insurance coverage is a major national concern. Health insurance coverage is critical to preventing disease, ensuring health and well-being and driving down the use of costlier providers of care. The Graham-Cassidy plan would end the ACA's Medicaid expansion and marketplace subsidies that reduce monthly premiums and out-of-pocket costs, and replace them with an inadequate block grant to states. This plan would significantly reduce federal Medicaid funding to all states. Some states would experience a sharp and immediate cut to federal Medicaid funding, with all states eventually being deeply impacted. The proposal would hit low-income and older Americans especially hard by leading to unaffordable premiums, higher out-of-pocket costs and significantly less or no coverage at all. Additionally, the proposal would eliminate Medicaid reimbursements to Planned Parenthood for one year resulting in patients losing care, more unintended births and increased spending for the Medicaid program.

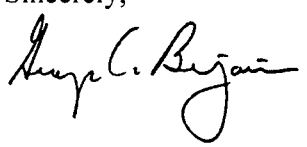
Consistent with previous proposals, the Graham-Cassidy plan would also eliminate the Prevention and Public Health Fund, the first and only mandatory funding stream specifically dedicated to public health and prevention activities. The fund has already provided more than $6 billion to support a variety of public health activities in every state including tracking and preventing infectious diseases like the Ebola and Zika viruses, community and clinical prevention programs, preventing childhood lead poisoning and expanding access to childhood immunizations. Eliminating the fund would devastate the budget of the Centers for Disease Control and Prevention. The fund currently makes up 12 percent of CDC's budget and eliminating this funding stream

would force Congress to replace the funding through the regular appropriations process where resources for nondefense discretionary programs are already too low.

The Affordable Care Act has made progress in addressing the biggest challenges facing our health system including reducing the number of uninsured, uneven quality of care, deaths due to medical errors, discriminatory practices by health insurance providers and the shrinking ranks of the nation's primary care providers. The ACA has also made important progress in shifting our health system from one that focuses on treating the sick to one that focuses on keeping people healthy.

We ask you to oppose the Graham-Cassidy proposal and any future effort to repeal or weaken the ACA. Instead, we urge you to continue the bipartisan efforts to improve and build upon the successes of the ACA, and ensure health insurance coverage to the more than 28 million who still lack coverage. We look forward to working with you to create the healthiest nation in one generation.

Sincerely,



Georges C. Benjamin, MD
Executive Director

APA Voices Opposition to Graham-Cassidy Bill; Renews Call for Bipartisan Solution to Health Care

ARLINGTON, Va. — The American Psychiatric Association (APA) today voiced its strong opposition to the Graham-Cassidy bill under consideration in the U.S. Senate.

"This legislation, the latest attempt to repeal the Affordable Care Act, will lead to millions of Americans losing their health care coverage," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "We are particularly concerned that this bill would make drastic cuts to the Medicaid program and rollback expansion, which has allowed 1.3 million Americans with serious mental illness and 2.8 million Americans with substance use disorders to gain coverage for the first time. This bill harms our must vulnerable patients.

"The APA is ready to work with members of both parties to craft a bipartisan solution that stabilizes the health insurance market and ensures Americans have access to quality, affordable health care."

American Psychiatric Association

The American Psychiatric Association is the oldest medical association in the country founded in 1844. The APA is also the largest psychiatric association in the world with more than 37,000 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment.

Coalition Letter Urges Senate to Set Aside Health Care Reform Proposal

This letter was sent to U.S. Senate Majority Leader Mitch McConnell and U.S. Senate Minority Leader Charles Schumer.

CHICAGO- Sept. 13, 2017- The undersigned organizations are concerned with the proposal introduced today by Senators Cassidy and Graham, which we believe will have a negative impact on affordable coverage for patients across our nation. We would note that a similar proposal was put forth by these two Senators in July. Based on our analysis, the revised proposal may actually be worse than the original.

Our organizations, which represent over 560,000 physicians, oppose the new Graham-Cassidy bill and its approach to reforming our health care system. The proposal fails to protect the health care coverage and consumer protections available under current law. Additionally, it would create a health care system built on state-by-state variability that would exacerbate inequities in coverage and most likely place millions of vulnerable individuals at risk of losing their health care coverage.

This week, the U.S. Census Bureau released a report that shows the US uninsured rate fell to a historic low of 8.8 percent in 2016. Since enactment of the Affordable Care Act, we have seen three consecutive years of significant decreases in our national uninsured rate. 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

Further, we are very concerned about rushing through any legislation to repeal and replace the ACA, including the Graham/Cassidy proposal, through the current budget reconciliation authorization. We have consistently called for any legislation to amend current law to be developed through regular order, with hearings, debate, and committee mark-ups, and with sufficient time for independent analysis by the Congressional Budget Office (CBO), independent experts, and the clinicians and patients directly affected by the proposed changes. Especially given how disruptive and harmful the Graham/Cassidy proposal will be for patients, we oppose any effort to try to rush it through the legislative process so a vote can occur before the current reconciliation measure expires on October 1.

Instead, we call on the United States Senate to set aside the Graham/Cassidy proposal and, instead, focus on bipartisan efforts to stabilize the health insurance marketplaces, create competition

among insurers, and lower the costs of health. Our organizations have provided the HELP Committee recommendations on how these goals could be achieved.

We urge your support of the bipartisan policies being developed by the HELP Committee through regular order, and stand ready to work with you and the full Senate to secure passage of legislation that would build upon the successes we have made in extending health care coverage to millions of previously uninsured individuals.

Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics
American College of Physicians
American Congress of Obstetricians and Gynecologists
American Osteopathic Association
American Psychiatric Association

About the American Osteopathic Association

The American Osteopathic Association (AOA) represents more than 129,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; and is the accrediting agency for osteopathic medical schools. Visit DoctorsThatDO.org to learn more about osteopathic medicine.

The Private Practice Section (PPS) of the American Physical Therapy Association (APTA), which represents over 4200 members nationwide has strong concerns regarding the content of the Graham-Cassidy proposal. Earlier this year we opposed health care reform proposals for similar reasons; this legislation gives us even greater pause.

In addition to other concerns, PPS fundamentally opposes allowing states to waive the Affordable Care Act's federal requirement that insurance companies include essential health benefits (EHBs)—which include the habilitative and rehabilitative care that physical therapists provide—in the insurance plans they offer. Eroding the EHBs would allow for the sale of "insurance" that would not cover crucial healthcare needs of enrollees.

Attached please find a letter detailing PPS' opposition to the Graham-Cassidy legislation.

Please let me know if you have any questions.

Thank you for the opportunity to weigh-in on this important issue.
Alpha

On behalf of the Private Practice Section of the American Physical Therapy Association
Alpha Lillstrom Cheng
alpha@lillstrom.com
301.787.0877 cell

September 21, 2017

United States Senate Washington, DC 20510

Dear Senators:

On behalf of the Private Practice Section (PPS) of the American Physical Therapy Association (APTA), which represents over 4200 members nationwide, I write to share strong concerns we have regarding the content of the Graham-Cassidy proposal. Earlier this year we opposed health care reform proposals for similar reasons; this legislation gives us even greater pause.

PPS endeavors to foster the growth, economic viability, and business success of physical therapist-owned physical therapy services provided. PPS members deliver a valuable service to communities in all fifty states and they do so in a convenient, cost-effective manner. As community-based providers, PPS members serve patients whose care is covered by Medicare, Medicaid, the Veterans Administration, as well as private insurance.

The Graham-Cassidy legislation's drastic cuts to Medicaid as well as the elimination of cost-sharing subsidies and tax credits to be replaced by block grants to states would put the more than 70 million Americans who rely on Medicaid and the individual market at risk for reduced quality of coverage—or even more bleakly—without coverage at all. PPS fundamentally opposes allowing states to waive the ACA's federal requirement that insurance companies include essential health benefits (EHBs)— which include the habilitative and rehabilitative care that physical therapists provide—in the insurance plans they offer. Eroding the EHBs would allow for the sale of "insurance" that would not cover crucial healthcare needs of enrollees.

We are deeply troubled that guaranteed protections for people with preexisting medical conditions will be eliminated. We object to states obtaining waivers that would allow insurance companies to increase premiums for these people, a practice which is prohibited under current law. While insurers would likely still offer insurance plans to people with pre-existing conditions, PPS anticipates that unaffordable premiums are

likely and could also limit coverage options. Under this scenario, a chronic or life-threatening illness or simply an accident could quickly become a financial catastrophe.

PPS is shocked that the Senate is considering a vote on a bill which has not yet received a full assessment by the Congressional Budget Office. Without a score, Congress is unable to determine the impact of the proposed legislation. However, it is clear that under Graham-Cassidy, tens of millions of Americans would lose their insurance coverage or the ability to pay for coverage they are currently ensured access to. This would come in many forms: states unable to maintain their expanded Medicaid coverage, the elimination of cost-sharing subsidies the federal government currently pays to insurance companies to lower the cost of some plans on the individual insurance markets, as well as protections against stark premium increases due to the increased age-ratings and reduced protections for those with pre-existing conditions.

Finally, PPS strongly encourages the Senate to employ regular order in its pursuit of the repeal and replacement of the ACA. A pro-forma hearing is insufficient; instead there should be full committee hearings and mark-ups where committee members from both parties could discuss the content and offer amendments. This would also allow for stakeholder input, which is fundamentally important for the development of quality policy that responds to the needs of the American people.

As we have all along, PPS is eager to continue to work with Congress to ensure access to affordable, quality healthcare to all Americans, regardless of their age, health status, or economic limitations.

Sincerely,

Terrence Brown, PT, DPT President, Private Practice Section of APTA

The Arc Responds to Graham-Cassidy-Heller-Johnson Health Care Proposal

Posted on September 14, 2017

"Architects of this bill are still ignoring the pleas of their constituents with disabilities"

Today, U.S. Senators Lindsey Graham (R-SC), Bill Cassidy (R-LA), Dean Heller (R-NV), Ron Johnson (R-WI) and former US Senator Rick Santorum (R-PA) unveiled the latest attempt to repeal the Affordable Care Act. The Arc released the following statement in response:

"While this piece of legislation has a new title and makes new promises, it is more of the same threats to Medicaid and those who rely on it for a life in the community. The Graham-Cassidy-Heller-Johnson proposal cuts and caps the Medicaid program. The loss of federal funding is a serious threat to people with disabilities and their families who rely on Medicaid for community based supports.

"Many of the provisions in this legislation are the same or worse than what we encountered earlier this year, which shows that the architects of this bill are still ignoring the pleas of their constituents with disabilities. The talking points sugar coat it, but the reality is simple – under this proposal less money would be available despite the fact the needs of people who rely on Medicaid have not decreased. The Arc remains staunchly opposed to legislation that includes per capita caps or block granting of Medicaid. We need Members of Congress to find a solution that actually takes into consideration the needs of people with intellectual and developmental disabilities," said Peter Berns, CEO of the The Arc.

Senator Brown,

The Area Agency on Aging District 7 urges you to stop any attempt, including Graham-Cassidy, to repeal and replace ACA that jeopardizes coverage and increases costs for older adults. We also urge you to reject cuts and caps to Medicaid. Please oppose any proposal during this debate that keeps this process moving without broad, bipartisan input.

Instead, any changes to healthcare must be done through an open, bipartisan and transparent process that protects older adults and preserves critical Medicaid funding. The PASSPORT Medicaid waiver program and other important Medicaid waiver programs that we offer and work with through our Agency provides vital services to support the health and well-being of older adults and those with disabilities so that they can remain in their home versus a higher-cost nursing facility. Cuts to these Medicaid programs would be devastating to those who rely on them so much for basic needs and support. Please, we ask for your support in stopping any attempt to repeal and replace ACA that jeopardizes coverage and increases costs for older adults. Too many Ohioans and individuals in our rural district depend on these services to remain healthy and happy in their home.

Thank You for your time and consideration.

Area Agency on Aging District 7
Serving 10 Counties in Ohio - Adams, Brown, Gallia, Highland, Jackson, Lawrence, Pike, Ross, Scioto and Vinton

Jenni Dovyak-Lewis
Director of Community Outreach and Training

Area Agency on Aging District 7, Inc.
F32-URG PO Box 500
Rio Grande, Ohio 45674
Office - 1.800.582.7277 Extension 224
Fax - 740.245.5844
E-Mail – jlewis@aaa7.org
Website - www.aaa7.org
Find Us On Facebook! - www.facebook.com/AreaAgencyOnAgingDistrict7
Helping You Age Better!

American Society of Clinical Oncology

2318 Mill Road, Suite 800
Alexandria, VA 22314
T: 571-483-1300
F: 571-366-9530
www.asco.org

September 21, 2017

The Honorable Mitch McConnell
Majority Leader, United States Senates
317 Russell Senate Office Building
Washington, DC 20510

Dear Leader McConnell,

On behalf of the American Society of Clinical Oncology (ASCO), I write to express our opposition to the Graham-Cassidy-Heller-Johnson Amendment to the American Health Care Act (H.R. 1628). ASCO's core mission is to ensure that cancer patients have meaningful access to high quality cancer care. The proposal runs counter to this goal.

ASCO's patient-centered principles for health reform support improvements to the current health care system for people with cancer. Our principles further identify specific areas where cancer patients may need additional protections. We shared these principles with Congress and the public in January of this year and use them to guide our decision-making on reform legislation, including our opposition today. ASCO calls on members of the Senate to work in a bipartisan manner to improve the health care system because we know Congress shares our belief that all people affected by cancer should receive high-quality care.

Our opposition to the Graham-Cassidy proposal stems from our concern that it will limit access to the full spectrum of cancer care services. Allowing states to obtain waivers to adjust premiums based on health status would make room for insurers to charge exorbitant premiums for patients with pre-existing conditions, including cancer survivors. Though Graham-Cassidy requires insurers to cover these conditions, it would make the coverage unattainable for Americans in waiver states.

As cancer care providers, we know the critical importance of screening services. ASCO opposes the inclusion of state waivers for essential health benefit coverage. We are further concerned by losses in coverage likely to stem from the repeal of Medicaid expansion. These coverage losses will lead to individuals with cancer being diagnosed later or not at all, negatively impacting lives and driving up costs to the health care system.

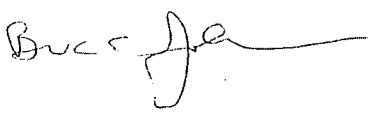
Medicaid payments should be sufficient to ensure that Medicaid patients can have access to quality cancer care. The proposal's inclusion of a transition from traditional Medicaid to a fixed per capita cap or block grant approach will leave already struggling Medicaid programs at greater disadvantage in their ability to provide these payments

and coverage. While variations will occur across states, the overall impact will be lower access to care for patients with cancer.

ASCO strongly opposes movement on and passage of the Graham-Cassidy proposal. We would welcome the opportunity to address health system reform that improves cancer care with you and your staff.

If you have any questions or would like assistance from ASCO on this or any issue involving the care of individuals with cancer, please do not hesitate to contact Amanda Schwartz at amanda.schwartz@asco.org or 571-483-1647.

Sincerely,



Bruce E. Johnson, MD, FASCO
President, American Society of Clinical Oncology

cc:

All Members of the US Senate

Bazelon Center Statement:

Sep 20

"#GrahamCassidy poses a huge threat to those covered under Medicaid! We have until 9/30 #ProtectOurCare and #SaveMedicaid!"

ACRM
AMERICAN CONGRESS OF REHABILITATION MEDICINE

Improving lives through interdisciplinary rehabilitation research

T + 1.703.435.5335
F + 1.866.692.1619
11654 Plaza America Dr #535
Reston VA 20190
www.ACRM.org

September 21, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

Re: The Graham-Cassidy Health Care Bill

Dear Senator McConnell and Senator Schumer:

The American Congress of Rehabilitation Medicine (ACRM) writes to express opposition to the Graham-Cassidy legislation (H.R. 1628), which would repeal and replace the Affordable Care Act (ACA). ACRM is an organization of rehabilitation professionals dedicated to serving people with disabling conditions by supporting research and services that promote health, independence, productivity, and quality of life; and meets the needs of rehabilitation clinicians and individuals with disabilities.

ACRM is seriously concerned that the current Graham-Cassidy bill will undercut the federal coverage standard for rehabilitation and habilitation services and devices established under the ACA. Access to rehabilitation enables individuals experiencing injuries, illnesses, and disabilities to maximize their quality of life by enhancing their health, function, and independence. We believe that any ACA repeal and replace bill that advances in Congress must maintain access to rehabilitation and habilitation services and devices.

In particular, the Graham-Cassidy legislation would seriously undermine coverage in the individual market through the use of block grants, under Medicaid expansion plans by phasing out this program, and under the original Medicaid program by implementing per capita caps. Additionally, the bill includes a provision that would allow states to apply for waivers exempting them from following important patient protections that are required by the Affordable Care Act (ACA), including age-related premium rating ratios and requirements for insurers to cover a defined package of essential health benefits (EHBs). We are deeply concerned that the bill would limit access to rehabilitation and habilitation services and devices—one of ten statutory EHBs—for many children and adults. ACRM believes that this provision will significantly undermine the health insurance coverage that patients need.

ACRM urges the Senate not to support the Graham-Cassidy bill and to work in a bipartisan manner to improve access to affordable, comprehensive care for all Americans, including those with chronic conditions and disabilities needing rehabilitation services and devices.

Sincerely,

Douglas Katz, MD, FACRM, FAAN
ACRM President

Wayne A. Gordon, Ph.D., ABPP
Policy and Legislation Committee Chair

Jon Lindberg, CEO, ABPP

International Association of Machinists and Aerospace Workers

9000 Machinists Place
Upper Marlboro, MD 20772-2687

Area Code 301
967-4500

OFFICE OF THE INTERNATIONAL PRESIDENT

September 20, 2017

The Honorable Sherrod Brown
United States Senate
713 Hart Senate Office Building
Washington, DC 20510-3505

Dear Senator Brown,

On behalf of the International Association of Machinists and Aerospace Workers (IAM), I strongly urge you to oppose the Cassidy-Graham plan to repeal the Affordable Care Act. Like previous attempts to repeal the Affordable Care Act (ACA), this version would be severely detrimental and disruptive to the United States healthcare system. The vast majority of Americans are once again rightly opposed to this latest repeal plan which would strip coverage from tens of millions of Americans, while raising costs for millions more, destabilizing individual insurance markets, eliminating protections for people with pre-existing conditions, and thoroughly gutting Medicaid in the process.

While the Congressional Budget Office has not yet scored the Cassidy-Graham plan, its similarity to previous repeal efforts clearly indicates that the impact on the U.S. healthcare

system would be devastating. Due to the elimination of Medicaid expansion and ACA marketplace subsidies, as well as drastic cuts to the Medicaid program overall; an estimated 15 million people would become uninsured in its first year and 32 million people would lose their healthcare coverage by 2027. The Cassidy-Graham plan is clearly intended as a giveaway to corporate America and the wealthy at the expense of the middle-class, the working-poor, and those most in need. This intent is made even clearer by the plan's elimination of the ACA medical device tax while leaving intact the ACA's 40% excise tax on healthcare plans, often referred to as the Cadillac tax.

The Cassidy-Graham plan would also destabilize individual insurance markets and group employer-sponsored markets by creating extreme market uncertainty. Under this plan, each of the fifty states would be left to devise their own market rules without any federal guidance or guardrails. Starting in 2020, insurers would be straddled with uncertainty about how the markets would operate and what risk pools would look like. This uncertainty would force insurers to impose large, immediate rate increases and some would likely leave certain markets altogether. The end result would leave Americans with higher prices and fewer choices.

The Cassidy-Graham plan would give states broad waiver authority to eliminate the ACA's essential health benefits requirements and protections for people with pre-existing conditions. If this plan becomes law, we would likely end up with a system that charges exorbitant premiums to millions of seniors, the less-healthy, and those with pre-existing medical conditions. In many cases these Americans might not be able to purchase medical coverage at all. Additionally, the elimination of the ACA's essential health benefits requirement would allow insurers and employers to offer healthcare plans which do not include fundamental benefits, such as hospitalization, maternity care, and prescription drugs.

Ramming this highly partisan repeal bill through the Senate, as its sponsors are proposing, will leave no time for regular order; adequate hearings, consultation with experts, constituent input, and the congressional amendment process. Perhaps by design, there will be no time for the public to fully understand the impacts of this horrible legislation on their health care and their families.

For all of these reasons, **I strongly urge you to oppose the Cassidy-Graham plan to repeal the Affordable Care Act.**

Please contact Legislative Director Hasan Solomon at (202) 420-5902 if you have any questions.

Sincerely,

Robert Martinez, Jr.
International President

Sixteen Patient and Provider Groups Oppose Graham/Cassidy Bill

September 18, 2017 Categories: Advocacy News

WASHINGTON, D.C., September 18, 2017 — Sixteen patient and provider groups oppose the proposal put forward by Senators Lindsey Graham (R-S.C.), Bill Cassidy (R-La.), Dean Heller (R-Nev.), and Ron Johnson (R-Wis.) that will negatively impact patients' access to adequate and affordable health coverage and care.

This bill would limit funding for the Medicaid program, roll back important essential health benefit protections, and potentially open the door to annual and lifetime caps on coverage, endangering access to critical care for millions of Americans. Our organizations urge senators to oppose this legislation.

Affordable, adequate care is *vital* to the patients we represent. This legislation fails to provide Americans with what they need to maintain their health. In fact, much of the proposal just repackages the problematic provisions of the Better Care Reconciliation Act (BCRA), which we opposed. Fortunately, the BCRA was voted down by Congress earlier this year.

Our organizations, instead, strongly support the bipartisan hearings spearheaded by Chairman Lamar Alexander (R-Tenn.) and Ranking Member Patty Murray (D-Wash.) in the Senate Health, Education, Labor and Pensions (HELP) Committee, and by Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-Ore.) in the Senate Finance Committee. These hearings, focused on market stabilization and other critical issues, represent a modest, yet promising first step towards addressing our nation's health care challenges. Bipartisan agreement on the Children's Health Insurance Program also represents a welcome return to regular order, and we applaud the committees for undertaking this critical work.

We urge Congress to continue this important bipartisan effort rather than advancing proposals that would weaken access to the care Americans need and deserve. We stand ready to work with both sides of the aisle to build long-lasting bipartisan solutions both now and in the future.

Signers:

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

NEWS

WASHINGTON, D.C. – Marilyn Tavenner, president and CEO of America's Health Insurance Plans (AHIP), offered the following statements upon the passage of the American Health Care Act (AHCA) by the House of Representatives:

"AHIP believes that every American deserves coverage and care that is affordable and accessible, including those with pre-existing conditions. The American Health Care Act needs important improvements to better protect low- and moderate-income families who rely on Medicaid or buy their own coverage. We stand ready to work with members of the Senate and all policymakers, offering our recommendations for how this bill can be improved to ensure the private market delivers affordable coverage for all Americans.

"Immediate challenges exist in the individual market today, and the bill includes key provisions to stabilize the market in 2018 and 2019. We need certainty now about funding for cost-sharing reductions that lower copayments for patients so they can better afford to get care from their doctor. The tax credit should be enhanced to reduce premiums and better meet the needs of people with low and modest incomes, are older, or live in areas with high health care costs.

"We want to work with the Senate to ensure the continued strength of the Medicaid program, which delivers real value to more than 70 million Americans. States need adequate resources to administer an efficient, effective program that helps beneficiaries improve their health. If changes are made to criteria for who is covered by Medicaid, we need to give people more time to adjust – and more time for the individual market to stabilize.

"More than 80 million Americans rely on the Medicaid and individual market, and they deserve affordable coverage and access to quality care. AHIP believes that by working together, we can create good private market solutions that improve the health and financial stability of all people."

About AHIP

America's Health Insurance Plans (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. Visit www.ahip.org Learn more about health insurance and how it works at myhealthplan.guide

AIDS United

EVERY PERSON EVERY COMMUNITY

The Honorable Sherrod Brown
United States Senate
Washington D.C. 20515
(Via e-mail)

September 19, 2017

Dear Senator Brown:

After careful consideration, AIDS United urges you to **vote no** on the "Cassidy-Graham" bill should it come to a vote in the Senate. AIDS United seeks a health care system that will eventually enable the end of HIV in the United States. Unfortunately, the Cassidy-Graham proposal makes major changes to the U.S. health care system that would, if passed, negatively impact and worsen the provision of HIV prevention services for people at risk for HIV and the treatment and care of people living with HIV.

Among other provisions in the amendment, AIDS United is concerned that the current bill would end matching payments for Medicaid expansion on January 1, 2020 and would make Medicaid a per capita program. Under these provisions, overall federal funding for this program will decline, leaving states in desperate search for funds to make up costs. Medicaid is the backbone of ensuring the provision of care for people living with HIV and other chronic conditions, and this change will dangerously cut the program for people living with HIV. In fact, Medicaid coverage of people with HIV in care increased significantly nationwide from 36% in 2012 to 42% in 2014 driven by Medicaid-expansion states. We must maintain this coverage.

AIDS United is further concerned that the amendment will make the U.S. health care system less accessible for people living with HIV. In the Cassidy-Graham proposal, states could allow insurers to not cover costs associated with some medical conditions. As noted in the New York Times, "[c]overage, while theoretically available, could become unaffordable for some people with costly conditions like cancer or AIDS, health policy experts say." People living with HIV have long experience with pre-existing condition stipulations, high-risk pools, and similar proposals that would separate them from a common marketplace. In agreement with sixteen other health advocacy organizations, AIDS United believes that the Cassidy-Graham proposal will not meet the needs of all low-

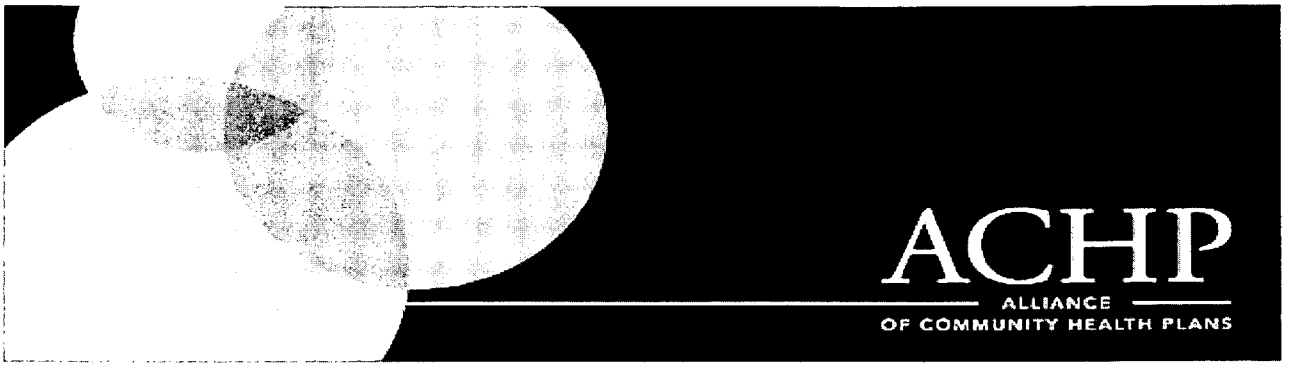
income people who are not able to attain other coverage, likely resulting in waiting lists and limitations on eligibility. Additionally, coverage in high-risk pools, should they be created by individual states, is often extremely expensive, much more than insurance in a regular marketplace, and often has limitations on coverage that affect health outcomes.

Further, the Cassidy-Graham plan would permit states to allow insurers to once again discriminate against older Americans, which specifically affects the aging population of people living with HIV. In 2014, the latest year for which we have statistics, people aged 50 and over accounted for 17% (7,391) of new HIV diagnoses in the U.S., and those 55 and older account for more than a quarter of people living with HIV. Because Cassidy-Graham would end federal tax credits for lower-income and older Americans, funding will not be adequate to fully assist older people, including those with HIV, who will also be paying much higher premiums to pay for insurance. AIDS United additionally objects to allowing states to add work credits and more.

The bill would additionally repeal funding for Prevention and Public Health Fund at the end of Fiscal Year 2018 and rescind any unobligated funds remaining at the end of FY2018. Although most of these funds are not used specifically for HIV, in many cases, these funds were being used for regular programs at the Centers for Disease Control and Prevention and it is not clear if they would be replaced.
AIDS United notes that thanks to Congress's strong response over many years, the U.S. has made substantial progress in responding to the HIV epidemic. With the success of antiretroviral medications that permit people living with HIV to live healthy, productive lives with similar life expectancies as those not living with HIV, the development of antiretroviral prevention technologies such as pre-exposure prophylaxis (PrEP) and treatment as prevention and the implementation of syringe services programs, the U.S. has the technological capability to reverse and potentially end the epidemic. However, doing so requires a strong health care system that can ensure that people living with HIV are able to access care and treatment and that people at risk for HIV are able to attain the educational and prevention services that they need. H.R. 1628 would actually reverse some of the gains that we have made in ensuring coverage for both prevention and treatment. AIDS United urges you to vote no.

Sincerely,

Ronald Johnson
Vice President of Policy and Advocacy



September 20, 2017

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

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

Dear Majority Leader McConnell and Minority Leader Schumer:

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.

1825 Eye Street, NW, Suite 401 | Washington, DC 20006 | p: 202.785.2247 | f: 202.785.4060 | www.achp.org

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 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

Ceci Connolly
President & CEO

Cc: Honorable Members of the United States Senate

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

September 19, 2017

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

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

Dear Majority Leader McConnell and Democratic Leader Schumer:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our opposition to the Cassidy-Graham-Heller-Johnson Amendment to H.R. 1628, the "American Health Care Act of 2017." We also urge the Senate to reject any other legislative efforts that would jeopardize health insurance coverage for tens of millions of Americans. Instead, in the short term we urge Congress to pursue legislation that will stabilize health insurance premiums in the individual insurance market by continuing to fund cost-sharing reduction payments.

Earlier this year the AMA put forward our vision for health system reform consisting of a number of key objectives reflecting AMA policy. Throughout the debates this year we have consistently recommended that any proposals to replace portions of current law should ensure that individuals currently covered do not become uninsured. Proposals should maintain key insurance market reforms, such as coverage for pre-existing conditions, guaranteed issue, and parental coverage for young adults; stabilize and strengthen the individual insurance market; ensure that low- and moderate-income patients are able to secure affordable and meaningful coverage; and guarantee that Medicaid, the Children's Health Insurance Program (CHIP), and other safety-net programs are adequately funded.

Unfortunately, the Graham-Cassidy Amendment fails to match this vision and violates the precept of "first do no harm." Similar to proposals that were considered in the Senate in July, we believe the Graham-Cassidy Amendment would result in millions of Americans losing their health insurance coverage, destabilize health insurance markets, and decrease access to affordable coverage and care. We are particularly concerned with provisions that repeal the ACA's premium tax credits, cost-sharing reductions, small business tax credit, and Medicaid expansion, and that provide inadequate and temporary block grant funds (only through 2026) in lieu of the ACA's spending on marketplace subsidies and the Medicaid expansion.

We are also concerned that the proposal would convert the Medicaid program into a system that limits federal support to care for needy patients to an insufficient predetermined formula based on per-capita-caps. Per-capita-caps fail to take into account unanticipated costs of new medical innovations or the fiscal impact of public health epidemics, such as the crisis of opioid abuse currently ravaging our nation. In addition, the amendment does not take steps toward coverage and access for all Americans, and while

insurers are still required to offer coverage to patients with pre-existing conditions, allowing states to get waivers to vary premiums based on health status would allow insurers to charge unaffordable premiums based on those pre-existing conditions. Also, waivers of essential health benefits will mean patients may not have access to coverage for services pertinent to treating their conditions.

Furthermore, we are concerned with other provisions of the legislation beyond those directly affecting insurance coverage. The ACA's Prevention and Public Health Fund was, according to the Department of Health and Human Services, established to "provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality." These activities are key to controlling health care costs and the elimination of support for them runs counter to the goal of improving the health care system. We also continue to oppose congressionally-mandated restrictions on where lower income women (and men) may receive otherwise covered health care services—in this case the prohibition on individuals using their Medicaid coverage at clinics operated by Planned Parenthood and other similar organizations. These provisions violate longstanding AMA policy on patients' freedom to choose their providers and physicians' freedom to practice in the setting of their choice.

We sincerely urge the Senate to take short-term measures to stabilize the health insurance market by continuing to fund cost sharing reduction payments. Over the longer term, we urge Congress to work in a bipartisan, bicameral manner to increase the number of Americans with access to quality, affordable health insurance, and we extend our commitment to work with you to achieve this goal.

Sincerely,

James L. Madara, MD

cc: United States Senate

Press Release

Statement on the Graham-Cassidy Proposal

Rick Pollack

President and CEO

American Hospital Association

September 19, 2017

We believe that coverage could be at risk for tens of millions of Americans under the Graham-Cassidy proposal. We continue to urge senators to work in a bipartisan manner to address the challenges facing our health care system.

This proposal would erode key protections for patients and consumers and does nothing to stabilize the insurance market now or in the long term. In addition, the block grant to provide support for the expansion population expires in 2026, thereby eliminating coverage for millions of Americans.

For these reasons, we oppose the Graham-Cassidy plan.

About the AHA

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA is the national advocate for its members, which include nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA website at www.aha.org.

AASA Call-To-Action: Save Medicaid In Schools

I know this seems like a bad case of deja vu, but we need superintendents from the following states to step up again and make some noise about Medicaid in schools and how important it is to the children you educate. If you live in AK, AZ, ME, NC, ND, OH, or WV please take 5 minutes out of your schedule to make a call to your Republican Senator(s).

Here is your script:

- As a constituent and a superintendent, I oppose the passage of Graham-Cassidy. Rather than close the gap and eliminate the rate of uninsured children in America, the current proposal will ration the health care America's most vulnerable children receive and undermine the ability of districts to meet the educational needs of students with disabilities and students in poverty.
- Children represent 46% of all Medicaid beneficiaries yet represent only 19% of the costs. Currently, 4-5 billion dollars flow to school districts every year, so they can make sure students with disabilities who need the help of therapists can learn and that students who can't get to a doctor regularly can receive the basic medical care they need to learn and thrive. The current proposal will jeopardize student's ability to receive comprehensive care at schools and create barriers to access.

- Graham-Cassidy would undermine critical healthcare services my district provides to children. It would also lead to layoffs of school personnel, the potential for new taxes to compensate for the Medicaid shortfall, and shifting general education dollars to special education programs to compensate for these cuts.

Email your Senators

Calling is much more effective, but if you choose to write your elected officials, use this template.

Dear Senator xxx,

As a constituent and a superintendent, I strongly oppose Graham-Cassidy, which would radically change Medicaid as we know it through block grants, per capita caps, or repealing the Medicaid expansion that has served as a lifeline to millions.

Specifically, a per capita cap system will undermine states' ability to provide America's neediest children access to vital healthcare that ensures they have adequate educational opportunities and can contribute to society. Medicaid is a cost-effective and efficient funder of essential health care services for children. In fact, while children comprise almost half of Medicaid beneficiaries, less than one in five dollars spent by Medicaid is consumed by children. Accordingly, a per capita cap, even one that is based on different groups of beneficiaries, will disproportionally harm children's access to care, including services received at school.

A school's primary responsibility is to provide students with a high-quality education. However, children cannot learn to their fullest potential with unmet health needs. As such, school district personnel regularly provide critical health services to ensure that all children are ready to learn and able to thrive alongside their peers. Schools deliver services effectively and efficiently since school is where children spend their days. Increasing access to health care services through Medicaid improves health care and educational outcomes for students. Providing health and wellness services for students in poverty and services that benefit students with disabilities ultimately enables more children to become employable and attend higher-education.

The current proposal would be devastating to schools and children, particularly those children with disabilities. Graham-Cassidy would undermine critical healthcare services my district provides to children. It would also lead to layoffs of school personnel, the potential for new taxes to compensate for the Medicaid shortfall, and shifting general education dollars to special education programs to compensate for these cuts.

I urge you to reject the Graham-Cassidy, and any subsequent effort to significantly change the funding structure of Medicaid.

AARP®
Real Possibilities

September 19, 2017

Dear Senator:

Older Americans care deeply about access to and affordability of health care. They need and deserve affordable premiums, lower out-of-pocket costs, and coverage they can count on as they age. On behalf of our nearly 38 million members in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP is urging the Senate to reject the Graham/Cassidy/Heller/Johnson bill because it would do precisely the opposite. Overall, the Graham/Cassidy/Heller/Johnson bill would increase health care costs for older Americans with an age tax, decrease coverage, and undermine pre-existing condition protections. In addition, this bill would jeopardize the ability of older Americans and people with disabilities to stay in their own homes as they age and threaten coverage for individuals in nursing homes.

Should this bill be brought to the Senate floor for a vote, we strongly urge all Senators to vote **NO**. As our members expect from AARP, we will monitor each Senator's vote should this bill come to the Senate floor and notify older Americans by reporting the vote in our publications, online, through the media, and in direct alerts to our members.

Costs in the Individual Private Insurance Market will Skyrocket

About 6.1 million Americans age 50-64 currently purchase insurance in the non-group market ("exchange"), and nearly 3.2 million are currently eligible to receive tax credits for health insurance coverage through an exchange. Affordability of both premiums and out-of-pocket costs is critical to older Americans and their ability to obtain and access health care. The Graham/Cassidy/Heller/Johnson bill would result in an age tax for older Americans who would see their health care costs increase under this bill. First, the bill would eliminate cost sharing reductions (CSRs) and take away the current tax credits that people receive today to help them afford their health care premiums. In doing so, the bill eliminates the protection that ensures both younger and older Americans do not pay over a specific percent of their income towards their health care premium. In addition, the bill entirely eliminates the funds available to states to lower health care premiums in 2026 and beyond. Furthermore, the bill reduces payments to states that have actively implemented and worked to improve coverage while increasing payments to states that have resisted efforts to expand coverage in the form of a "Market Based Innovation Grant".

The bill would also undermine the consumer protections which millions of Americans have benefited from and rely on today. We have serious concerns that Graham/Cassidy/Heller/Johnson would allow states to once again permit insurance

companies to charge people with pre-existing conditions more just because they have cancer, asthma or diabetes. This could be devastating to the 25 million Americans age 50-64 with a pre-existing condition. Furthermore, the bill would allow states to eliminate additional consumer protections enacted under the ACA, including the essential health benefits (EHB) requirement for all health plans. As a result, older consumers could once again see soaring premiums based on age and certain pre-existing conditions, as well as the re-imposition of lifetime caps on coverage.

Cuts to Medicaid and Long-Term Services and Supports Will Put Older Americans at Risk

AARP -- together with doctors, hospitals, and patient groups -- strongly opposed the Medicaid per capita cap and block grant funding proposals that were previously rejected by a majority of Senators. We continue to strongly oppose these changes to the Medicaid program. Changing Medicaid into a per capita cap financing or block grant structure would endanger the health, safety, and care of millions of individuals who depend on the essential services provided through Medicaid. Medicaid is a vital safety net and intergenerational lifeline for millions of individuals, including over 17.4 million seniors and children and adults with disabilities who rely on the program for critical health care and long-term services and supports (LTSS, i.e., assistance with daily activities such as eating, bathing, dressing, managing medications, and transportation). Older adults and people with disabilities now account for about 60 percent of Medicaid spending, and cuts of this magnitude will result in loss of benefits and services for this vulnerable population.

The growth rates set forth in the bill are far below historic Medicaid growth rates at a time when the number of older Americans is significantly growing and needing greater coverage and services. Per capita caps and block grants would not accurately reflect the cost of care for individuals in each state, including for adults with disabilities and seniors, especially those living with the most severe disabling conditions. This leaves states having to cut back or eliminate services such as home and community based services (HCBS), or reduces eligibility for coverage and services, and leaves fewer doctors and other providers willing to take patients or provide care because reimbursements are too low.

Recent AARP Public Policy Institute projections demonstrate that the Graham/Cassidy/Heller/Johnson bill will cut between $1.2 trillion and $3.2 trillion from total (federal and state) Medicaid spending over the 20-year period between 2017 and 2036 for the four non-expansion Medicaid enrollment groups: older adults, adults with disabilities, non-disabled children under age 19, and non-expansion adults. The projections do not include the proposed cuts to the adult Medicaid expansion population, which would also be considerable for those states that have expanded coverage.

We are deeply concerned these cuts will endanger the health, safety, and care of millions of individuals who depend on the essential services provided through Medicaid.

In addition, these cuts will be an overwhelming cost shift to states, taxpayers, and families, and will only compound over time.

AARP Urges Congress to Continue Bipartisan Market Stability Work

AARP has been encouraged by recent open and transparent efforts in the Senate to work on bipartisan market stability legislation. We urge Congress to continue working on common sense solutions that: ensures a robust insurance market with needed consumer protections, controls costs, improves quality; and provides affordable coverage to all Americans. We will continue to support health care principles that are vital to people 50 and older and their families.

Unanswered Questions on Impact of Legislation

As the Senate rushes to potentially consider Graham/Cassidy/Heller/Johnson next week we are especially troubled by the lack of regular order and transparency given the enormous impact this bill will have on all Americans, states and taxpayers. There have been no hearings, no mark-ups and the CBO now states that they will "not be able to provide point estimates of the effects on the deficit, health insurance coverage, or premiums for at least several weeks."[1] It is irresponsible for the Senate to take a vote on a bill impacting tens of millions of Americans and one-sixth of our nation's economy without information on the potential consequences.

Conclusion

We 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. AARP remains committed to working with Congress on commonsense, bipartisan solutions to increase coverage, lower costs, and stabilize the markets. If you have any questions, please feel free to contact me, or have your staff contact Joyce A. Rogers, Senior Vice President, Government Affairs at (202) 434-3750.

Sincerely,

Nancy A. LeaMond
Executive Vice President and Chief Advocacy and Engagement Officer

[1] https://www.cbo.gov/publication/53116

AAMC

Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0460 F 202 862 6161
www.aamc.org

Darrell G. Kirch, M.D.
President and Chief Executive Officer

September 19, 2017

Dear Senator:

On behalf of the nation's medical schools and major teaching hospitals, I write to express our strong opposition to the Graham-Cassidy-Heller-Johnson (GCHJ) proposal currently being circulated, and to urge you to vote against this measure if brought to the Senate floor.

The Association of American Medical Colleges (AAMC) has continually advocated for a number of key principles as fundamental cornerstones of any successful health care system. These principles include offering high-quality, affordable health insurance to all; preserving and fortifying the safety net through Medicaid and other policies; and encouraging innovation in the delivery system, among others. The GCHJ legislation does not meet these principles, as it repeals the individual and employer mandates, repeals Medicaid expansion, and caps traditional Medicaid funding. Under this legislation, the number of uninsured patients nationwide will increase dramatically and important existing patient protections will be at risk. Importantly, the GCHJ proposal, which represents a complete overhaul of the health care system, should be fully and adequately examined by the Congressional Budget Office (CBO) before any further action is taken.

We support the thoughtful and deliberative process that the Senate Health, Education, Labor and Pensions (HELP) and Finance Committees are pursuing to address flaws in the current health care marketplace. Instead of supporting the GCHJ legislation, we urge the Senate to continue to engage in close collaboration with health care stakeholders and to craft a bipartisan bill that is responsive to the issues presented during the Senate HELP and Finance hearings.

Please feel free to contact me or Karen Fisher, JD, AAMC chief public policy officer, at (kfisher@aamc.org) with any questions.

Sincerely,

Darrell G. Kirch

Darrell G. Kirch, MD

Graham-Cassidy Bill Introduced

September 13, 2017 by NDNRC

Today, Senators Graham (R-SC) and Cassidy (R-LA) introduced their bill to repeal and the replace the Affordable Care Act (ACA). Graham-Cassidy would essentially take all the money the federal government spends on Medicaid, premium tax credits, etc. and give that money to the states in the form of a block grant which states could then use to design health care plans for each state. The Senators released a section-by-section analysis of the bill which summarizes its provisions and a formula description which explains how the amount of the block grants will be calculated.

As was the case with the prior repeal and replace bills in the House and Senate, we believe that Graham-Cassidy fails to preserve the protections the ACA provided for people with disabilities. In fact, in many ways Graham-Cassidy is worse than the prior repeal and replace bills were. Presumably, under Graham-Cassidy, a state could receive waivers and enact a system which allows insurance companies to deny coverage for pre-existing conditions, charge more to these individuals or restrict access to many essential health benefits. The block grants would also result in drastic cuts to the Medicaid program upon which many people with disabilities rely for their health coverage. For these reasons, the American Association on Health and Disability (the lead partner for the NDNRC) opposes Graham-Cassidy and urges Congress to reject it.

You can view the NDNRC statement on health reform which we released after the election last November which includes the provisions of the ACA which we believe are vital to people with disabilities. In the statement entitled "Preserve the Protections Provided by the Affordable Care Act," we call on Congress and the Administration to protect provisions in the ACA which have benefited people with disabilities.

ACLU Statement:

"The #GrahamCassidy bill would end Medicaid as we know it, which would have especially devastating consequences for people with disabilities."

ACCSES Statement:

"#CassidyGraham would hurt people with disabilities. We need to #ProtectMedicaid"

View this email in your browser.

ACAP
Association for Community Affiliated Plans

We Oppose Cassidy-Graham. Here's Why.

The Cassidy-Graham amendment, a bill currently being considered on Capitol Hill authored by Sens. Bill Cassidy (R-La.), Lindsey Graham (R-S.C.), Dean Heller (R-Nev.), and Ron Johnson (R-Wisc.), would convert most public funding of Medicaid and Marketplace programs to a block grant and allow states to opt out of many consumer protections established by the Affordable Care Act.

Today, ACAP issued the following statement in opposition to the Cassidy-Graham amendment.

'We are disappointed to see that the Senate is repeating – and in some ways, doubling down on – many of the same mistakes as it made with the Better Care Reconciliation Act. As with previous efforts to overhaul the health care system, ACAP has compared the language of the Cassidy-Graham proposal against a set of stated principles surrounding health reform, which we have shared with Congress before.

'The bill would end the Medicaid expansion, convert the rest of the program to a per-capita allotment and then underfund those allotments. Compared with current funding, the cuts would amount to more than $80 billion nationwide in 2026 alone. What's more, a funding cliff would kick in the next year as the block grant ends—and cuts would increase to nearly $300 billion in a single year. This would have a devastating effect on health coverage for more than 74 million low-income Americans, 20 million of whom receive services through ACAP-member Safety Net Health Plans.

'What's more, the bill allows states to opt out of a wide range of consumer protections put in place by the Affordable Care Act, ranging from essential health benefits to community-rating provisions. While we agree with Senators Cassidy and Graham that the costs of health care for consumers and others is an issue that needs to be addressed, simply allowing for coverage to be pared back is not the solution.

'Given its erosion of coverage and consumer protections, its steep funding cuts, and the likelihood that it will be voted on without a full analysis from the Congressional Budget Office, we must oppose this bill.

'We've seen what's possible with health reform; there have been promising talks in the Senate HELP Committee around stabilizing Marketplaces and bipartisan progress around the must-pass funding extension for the Children's Health Insurance Program (CHIP), for which no new allotments exist after the end of the month. We urge the Senate in the strongest possible terms to turn away from partisan politics and instead build on the promising work around CHIP and the HELP committee."

Meg Murray
CEO
Association for Community Affiliated Plans
1155 15th Street NW, Suite 600
Washington, DC 20005
202.204.7509 | 301.221.5137 mobile
www.communityplans.net | @safetynetplans

Say NO to cuts to Medicaid.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

AMERICAN OSTEOPATHIC ASSOCIATION

AMERICAN PSYCHIATRIC ASSOCIATION

September 13, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

The undersigned organizations are concerned with the proposal introduced today by Senators Cassidy and Graham, which we believe will have a negative impact on affordable coverage for patients across our nation. We would note that a similar proposal was put forth by these two Senators in July. Based on our analysis, the revised proposal may actually be worse than the original.

Our organizations, which represent over 560,000 physicians, oppose the new Graham-Cassidy bill and its approach to reforming our health care system. The proposal fails to protect the health care coverage and consumer protections available under current law. Additionally, it would create a health care system built on state-by-state variability that would exacerbate inequities in coverage and most likely place millions of vulnerable individuals at risk of losing their health care coverage.

This week, the U.S. Census Bureau released a report that shows the US uninsured rate fell to a historic low of 8.8 percent in 2016. Since enactment of the Affordable Care Act, we have seen three consecutive years of significant decreases in our national uninsured rate. 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.

Further, we are very concerned about rushing through any legislation to repeal and replace the ACA, including the Graham/Cassidy proposal, through the current budget reconciliation authorization. We have consistently called for any legislation to amend current law to be developed through regular order, with hearings, debate, and committee mark-ups, and with sufficient time for independent analysis by the Congressional Budget Office (CBO), independent experts, and the clinicians and patients directly affected by the proposed changes. Especially

given how disruptive and harmful the Graham/Cassidy proposal will be for patients, we oppose any effort to try to rush it through the legislative process so a vote can occur before the current reconciliation measure expires on October 1.

Instead, we call on the United States Senate to set aside the Graham/Cassidy proposal and, instead, focus on bipartisan efforts to stabilize the health insurance marketplaces, create competition among insurers, and lower the costs of health. Our organizations have provided the HELP Committee recommendations on how these goals could be achieved.

We urge your support of the bipartisan policies being developed by the HELP Committee through regular order, and stand ready to work with you and the full Senate to secure passage of legislation that would build upon the successes we have made in extending health care coverage to millions of previously uninsured individuals.

Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics
American College of Physicians
American Congress of Obstetricians and Gynecologists
American Osteopathic Association
American Psychiatric Association

American Association of Clinical Endocrinologists
245 Riverside Avenue • Suite 200 • Jacksonville, FL 32202 • Ph: (904) 353-7878 • Fax: (904) 353-8185 • www.aace.com

September 21, 2017

Dear Senator,

On behalf of the American Association of Clinical Endocrinologists (AACE), I write to urge that you maintain important insurance market reforms in any proposal the Senate may consider to repeal the Affordable Care Act. I have attached AACE principles for health care reform for your review.

The majority of patients that AACE members treat, are those with chronic diseases, such as diabetes. Diabetes exacts a significant human and economic toll in the U.S., with more than 26 million Americans currently having a diagnosis of diabetes and another 86 million at risk of developing the disease.

We are concerned that a block grant approach, to provide greater flexibility to the states in designing their own programs, will erode and potentially eliminate critical insurance market reforms that have led to access to affordable coverage for patients with pre-existing conditions. Patients with diabetes require access to medications and services, in order to effectively manage their disease. Daily management and control must be a priority to prevent devastating, and sometimes life-threatening, complications. Allowing states to obtain waivers from community rating and the essential health benefits package will undermine patient access to affordable coverage that meets their specific health care needs.

Diabetes is among the top drivers of health care costs. The United States spends $322 billion annually controlling diabetes and the cardiac, nerve, kidney, eye and newly recognized cancer-related complications of the disease. Efforts to effectively prevent and manage diabetes can have positive outcomes for a host of other chronic diseases and conditions and achieve significant cost savings.

AACE greatly appreciates your ongoing work to implement health system reform and provide access to affordable health care coverage for all Americans. Our patients with diabetes and other pre-existing conditions have benefited from the much needed insurance reforms enacted in recent years. Those reforms have improved access to treatment and preventive care. As the Senate reviews proposals in health care reform, we urge you to consider the attached AACE principles for health care reform when you continue this very important effort.

Sincerely,

Jonathan D. Leffert

Jonathan D. Leffert, MD, FACP, FACE, ECNU
President

Attachment

American Association of Clinical Endocrinologists
245 Riverside Avenue • Suite 200 • Jacksonville, FL 32202 • Ph: (904) 353-7878 • Fax: (904) 353-8185 • www.aace.com

May 5, 2017 - The American Association of Clinical Endocrinologists (AACE) supports legislative efforts that seek to increase access to affordable health insurance for all Americans. As health system reform moves through the legislative process, we affirm our commitment to the following principles that ensure high quality health care for our patients:

- Access to affordable comprehensive health care, including continuity of care to prevent and treat chronic conditions such as diabetes, should be available to all individuals and their families over their lifetimes;
- Insurance market reforms that prevent discrimination against individuals and families based upon a current or pre-existing health condition, family history, race, gender identity or sexual orientation must be retained;
- Policies prohibiting health insurers from imposing annual and lifetime caps on benefits should be retained, and should continue to be applicable to both public and private insurance;
- Coverage for young adults under their parents' insurance plans should be retained;
- Individuals must be empowered to control how their own health care dollars are spent;
- Health care should be provided in an accessible, comprehensive, culturally and linguistically appropriate manner.

AACE believes that health care policies should always be clinically based, and that treatment decisions should be made between physicians and their patients. We are committed to securing appropriate access to medical services so that AACE members can provide the highest quality of care to our patients with endocrine disorders.

September 25, 2017

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

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

Dear Majority Leader McConnell and Minority Leader Schumer:

The undersigned organizations represent nearly 15 million of our fellow citizens in need of healthcare access through the Medicaid program in close to 30 states across the country, including AZ, CO, LA, OH, SC, and WV. Medicaid is an effective and efficient program that has and continues to improve the lives of millions of Americans. **With our members and the program that serves them in mind, we write in opposition to the Graham-Cassidy-Heller-Johnson proposal because it reduces Medicaid and Marketplace coverage, shifts costs and financial risks to states, and allows states to eliminate many consumer protections.** In short, millions of low-income Americans, including the working poor, will be without affordable, meaningful coverage.

The proposal is unprecedented in its effort to change the overall structure of a key American safety net – one which fundamentally defines who we are as a country – as it is in its absence of substantive policy reform discussions or constructive, public debate. The proposed legislation does not include sound principles to improve the Medicaid program and to protect our most vulnerable citizens. Development of this legislation did not include input from the public, state governments and other health care industry stakeholders including insurers, providers, and advocates who hold a true understanding of the program. As a result, the Medicaid changes this bill proposes are of greater scope and scale than any proposed since the program's inception, and absent a comprehensive score from the Congressional Budget Office, their true impact may not be known until after a vote has been cast.

The research firm Avalere Health has analyzed the Graham-Cassidy-Heller-Johnson proposal and the results are chilling.[1] By 2026, 16 states will receive increased funding at the expense of 34 states and the District of Columbia who will experience funding cuts. Similarly, data released last week by the Center for Medicare and Medicaid Services confirms that the overwhelming majority of states will be negatively impacted by the bill.[2] According to Avalere, the most concerning part of the report is what happens after 2026, when block grants hit a "funding cliff" and states lose nearly $300 billion in one year alone. Accordingly, by 2036, *all states* would see a reduction in federal funds relative to

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[1]Avalere Health. *Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States by $215 Billion.* Retrieved Sept 20, 2017 from http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta

[2]Centers for Medicare and Medicaid Services. *Estimated State Funding Amounts under Current Law compared to Graham Cassidy.* Retreived Sept 21, 2017 from https://www.documentcloud.org/documents/4058669-CMS-Graham-Cassidy.html

current law of over $4 trillion dollars or 71 percent, which the Brookings Institution estimates will leave a minimum of 32 million consumers without healthcare coverage.[3] This is compared to Congressional Budget Office projections that the *Better Care Reconciliation Act* would cut federal funding 35 percent by 2036, a proposal that was opposed by a clear majority of senators.

Because Medicaid is a safety net program it requires a funding model that provides states with counter-cyclical protection against economic downturns, epidemics and natural disasters while allowing for investment in program infrastructure, provider participation and the introduction of new lifesaving technologies and pharmaceuticals. By its nature, the capped federal financing model in this legislation does not offer such protections.

While block grants may promise some degree of increased program flexibility for states, they impede preparation for and timely response to public health emergencies. Past examples include the outbreak of the Zika virus and new, vaccine-resistant strains of the flu. Most recent examples include the needed response to Hurricanes Harvey and Irma. Affected undersigned plans are working diligently to support the millions of Americans impacted. This support includes: allowing early refills of medication; supplying replacements of essential medical supplies and equipment damaged during the storms; and permitting medically necessary services to be provided by out of network/out of state providers. As mandatory evacuations of medical facilities along coastal regions were announced our infant members in Neonatal Intensive Care Units (NICU) and senior members in nursing homes were moved out of harm's way to facilities outside the storms' paths.

Safety nets protect not just the individual from falling, but entire communities from being fallen upon. Therefore it is the mission of the Medicaid program and our companies to support our entire communities.

We recognize that our health care system and the health needs of Americans have evolved over the last 50 years, therefore we are not advocating for the maintenance of the status quo; but for meaningful, bipartisan Medicaid enhancements. We are not alone in this pursuit. Former Republican and Democratic CMS Administrators, Dr. Gail Wilensky and Andy Slavitt, have also urged Congress to address the stability of Marketplace coverage now and institute a deliberate, transparent process to enhance the Medicaid program over the long term. As they articulated, we should thoroughly debate and consider policies to allow for greater state innovation, hold states accountable for their Medicaid dollars, improve access to care – including through expanding services to address cost-driving social determinants of health, and enable greater coordinated and efficient care for our neediest and most costly populations, such as those dually eligible for Medicaid and Medicare.

We urge Congress, instead, to continue consideration of bipartisan efforts to reform the healthcare system, including efforts to stabilize the individual market and to reauthorize the Children's Health Insurance Plan.

We stand ready to work with you to craft solutions that enhance Medicaid and ensure its long-term stability and impact.

---

[3] The Brookings Institution. *How will the Graham-Cassidy proposal affect the number of people with health insurance?* Retrieved on September 22, 2017 from: https://www.brookings.edu/research/how-will-the-graham-cassidy-proposal-affect-the-number-of-people-with-health-insurance-coverage/.

Sincerely,

Paul A. Tufano
Chairman and CEO
AmeriHealth Caritas

Paul Markovich
President and CEO
Blue Shield of California

Michael Schrader
Chief Executive Officer
CalOptima

Pamela Morris
President and CEO
CareSource

Gretchen McGinnis, MSPH
Senior Vice President
Colorado Access

Christopher D. Palmieri
President and CEO
Commonwealth Care Alliance, Inc.

Kenneth W. Janda
President and CEO
Community Health Choice, Inc.

Robin D. Wittenstein, Ed.D.
Chief Executive Officer
Denver Health & Hospital Authority

Pat Wang
President and CEO
Healthfirst (NY)

Douglas A. Hayward
Chief Executive Officer
Kern Health Systems

Bradley P. Gilbert, MD, MPP
Chief Executive Officer
Inland Empire Health Plan

John Baackes
Chief Executive Officer
LA Care Health Plan

Joseph White
Interim Chief Executive Officer
Molina Healthcare, Inc

Kathleen Oestreich
Vice President and CEO
University of Arizona Health Plans

John Lovelace
President
UPMC for You, Inc.

September 22, 2017

The Honorable Mitch McConnell

Majority Leader

United States Senate

Washington, DC 20510

The Honorable Charles Schumer

Minority Leader

United States Senate

Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

On behalf of physicians, certified nurse midwives/certified midwives and nurse practitioners who provide care for the women of America, along with our patient partners, we stand together for patients and against Senate passage of the Graham-Cassidy-Heller-Johnson proposal (Graham-Cassidy proposal) to repeal the Affordable Care Act. The legislation would repeal valuable women's health protections that have improved access to critical health and wellness services for women and their families, such as pregnancy and newborn care. These should be built upon and improved, not rolled back. We urge the Senate to dispose of

this legislation and instead to continue work on bipartisan efforts to stabilize the individual insurance market.

The Graham-Cassidy proposal fails to ensure affordable access to high-quality care for individuals of all income levels, regardless of where they reside. This health care repeal is even worse than the ones that have come before it. We are deeply concerned that this legislation puts women's health and mental health at risk and is a step toward reinstituting unnecessary barriers to care. Research shows that women routinely face financial barriers to affording care. In fact, unmet health care needs due to cost are significantly more common among women than among men.

Of particular concern:

- The Graham-Cassidy proposal threatens women's access to Essential Health Benefits. By allowing states to waive certain standards about which benefits insurers must cover, insurers are given more latitude to increase out-of-pocket costs (e.g., deductibles, co-insurance, co-pays) and exclude coverage of certain services, such as maternity care. That means insurers could shift more costs to women and families, including for essential health services, once again putting

critical health care services like maternity care and mental health services out of reach.

- The Graham-Cassidy proposal allows states to waive prohibitions against charging higher premiums for those with pre-existing conditions. Current law ensures that the 65 million women with a pre-existing condition aren't denied or charged more for coverage.[ii] Stripping this protection would put at risk, once again, women with conditions such as depression, having a prior C-section, cancer, or prior treatment for domestic violence.
- The Graham-Cassidy proposal would strip basic essential coverage from tens of millions of people by replacing marketplace subsidies and the Medicaid expansion with a block grant that would end in 2026.
    - Hundreds of thousands of women with a substance use disorder are receiving treatment under Medicaid expansion. Maintaining this coverage is essential as our nation struggles with an opioid epidemic. Women are more likely to have chronic pain, be prescribed higher doses of prescription pain relievers, and use them for longer time periods than men. In fact, prescription pain reliever overdose deaths among women increased more than 400% from 1999 to 2010.[iii]

- The Medicaid expansion enabled millions of no-income and low-income non-pregnant women to access coverage, contributing to a reduction in the uninsured rate among women ages 18-64 by nearly half.[iv]

- The Graham-Cassidy proposal would further decimate the Medicaid program via a fundamental restructuring. This massive, unprecedented cost shift to states means millions of people will lose Medicaid coverage and millions of women, children, seniors, disabled individuals, and other vulnerable populations who rely on the program will be at risk. As providers and patient advocates, we know that Medicaid:
  - Ensures access to family planning services, including contraceptives, and important cancer screenings. In 2015, 20% of all reproductive-aged women in the U.S. were covered by Medicaid.[v] Medicaid accounts for 75% of all public dollars invested in family planning[vi], which helped bring our Nation's teen pregnancy rate to the lowest level in our nation's history;
  - Ensures healthy moms and babies. Medicaid covers approximately half of all births in the United States. These cuts would jeopardize women's access to essential maternity care.

- Ensures coverage for children. Medicaid covers 35 million children, and is critical to caring for the pediatric population. On average, 52 percent of patients at children's hospitals are covered by Medicaid; and
- Is a key driver to our nation's economy. Girls enrolled in Medicaid are more likely to attend college, with an estimated $656 increase in wages for each additional year of Medicaid coverage from birth to age 18.[vii]

- The Graham-Cassidy proposal would eliminate Medicaid coverage for primary and preventive care at women's health clinics, specifically Planned Parenthood health centers. We reject this bold-faced political interference in the patient-provider relationship as well as the dangerous precedent that would be set in allowing Congress to pick and choose among qualified providers who may participate in this essential program.1 We are concerned about patient access -- any reform needs to increase physician participation in Medicaid, not create additional barriers to providers.
  - Cutting qualified providers who practice at Planned Parenthood out of the Medicaid program would decimate access for those in rural areas and areas without other options, and cost taxpayers $77 million more in Medicaid spending by 2026.[viii]
- The proposed Medicaid per capita cap could have a widespread impact on low-income women's ability to get care as capping would shrink overall dollars

available for Medicaid. This proposal would put at risk access to care for low-income women with high-risk pregnancies, such as those with Zika virus, substance use disorder, diabetes, or preeclampsia. Further, the proposal would pit the needs of pregnant or reproductive age women against the long-term care needs of impoverished older women. Access to health care wellness services is essential during the reproductive years in order to support optimal pregnancy outcomes, and decrease the risk and severity of chronic disease and other medical conditions that occur as women age. Women make up the majority (60%) of all low-income people on Medicare who receive additional assistance from Medicaid.ix

1 See also September 19, 2017 letter from James L. Madara, MD, Executive Vice President and CEO of the American Medical Association. Available at https://searchlf.amaassn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-9-19AMA-Letter-on-Graham-Cassidy-Amendment-Final.pdf

The Graham-Cassidy proposal limits women's access to necessary health services and puts at risk their health and the health of their families. When women have access to quality, evidence-based, affordable care, they enrich our workforce, achieve higher levels of education, reach their goals, and actively contribute to the success of their families and their communities.

We urge the US Senate in the strongest possible terms to get it right, not fast, and to focus on bipartisan efforts to stabilize health insurance markets. The Graham-Cassidy proposal will turn the clock back on women's health and should not move forward.

Sincerely,

American Academy of Pediatrics

American College of Nurse-Midwives

American College of Physicians

American Congress of Obstetricians and Gynecologists

National Association of Nurse Practitioners in Women's Health

National Family Planning & Reproductive Health Association

National Partnership for Women & Families

Planned Parenthood Federation of America

i Shartzer, A, Long, S.K., & Benatar, S. (2015). Health Reform Monitoring Service: Health Care Costs Are a Barrier to Care for Many Women. Urban Institute Health Policy Center. Retrieved 9 March 2017, from http://hrms.urban.org/briefs/Health-Care-Costs-Are-a-Barrier-to-Care-forMany-Women.html ii https://aspe.hhs.gov/basic-report/risk-pre-existing-conditions-could-affect-1-2-americans iii Centers for Disease Control and Prevention. (2013, June). Prescription Painkiller Overdoses: A Growing Epidemic, Especially Among Women. Retrieved 19 September 2017, from http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/index.html iv Simmons, A et. al. The Affordable Care Act: Promoting Better Health for Women. Office of the Assistant Secretary for Planning and Evaluation Issue Brief. Department of Health and Human Services. June 14, 2016, available at https://aspe.hhs.gov/sites/default/files/pdf/205066/ACAWomenHealthIssueBrief.pdf. v Guttmacher https://www.guttmacher.org/gpr/2017/03/why-protecting-

medicaid-means-protecting-sexual-and-reproductive-health vi Guttmacher https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health vii Brown, D.W., Kowalski, A.E., and Lurie, I.Z. (2015). Medicaid As an Investment in Children: What Is the Long-Term Impact on Tax Receipts?, National Bureau of Economic Research Working Paper, 20835. Available at: http://www.nber.org/papers/w20835. viii The Congressional Budget Office. (2017). American Health Care Act. Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce. ix Jacobson, G, Neuman, T, and Musumeci M. (2017, March 24). What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare? Kaiser Family Foundation. Retrieved 19 September 2017, from http://www.kff.org/medicare/issue-brief/what-could-a-medicaid-percapita-cap-mean-for-low-income-people-on-medicare/

American Diabetes Association®

Senate Finance Committee
Hearing to Consider the Graham-Cassidy-Heller-Johnson Proposal
Monday September 25, 2017

Submitted by:
American Diabetes Association
2451 Crystal Drive, Suite 900
Arlington, VA 22202

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

American Diabetes Association®

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 wellbeing 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.

2451 Crystal Drive, Suite 900
Arlington, VA 22202
1-800-DIABETES
diabetes.org

AFSCME
We Make America Happen

September 22, 2017

The Honorable Orrin Hatch
Chairman, Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Finance Committee
United States Senate
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the 1.6 million members of the American Federation of State, County and Municipal Employees (AFSCME), I am writing to express our strong opposition to the Cassidy-Graham proposal, which would phase out the Affordable Care Act's (ACA) Medicaid expansion and tax credits and convert Medicaid to a per capita cap grant. Like its predecessor proposals -- the Better Care Reconciliation Act (BCRA) and the American Health Care Act (AHCA) -- the Cassidy-Graham proposal would inflict enormous harm on millions of Americans.

According to research by Avalere Health, Cassidy-Graham would reduce federal funding for health coverage by $215 billion between 2020 and 2026 and by more than $4 trillion from 2020 to 2036, compared with current law. These are devastating cuts which will cause as many as 32 million to lose their health care coverage, based on previous Congressional Budget Office analyses. The proposal ends the guarantee that the federal government will fund a specified share of state Medicaid costs, putting health services for many of the nation's most vulnerable individuals at risk, including long term care services for frail seniors and people with disabilities.

Under this proposal, those with pre-existing conditions would no longer be protected by federal rules which prevent insurance companies from charging higher premiums. Those with pre-existing conditions would also lose the guarantee that the health coverage available to them will provide the services they need for their condition. In addition, the Cassidy-Graham proposal eliminates protections that limit premiums for older Americans.

Because of the ACA, millions have gained access to mental health and substance use treatment. Cassidy-Graham would roll back this progress at the very time that communities across the country are challenged by the opioid epidemic.

For these reasons and more, the Cassidy-Graham proposal would be devastating to the well-being of millions of families. Rather than tear down our health care system, we urge the Senate to work in a bipartisan fashion to strengthen the individual insurance market.

Sincerely,

Scott Frey
Director of Federal Government Affairs

SF:LB:rf

American Federation of State, County and Municipal Employees, AFL-CIO
TEL (202) 429-1000 FAX (202) 429-1293 TDD (202) 659-0446 WEB afscme.org 1625 L Street, NW, Washington, DC 20036-5687

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03:17

AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and CEO

September 22, 2017

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

Ensuing 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 ten

Advocacy Office:
1331 Pennsylvania Avenue NW, Suite 1425 North
Washington, DC 20004-1710
Ph: 202-785-3355 F: 202-452-1805

Corporate Office:
55 West Wacker Drive, Suite 1150 | Chicago, IL 60601
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

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.

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)

[redacted]

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 marketplace. 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 logically 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 smokefree 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.

[redacted]

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.

Sincerely,

Harold Wimmer

Harold P. Wimmer
National President and CEO

CC: Senate Committee on Finance

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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

[2] Garfield, R, L. Levitt, R. Ridowitz, & G. Claxton. (Sept 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-8zPzKBNCEcMSoTS44BvZ5dEMU9V3hSK5Dh9szFGzXXFfUfDR4tvoitcSujaJ7zaC3g_XtOqSoX3yW1v88SobKzecl8pQ&_hsmi=56569375

[3] Garfield, R, L. Levitt, R. Ridowitz, & G. Claxton. (Sept 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-8zPzKBNCEcMSoTS44BvZ5dEMU9V3hSK5Dh9szFGzXXFfUfDR4tvoitcSujaJ7zaC3g_XtOqSoX3yW1v88SobKzecl8pQ&_hsmi=56569375

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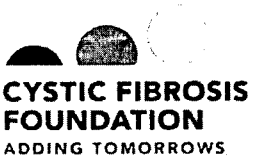

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care 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 health care 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.

AMERICAN LUNG ASSOCIATION.

LUNG CANCER ALLIANCE

ALCMI ADDARIO LUNG CANCER MEDICAL INSTITUTE

BONNIE J. ADDARIO LUNG CANCER FOUNDATION

CANCER SUPPORT COMMUNITY.

CanSAR™ Cancer Survivors Against Radon

CANCERcare®

Caring Ambassadors

CR3 Citizens for Radioactive Radon Reduction

LiveLung AND PROSPER LIVELUNG.ORG

Hope Strength.. Faith.. Courage Free ME from Lung Cancer

free to breathe a partnership for lung cancer survival

LUNG CANCER CIRCLE OF HOPE

LUNG CANCER INITIATIVE of North Carolina

LUNG RESEARCH

Lung Cancer Research FOUNDATION™

LUNGEVITY Find it. Treat it. Live.

RESPIRATORY HEALTH ASSOCIATION®

HUDDLE UP FOR HOPE REXANNA'S FOUNDATION

Upstage Lung Cancer

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 five-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 five-year survival rate is only 4 percent.

To help improve these often-grim statistics, in the last two 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
Lung Cancer Alliance
Addario Lung Cancer Medical Institute
Bonnie J. Addario Lung Cancer Foundation
Cancer Support Community
Cancer Survivors Against Radon, Inc. (CanSAR)
Cancer*Care*
Caring Ambassadors Program, Inc.
Citizens for Radioactive Radon Reduction, Inc.
Dusty Joy Foundation (LiveLung)
Free ME from Lung Cancer
Free to Breathe
Lung Cancer Circle of Hope
Lung Cancer Initiative
Lung Cancer Research Council
Lung Cancer Research Foundation
LUNGevity Foundation
Respiratory Health Association
Rexanna's Foundation for Fighting Lung Cancer
Upstage Lung Cancer

OHIO MAYORS ALLIANCE

September 23, 2017

The Honorable U.S. Senator Sherrod Brown
713 Hart Senate Office Building
Washington, D.C. 20510

The Honorable U.S. Senator Rob Portman
448 Russell Senate Office Building
Washington, D.C. 20510

RE: Ohio Mayors Alliance urges opposition to Graham-Cassidy bill because of potential for significant reductions in addiction treatment funding

Dear Senators Brown and Portman:

On behalf of the Ohio Mayors Alliance, a bipartisan coalition of mayors in Ohio's largest cities and suburbs, we write to express our opposition to the Graham-Cassidy bill. We strongly urge you to reject this measure in its current form.

We have previously expressed our appreciation for the commitment you have both shown in your efforts to address the opioid epidemic and its devastating impacts on Ohio's communities. However, the Graham-Cassidy bill could have serious consequences on those efforts.

Specifically, the changes to Medicaid under the Graham-Cassidy proposal go further and cut deeper than previous bills to reform our federal healthcare laws. Under this plan, Ohio is estimated to lose more than $2.6 billion in federal funding by 2026. The bill would also alter the traditional Medicaid funding into a per capita cap, a method which makes federal funding less responsive to the actual needs of the state. Lastly, it would completely dismantle Medicaid expansion by eliminating enhanced matching rates of federal funding and replacing them instead with inadequate block grants, which decreases funding over time until it is eliminated in 2026.

Medicaid pays for 49.5 percent of the cost for addiction treatment in Ohio (*Source: IMS Institute for Healthcare Informatics*) and provides nearly $650 million in substance abuse treatment in Ohio every year. While previous Senate bills included $45 billion in funding to make up for cuts in treatment, this new proposal fails to provide any explicit funding for treatment of opioid use disorders. And, unlike previous ACA Repeal bills defeated in the Senate, the Graham-Cassidy proposal does not implement any replacements to the ACA provisions that it repeals, which would make these changes to Medicaid even more devastating.

We strongly urge you to oppose the Graham-Cassidy bill, and any other federal legislation brought forth that would result in cuts or caps to Medicaid funding or reductions in treatment options. Our cities are on the frontlines of the opioid epidemic, and as mayors, we understand the critical need to protect treatment funding for those battling addiction. A better approach would be for Congress to come together in a bipartisan effort to find solutions that improve our health care system and help states and local communities stop the scourge of opioid addiction.

As always, we welcome the opportunity to provide additional insight and perspective as to how this bill would severely hinder our efforts to combat one of the deadliest drug epidemics our state as ever seen. Please feel free to reach out if we can be of help in providing a voice to our local communities in the efforts to create a health care system that works for all Americans.

Thank you in advance for your thoughtful consideration of our concerns and your committed leadership to our communities and our state.

Respectfully submitted,

John Cranley
Mayor, City of Cincinnati

Lydia Mihalik
Mayor, City of Findlay

Tim DeGeeter
Mayor, City of Parma

Andrew J. Ginther
Mayor, City of Columbus

Don Patterson
Mayor, City of Kettering

OHIO MAYORS ALLIANCE MEMBERS

Mayor Daniel Horrigan, AKRON • Mayor Bob Stone, BEAVERCREEK • Mayor Tom Bernabei, CANTON • Mayor John Cranley, CINCINNATI • Mayor Cheryl Stephens, CLEVELAND HEIGHTS • Mayor Andrew J. Ginther, COLUMBUS • Mayor Don Walters, CUYAHOGA FALLS • Mayor Nan Whaley, DAYTON • Mayor Gregory S. Peterson, DUBLIN • Mayor Holly C. Brinda, ELYRIA • Mayor Kirsten Holzheimer Gail, EUCLID • Mayor Steve Miller, FAIRFIELD • Mayor Lydia L. Mihalik, FINDLAY • Mayor Richard "Ike" Stage, GROVE CITY • Mayor Don Patterson, KETTERING • Mayor Mike Summers, LAKEWOOD • Mayor David J. Berger, LIMA • Mayor Chase Ritenauer, LORAIN • Mayor Lawrence P. Mulligan, Jr., MIDDLETOWN • Mayor Timothy J. DeGeeter, PARMA • Mayor Warren R. Copeland, SPRINGFIELD • Mayor Paula Hicks-Hudson, TOLEDO • Mayor William "Doug" Franklin, WARREN • Mayor John A. McNally, YOUNGSTOWN • For more information visit us at **www.OhioMayorsAlliance.org**

The following statement was jointly released on September 23, 2017 by the American Medical Association, American Academy of Family Physicians, American Hospital Association, Federation of American Hospitals, America's Health Insurance Plans, and the BlueCross BlueShield Association regarding the Graham-Cassidy-Heller-Johnson legislation.

We represent the nation's doctors, hospitals, and health plans. Collectively, our organizations include hundreds of thousands individual physicians, thousands of hospitals, and hundreds of health plans that serve tens of millions of American patients, consumers, and employers every day across the United States.

While we sometimes disagree on important issues in health care, we are in **total agreement** that Americans deserve a stable healthcare market that provides access to high-quality care and affordable coverage for all. The Graham-Cassidy-Heller-Johnson bill does not move us closer to that goal. The Senate should reject it.

We agree that the bill will cause patients and consumers to lose important protections, as well as undermine safeguards for those with pre-existing conditions. Without these guaranteed protections, people with significant

medical conditions can be charged much higher premiums and some may not be able to buy coverage at all.

We agree that the bill will result in dramatic cuts to Medicaid and a funding cliff in the future, fundamentally changing the way that states provide coverage for some of our most vulnerable citizens. This means that millions of patients will lose their coverage and go without much-needed care.

We agree that the individual insurance market will be drastically weakened, making coverage more expensive and jeopardizing Americans' choice of health plans. By not providing *all* states with sufficient funds to support working families who need help buying coverage, millions will go without it.

We agree that the bill's current implementation timelines are not workable. State and industry leaders will need to completely transform their individual insurance markets and Medicaid programs in little more than a year – an impossible task.

Health care is too important to get wrong. Let's take the time to get it right. **Let's agree** to find real, bipartisan solutions that make health care work for every American.

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of the American Association of Colleges of Nursing (AACN), I write to express our opposition to the Graham-Cassidy-Heller-Johnson proposal. AACN represents over 800 schools of nursing in all 50 states and the District of Columbia. Our membership, comprising deans, faculty, students, clinicians, and researchers, remain firm in our commitment that any healthcare reform proposal should put patients first.

AACN holds strong to three main principles in evaluating any health reform proposal: patients have access to quality health care with affordable coverage options and that coverage of pre-existing conditions are not weakened through any policy; essential health benefits are not diminished or eliminated; and Medicaid policy should be preserved to maintain its ability to protect our nation's most vulnerable populations. Based on these principles, AACN believes that the Graham-Cassidy-Heller-Johnson proposal would place individuals, families, and communities at risk of receiving timely, accessible, affordable, and high-quality health care.

This proposal, like the House and Senate bills before it, must include a full evaluation by the Congressional Budget Office to understand the impact of the legislation. AACN

supports thoughtful deliberation of all health reform measures and thanks the Senate Finance Committee for holding a hearing on this legislation on Monday, September 25. At the same time, we believe that more dialogue is needed on health reform in Congress.

AACN stands ready to continue the dialogue and find a measured solution that will put patients first. If our organization can be of any assistance, please contact AACN's Chief Policy Officer, Dr. Suzanne Miyamoto at smiyamoto@aacnnursing.org or AACN's Director of Government Affairs, Lauren Inouye at linouye@aacnnursing.org.

Sincerely,

Deborah Trautman, PhD, RN, FAAN

President and CEO

Letter from the American Academy of Actuaries

September 22, 2017

The American Academy of Actuaries is a 19,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

The Honorable Mitch McConnell

Majority Leader,

U.S. Senate S-230 Capitol Building

Washington, DC 20510

The Honorable Chuck Schumer

Democratic Leader,

U.S. Senate S-221 Capitol Building

Washington, DC 20510

Re: The Graham-Cassidy-Heller-Johnson Proposal

Dear Leader McConnell and Leader Schumer:

On behalf of the American Academy of Actuaries1 Health Practice Council (HPC), I would like to offer comments on the legislation recently proposed by Sens. Graham, Cassidy, Heller, and

Johnson ("GCHJ"). Our comments focus primarily on the proposed revisions to the individual health insurance market and approaches to federal Medicaid funding.

The HPC encourages policymakers to improve the affordability and accessibility of health insurance coverage and has published a number of policy statements in this area (highlighted at the end of this letter) that provide additional detail related to the specific comments below.

We appreciate this opportunity to provide input on these unique actuarial issues and encourage you to consider our comments as you move forward. Our long-established mission is to inform public policy deliberations in an objective and unbiased way.

Executive Summary

To be sustainable, the individual market requires sufficient enrollment numbers and a balanced risk profile. It also requires a stable regulatory environment that facilitates fair competition, with sufficient health insurer participation and plan offerings.

In the near term, GCHJ would not address cost-sharing reduction (CSR) funding and would eliminate the individual mandate. As a result, it would exert upward pressure on premiums.

GCHJ would fund short-term financial assistance to states in 2019 and 2020. Depending on how it is used, this funding could offset some of the upward premium pressure. But overall, premiums would likely increase, enrollment would likely decline, and more insurers may withdraw from the market.

Beginning in 2020, GCHJ would terminate federal funding for the ACA's premium and costsharing subsidies, Medicaid expansion, and Basic Health Program. Instead, a portion of the federal money previously used for these programs would be converted to Market-Based Health Care grants to states. Funding would be redistributed from states that expanded Medicaid or had higher enrollment of low- and moderate-income individuals in individual market plans to states that didn't expand Medicaid or had lower enrollment among low- and moderate-income individuals.

States would be able to use the funding for a broad range of purposes (e.g., helping high-risk individuals purchase insurance, stabilizing premiums and promoting insurance market participation, paying providers for health care services) and would be able to waive many of the current market rules that provide protections to individuals with health conditions. There is a great deal of uncertainty regarding how states would use their funds and whether they would

waive current market rules. In addition, there is concern whether, given actuarial, administrative, and legislative complexities, states would have the ability to make and implement their decisions in time for 2020 enrollment.

Unless the funds allocated in the proposal are used to create stable markets by maintaining a level playing field for insurers and achieving a balanced risk pool, GCHJ would likely lead to higher individual market premiums, lower enrollment, eroded protections for those with preexisting conditions, lower insurer participation, and more unstable markets than under current law.

GCHJ would also modify the federal funding structure of the Medicaid program. Aside from terminating the Medicaid expansion and incorporating that funding into the Market-Based Health Care grants to states, it would set expenditure caps for the traditional Medicaid population. The caps would limit federal funding on a per enrollee basis based on inflation rates that are projected to be outpaced by long-term Medicaid costs. In combination, these modifications could result in lower federal financing per enrollee than is received under current law.

Individual Health Insurance Market

Criteria for a Stable Market

We have identified four criteria necessary for the stability and sustainability of the individual health insurance market:

- Individual enrollment at sufficient levels and a balanced risk pool;
- A stable regulatory environment that facilitates fair competition;
- Sufficient health insurer participation and plan offerings to provide consumer choice; and
- Low health spending growth and high quality of care.

Experience under the ACA has varied, with the markets in some states faring relatively well. More typically, however, the results thus far indicate the need for improvement along most of these criteria. In general, enrollment in the individual market has been lower than initially projected and enrollees have been less healthy than expected. The uncertain and changing legislative and regulatory environment—including legal challenges, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—has contributed to adverse experience among many insurers. As a result of these and other factors, insurer participation and consumer plan choice decreased in 2016 and 2017, and some insurers have announced they will withdraw from the market in 2018. Insurers are currently finalizing their decisions on

whether to participate in the market in 2018, and if so, where to set their premiums. Continued uncertainty adds to the risk that insurers will discontinue their participation.

To improve the stability and sustainability of the individual market, several actions are needed in the short term. These include:

- Continued funding of the CSR reimbursements;
- Enforcement of the individual mandate;
- Increased external funding through increased premium subsidies or to offset costs for high-cost enrollees; and
- Forestalling legislative or regulatory actions that could increase uncertainty or threaten stability.

When evaluating the overall impact of GCHJ, it is important to consider not only the impact of particular provisions, but also how the various provisions interact to affect enrollment decisions, premiums and cost sharing, insurer participation, and federal spending.

GCHJ Near-Term Effects

In the near term, GCHJ would eliminate the individual mandate retroactively to 2016 and provide external funding in 2019 and 2020 to address coverage and access disruption. In addition, eligibility for catastrophic plans would be expanded to include all individuals.

Continued uncertainty regarding CSR funds would put upward pressure on premiums. GCHJ does not include a provision to fund CSRs. Decisions to not pay the reimbursements or even uncertainty about whether the reimbursements would be paid could result in 2018 premium increases averaging about 20 percent for silver plans, over and above premium increases due to medical inflation and other factors.2 These estimates could understate silver plan premium increases; silver plan enrollment would likely shift toward lower-income enrollees with higher cost-sharing subsidies, thus necessitating higher premiums. Federal spending would likely increase if CSR payments are not made, as the increase in federal premium subsidies would exceed federal savings due to eliminating CSR payments to insurers.

Eliminating the individual mandate would put upward pressure on premiums. GCHJ would eliminate the mandate retroactively to 2016. The mandate was intended to encourage healthy individuals to enroll. In practice, its financial penalty is usually low as a share of premiums,

many individuals are exempt, and enforcement is weak. Nevertheless, the mandate, especially in conjunction with the premium- and cost-sharing subsidies, likely increases enrollment above what it would otherwise be. In their 2018 rate filings, some insurers have cited the impact of a weakened or eliminated mandate. For instance, the Pennsylvania insurance commissioner announced that if the mandate is repealed, 2018 premiums would be an estimated 15 percent higher on average. Eliminating the mandate would remove the incentives for individuals to enroll, leading to a deterioration of the risk pool, as those most likely to enroll in a guaranteed issue environment are those with higher health care needs.

If known in advance, insurers can reflect an elimination of the individual mandate penalty in their premiums. Premiums for 2018 are nearly final, and premiums for 2017 are already final and in force. GCHJ would eliminate the penalty retroactively, and many individuals could drop coverage during the balance of 2017. Those dropping coverage would on balance likely be healthy individuals and those without immediate health care needs; individuals with ongoing or immediate health care needs would be more likely to retain coverage. As a result, the risk pool could deteriorate and premiums may be insufficient to cover claims in 2017.

Short-term assistance to states could offset, at least in part, the premium increases arising from an elimination of the individual mandate or the elimination of CSR funding, but not both. GCHJ would allocate $10 billion in 2019 and $15 billion in 2020 to be used to "fund arrangements with issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within states." However, fund allocations would be at the discretion of Centers for Medicare and Medicaid Services (CMS) administrator. It is unclear where and how the funds would be allocated, and therefore the extent they would affect premiums and insurer participation is unknown and could vary by state. If funds are targeted to particular states—for instance, those at highest risk of having no participating insurers—then funds would not be available to other states to offset higher premiums caused by eliminating the individual mandate and/or CSR funding. If funds were used to offset an elimination of CSR funding, little or no funds would be left to address other market stability concerns.

Increasing the availability of catastrophic plans could provide an additional coverage option. Currently, catastrophic plans are available to young adults and individuals who qualify for a hardship exemption from the individual mandate. GCHJ would expand catastrophic plan eligibility to all individuals regardless of age. The actuarial value of catastrophic plans is similar

to bronze plans. Although catastrophic plans are part of the single risk pool, current regulations allow catastrophic plan premiums to be adjusted to reflect the expected impact of catastrophic plan eligibility. As a result, premiums for catastrophic plans can be lower than for bronze plans. However, if catastrophic plan eligibility is broadened, the premium advantage relative to bronze

4 For 2017, the penalty is the greater of 2.5 percent of household income (up to the national average price of a bronze plan) or $695 per adult and $347.50 per child (up to a maximum of $2,085). 5 Pennsylvania Insurance Department, "Insurance Commissioner Announces Single-Digit Aggregate 2018 Individual and Small Group Market Rate Requests, Confirming Move Toward Stability Unless Congress or the Trump Administration Act to Disrupt Individual Market," June 1, 2017. plans would likely disappear, as plan eligibility would no longer be different than the metal level plans.6

Uncertainty regarding longer-term market structure could affect near-term insurer participation. Current uncertainty regarding the enforcement of the individual mandate and whether the costsharing reductions will be funded are contributing to higher premiums and insurer withdrawals from the market. Questions regarding how states would structure their insurance rating rules, coverage requirements, and premium subsidies under the GCHJ block grant structure beginning in 2020 add to the uncertainty and potential instability regarding

future enrollment, premium rates, and risk pool profiles. In light of this uncertainty, insurers might reconsider their current participation in the market and some may choose to exit in the near term. This could lead to more market disruption and loss of coverage among individual market enrollees.

GCHJ Long-Term Effects Beginning in 2020, GCHJ would replace federal funding for ACA premium subsidies, costsharing subsidies, Medicaid expansion, and the Basic Health Program with Market-Based Health Care grants to states. Over 2020–2026, funding for the block grants would be about 8 percent lower than that under current law.7 Funds would be allocated to states by a complex formula that would change over time. In general, funds would be redistributed from states that expanded Medicaid or have high enrollment of individuals with premium subsidies to states that didn't expand Medicaid or have low enrollment of individuals with premium subsidies. Nearly twothirds of states would receive lower funding under GCHJ than under current law over the 2020– 2026 period.8 As a result, states that expanded Medicaid coverage or that had high enrollment of low- and moderate-income individuals into individual market coverage would receive less funding than under current law.

GCHJ would allow states to use their block grant funding for a broad range of purposes, including helping high-risk individuals purchase insurance, stabilizing premiums and promoting

insurance market participation, paying providers for health care services, funding assistance to lower out-of-pocket costs, helping individuals purchase coverage, and providing insurance coverage for Medicaid-eligible individuals. States could decide to provide premium or cost-sharing subsidies but would need to set up an infrastructure to do so if they don't already have one in place.

GCHJ would retain the ACA market rules but would allow states to waive many of them. Insurers would still be prohibited from denying coverage to individuals with pre-existing conditions, but other provisions could undermine these protections. States could loosen premium rating rules, including those related to health status (but not gender), essential health benefit (EHB) requirements, and minimum medical loss ratios. As a result, states would be able to widen the age rating bands, charge higher premiums to people with health conditions, reduce or eliminate certain EHB categories or EHB requirements altogether, and reduce or eliminate minimum coverage levels (i.e., actuarial value). And although it appears that states would not be allowed to waive out-of-pocket cost sharing limits, those limits would become less meaningful if insurers are allowed to exclude benefit categories from coverage.

Projecting the effects of the Market-Based Health Care grants is difficult, because they depend on each state's action. The lower overall federal funding would likely result in more uninsured in the aggregate. The effects on a particular state's individual market, premiums, and enrollment would depend on its funding allocation and how it uses its block grant.

Many states, especially those in which the legislature meets infrequently, could find it difficult to make and implement decisions, rules, and necessary infrastructure by 2020, given the actuarial and administrative complexities. Moreover, insurers would need to know about any market rule changes by early to mid-2019, when they are developing 2020 premium rates. Markets in states that do not take action to use block grants would operate under the ACA market rules, but there would be no federal premium or cost-sharing subsidies and no individual mandate. In those states, enrollment would be expected to plummet, premiums would skyrocket, and insurers would likely be reluctant to participate in the market.

States would be able to use their block grants to provide premium or cost-sharing subsidies, or for reinsurance programs or high-risk pools. Depending on how they are structured, these mechanisms could help avoid a destabilization of the market by encouraging enrollment among heathy individuals to achieve a balanced risk pool. Nevertheless, unless a state enacts its own

individual mandate or an alternative incentive to encourage enrollment among healthy individuals, the risk pool would likely be worse than under current law, especially in states in which federal block grant funds are lower than federal funds for ACA coverage under current law. Even in states in which block grants would exceed current law federal funding, there are many potential uses for the money, some of which wouldn't lower premiums (e.g., paying providers for health care services).

To lower premiums, some states might decide to exclude certain benefit categories. The costs of specific benefits, such as maternity care or mental health and substance abuse services, are relatively small when spread over the entire insured population.9 Eliminating such services would not necessarily result in a large reduction in premiums. However, if those coverage requirements are removed and consumers are allowed to choose whether to have specific benefits, the additional premiums for those specific benefits will be high because insurers would anticipate that only enrollees more likely to use them would opt for them.

Also, reducing the comprehensiveness of coverage would erode out-of-pocket protections, as only out-of-pocket spending used toward covered benefits would count toward an enrollee's out of-pocket limit; annual out-of-pocket limits would not apply to non-essential benefits.

Reducing the comprehensiveness of coverage or increasing the variation of EHB requirements would increase the need for risk adjustment to reduce insurer incentives to avoid high-cost enrollees or enrollees with particular conditions. However, increased flexibility in benefit designs could make the implementation of risk adjustment more challenging. As a result, a reduction or elimination of EHB requirements would lead to a deterioration of pre-existing condition protections.

Similarly, allowing insurers to vary premiums by health status would erode pre-existing condition protections. Although premiums would be lower for healthy individuals, whose participation is needed to achieve a balanced risk pool, individuals with health conditions would pay higher premiums than they do under current law, making it more difficult for them to afford coverage.

To waive current ACA market rules regarding premium rating, benefit coverage, etc., states would be required only to describe how the state intends to "maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions." However, these requirements are much weaker than under the current 1332 innovation waiver process,

which requires actuarial and economic analyses to demonstrate coverage would be at least as comprehensive and affordable as under ACA market rules.

Funding for the block grants would expire after 2026, meaning funding would need to be reauthorized for 2027 and beyond. This adds uncertainty for states as they make their decisions for 2020 and could affect whether and how they decide to use the block grant funding. It also raises uncertainty for insurers as they consider their long-term market participation strategy.

Approaches to Federal Medicaid Funding

Modifying the federal funding structure of the Medicaid program10 from one based on a percentage of total program expenditures to one that caps or limits federal funding to states would have significant implications. Details regarding the approach to actuarial soundness requirements, setting caps including growth rate assumptions, and program flexibility provided to states may impact the stability and long-term viability of the Medicaid program.

More than 15 million adults are currently covered through the Medicaid expansions undertaken pursuant to the ACA.11 Under current law, states receive enhanced federal funding for this population (federal match is 94 percent in 2018, phasing down to 90 percent by 2020). GCHJ

would eliminate funding for the ACA Medicaid expansion as well as coverage for childless nondisabled adults. As noted earlier, the federal funds used for Medicaid expansion, the premium and cost-sharing subsidies, and the states' basic health programs would be combined under a block grant, the Market-Based Health Care grant. GCHJ would establish a formula by which block grant funds would be distributed to states, with a targeted goal that by 2026, every state would receive the same base dollar amount on a per person basis using the low-income population as the basis for financial parity. From an actuarial perspective, the formula may not provide the financial parity across states intended by the sponsors of the legislation. In order to determine that level of parity, the formula would need to take into account both the block grants as well as traditional Medicaid funding for all lowincome populations below an established threshold (e.g., 138 percent of the federal poverty level).

Continuing actuarial soundness requirements As of 2014, more than 60 percent of Medicaid enrollees are covered through Medicaid managed care organizations (MCOs.)12 To ensure that the capitation rates paid to these MCOs recognize all reasonable, appropriate, and attainable costs for the services they provide, federal law requires actuarial soundness of the capitation rates they receive from the state.

Though not addressed in GCHJ, policymakers should continue to require actuarial soundness of capitation rates with all federal funds, including the Market-Based Health Care grant funds, to

ensure sustainability of capitated models both within and outside the Medicaid program. Payment of rates above or below levels necessary to induce MCOs to participate in the Medicaid and low-income coverage programs do not serve the public interest. Capitation rates that are above such levels unnecessarily increase the cost of the federally funded programs to the public. Rates that are below those levels are unsustainable in the long term and may cause MCOs to exit the program. This would lead to breaks in continuity of care for beneficiaries, potentially lowering quality of care and increasing costs. Furthermore, if actuarial soundness requirements would require a sustainable rate to be outside of the proposed 25 percent threshold under the Medicaid per capita allotments, states could see a reduction in future federal funding. The reduced federal funding may result in increased pressure to lower capitation rates below the actuarial soundness requirement or face budget overruns.

Approach to setting state caps GCHJ would set per-enrollee caps based on states' Medicaid expenditures during a statespecified base period. Medicaid per capita costs vary by state based on state decisions such as covered populations and benefits, provider reimbursement levels, and delivery system approach. Medicaid provider pass-through supplemental and upper payment limit (UPL) payment programs, as well as provider taxes, also vary widely by state.13 Basing per capita caps on a state-specific period solidifies all these different decisions. This

approach could be considered to reward states with richer programs while limiting the ability for states with leaner programs to expand coverage or increase provider reimbursement rates to be equitable with other states. The approach would also penalize states with the most efficient programs, because states with historically less-efficient programs would presumably have greater opportunities for savings to avoid state budget overruns.

GCHJ does attempt to push Medicaid per capita amounts toward a national average by increasing / decreasing per capita amounts (modestly) if the state specific amounts are 25 percent below / above national averages (with certain rural state exclusions). Because the age distribution and disease burden within population cohorts may change over time, consideration should also be given to allowing adjustments where there are significant demographic and health risk changes. These considerations could be applied in a manner similar to the proposal for the adjustments to the Market-Based Health Care grant allotments.

Although state Medicaid programs are generally large enough to be fully credible in aggregate, expenditures, particularly for small(er) population categories, may vary by year. To the extent the base period was a higher or lower year than average, using that specific period as a baseline may provide a significant advantage or disadvantage for a state. It may be more appropriate to

have flexibility to use an average of a few recent years of experience to determine a reasonable baseline.

Growth rate methodology GCHJ would vary the annual growth rate by enrollee category: For the non-elderly, nondisabled, non-expansion adults and children populations, the rate would be CPI-M through 2024 and CPI-U thereafter; for the elderly and disabled adult populations, the rate would be CPI-M +1 percentage point through 2024 and CPI-M thereafter. Projected per-enrollee Medicaid health care costs over the long term are projected to outpace CPI-M as health care cost growth is driven not just by unit cost increases, but also by utilization increases, new treatments (e.g., the costly new biological drugs recently made available), and unexpected events such as natural disasters or pandemics.14 States can also make investments in one year with an expectation of program improvements or savings in future years (e.g., paying incentive bonuses to MCOs for improved outcomes). If CPI-M does not keep pace with total health care cost changes, it will likely be difficult for states to sustain or improve their current programs. Efforts to close budget gaps including eligibility and benefit changes may reduce Medicaid spending but they will not reduce total spending; the cost of care will be transferred to providers, insurers, employers, and to the individuals who seek needed care.

Additionally, efforts to reduce total costs, such as implementing or increasing participant premiums or increasing the burden on participants seeking coverage, could deter enrollment among those who are healthy and have relatively low health care costs, resulting in selection that in turn drives up per capita costs because those with health needs will continue to be motivated to enroll. This selection dynamic would drive up per capita costs, making it more difficult for states to stay within their per capita caps. This change in underlying morbidity could be calculated and payments adjusted via a risk scoring tool. An alternative approach, although less precise in matching payment to risk, would be to address selection funding concerns by applying an enrollment floor, such that the aggregate cap would be calculated by multiplying the indexed per capita rates by the greater of actual enrollment for that year and a historical enrollment baseline.

Program flexibility provided to states Under current law, states must comply with specific Medicaid program requirements to receive federal funding. Because moving to per capita caps would shift more funding risk to states, the states would need the flexibility to modify components (such as eligibility, benefits, provider payments, provider access, delivery system, premiums and cost sharing, etc.) of their Medicaid programs to stay within their budgets to avoid having to either raise additional revenue through taxes or assessments or reallocate funding designated for other state programs to Medicaid. States do not have unlimited funding

for their Medicaid programs, so not allowing state flexibility could create a financially unsound funding mechanism for Medicaid programs. The block grant option for states under GCHJ does provide several elements of flexibility for state consideration.

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We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact David Linn, senior health policy analyst, at linn@actuary.org or 202-785-6931.

Sincerely,

Shari Westerfield, MAAA, FSA Vice President, Health Practice Council American Academy of Actuaries

cc: Members of the U.S. Senate Members of the U.S. House U.S. Governors

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For more information, see related publications from the American Academy of Actuaries:

Steps Toward a More Sustainable Individual Health Insurance Market (Issue brief, April 2017) Selling Insurance Across State Lines (Issue brief, February 2017) Association Health Plans (Issue brief, February 2017) Using High-Risk Pools to Cover High-Risk Enrollees (Issue brief, February 2017) Proposed Approaches to Medicaid Funding (Issue brief, March 2017) How Changes to Health Insurance Market Rules Would Affect Risk Adjustment (Issue brief, May 2017) An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes (Issue paper, January 2017) Comments to U.S. House on American Health Care Act (AHCA) (March 2017) Comments on market stabilization proposed rule (March 2017) Comments to U.S. Senate on the Better Care Reconciliation Act (BCRA) (June 2017) Comments to U.S. Senate HELP Committee on Stabilizing the Individual Health Insurance Market (September 2017)

Letter from the American Academy of Actuaries

September 22, 2017

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Majority Leader,

U.S. Senate S-230 Capitol Building

Washington, DC 20510

The Honorable Chuck Schumer

Democratic Leader,

U.S. Senate S-221 Capitol Building

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Re: The Graham-Cassidy-Heller-Johnson Proposal

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waive current market rules. In addition, there is concern whether, given actuarial, administrative, and legislative complexities, states would have the ability to make and implement their decisions in time for 2020 enrollment.

Unless the funds allocated in the proposal are used to create stable markets by maintaining a level playing field for insurers and achieving a balanced risk pool, GCHJ would likely lead to higher individual market premiums, lower enrollment, eroded protections for those with preexisting conditions, lower insurer participation, and more unstable markets than under current law.

GCHJ would also modify the federal funding structure of the Medicaid program. Aside from terminating the Medicaid expansion and incorporating that funding into the Market-Based Health Care grants to states, it would set expenditure caps for the traditional Medicaid population. The caps would limit federal funding on a per enrollee basis based on inflation rates that are projected to be outpaced by long-term Medicaid costs. In combination, these modifications could result in lower federal financing per enrollee than is received under current law.

Individual Health Insurance Market

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- Sufficient health insurer participation and plan offerings to provide consumer choice; and
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whether to participate in the market in 2018, and if so, where to set their premiums. Continued uncertainty adds to the risk that insurers will discontinue their participation.

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- Continued funding of the CSR reimbursements;
- Enforcement of the individual mandate;
- Increased external funding through increased premium subsidies or to offset costs for high-cost enrollees; and
- Forestalling legislative or regulatory actions that could increase uncertainty or threaten stability.

When evaluating the overall impact of GCHJ, it is important to consider not only the impact of particular provisions, but also how the various provisions interact to affect enrollment decisions, premiums and cost sharing, insurer participation, and federal spending.

GCHJ Near-Term Effects

In the near term, GCHJ would eliminate the individual mandate retroactively to 2016 and provide external funding in 2019 and 2020 to address coverage and access disruption. In addition, eligibility for catastrophic plans would be expanded to include all individuals.

Continued uncertainty regarding CSR funds would put upward pressure on premiums. GCHJ does not include a provision to fund CSRs. Decisions to not pay the reimbursements or even uncertainty about whether the reimbursements would be paid could result in 2018 premium increases averaging about 20 percent for silver plans, over and above premium increases due to medical inflation and other factors.2 These estimates could understate silver plan premium increases; silver plan enrollment would likely shift toward lower-income enrollees with higher cost-sharing subsidies, thus necessitating higher premiums. Federal spending would likely increase if CSR payments are not made, as the increase in federal premium subsidies would exceed federal savings due to eliminating CSR payments to insurers.

Eliminating the individual mandate would put upward pressure on premiums. GCHJ would eliminate the mandate retroactively to 2016. The mandate was intended to encourage healthy individuals to enroll. In practice, its financial penalty is usually low as a share of premiums,

many individuals are exempt, and enforcement is weak. Nevertheless, the mandate, especially in conjunction with the premium- and cost-sharing subsidies, likely increases enrollment above what it would otherwise be. In their 2018 rate filings, some insurers have cited the impact of a weakened or eliminated mandate. For instance, the Pennsylvania insurance commissioner announced that if the mandate is repealed, 2018 premiums would be an estimated 15 percent higher on average. Eliminating the mandate would remove the incentives for individuals to enroll, leading to a deterioration of the risk pool, as those most likely to enroll in a guaranteed issue environment are those with higher health care needs.

If known in advance, insurers can reflect an elimination of the individual mandate penalty in their premiums. Premiums for 2018 are nearly final, and premiums for 2017 are already final and in force. GCHJ would eliminate the penalty retroactively, and many individuals could drop coverage during the balance of 2017. Those dropping coverage would on balance likely be healthy individuals and those without immediate health care needs; individuals with ongoing or immediate health care needs would be more likely to retain coverage. As a result, the risk pool could deteriorate and premiums may be insufficient to cover claims in 2017.

Short-term assistance to states could offset, at least in part, the premium increases arising from an elimination of the individual mandate or the elimination of CSR funding, but not both. GCHJ would allocate $10 billion in 2019 and $15 billion in 2020 to be used to "fund arrangements with issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within states." However, fund allocations would be at the discretion of Centers for Medicare and Medicaid Services (CMS) administrator. It is unclear where and how the funds would be allocated, and therefore the extent they would affect premiums and insurer participation is unknown and could vary by state. If funds are targeted to particular states—for instance, those at highest risk of having no participating insurers—then funds would not be available to other states to offset higher premiums caused by eliminating the individual mandate and/or CSR funding. If funds were used to offset an elimination of CSR funding, little or no funds would be left to address other market stability concerns.

Increasing the availability of catastrophic plans could provide an additional coverage option. Currently, catastrophic plans are available to young adults and individuals who qualify for a hardship exemption from the individual mandate. GCHJ would expand catastrophic plan eligibility to all individuals regardless of age. The actuarial value of catastrophic plans is similar

to bronze plans. Although catastrophic plans are part of the single risk pool, current regulations allow catastrophic plan premiums to be adjusted to reflect the expected impact of catastrophic plan eligibility. As a result, premiums for catastrophic plans can be lower than for bronze plans. However, if catastrophic plan eligibility is broadened, the premium advantage relative to bronze

4 For 2017, the penalty is the greater of 2.5 percent of household income (up to the national average price of a bronze plan) or $695 per adult and $347.50 per child (up to a maximum of $2,085). 5 Pennsylvania Insurance Department, "Insurance Commissioner Announces Single-Digit Aggregate 2018 Individual and Small Group Market Rate Requests, Confirming Move Toward Stability Unless Congress or the Trump Administration Act to Disrupt Individual Market," June 1, 2017. plans would likely disappear, as plan eligibility would no longer be different than the metal level plans.6

Uncertainty regarding longer-term market structure could affect near-term insurer participation. Current uncertainty regarding the enforcement of the individual mandate and whether the costsharing reductions will be funded are contributing to higher premiums and insurer withdrawals from the market. Questions regarding how states would structure their insurance rating rules, coverage requirements, and premium subsidies under the GCHJ block grant structure beginning in 2020 add to the uncertainty and potential instability regarding

future enrollment, premium rates, and risk pool profiles. In light of this uncertainty, insurers might reconsider their current participation in the market and some may choose to exit in the near term. This could lead to more market disruption and loss of coverage among individual market enrollees.

GCHJ Long-Term Effects Beginning in 2020, GCHJ would replace federal funding for ACA premium subsidies, costsharing subsidies, Medicaid expansion, and the Basic Health Program with Market-Based Health Care grants to states. Over 2020–2026, funding for the block grants would be about 8 percent lower than that under current law.7 Funds would be allocated to states by a complex formula that would change over time. In general, funds would be redistributed from states that expanded Medicaid or have high enrollment of individuals with premium subsidies to states that didn't expand Medicaid or have low enrollment of individuals with premium subsidies. Nearly twothirds of states would receive lower funding under GCHJ than under current law over the 2020– 2026 period.8 As a result, states that expanded Medicaid coverage or that had high enrollment of low- and moderate-income individuals into individual market coverage would receive less funding than under current law.

GCHJ would allow states to use their block grant funding for a broad range of purposes, including helping high-risk individuals purchase insurance, stabilizing premiums and promoting

insurance market participation, paying providers for health care services, funding assistance to lower out-of-pocket costs, helping individuals purchase coverage, and providing insurance coverage for Medicaid-eligible individuals. States could decide to provide premium or cost-sharing subsidies but would need to set up an infrastructure to do so if they don't already have one in place.

GCHJ would retain the ACA market rules but would allow states to waive many of them. Insurers would still be prohibited from denying coverage to individuals with pre-existing conditions, but other provisions could undermine these protections. States could loosen premium rating rules, including those related to health status (but not gender), essential health benefit (EHB) requirements, and minimum medical loss ratios. As a result, states would be able to widen the age rating bands, charge higher premiums to people with health conditions, reduce or eliminate certain EHB categories or EHB requirements altogether, and reduce or eliminate minimum coverage levels (i.e., actuarial value). And although it appears that states would not be allowed to waive out-of-pocket cost sharing limits, those limits would become less meaningful if insurers are allowed to exclude benefit categories from coverage.

Projecting the effects of the Market-Based Health Care grants is difficult, because they depend on each state's action. The lower overall federal funding would likely result in more uninsured in the aggregate. The effects on a particular state's individual market, premiums, and enrollment would depend on its funding allocation and how it uses its block grant.

Many states, especially those in which the legislature meets infrequently, could find it difficult to make and implement decisions, rules, and necessary infrastructure by 2020, given the actuarial and administrative complexities. Moreover, insurers would need to know about any market rule changes by early to mid-2019, when they are developing 2020 premium rates. Markets in states that do not take action to use block grants would operate under the ACA market rules, but there would be no federal premium or cost-sharing subsidies and no individual mandate. In those states, enrollment would be expected to plummet, premiums would skyrocket, and insurers would likely be reluctant to participate in the market.

States would be able to use their block grants to provide premium or cost-sharing subsidies, or for reinsurance programs or high-risk pools. Depending on how they are structured, these mechanisms could help avoid a destabilization of the market by encouraging enrollment among heathy individuals to achieve a balanced risk pool. Nevertheless, unless a state enacts its own

individual mandate or an alternative incentive to encourage enrollment among healthy individuals, the risk pool would likely be worse than under current law, especially in states in which federal block grant funds are lower than federal funds for ACA coverage under current law. Even in states in which block grants would exceed current law federal funding, there are many potential uses for the money, some of which wouldn't lower premiums (e.g., paying providers for health care services).

To lower premiums, some states might decide to exclude certain benefit categories. The costs of specific benefits, such as maternity care or mental health and substance abuse services, are relatively small when spread over the entire insured population.9 Eliminating such services would not necessarily result in a large reduction in premiums. However, if those coverage requirements are removed and consumers are allowed to choose whether to have specific benefits, the additional premiums for those specific benefits will be high because insurers would anticipate that only enrollees more likely to use them would opt for them.

Also, reducing the comprehensiveness of coverage would erode out-of-pocket protections, as only out-of-pocket spending used toward covered benefits would count toward an enrollee's out of-pocket limit; annual out-of-pocket limits would not apply to non-essential benefits.

Reducing the comprehensiveness of coverage or increasing the variation of EHB requirements would increase the need for risk adjustment to reduce insurer incentives to avoid high-cost enrollees or enrollees with particular conditions. However, increased flexibility in benefit designs could make the implementation of risk adjustment more challenging. As a result, a reduction or elimination of EHB requirements would lead to a deterioration of pre-existing condition protections.

Similarly, allowing insurers to vary premiums by health status would erode pre-existing condition protections. Although premiums would be lower for healthy individuals, whose participation is needed to achieve a balanced risk pool, individuals with health conditions would pay higher premiums than they do under current law, making it more difficult for them to afford coverage.

To waive current ACA market rules regarding premium rating, benefit coverage, etc., states would be required only to describe how the state intends to "maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions." However, these requirements are much weaker than under the current 1332 innovation waiver process,

which requires actuarial and economic analyses to demonstrate coverage would be at least as comprehensive and affordable as under ACA market rules.

Funding for the block grants would expire after 2026, meaning funding would need to be reauthorized for 2027 and beyond. This adds uncertainty for states as they make their decisions for 2020 and could affect whether and how they decide to use the block grant funding. It also raises uncertainty for insurers as they consider their long-term market participation strategy.

Approaches to Federal Medicaid Funding

Modifying the federal funding structure of the Medicaid program10 from one based on a percentage of total program expenditures to one that caps or limits federal funding to states would have significant implications. Details regarding the approach to actuarial soundness requirements, setting caps including growth rate assumptions, and program flexibility provided to states may impact the stability and long-term viability of the Medicaid program.

More than 15 million adults are currently covered through the Medicaid expansions undertaken pursuant to the ACA.11 Under current law, states receive enhanced federal funding for this population (federal match is 94 percent in 2018, phasing down to 90 percent by 2020). GCHJ

would eliminate funding for the ACA Medicaid expansion as well as coverage for childless nondisabled adults. As noted earlier, the federal funds used for Medicaid expansion, the premium and cost-sharing subsidies, and the states' basic health programs would be combined under a block grant, the Market-Based Health Care grant. GCHJ would establish a formula by which block grant funds would be distributed to states, with a targeted goal that by 2026, every state would receive the same base dollar amount on a per person basis using the low-income population as the basis for financial parity. From an actuarial perspective, the formula may not provide the financial parity across states intended by the sponsors of the legislation. In order to determine that level of parity, the formula would need to take into account both the block grants as well as traditional Medicaid funding for all lowincome populations below an established threshold (e.g., 138 percent of the federal poverty level).

Continuing actuarial soundness requirements As of 2014, more than 60 percent of Medicaid enrollees are covered through Medicaid managed care organizations (MCOs.)12 To ensure that the capitation rates paid to these MCOs recognize all reasonable, appropriate, and attainable costs for the services they provide, federal law requires actuarial soundness of the capitation rates they receive from the state.

Though not addressed in GCHJ, policymakers should continue to require actuarial soundness of capitation rates with all federal funds, including the Market-Based Health Care grant funds, to

ensure sustainability of capitated models both within and outside the Medicaid program. Payment of rates above or below levels necessary to induce MCOs to participate in the Medicaid and low-income coverage programs do not serve the public interest. Capitation rates that are above such levels unnecessarily increase the cost of the federally funded programs to the public. Rates that are below those levels are unsustainable in the long term and may cause MCOs to exit the program. This would lead to breaks in continuity of care for beneficiaries, potentially lowering quality of care and increasing costs. Furthermore, if actuarial soundness requirements would require a sustainable rate to be outside of the proposed 25 percent threshold under the Medicaid per capita allotments, states could see a reduction in future federal funding. The reduced federal funding may result in increased pressure to lower capitation rates below the actuarial soundness requirement or face budget overruns.

Approach to setting state caps GCHJ would set per-enrollee caps based on states' Medicaid expenditures during a statespecified base period. Medicaid per capita costs vary by state based on state decisions such as covered populations and benefits, provider reimbursement levels, and delivery system approach. Medicaid provider pass-through supplemental and upper payment limit (UPL) payment programs, as well as provider taxes, also vary widely by state.13 Basing per capita caps on a state-specific period solidifies all these different decisions. This

approach could be considered to reward states with richer programs while limiting the ability for states with leaner programs to expand coverage or increase provider reimbursement rates to be equitable with other states. The approach would also penalize states with the most efficient programs, because states with historically less-efficient programs would presumably have greater opportunities for savings to avoid state budget overruns.

GCHJ does attempt to push Medicaid per capita amounts toward a national average by increasing / decreasing per capita amounts (modestly) if the state specific amounts are 25 percent below / above national averages (with certain rural state exclusions). Because the age distribution and disease burden within population cohorts may change over time, consideration should also be given to allowing adjustments where there are significant demographic and health risk changes. These considerations could be applied in a manner similar to the proposal for the adjustments to the Market-Based Health Care grant allotments.

Although state Medicaid programs are generally large enough to be fully credible in aggregate, expenditures, particularly for small(er) population categories, may vary by year. To the extent the base period was a higher or lower year than average, using that specific period as a baseline may provide a significant advantage or disadvantage for a state. It may be more appropriate to

have flexibility to use an average of a few recent years of experience to determine a reasonable baseline.

Growth rate methodology GCHJ would vary the annual growth rate by enrollee category: For the non-elderly, nondisabled, non-expansion adults and children populations, the rate would be CPI-M through 2024 and CPI-U thereafter; for the elderly and disabled adult populations, the rate would be CPI-M +1 percentage point through 2024 and CPI-M thereafter. Projected per-enrollee Medicaid health care costs over the long term are projected to outpace CPI-M as health care cost growth is driven not just by unit cost increases, but also by utilization increases, new treatments (e.g., the costly new biological drugs recently made available), and unexpected events such as natural disasters or pandemics.14 States can also make investments in one year with an expectation of program improvements or savings in future years (e.g., paying incentive bonuses to MCOs for improved outcomes). If CPI-M does not keep pace with total health care cost changes, it will likely be difficult for states to sustain or improve their current programs. Efforts to close budget gaps including eligibility and benefit changes may reduce Medicaid spending but they will not reduce total spending; the cost of care will be transferred to providers, insurers, employers, and to the individuals who seek needed care.

Additionally, efforts to reduce total costs, such as implementing or increasing participant premiums or increasing the burden on participants seeking coverage, could deter enrollment among those who are healthy and have relatively low health care costs, resulting in selection that in turn drives up per capita costs because those with health needs will continue to be motivated to enroll. This selection dynamic would drive up per capita costs, making it more difficult for states to stay within their per capita caps. This change in underlying morbidity could be calculated and payments adjusted via a risk scoring tool. An alternative approach, although less precise in matching payment to risk, would be to address selection funding concerns by applying an enrollment floor, such that the aggregate cap would be calculated by multiplying the indexed per capita rates by the greater of actual enrollment for that year and a historical enrollment baseline.

Program flexibility provided to states Under current law, states must comply with specific Medicaid program requirements to receive federal funding. Because moving to per capita caps would shift more funding risk to states, the states would need the flexibility to modify components (such as eligibility, benefits, provider payments, provider access, delivery system, premiums and cost sharing, etc.) of their Medicaid programs to stay within their budgets to avoid having to either raise additional revenue through taxes or assessments or reallocate funding designated for other state programs to Medicaid. States do not have unlimited funding

for their Medicaid programs, so not allowing state flexibility could create a financially unsound funding mechanism for Medicaid programs. The block grant option for states under GCHJ does provide several elements of flexibility for state consideration.

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We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact David Linn, senior health policy analyst, at linn@actuary.org or 202-785-6931.

Sincerely,

Shari Westerfield, MAAA, FSA Vice President, Health Practice Council American Academy of Actuaries

cc: Members of the U.S. Senate Members of the U.S. House U.S. Governors

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For more information, see related publications from the American Academy of Actuaries:

Steps Toward a More Sustainable Individual Health Insurance Market (Issue brief, April 2017) Selling Insurance Across State Lines (Issue brief, February 2017) Association Health Plans (Issue brief, February 2017) Using High-Risk Pools to Cover High-Risk Enrollees (Issue brief, February 2017) Proposed Approaches to Medicaid Funding (Issue brief, March 2017) How Changes to Health Insurance Market Rules Would Affect Risk Adjustment (Issue brief, May 2017) An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes (Issue paper, January 2017) Comments to U.S. House on American Health Care Act (AHCA) (March 2017) Comments on market stabilization proposed rule (March 2017) Comments to U.S. Senate on the Better Care Reconciliation Act (BCRA) (June 2017) Comments to U.S. Senate HELP Committee on Stabilizing the Individual Health Insurance Market (September 2017)

Franklin County
Where Government Works

Commissioner John O'Grady • Commissioner Marilyn Brown • Commissioner Kevin L. Boyce
President

September 25, 2017

The Honorable Senator Sherrod Brown
U.S. Senate
713 Hart Senate Office Building
Washington, DC 20510

Dear Senator Brown,

We write on behalf of the hundreds of thousands of Franklin County residents for whom healthcare is jeopardized by the Graham-Cassidy bill and the many more who would bear significant financial and health burdens as a result of the bill's abandonment of critical federal standards for healthcare access. We urge you to oppose Graham-Cassidy and instead work with your colleagues in the Senate to advance legislation that improves, rather than destroys, our current healthcare system.

The Graham-Cassidy bill, not yet evaluated by the CBO, selects winners and losers among states and, even worse, among people.

Senator Brown, Ohioans count on you to protect them and make the best decisions based on the best information available. At this point, even without the CBO weighing in, it is plain to see the damage that this bill would do to tens of thousands of Ohio families, and tens of million across the nation. That is why, as you know, virtually every leading health organization in the country stands firmly in opposition, including the American Medical Association, AARP, American Hospital Association and the Children's Hospital Association, just to name a few.

Counties are on the frontlines of ensuring the wellbeing of our residents, and our nation's healthcare system works best when counties have a strong federal partner in delivering quality, affordable health care. This is not about liberal or conservative policies, and it's not about political alliances. This is about our nation's healthcare system and the responsibility of federal, state and local governments to work together to improve it. We stand ready to do so.

Sincerely,

John O'Grady
Board President, Franklin County

Marilyn Brown
Commissioner, Franklin County

Kevin L. Boyce
Commissioner, Franklin County

373 South High Street, 26th Floor, Columbus, Ohio 43215-6314
Tel: 614-525-3322 Fax:614-525-5999 www.FranklinCountyOhio.gov

APIAHF
ASIAN & PACIFIC ISLANDER
AMERICAN HEALTH FORUM

WRITTEN STATEMENT FOR THE RECORD
http://www.apiahf.org/
FOR THE HEARING ENTITLED "GRAHAM-CASSIDY-HELLER-JOHNSON PROPOSAL"

UNITED STATES SENATE
COMMITTEE ON FINANCE

SEPTEMBER 25, 2017

BY THE
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM
1629 K STREET NW, SUITE 400
WASHINGTON, DC 20006

The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the September 25, 2017 hearing before the Senate Committee on Finance entitled "Graham-Cassidy-Heller-Johnson Proposal."

We believe it is time for Congress to put aside attempts to repeal the Affordable Care Act (ACA) and instead take needed steps to ensure that all Americans are able to afford and access health insurance that meets their needs. APIAHF is the nation's leading policy organization working to advance the health and well-being of over 20 million Asian Americans (AA), Native Hawaiians and Pacific Islanders (NHPI) across the U.S. and territories. From our work with AA and & NHPI communities, we understand the role the ACA has played in improving access to health insurance for communities of color across the nation. Since 2010, the uninsured rate has fallen from 15.1 percent to 6.5 percent in 2016 for AAs and from 14.5 percent to 7.7 percent for NHPIs, higher than any other racial group. In addition, the uninsured rate fell from 17.8% to 9.4% for African Americans, 30.9% to 18% for Latinos, and 24.2% to 14.4% for American Indians and Alaska Natives.[1]

As an organization that has worked for over 30 years at the federal, state, and local levels to advance sensible policies that reduce health disparities and promote health equity, we are deeply troubled by the Graham-Cassidy proposal and its potential impact on the nation's health system. It would remove an estimated $215 billion in federal health care funding to

[1] American Community Survey Table S0201, 2010 and 2016 1 year estimates.

states through 2026, forcing them to make difficult and likely harmful decisions about providing for their residents.[2]

Millions of Americans, including AAs and NHPIs, who rely on coverage under the ACA will be worse off under the Graham-Cassidy repeal bill. Under the guise of flexibility, this plan would end Medicaid as we know it by phasing in per-capita caps and ending its expansion. Under the guise of access, the bill would completely eliminate financial support that is currently allowing millions of low- and moderate-income Americans to afford their monthly premiums. More than eight in 10 previously uninsured AAs and NHPIs qualify for financial assistance through the ACA.[3] In short, Graham-Cassidy is a major repeal not only of the ACA, but a serious threat to the stability of the nation's insurance markets.

Graham-Cassidy Would End Medicaid

As proposed, Graham-Cassidy would end Medicaid's guarantee as a safety net to the poor, elderly and disabled, capping Medicaid funding to the states. As such, the repeal bill would effectively end Medicaid as we know it, breaking the over 50 year promise and partnership between the federal government, states and its most vulnerable citizens. By eliminating the Medicaid Expansion, which has drastically reduced uninsured in the states that took up the option, and replacing the current funding formula with per-capita caps, the bill represents an overall major net loss for states.[4] In the absence of federal funding, states would have to make harsh choices, to either limit eligibility, benefits, services or reimbursements. In total, the very people whom the program is designed to protect and serve, low-income Americans, would be harmed.

This includes people like Mee Pwa, a mother of four struggling to support not only her family, but her parents as well. Mee's daughter has a lifetime disability and requires monthly hospital visits to check on her kidneys and constant care at school. Her nurse changes her catheter every three hours. Medicaid pays for these hospital visits, the medical supplies, and care that her daughter receives. Medicaid keeps her child alive.

And then there are families like Tuyet from New Orleans, Louisiana. After her husband died a premature death from lung cancer, she became the sole provider for her 6 children. Like all parents, Tuyet sacrificed her health for that of her children and was lucky to be able to rely on Medicaid to keep them healthy. Tuyet's son, Quynh Vo, has down syndrome and counts

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[2] Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States By $215 Billion, Avalere Health, September 20, 2017. Available at: http://go.avalere.com/acton/attachment/12909/f-04e3/1/-/-/-/-/Avalere%20CAP%20Graham%20Cassidy%20Bill%20Analysis.pdf

[3] Wendt, Minh et al, Eligible Uninsured Asian Americans, Native Hawaiians, And Pacific Islanders: 8 In 10 Could Receive Health Insurance Marketplace Tax Credits, Medicaid Or CHIP, Office of the Assistant Secretary for Planning and Evaluation, March 18, 2014. https://aspe.hhs.gov/pdf-report/eligible-uninsured-asian-americans-native-hawaiians-and-pacific-islanders-8-10-could-receive-health-insurance-marketplace-tax-credits-medicaid-or-chip

[4] Greater Drop in Uninsured Rate Among Adults in Medicaid Expansion States, Center on Budget and Policy Priorities. Available at: https://www.cbpp.org/greater-drop-in-uninsured-rate-among-adults-in-medicaid-expansion-states

on Medicaid. Without Medicaid, how would Tuyet afford a home for herself and her son? In her words:

> ***"Sometimes I lay awake at night wondering what will happen to Quynh Vo after I pass. If Medicaid is taken away from him, how will he go see a doctor or pay for hospital stays?"***

Graham-Cassidy would eliminate the Medicaid program and cut funding for people with disabilities by 15 percent.[5] It would also eliminate the health and well-being and threaten the very ability to survive for the over 74 million Americans counting on Medicaid.[6] Such changes would be particularly devastating to communities of color who rely on Medicaid, including 33.4% of African Americans, 30.7% of Latinos, 16.9% of Asian Americans, 34% of Native Hawaiians and Pacific Islanders and 34.1% of American Indians and Alaska Natives.[7] NHPIs match American Indians as the racial community with the highest percent of its population on Medicaid. Medicaid's role in covering the nation's most vulnerable populations, whom are disproportionately people of color, means that any cuts to Medicaid will hurt efforts to improve health equity.

Graham-Cassidy Would Result in Discrimination in Healthcare for the at Least 50 million Americans with a Pre-existing Condition[8]

Racial and ethnic minorities, including AAs and NHPIs, disproportionately experience a number of chronic conditions due to factors including poverty, inability to afford quality coverage, and challenges accessing culturally competent care, among others. The AA and NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries. As of 2016, 11% of AAs and 23% of NHPI families live below the poverty line.[9] Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.

Graham-Cassidy would deepen those disparities by turning back the clock on coverage gains that have substantially reduced uninsurance amongst communities of color. In addition, the

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[5] Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States By $215 Billion, Avalere Health, September 20, 2017. Available at: http://go.avalere.com/acton/attachment/12909/f-04e3/1/-/-/-/-/Avalere%20CAP%20Graham%20Cassidy%20Bill%20Analysis.pdf

[66] Total Monthly Medicaid and CHIP Enrollment, Kaiser Family Foundation, June 2017. Available at: www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D

[7] *Summary Health Statistics: National Health Interview Survey*, 2015, National Center for Health Statistics, *available at*: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-11.pdf.

[8] At Risk: Pre-existing Conditions Could Affect 1 In 2 Americans, Assistant Secretary for Planning and Evaluation, November 1, 2011. Available at: https://aspe.hhs.gov/basic-report/risk-pre-existing-conditions-could-affect-1-2-americans

[9] Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity, Section 1: Demographics*, Kaiser Family Foundation, June 7, 2016, *available at*: http://kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-1-demographics/.

repeal bill would permit states to eliminate pre-existing condition protections, disproportionately impacting AAs and NHPIs.

AAs and NHPIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention. NHPIs have the highest age-adjusted percentage of people with diabetes (20.6%), more than 3 times that of Whites (6.8%).[10] AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.[11] Certain AA and NHPI subpopulations suffer from even greater health disparities. Fourteen percent of Indian Americans have diabetes, a rate higher than that of nearly all other racial groups.[12] Vietnamese women have cervical cancer rates five times higher than White women.[13] NHPIs are 30% more likely to be diagnosed with cancer than whites.[14] Allowing insurance companies to discriminate and deny coverage on the basis of a pre-existing condition would make coverage cost prohibitive for these individuals.

Graham-Cassidy Would Eliminate Coverage for Tens of Millions

By eliminating the ACA's Medicaid expansion, ending Medicaid, and repealing the ACA's financial assistance, the bill would likely end health coverage for tens of millions of Americans, rendering it unaffordable. The result would be predicable consequences seen prior to passage and implementation of the ACA, including increased uncompensated care and delays in accessing critical care amongst the uninsured. Prior to the ACA, 59% of the uninsured delayed health care.[15] This majority included people like Tuyet from New Orleans, Louisiana. In 2004, Tuyet's husband was diagnosed with stage four lung cancer and died soon thereafter, leaving her as the sole provider and parent to their six children, then aged 9 through 18. Tuyet still wonders if they would have caught her husband's cancer earlier if he had health coverage.

Without financial assistance, millions of Americans would not be able to afford private coverage through the ACA's Marketplaces. This includes Fangyu Wu from Ohio, a successful business woman and mom of five. In her words:

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[10] Asian and Pacific Islander American Health Forum, *Native Hawaiian and Pacific Islander Health Disparities*, 2010, *available at*: www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf

[11] Heron, Melonie, *Deaths: Leading Causes for 2014. National Vital Statistics Reports* Volume 65, Number 5. United States Centers for Disease Control, 2016.

[12] Spanakis, Elias and Sherita Hill Golden, *Race/Ethnic Difference in Diabetes and Diabetic Complications*. Curr Diab Rep. 13(6), 2013, *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/

[13] Miller BA et al., *Racial/Ethnic Patterns of Cancer in the United States, 1988-1992*, 1996, *available at*: https://seer.cancer.gov/archive/publications/ethnicity/

[14] *Cancer and Native Hawaiians/Pacific Islanders*, U.S. Department of Health & Human Services: Office of Minority Health, Last updated March 29, 2016, *available at*: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=76.

[15] Brown, Alyssa, Costs Still Keep 30% of Americans From Getting Treatment, Gallup, December, 9 2013, available at: www.gallup.com/poll/166178/ costs-keep-americans-getting-treatment.aspx

"It [Affordable Care Act] has helped me a lot. I have less to worry about and feel much better. Now I am able to focus on being a mom, building my business, and enjoying my new beginning."

Prior to the ACA, high costs caused many AAs and NHPIs to either forgo care entirely or sell everything they had to afford care. People like Trieu, a young adult from Pennsylvania, had to skip care and hoped he did not get sick until he got coverage thanks to the ACA's financial help.

The ACA's financial assistance saved the life of Jirapon in Georgia. Jirapon is a single mom with three children who works as a cook. Thanks to a local community based organization, she was able to enroll in health care for the first time. She qualified for subsidies as well as Medicaid for her youngest child. After getting covered, Jirapon went for a general screening and was diagnosed with breast cancer. She was able to access affordable surgery, reconstruction, and long-term care because of the ACA.

Falani and his wife, Teuloi, from Utah went uninsured for 15 years prior to the ACA, even though Falani was battling stomach cancer and diabetes. Without coverage, he resorted to home remedies and emergency care when things got really bad. The ACA changed their lives when they realized they could afford a plan for $45 a month and finally get much needed dialysis.

The Graham-Cassidy bill would eliminate coverage for these individuals and millions of others, create chaos in the marketplace and drastically reduce funding for states. As such, APIAHF strongly opposes the bill.

For questions contact Amina Ferati, Senior Director of Government Relations & Policy aferati@apiahf.org (202-466-3550).

January 19, 2017
Redistributed Sept 26, 2017

Dear Member of Congress,

As members of law enforcement, we are on the front lines of the opioid epidemic and we believe it would be a huge mistake to cut funding for Medicaid in the middle of this mounting crisis. Our officers are on the street every day responding to overdoses and working to get people with opioid dependence into treatment and recovery programs. Medicaid is essential for their success because it provides insurance coverage for addiction treatment for the majority of the people we help.

We are joining hundreds of other law enforcement officers in a nonpartisan effort to urge Members of Congress to stand with law enforcement and not cut Medicaid funding for addiction treatment. Changes in national health policy, especially those that affect access to care for opioid use disorders, can have immediate negative consequences on public safety in our community, and we need your help to prevent this from happening.

As Congress considers changes to the Affordable Care Act, Medicaid, and other federal health programs, we urge you to work against any proposals that will make it harder for individuals with substance use disorders to access treatment. Simply put, you can't say you are in the fight against opioids and support cutting Medicaid.

For example, the Affordable Care Act made parity for mental health and addiction treatment a requirement for all public and private insurance plans. If that requirement is not maintained, many people with mental illness and/or addiction in our community will not be able to get treatment. Also, the expansion of treatment providers that is now underway and that is making it easier for people to get help will end and treatment providers will start to cut back if Medicaid and other insurance coverage is ending. The latest repeal bill undermines these advances and represents a step backward. Right now American families need more help, not less.

Our police departments joined the Police Assisted Addiction and Recovery Initiative (PAARI) because the opioid epidemic hit our communities hard and we realized that we cannot arrest our way out of it. Traditional criminal justice approaches to addiction have not been effective, so we are part of this nationwide movement led by law enforcement that recognizes addiction is a chronic disease that needs long-term treatment, not arrest and jail. A key tool in combatting the opioid epidemic is getting people into treatment and Medicaid and health insurance coverage are vital to accessing treatment. Medicaid provides insurance coverage for addiction treatment for the majority of the people we help. PAARI has nearly 300 law enforcement department partners in 31 states saving lives every day. Together, we have helped an estimated 10,000 people into treatment to date. These programs make our cities safer and prevent overdose deaths. Undermining these programs will further burden law enforcement agencies like ours that are doing everything we can to grapple with this mounting crisis.

The opioid epidemic is the most urgent public health and public safety issue we face today, as a country and as law enforcement. As any health policy change is considered in Congress, we hope you make the opioid epidemic a top priority. We urge you to stand with law enforcement and vote "no" on any legislation that makes it harder for police departments like ours to prevent overdose deaths and protect our citizens. Thank you for considering the voice of law enforcement as you move forward.

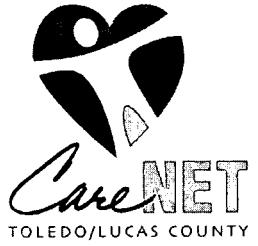
Sincerely,

PAARI National Police Council
Chief Frederick Ryan, Arlington Massachusetts Police Department
Sergeant Michael Braley, Everett Washington Police Department
Sergeant Brittney Garrett, Jeffersontown Kentucky Police Department
Chief Danny Langloss, Dixon Illinois Police Department
Chief Timothy Lentz, Covington Louisiana Police Department
Chief Scott Allen, East Bridgewater Massachusetts Police Department
Chief Robbie Moulton, Scarborough Maine Police Department
Chief Joseph Solomon, Methuen Massachusetts Police Department
Chief Michael Botieri, Plymouth Massachusetts Police Department
Gil Kerlikowske, former Director of the White House Office of National Drug Control Policy

With additional support from the following law enforcement officials:

Chief Matt Vanyo, Olmsted Township Ohio Police Department
Chief Thomas Bashore, Nashville North Carolina Police Department
Chief Thomas Hanley, Middlebury Vermont Police Department
Chief Mark Holden, Willard Ohio Police Department
Special Agent Brannon Prevett, Homeland Security Investigations, Corpus Christi Texas
Chief Michael Covert, Cooperstown New York Police Department
Chief Troy J Westfall, City of Salamanca Police, New York
Chief Gerald Sticker, Mandeville Louisiana Police Department
Police Commissioner Stephen G. McAllister, Floral Park New York Police Department
Chief Damien Pickel, Milo Maine Police Department
Mental Health Peace Officer Chris Morgan, City of North Richland Hills, Texas
Sheriff John Simonton, Lee County Sheriff's Department, Illinois
Chief Brian Costa, Keene New Hampshire Police Department
Chief Janine Roberts, Westbrook Maine Police Department
Deputy Chief Jeff Satur, Longmont Colorado Department of Public Safety
Chief Rick Brandt, Evans Colorado Police Department
Chief Martin Berber, Village of Phoenix Police, New York
Captain, Cory Nelson, Madison Wisconsin Police Department
Deputy Chief Edward J. McGinn Jr., Worcester Massachusetts Police Department
Chief Peter Volkmann, MSW, Village of Chatham, New York
Sergeant Teresa Meade, Wise Virginia County Sheriff's Office
Chief Keith Keough, Lodi Ohio Police Department
Chief Michael Richards, Newton New Jersey Police Department
Chief Adam Klimczak, LaPorte City Indiana Police Department
Chief Marc Montminy, Manchester Connecticut Police Department
Chief Tammy Nelson, Rock Falls Illinois Police Department
Chief Gary Sullivan, Easton Massachusetts Police Department
Chief Scott D. Benton, Whitman Massachusetts Police Department
Sheriff Anthony Wickersham, Macomb County Sheriff's Office, Michigan
Chief Sean Fagan, Rolla Montana Police Department
Chief Robert Bongiorno, Bedford Massachusetts Police - Central Middlesex Police Partnership
Chief Mark W. Dubois, Maynard Massachusetts Police Department
Chief Paul Burdette, Beaufort North Carolina Police Department
Chief Robert Francaviglia, Hillsdale New Jersey Police Department
Corporal Detective Patrice Ottey, Ocean Pines Maryland Police Department
Chief Jerome Uschold, Town of Tonawanda Police Department, New York
Chief Douglas F. Wyman, Jr., Sandwich New Hampshire Police Department
Chief Patrick Dillon, Plympton Massachusetts Police Department
Chief Craig Mace, Seekonk Massachusetts Police Department
Chief William Oswalt, Jaffrey New Hampshire Police Department
Chief Todd Barkalow, Freeport Illinois Police Department
Chief Jeffery Blake, Amboy Illinois Police Department
Chief Eric J. Guenther, Mundelein Illinois Police Department
Deputy Chief Matt Hollinger, Rockton Illinois Police Department
State's Attorney Mike Nerheim, Lake County State's Attorney's Office, Illinois
Chair Mike Nerheim, Lake County Opioid Initiative Illinois
Chief Kurt Cavanaugh, Polo Illinois Police Department
Chief Nick Ficarello, Braidwood Illinois Police Department
Sheriff David Ernest, Boone County Sheriff Office, Illinois
Chief Lianne Tuomey, University of Vermont Police Services
Chief Mary R. Lyons, Mattapoisett Massachusetts Police Department
James and Holly Conley, James Conley, U.S. Marshal, Ohio
Chief Steven Casstevens, President, Illinois Association of Chiefs of Police
Program Director Michael, AEA of Dixon Illinois
Chief Stephen Schaible, Lena Illinois Police Department
Debra Deagle, Revere Massachusetts Police Department
Gina Marie Garofalo, Methuen Massachusetts Police Department
Christopher Rousseau, Methuen Massachusetts Police Department
Chief Michael Ward, City of Alexandria Kentucky Police Department
Chief Bob Lippert, Huron Ohio Police Department
Lieutenant Donna Daniels, White County Tennessee Sheriff's Department

Chief Brian Fengel, Bartonville Illinois Police Department
Sheriff Jeff Doran, Carroll County Sheriff's Office, Illinois
Chief Peter Morency, Berlin New Hampshire Police Department
Chief Jonathan Ventura, Arlington Police Department, Washington State
Chief Kenneth Strish, Borough of Berwick Police Department, Pennsylvania
Chief David Koepke, Bucyrus Ohio Police Department
Chief Thomas Davoren, City of Groton Police Department, Connecticut
Patrolman Craig Hoover, East Brunswick New Jersey Police Department
Chief Warren Nelson, Bolton Massachusetts Police Department
Director / Police Chief Frederick Harran, Bensalem Township Police Department, Pennsylvania
Sheriff Ronnie Oaks, Wise County Sheriff's Office, Virginia
Chief Michael Sauschuck, Portland Maine Police Department
Lieutenant / Angel Program Coordinator David Quinn, Gloucester Massachusetts Police Department
Chief James Spinney, Chelmsford Massachusetts Police Department
District Attorney Andy Watson, All Potter County Law Enforcement Agencies, Pennsylvania
Chief Brett Botbyl, Menominee Michigan Police Department
Chief Richard Stillman, Bridgeton Maine Police Department
Chief Paul A. Nikas, Ipswich Massachusetts Police Department
Chief Michael, Caribou Maine Police Department
Chief Michael Gahagan, Caribou Maine Police Department
Chief Leonard Wetherbee, Moultonborough New Hampshire Police Department
Chief Joseph Massey, Waterville Maine Police Department
Chief Edward Tolan, Falmouth Maine Police Department
Chief Robert C. Gregoire, Augusta Maine Police Department
Chief Walter Sweeney, Hanover Massachusetts Police Department
Chief Marc Duphily, Carver Massachusetts Police Department
Patrolman Heather Bauer, Norton Ohio Police Department
Chief Kris Nietert, Bedford Ohio Police Department
Chief Shawn O'Leary, Winslow Maine Police Department
Chief Jerome Uschold, Town of Tonawanda New York Police Department
Chief Marc Duphily, Carver Massachusetts Police Department
Chief Michael Miksch, Hanson Massachusetts Police Department
Assistant Chief of Police Eugene Wehrfritz, Town of Orchard Park Police Department, New York
Chief Richard Caton IV, Jay Maine Police Department
Sheriff David Snyders, Stephenson County Sheriff's Office, Illinois
Chief Sean P. Geagan, Bucksport Maine Police Department
Chief Craig Sanford, Kennebunkport Maine Police Department
Chief John A. Dalessandro, Norton Ohio Police Department
Chief Chris Hunt, Bladenboro North Carolina Police Department
Chief Patricia L. Arnaudin, Ogunquit Maine Police Department
Deputy Chief, Marla St Pierre, Scarborough Maine Police Department
Chief Victor R. Flaherty Jr., West Bridgewater Massachusetts Police Department
Lee County State's Attorney Matthew Klahn, Lee County State's Attorney's Office, Illinois
Sheriff Kelly C Wilhelmi, Whiteside County Sheriff's Office, Illinois
Chief Edward J. Googins, South Portland Maine Police Department
Chief Kevin Ouellet, Amesbury Massachusetts Police Department
Chief Kevin Simpson, Hinsdale Illinois Police Department
Assistant Superintendent, James P. Muscato, Plymouth County Sheriff's Office, Massachusetts
Chief Bruce Boucher, City of Rockland Maine Police Department
Chief Charles Gray, North Andover Massachusetts Police Department
Chief Marc Maton, Village of Lemont Illinois Police Department
Chief Steven Vaccaro, Mokena Illinois Police Department
Chief Terry Lemming, Lockport Illinois Police Department
Chief Hartley Mowatt, Paris Maine Police Department
Chief John Llewellyn, Rockland Massachusetts Police Department
Chief Timothy Morgan, Sterling Illinois Police Department
Deputy Chief Anthony Haugh, Haverhill Massachusetts Police Department
Chief Tom Davis, Lynnwood Police Department, Washington State
Sergeant of Police, Coleman Langdon, Lynnwood Police Department, Washington State
Chief James Fitzpatrick, Lawrence Massachusetts Police Department
Chief Kevin Walsh, Wareham Massachusetts Police Department
Bradley DeCamp, Executive Director, Crawford-Marion ADAMH Board, Marion, Ohio



September 22, 2017

Dear Senator Brown,

Toledo/Lucas County CareNet, a non-profit organization focused on connecting low income individuals to healthcare services, does not support the Graham-Cassidy proposal. We believe it places coverage at risk for tens of millions of Americans, especially 20% of Lucas County residents who receive their healthcare coverage from Medicaid, Medicare or Marketplace. The proposal would erode key protections for patients and consumers and does nothing to stabilize the insurance market now or in the long term.

Earlier this month Ohio learned its Navigator funding was cut by 71% and then learned it would no longer have a federal navigator grant. As the Senate considers legislation to repeal and replace parts of the Affordable Care Act, please stand with America's hospitals, health systems and free clinics to protect health coverage for the patients we care for.

The Graham-Cassidy proposal would significantly cut Medicaid and weaken essential protections for older and sicker patients, including those with pre-existing conditions,

such as cancer patients and the chronically ill. In Lucas County alone, 34% of the population has high blood pressure, 25% have high cholesterol and 13% have had a cancer diagnosis. Millions of Americans could be left without health coverage or coverage for their pre-existing conditions.

As the backbone of our nation's health safety net, America's hospitals and health systems believe it's vital that coverage be protected, particularly for our most vulnerable and those most prone to health disparities. As a member of the Ohio Association of Free Clinics, I urge you to protect coverage and reject the Graham-Cassidy proposal and any legislation that would harm patients' ability to get the coverage and care they need.

Sincerely,

Jan. L. Ruma – Executive Director

Toledo/Lucas County CareNet

ASIA, Inc.
ICHC
International Community Health Center

International Community Health Center
3820 Superior Ave.
Ste. 214
Cleveland, OH 44114
P: 216-361-1223
F: 216-361-1568

ASIA Cleveland Office
3631 Perkins Ave.
Ste. 2A-W
Cleveland, OH 44114
P: 216-881-0330
F: 216-881-6920

ASIA Akron Office
730 Carroll Street
Akron, OH 44304
P: 330-535-3263
F: 330-535-3338

September 23, 2017

Dear Senators Portman and Brown,

We are deeply concerned about the dangerous impacts of the Cassidy-Graham bill. And the recent announcement from Senator McCain also reinforces the fact that the bill is flawed and can harm many including Ohio's fastest growing Asian American and Pacific Islander (AAPI) community.

The International Community Health Center (ICHC) was established because we had documented for many years the plight of Cleveland's AsiaTown residents who would forego or delay healthcare because the lack of culturally and linguistically specific medical services. This has led some to go to great extent, such as taking a midnight bus, to New York City's Chinatown, for services.

ICHC was possible because of the provisions in the Affordable Care Act (ACA). In 2013, ICHC became a federally qualified health center (FQHC). Today, we serve nearly 2,000 individuals; and those individuals who went to New York City for care now have a medical home that speak their language and understand their culture.

The ACA is overwhelmingly supported by Ohio's AAPI community. In March of this year, we conducted a phone banking survey of over 30,000 registered AAPI voters in Ohio. **71% of AAPIs in Ohio are in support of the ACA** and **71% of AAPIs in Ohio do not favor repeal of the ACA.**

Healthcare for our community, including for our most vulnerable, means our community members can focus on contributing to the economic and social vitality of the region. We see this in the recent economic impact study released by the Refugee Services Collaborative of Greater Cleveland. The economic impact of refugees and refugee serving organizations in our region were responsible for **$88.2 million of spending activities.** We also see more ethnic businesses created and cultural festivals established that offer our receiving communities great access to opportunities not available before.

In closing, please remember Ohio's AAPI community, we need your steadfast support to ensure that the Cassidy-Graham bill does not move forward. Should you have any questions, please contact me at mbyun@asiaohio.org or 330-612-0483.

Sincerely,

Michael Byun, MPA – Chief Executive Officer

Statement from Seneca County Pax Christi

Blessings to you Senator Brown!

On behalf of Seneca County Pax Christi peace organization, I ask you, I plead with you to stand strong against the Graham Cassidy healthcare bill. To think of all the resulting pain and suffering and worry, such a bill would cause to around 32,000,000 people, is unthinkable. Our Congress people are supposed to have the peoples' welfare in mind for ANY legislation, not a neat little budget which makes them look good.
much peace to you in your efforts to ensure justice far and wide.
sr. Paulette Schroeder/osf Tiffin, OH

Planned Parenthood®
Care. No matter what.

Planned Parenthood
Federation of America

Planned Parenthood®
Act. No matter what.

Planned Parenthood Action Fund

STATEMENT FROM PLANNED PARENTHOOD FEDERATION OF AMERICA FOR THE SENATE FINANCE COMMITTEE
HEARING TO CONSIDER THE GRAHAM-CASSIDY-HELLER-JOHNSON PROPOSAL

MONDAY, SEPTEMBER 25, 2017

Planned Parenthood Federation of America stands in strong opposition to the Graham-Cassidy-Heller-Johnson proposal under consideration today that would go much further than any previous proposal to repeal the Affordable Care Act and would result in millions of individuals losing access to health care - affecting women and children the most.

Planned Parenthood is the nation's leading provider and advocate of high-quality, affordable health care for women, men, and young people, as well as the nation's largest provider of sex education. With more than 600 health centers across the country, Planned Parenthood health centers provide affordable birth control, lifesaving cancer screenings, testing and treatments for STDs and other essential care to nearly three million patients every year. Seventy five percent of Planned Parenthood patients have incomes at or below 150 percent of the federal poverty level, and are among the most vulnerable, facing limited access to reliable and affordable health care.

Planned Parenthood strongly opposes this dangerous legislation that would block Medicaid beneficiaries from accessing preventive care at Planned Parenthood, restructure the Medicaid program, end nationwide protections for maternity coverage;once again allow women to be charged more because they have pre-existing condition, including pregnancy; and impose a national ban on private insurance coverage of abortion.

Blocking Care at Planned Parenthood
Many Medicaid patients already have limited options for care such as birth control, cancer screenings, and regular checkups. Preventing them from coming to Planned Parenthood would leave many with nowhere to go for basic reproductive health care. The American Medical Association (AMA) said that parts of the bill that block access to care at Planned Parenthood health centers "violate longstanding AMA policy on patients' freedom to choose their providers and physicians' freedom to practice in the setting of their choice."

One in five women in America have relied on Planned Parenthood in her lifetime. More than half of Planned Parenthood's patients rely on Medicaid for care, and 56 percent of Planned Parenthood's health centers are in rural or otherwise medically underserved areas.

Under this bill, all Medicaid patients would be prohibited from coming to Planned Parenthood health centers for care — leaving many women with nowhere to go for basic care such as cancer screenings,

birth control, STD treatment, and more. We've seen what happens at the state level when policies like this are put in place, and they're devastating.

Ending Medicaid As We Know It

Millions of women will lose access to health insurance altogether because of the deep cuts to the Medicaid program —affecting one in five women of reproductive age. Medicaid is the largest insurance program for women in this country. Women are the majority of Medicaid enrollees; in fact, two-thirds of adults with Medicaid coverage are women. Due to discriminatory systemic barriers, women of color disproportionately comprise the Medicaid population, with 30 percent of Black women and 24 percent of Hispanic women enrolled in Medicaid, compared to 14 percent of white women.

Medicaid covers more women's health services than any other health insurance program. Medicaid is the largest source of coverage for reproductive health care in the country, covering nearly half of all births in the United States and 75 percent of family planning services.

The Graham-Cassidy-Heller-Johnson bill will completely eviscerate Medicaid, and drastically reduce the amount of funding that goes toward the program. The Medicaid cuts come in three devastating phases:

- Stopping Medicaid Expansion: Starting this month (September 2017), Medicaid expansion will be stopped in its tracks — states will no longer be able to expand coverage to people who need it. *States that expanded Medicaid cut the rate of uninsured women of reproductive age nearly in half between 2013 and 2015,* meaning an end to this program would take women backward.
- Slash the Medicaid Program: Starting in 2020, all Medicaid funding will be cut drastically. In its place, the Graham-Cassidy-Heller-Johnson bill would provide small, temporary pots of money for states to use for health coverage and other health care purposes. These pots of money would be fixed amounts, which means that funding would not adjust for the higher costs states will invariably face due to things like enrollment increases as a result of a recession, or higher costs due to public health emergencies (like Zika) or natural disasters. States would be forced to either dramatically increase their own spending or to deny healthcare coverage to people who are struggling to get by.
- Revoke Expanded Medicaid Coverage: By the end of 2026, Medicaid expansion will be completely shut down. The 11 million people who gained Medicaid coverage under the ACA would effectively be forced off of health coverage. For instance, before the ACA, a woman living in Ohio with HIV may not have qualified for Medicaid until she became sick enough to be considered disabled. The Medicaid expansion eliminated the requirements for low-income people to fit into certain categories, but under the Graham-Cassidy-Heller-Johnson proposal, this woman would lose her coverage.

Forcing Women to Choose Between Being with Their Newborns or Keeping their Insurance

This cruel provision could force women back to work only 60 days after having a baby, or else they lose their health insurance. For women who are actually able to keep their Medicaid coverage, starting just

next month (October 2017), mothers of newborns may be forced to find a job within 60 days of giving birth or lose their health insurance.

Women Will Pay More for Less

Under this bill, women will lose critical nationwide coverage protections for maternity coverage, prescription drug coverage, *and mental health services. Whether a woman has coverage for this services will depend on what state she lives in.* And no matter where she lives, the cost of insurance will increase.

Under this proposal, maternity coverage could be gone for millions. States can immediately seek to waive nationwide protections for maternity care, prescription drug benefits, and mental health care. Before the Affordable Care Act, millions of women didn't have insurance coverage for maternity care or other basic care. This bill again puts the maternity coverage of approximately 13 million women at risk. Without insurance, a vaginal birth can cost $30,000 and a C-section can cost $50,000 in out-of-pocket expenses.

The proposal also includes the cost of private insurance. In addition to kicking millions of women off of Medicaid, the bill simultaneously makes it harder to afford private insurance. Beginning in 2020, the bill completely eliminates ACA tax credits to help people afford private insurance.

Other provisions in the bill will also lead to increased costs. Under the ACA, even as premiums have risen, enrollees were insulated from the rising costs. For instance, in 2016 and 2017, enrollees eligible for tax credits on average saw only a $1 to a $4 per month increase in monthly premiums. Eighty-five percent of people purchasing coverage on the marketplace receive a tax credit to purchase insurance. These millions of people would no longer be insulated from rising costs because the tax credits would be repealed. Studies show that women are more likely than men to forgo care because of cost.

The increased costs of care would disproportionately impact women, particularly women of color, given the inequities in earnings for women. This is particularly true for the 15 million households — disproportionately led by Black and Latina women — where women are the head of households. People of color — even those who are insured — already report less confidence in being able to afford care.

Additionally, women with pre-existing conditions, which includes pregnancy, will be charged more under this proposal. Insurers get to unilaterally decide what is considered a pre-existing condition and thus, who they can charge more for coverage. Before the ACA, people who had a baby, a C-section, breast cancer, or even an eating disorder, anxiety, depression, or substance abuse were deemed to have a pre-existing condition. Sixty-five million women were considered to have a pre-existing condition. While women can not be denied coverage based on pre-existing conditions, insurance companies will once again be permitted to charge them more for health care coverage. For many, the Cassidy-Graham-Heller-Johnson proposal could mean that your health insurance isn't just more expensive, it's completely out of reach. Insurance companies could charge patients $28,660 more for having breast cancer, and $142,650 more for cancer that has metastasized. Just giving birth would allow insurers to charge a woman an additional

$17,320 per year (compared to a similarly situated person who has not given birth), and it's important to remember: four out of five women will give birth in her lifetime.

Should this proposal become law, people with serious illnesses will again face barriers to insurance coverage, life-saving treatments and care. For instance, people living with HIV have historically experienced barriers to accessing care in part due to discrimination by insurance companies who refused to cover them or their care, and today, the majority of people living with HIV do not have their HIV under control with treatment. The bill would mean that once again people living with HIV could be priced out of care. African-American and trans women are the women most likely to have HIV and would be the most impacted by exorbitant premium costs.

Black and Latina women face higher rates of many chronic illnesses, meaning these exorbitant costs will hurt the health and financial security of women of color the most. For instance, Black women are the group of people most likely to die from breast cancer. The ability to charge people more based on pre-existing conditions would permit insurers to charge a breast cancer survivor $28,660 more annually for insurance coverage. Without healthcare coverage, racial disparities in breast cancer rates could persist or even widen.

Imposing a National Ban on Private Insurance Coverage for Abortion
The Graham-Cassidy-Heller-Johnson bill will force private insurance plans to drop coverage of abortion almost immediately. In 2018, tax credits cannot be used to pay for a plan that include abortion coverage outside of the instance of rape, incest, or life endangerment.

For the two-year period in which tax credits are still available to purchase health insurance coverage (the credits will be repealed in 2020), individuals will be prohibited from using their financial help to purchase a plan that covers abortion. At least 870,000 women will lose access to ACA marketplace insurance plans that cover abortion.

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Planned Parenthood believes Congress should heed the calls of the rapidly growing number of health experts from across the political spectrum, including the Bipartisan Policy Center, the National Association of Medicaid Directors, and a group of governors representing both parties calling for a deliberative, bipartisan process to address challenges to the health care system. We stand ready to work with Members of Congress across the political spectrum to be sure that the health of women and families is centered is any legislative proposal under consideration in this Congress.

National
Multiple Sclerosis
Society

To: Senate Finance Committee

From: Bari Talente, Executive Vice President, Advocacy
National Multiple Sclerosis Society
bari.talente@nmss.org, 202-408-1500

Re: Statement for the Record for Hearing to Consider the Graham-Cassidy-Heller-Johnson Proposal, September 25, 2017

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.[i]

"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 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.[ii] 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 ok 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 wellbeing 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.*

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[i] Manatt Health, State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal, September 2017.

[ii] Ibid.

APIAHF
ASIAN & PACIFIC ISLANDER
AMERICAN HEALTH FORUM

WRITTEN STATEMENT FOR THE RECORD
http://www.apiahf.org/
FOR THE HEARING ENTITLED "GRAHAM-CASSIDY-HELLER-JOHNSON PROPOSAL"

UNITED STATES SENATE
COMMITTEE ON FINANCE

SEPTEMBER 25, 2017

BY THE
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM
1629 K STREET NW, SUITE 400
WASHINGTON, DC 20006

The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the September 25, 2017 hearing before the Senate Committee on Finance entitled "Graham-Cassidy-Heller-Johnson Proposal."

We believe it is time for Congress to put aside attempts to repeal the Affordable Care Act (ACA) and instead take needed steps to ensure that all Americans are able to afford and access health insurance that meets their needs. APIAHF is the nation's leading policy organization working to advance the health and well-being of over 20 million Asian Americans (AA), Native Hawaiians and Pacific Islanders (NHPI) across the U.S. and territories. From our work with AA and & NHPI communities, we understand the role the ACA has played in improving access to health insurance for communities of color across the nation. Since 2010, the uninsured rate has fallen from 15.1 percent to 6.5 percent in 2016 for AAs and from 14.5 percent to 7.7 percent for NHPIs, higher than any other racial group. In addition, the uninsured rate fell from 17.8% to 9.4% for African Americans, 30.9% to 18% for Latinos, and 24.2% to 14.4% for American Indians and Alaska Natives.[1]

As an organization that has worked for over 30 years at the federal, state, and local levels to advance sensible policies that reduce health disparities and promote health equity, we are deeply troubled by the Graham-Cassidy proposal and its potential impact on the nation's health system. It would remove an estimated $215 billion in federal health care funding to

[1] American Community Survey Table S0201, 2010 and 2016 1 year estimates.

states through 2026, forcing them to make difficult and likely harmful decisions about providing for their residents.[2]

Millions of Americans, including AAs and NHPIs, who rely on coverage under the ACA will be worse off under the Graham-Cassidy repeal bill. Under the guise of flexibility, this plan would end Medicaid as we know it by phasing in per-capita caps and ending its expansion. Under the guise of access, the bill would completely eliminate financial support that is currently allowing millions of low- and moderate-income Americans to afford their monthly premiums. More than eight in 10 previously uninsured AAs and NHPIs qualify for financial assistance through the ACA.[3] In short, Graham-Cassidy is a major repeal not only of the ACA, but a serious threat to the stability of the nation's insurance markets.

Graham-Cassidy Would End Medicaid

As proposed, Graham-Cassidy would end Medicaid's guarantee as a safety net to the poor, elderly and disabled, capping Medicaid funding to the states. As such, the repeal bill would effectively end Medicaid as we know it, breaking the over 50 year promise and partnership between the federal government, states and its most vulnerable citizens. By eliminating the Medicaid Expansion, which has drastically reduced uninsured in the states that took up the option, and replacing the current funding formula with per-capita caps, the bill represents an overall major net loss for states.[4] In the absence of federal funding, states would have to make harsh choices, to either limit eligibility, benefits, services or reimbursements. In total, the very people whom the program is designed to protect and serve, low-income Americans, would be harmed.

This includes people like Mee Pwa, a mother of four struggling to support not only her family, but her parents as well. Mee's daughter has a lifetime disability and requires monthly hospital visits to check on her kidneys and constant care at school. Her nurse changes her catheter every three hours. Medicaid pays for these hospital visits, the medical supplies, and care that her daughter receives. Medicaid keeps her child alive.

And then there are families like Tuyet from New Orleans, Louisiana. After her husband died a premature death from lung cancer, she became the sole provider for her 6 children. Like all parents, Tuyet sacrificed her health for that of her children and was lucky to be able to rely on Medicaid to keep them healthy. Tuyet's son, Quynh Vo, has down syndrome and counts

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[2] Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States By $215 Billion, Avalere Health, September 20, 2017. Available at: http://go.avalere.com/acton/attachment/12909/f-04e3/1/-/-/-/-/Avalere%20CAP%20Graham%20Cassidy%20Bill%20Analysis.pdf

[3] Wendt, Minh et al, Eligible Uninsured Asian Americans, Native Hawaiians, And Pacific Islanders: 8 In 10 Could Receive Health Insurance Marketplace Tax Credits, Medicaid Or CHIP, Office of the Assistant Secretary for Planning and Evaluation, March 18, 2014. https://aspe.hhs.gov/pdf-report/eligible-uninsured-asian-americans-native-hawaiians-and-pacific-islanders-8-10-could-receive-health-insurance-marketplace-tax-credits-medicaid-or-chip

[4] Greater Drop in Uninsured Rate Among Adults in Medicaid Expansion States, Center on Budget and Policy Priorities. Available at: https://www.cbpp.org/greater-drop-in-uninsured-rate-among-adults-in-medicaid-expansion-states

on Medicaid. Without Medicaid, how would Tuyet afford a home for herself and her son? In her words:

> ***"Sometimes I lay awake at night wondering what will happen to Quynh Vo after I pass. If Medicaid is taken away from him, how will he go see a doctor or pay for hospital stays?"***

Graham-Cassidy would eliminate the Medicaid program and cut funding for people with disabilities by 15 percent.[5] It would also eliminate the health and well-being and threaten the very ability to survive for the over 74 million Americans counting on Medicaid.[6] Such changes would be particularly devastating to communities of color who rely on Medicaid, including 33.4% of African Americans, 30.7% of Latinos, 16.9% of Asian Americans, 34% of Native Hawaiians and Pacific Islanders and 34.1% of American Indians and Alaska Natives.[7] NHPIs match American Indians as the racial community with the highest percent of its population on Medicaid. Medicaid's role in covering the nation's most vulnerable populations, whom are disproportionately people of color, means that any cuts to Medicaid will hurt efforts to improve health equity.

Graham-Cassidy Would Result in Discrimination in Healthcare for the at Least 50 million Americans with a Pre-existing Condition[8]

Racial and ethnic minorities, including AAs and NHPIs, disproportionately experience a number of chronic conditions due to factors including poverty, inability to afford quality coverage, and challenges accessing culturally competent care, among others. The AA and NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries. As of 2016, 11% of AAs and 23% of NHPI families live below the poverty line.[9] Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.

Graham-Cassidy would deepen those disparities by turning back the clock on coverage gains that have substantially reduced uninsurance amongst communities of color. In addition, the

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[5] Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States By $215 Billion, Avalere Health, September 20, 2017. Available at: http://go.avalere.com/acton/attachment/12909/f-04e3/1/-/-/-/-/Avalere%20CAP%20Graham%20Cassidy%20Bill%20Analysis.pdf

[66] Total Monthly Medicaid and CHIP Enrollment, Kaiser Family Foundation, June 2017. Available at: www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D

[7] *Summary Health Statistics: National Health Interview Survey*, 2015, National Center for Health Statistics, *available at*: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-11.pdf.

[8] At Risk: Pre-existing Conditions Could Affect 1 In 2 Americans, Assistant Secretary for Planning and Evaluation, November 1, 2011. Available at: https://aspe.hhs.gov/basic-report/risk-pre-existing-conditions-could-affect-1-2-americans

[9] Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity, Section 1: Demographics*, Kaiser Family Foundation, June 7, 2016, *available at*: http://kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-1-demographics/.

repeal bill would permit states to eliminate pre-existing condition protections, disproportionately impacting AAs and NHPIs.

AAs and NHPIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention. NHPIs have the highest age-adjusted percentage of people with diabetes (20.6%), more than 3 times that of Whites (6.8%).[10] AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.[11] Certain AA and NHPI subpopulations suffer from even greater health disparities. Fourteen percent of Indian Americans have diabetes, a rate higher than that of nearly all other racial groups.[12] Vietnamese women have cervical cancer rates five times higher than White women.[13] NHPIs are 30% more likely to be diagnosed with cancer than whites.[14] Allowing insurance companies to discriminate and deny coverage on the basis of a pre-existing condition would make coverage cost prohibitive for these individuals.

Graham-Cassidy Would Eliminate Coverage for Tens of Millions

By eliminating the ACA's Medicaid expansion, ending Medicaid, and repealing the ACA's financial assistance, the bill would likely end health coverage for tens of millions of Americans, rendering it unaffordable. The result would be predicable consequences seen prior to passage and implementation of the ACA, including increased uncompensated care and delays in accessing critical care amongst the uninsured. Prior to the ACA, 59% of the uninsured delayed health care.[15] This majority included people like Tuyet from New Orleans, Louisiana. In 2004, Tuyet's husband was diagnosed with stage four lung cancer and died soon thereafter, leaving her as the sole provider and parent to their six children, then aged 9 through 18. Tuyet still wonders if they would have caught her husband's cancer earlier if he had health coverage.

Without financial assistance, millions of Americans would not be able to afford private coverage through the ACA's Marketplaces. This includes Fangyu Wu from Ohio, a successful business woman and mom of five. In her words:

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[10] Asian and Pacific Islander American Health Forum, *Native Hawaiian and Pacific Islander Health Disparities*, 2010, *available at*: www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf

[11] Heron, Melonie, *Deaths: Leading Causes for 2014. National Vital Statistics Reports* Volume 65, Number 5. United States Centers for Disease Control, 2016.

[12] Spanakis, Elias and Sherita Hill Golden, *Race/Ethnic Difference in Diabetes and Diabetic Complications*. Curr Diab Rep. 13(6), 2013, *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/

[13] Miller BA et al., *Racial/Ethnic Patterns of Cancer in the United States, 1988-1992*, 1996, *available at*: https://seer.cancer.gov/archive/publications/ethnicity/

[14] *Cancer and Native Hawaiians/Pacific Islanders*, U.S. Department of Health & Human Services: Office of Minority Health, Last updated March 29, 2016, *available at*: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=76.

[15] Brown, Alyssa, Costs Still Keep 30% of Americans From Getting Treatment, Gallup, December, 9 2013, available at: www.gallup.com/poll/166178/ costs-keep-americans-getting-treatment.aspx

"It [Affordable Care Act] has helped me a lot. I have less to worry about and feel much better. Now I am able to focus on being a mom, building my business, and enjoying my new beginning."

Prior to the ACA, high costs caused many AAs and NHPIs to either forgo care entirely or sell everything they had to afford care. People like Trieu, a young adult from Pennsylvania, had to skip care and hoped he did not get sick until he got coverage thanks to the ACA's financial help.

The ACA's financial assistance saved the life of Jirapon in Georgia. Jirapon is a single mom with three children who works as a cook. Thanks to a local community based organization, she was able to enroll in health care for the first time. She qualified for subsidies as well as Medicaid for her youngest child. After getting covered, Jirapon went for a general screening and was diagnosed with breast cancer. She was able to access affordable surgery, reconstruction, and long-term care because of the ACA.

Falani and his wife, Teuloi, from Utah went uninsured for 15 years prior to the ACA, even though Falani was battling stomach cancer and diabetes. Without coverage, he resorted to home remedies and emergency care when things got really bad. The ACA changed their lives when they realized they could afford a plan for $45 a month and finally get much needed dialysis.

The Graham-Cassidy bill would eliminate coverage for these individuals and millions of others, create chaos in the marketplace and drastically reduce funding for states. As such, APIAHF strongly opposes the bill.

For questions contact Amina Ferati, Senior Director of Government Relations & Policy aferati@apiahf.org (202-466-3550).

STATEMENT FOR THE RECORD SENATE FINANCE HEARING ON GRAHAM-CASSIDY-HELLER-JOHNSON

SUBMITTED BY STACEY D. STEWART, PRESIDENT MARCH OF DIMES

SEPTEMBER 25, 2017

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.

i 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.ii

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

Office of Government Affairs 1250 H Street, NW Suite 400B Washington, DC 20005 Telephone (202) 659-1800 Fax (202) 296-2964

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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,iii 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 aloneiv. 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 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 pregnancyv; 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 two 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 two years, preterm birth rates have increased, after

declining for the prior several years.[vi] Maternal mortality rates across the U.S. exceed those in most developed nations.[vii] In many U.S. communities, infant mortality rates rival those of third world countries.[viii] 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 GrahamCassidy-Heller-Johnson proposal provides none of the tools necessary to make that possible.

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-CassidyHeller-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.

Markus AR, Andres E, West KD, Garro N, 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. ii Markus A, Garro N, Krohe S, Gerstein M, 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.

iii http://www.marchofdimes.org/news/statement-of-stacey-d-stewart-president-march-of-dimes-onrelease-of-the-better-care-reconciliation-act.aspx iv http://avalere.com/expertise/managed-care/insights/graham-cassidy-heller-johnson-bill-would-reducemedicaid-funds-to-states-by

v http://www.marchofdimes.org/advocacy/affordable-care-is-essential-to-moms-and-babies.aspx

vi https://www.cdc.gov/nchs/data/vsrr/report002.pdf

vii http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ viii https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_05.pdf

NASUAD
National Association of States
United for Aging and Disabilities

1201 15th Street NW
Suite 350
Washington, DC 20005
Phone 202-898-2578
Fax 202-898-2583
www.nasuad.org

September 21, 2017

Hon. Mitch McConnell
Majority Leader
U.S. Senate

Hon. Orrin Hatch
Chairman
Senate Finance Committee

Dear Majority Leader McConnell and Chairman Hatch:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to you in regards to the current efforts to repeal and replace the Affordable Care Act. NASUAD is a nonpartisan association of state government agencies and represents the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and individuals with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including Medicaid long-term services and supports (LTSS), the Older Americans Act (OAA), and a variety of other health and human services programs. Together with our members, we work to design, improve, and sustain state systems delivering home and community-based services and supports for people who are older or have a disability and for their caregivers.

We have reviewed the text of the legislation released on September 13th by Senators Cassidy (R-LA), Graham (R-SC), Heller (R-NV), and Johnson (R-WI). As you know, the legislation would transform the ACA coverage expansions, including the Medicaid Childless Adult Group, the Advance Premium Tax Credits, the Cost Sharing Reductions, and the Basic Health Plan, into a block grant to states. The legislation would also provide the opportunity for states to apply for waivers of ACA insurance regulations, such as community rating and essential health benefits. Additionally, the legislation would make significant changes to the core Medicaid program by establishing a per capita limitation on total federal funding for each state. As a nonpartisan organization, we are not taking a stance on the efforts to repeal and replace the Affordable Care Act. However, as administrators of Medicaid long-term services and supports, as well as other programs for older adults and persons with disabilities, we have concerns about several of the policies included in the bill text. We specifically have concerns that this legislation seeks to impose a per capita cap on Medicaid expenditures, which is outside the scope of ACA's coverage expansion and insurance regulations. Below, we provide a summary of our concerns and, where appropriate, provide recommendations for improving these provisions.

Establishment of Per Capita Caps

Section 124 of the legislation sets an upper limit of Federal match that a state may receive based on the number enrollees in Medicaid. The per capita caps are established using state FY2016 expenditures for four groups:

- Individuals age 65 or older;
- Individuals who are blind or have a disability;
- Children under the age of 19 without disabilities who are not eligible via CHIP; and
- Adults who are not included in the prior groups.

An aggregate cap is then placed on total Medicaid spending by multiplying the per capita spending limits for each of the groups by the average number of monthly enrollees within the group. As we have previously discussed in our comments on prior ACA repeal and replace proposals, this policy will create a number of challenges to states, including:

- It prevents states from targeting Medicaid to individuals with the highest level of need: Under this policy, states do not have the ability to target individuals with the highest need because the spending caps are based upon historical spending for all individuals within each enrollee category without any risk-adjustment provisions. This will create challenges if states experience budget pressure and look to restrict eligibility in a way that preserves services for individuals with the highest level of need. For example, if a state experiencing a budget shortfall increases the level of care requirements for LTSS eligibility, the new eligibility policy would ensure that services remain available for individuals with the highest level of need. However, the resulting higher acuity of individuals who remain in the program would result in a higher per-person cost of care which would likely create challenges with the per capita caps. In short, the policy creates incentives to serve a larger number of individuals with lower care requirements instead of focusing supports on those with the most significant health and LTSS needs.
- The policy limits states' ability to expand benefits: States without optional benefits would find it difficult to add additional services that could be valuable for participants, such as adult dental care; expanded rehabilitation benefits; or enhanced HCBS programming. Many states have made efforts to broaden benefits in order to improve the overall health and well-being of their Medicaid beneficiaries while simultaneously reducing the need for institutional LTSS and reducing hospitalization. Since these high-cost services are often financed by Medicare, any savings generated from the expanded Medicaid benefits would not be reflected in the cap calculations. Thus, benefit enhancements that result in improved health and reduced overall expenditures would be unworkable under this bill;
- The policy forces states to freeze or reduce provider rates: Freezing spending based on historic levels undermines efforts to increase provider rates, as provider payments constitute the vast majority of Medicaid spending. Thus, increases to payment rates will violate the spending caps. Additionally, states that were forced to implement payment rate reductions or benefit restrictions during economic downturns would be prevented from restoring those cuts once state finances rebound. CMS has been working with states to promote access to services, which has included review of state reimbursement rates

compared to other health insurance programs.[1] Implementation of these caps on spending will undermine these efforts and prevent states from any upward adjustment of provider rates;

- It limits the ability of states to respond to new requirements: Medicaid spending is often driven by factors beyond state control, such as new and costly treatments and technology, increases to provider payments due to wage growth and staffing changes, or changes to federal requirements. For example, complying with the 2014 Home and Community-Based Services final rule[2] is likely to require increased staffing ratios at various LTSS providers, which requires increased spending that results in a violation of the caps. Similarly, the Department of Labor has modified FLSA rules in a manner that continues to increase LTSS expenditures and will likely exacerbate the challenges to remain compliant with the caps;[3]
- It creates competition between spending for different populations in Medicaid: The per capita caps are calculated independently for each population, but they are applied in an aggregate manner. Thus, increased spending for one category of enrollees would need to be offset by other groups. Given that older adults, people with disabilities, and LTSS participants represent a disproportionate portion of the total Medicaid spend, they are likely to be places where spending constraints are applied and felt most acutely.
- It uses a base-year that is already completed: The calculation is based upon prior state expenditures for these populations, allowing states to select baseline expenditures from fiscal year quarters that fall between the first fiscal quarter of 2014 and the third fiscal quarter of 2017. This policy would not be responsive to changes that have been made since that date, nor would it account for mid-year modifications that could have altered expenditures for a period of less than the entire fiscal year. States would effectively be limited to policies in place during a previous period, and any improvements to services, reimbursement increases, or other policies with a fiscal impact would need to be undone. For example, states that have aggressively moved to address the opioid epidemic through in calendar year 2017 their Medicaid program would need to either roll-back any of those increased expenditures or find offsetting reductions in other parts of the program.

Due to all of these challenges, we recommend that Congress remove the per capita cap policies included in this legislation. States have a vested interest in the fiscal sustainability of the program and must ensure that they have balanced budgets each year. The existing financing arrangement where states establish the appropriate eligibility, benefits, and reimbursement policies based upon their unique characteristics and available finances should be maintained.

Lack of Flexibility for States

The legislation includes significant new restrictions to Federal financing for states but does not offer any corresponding state flexibility. When discussing the value of Medicaid reform proposals, state flexibility is the most significant benefit that policymakers propose to give state agencies in exchange for limitations in Federal funds. Yet this legislation leaves the major Medicaid

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[1] https://www.federalregister.gov/documents/2015/11/02/2015-27697/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services

[2] https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

[3] https://www.dol.gov/whd/homecare/agencies-what-are-requirements.htm

requirements that drive state spending intact. This includes retaining all mandatory Medicaid eligibility categories, mandatory services, the early and periodic screening, diagnostic, and treatment (EPSDT) benefit, and the Medicaid drug rebate coverage requirements. We specifically note that in the LTSS space the legislation does not address Medicaid's institutional bias or provide opportunities to reduce expenditures by rebalancing LTSS towards home and community-based services. In fact, some of the policies, as discussed below, actually reduce the ability of states to provide HCBS in their Medicaid programs.

We note that the Flexible Block Grant option does provide some greater ability of states to modify their programs; however, in some cases it actually includes more expansive benefit requirements than the 1905(a) services. Similarly, it maintains all mandatory Medicaid populations without including much opportunity to adjust for enrollment changes. This creates a challenging dynamic that may make it challenging for states to effectively leverage the flexibilities that a block grant could otherwise provide.

All of these requirements place significant responsibilities on states regarding the individuals and services that must be covered. Thus, keeping them in place will severely limit the ability of states to respond to the bill's funding limitation by implementing flexible, innovative, and targeted reforms that reduce the spending growth in Medicaid while maintaining the health of individuals covered. Without corresponding flexibility to accompany the limitation in Federal funding, the legislation will simply serve as a cost-shift from the Federal government to states rather than a reform that strengthens the program.

Repeal of the Community First Choice Matching Increase

The legislation repeals the six percent increase in matching funds provided to state programs established under 1915(k) of the Social Security Act. These programs, called "Community First Choice" or "CFC," provide valuable and necessary attendant care services to older adults and individuals with significant disabilities that enable them to live in the community. The most beneficial parts of the CFC program are that the program does not include limitations on the number of individuals served and the increased Federal matching funds. These increased funds are one of the major factors that enable states to use CFC as a mechanism to reduce waiting lists for home and community-based services (HCBS). Repealing this increased funding will likely result in states needing to re-establish waiting lists for HCBS due to the reduction in available resources.

Several other important programs that promote the use of HCBS in lieu of institutional services have lapsed during the past several years, including the Balancing Incentives Program (BIP) and the Money Follows the Person Program (MFP). The expiration of MFP and BIP are already reducing the Federal government's support of deinstitutionalization activities, and the repeal of enhanced funding for these important CFC services will further exacerbate the lack of funding. Ultimately, this will be detrimental to both the states and the people served in LTSS programs. We encourage Congress to maintain this important program and the enhanced funding that it provides.

HCBS Provider Payment Adjustment Grant

We appreciate that the legislation includes $8 billion in funding to address HCBS quality and access

issues. We request clarification regarding how the payment adjustments will be calculated, as well as the limitation on individual providers. Lastly, we note that the legislation does not appear to specifically exclude these payment adjustments from the calculation of 1903A per capita caps. In the event that the per capita cap policy is retained, we request clarification regarding how the increased payments under this provision would interact with the aggregate limit on expenditures.

Medicaid Expansion and Market-Based Health Care Grant Program

We note that the legislation creates a new block grant using funding derived from repealing the ACA's Medicaid expansion, advance premium tax credits, cost sharing reduction payments, and Basic Health Plan. While we appreciate the way that these programs focus on state flexibility, we are concerned with the long-term sustainability of the fund. Current ACA provisions are responsive to growth in population, medical inflation, and increased eligibility due to economic downturns. In contrast, the block grants grow at a defined rate without regard to these factors. The block grants also do not take into account regional in cost of living and health care expenses. Lastly, the block grants would necessitate transitioning individuals from Medicaid into the private marketplace, which historically has higher per-person costs. Since the grant allocations are based upon current spending under the ACA, this shift could increase expenses beyond what the grants are funded to cover. We are concerned that, without appropriate funding, these programs will have the unintended consequences of reducing coverage for individuals while increasing out of pocket costs.

This concern is particularly relevant to individuals with disabilities and health conditions who may struggle to secure affordable care in the private marketplace. A study published in Health Affairs[4] found a significant number of individuals eligible under the ACA expansion to have chronic health conditions and/or disabilities. We believe that any ACA replacement should provide states with the funding needed to protect and preserve the health, welfare, and services for individuals with significant health needs and disabilities.

Repeal of the Public Health Prevention Fund

While we recognize and understand Congress' concerns with the broad scope of activities that can be included in this fund, we wish to highlight the value of some of its activities. The public health and prevention fund has been used to support a number of programs that are crucial to assisting older adults with chronic conditions and other health needs. The Administration for Community Living has used resources from this fund to support several important activities, including chronic disease self-management, falls prevention, and Alzheimer's education and outreach. Other programs through this fund have focused on diabetes and stroke prevention, which are significant for older adults. Repealing the bill would represent a step backwards for preventive care, research, and health promotion of older adults. We believe that some of Congress' concerns could be alleviated through stringent monitoring and evaluation of grant activities, instead of repealing the fund completely.

[4] http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/

Concluding Thoughts

As noted earlier, NASUAD is a nonpartisan organization and will not be taking a stance on the efforts to repeal and replace the Affordable Care Act nor will we be endorsing or opposing any specific pieces of legislation. However, we have serious concerns about the impact the bill may have on state governments, on LTSS programs, as well as on older adults, persons with disabilities, and their caregivers. We would be pleased to work with Congress to find ways to improve the legislation in a manner that supports and promotes the health, welfare, and community living of the individuals we serve.

If you have any questions regarding this letter, please feel free to contact Damon Terzaghi of my staff at dterzaghi@nasuad.org or (202) 898-2578.

Sincerely,

Martha A Roherty

Martha A. Roherty
Executive Director
NASUAD

Cc:

Members of the U.S. Senate

Submitted Electronically

September 22, 2017

Re: Access to Rehabilitation Services and Devices under Graham-Cassidy ACA Repeal and Replace Legislation

Dear Senator:

The undersigned organizations write as members of the Coalition to Preserve Rehabilitation (CPR) to express our opposition to the Graham-Cassidy legislation (H.R. 1628) which would repeal and replace the Affordable Care Act (ACA). This legislation would seriously undermine coverage: in the individual market through the use of block grants, under Medicaid expansion plans by phasing out this program, and under the original Medicaid program by implementing per capita caps. Taken together, these policies will lead to significantly less coverage of rehabilitation services and devices. CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

We stress the importance of maintaining access to rehabilitation services and devices as an essential health benefit in any ACA repeal and replace bill 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]

This definition is a floor for individual insurance plans sold under the ACA exchanges. It was also adopted by states that chose to expand their Medicaid programs. For the first time, this definition established a uniform, understandable federal definition of rehabilitation services and devices that

[1] http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf, at 10811.

became a standard for national insurance coverage. CPR supports the preservation of the EHB category of "rehabilitative and habilitative services and devices," and the subsequent regulatory definition and related interpretations duly promulgated, as a standard of coverage for rehabilitation under any version of ACA replacement legislation. CPR believes that adopting the uniform federal definition of rehabilitation services and devices minimizes both the variability in benefits across states and the uncertainty in coverage for children and adults in need of rehabilitation.

We encourage future bipartisan efforts to stabilize the marketplace, and ensure that Americans have access to affordable and meaningful coverage of rehabilitative services and devices through both the private market and Medicaid.

Thank you for your willingness to consider our views. Should you have further questions regarding this information, please contact any of the steering committee members listed below.

Sincerely,

CPR Steering Committee

Judith Stein	Center for Medicare Advocacy	JStein@medicareadvocacy.org
Alexandra Bennewith	United Spinal Association	ABennewith@unitedspinal.org
Kim Calder	National Multiple Sclerosis Society	Kim.Calder@nmss.org
Amy Colberg	Brain Injury Association of America	AColberg@biausa.org
Kim Beer	Christopher and Dana Reeve Foundation	Kbeer@ChristopherReeve.org
Sam Porritt	Falling Forward Foundation	fallingforwardfoundation@gmail.com

CPR Members

Academy of Spinal Cord Injury Professionals
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Association of People with Disabilities
American Congress of Rehabilitation Medicine
American Heart Association
American Music Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
ACCSES
Brain Injury Association of America
Center for Medicare Advocacy
Child Welfare League of America
Christopher and Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Easterseals
Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
Lupus Foundation of America

The Michael J. Fox Foundation for Parkinson's Research
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers (NASW)
National Association of State Head Injury Administrators
National Council for Behavioral Health
The National Council on Independent Living
National Disability Institute
National Disability Rights Network
National Multiple Sclerosis Society
National Rehabilitation Association
National Stroke Association
Paralyzed Veterans of America
Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association

Cleveland Clinic Statement

Graham-Cassidy Legislation

Sept. 22, 2017

"It is our mission to deliver the best possible care to all the patients we serve. We believe that healthcare should be of the highest quality, affordable and accessible to all Americans. The proposed Graham-Cassidy healthcare bill does not support what our organization thinks healthcare in America should be, therefore we oppose the pending legislation. As an organization, we will continue to communicate with our policymakers to implement changes that have a positive impact on our nation's healthcare system."

Why Cleveland Clinic Opposes Graham-Cassidy Bill

States, hospitals, patients will all suffer under proposed healthcare overhaul.

By Toby Cosgrove, M.D.

Cleveland Clinic President and CEO

Deciphering a dense piece of proposed federal legislation is no easy task. But in the case of the Graham-Cassidy proposal under consideration in the US Senate,

one key question can provide crucial focus: Who benefits from this latest effort to gut the Affordable Care Act?

Not states. Overall federal funding for Medicaid and state coverage expansions would drop $160 billion between 2020 and 2026 under Graham-Cassidy, compared to current law, according to the Kaiser Family Foundation. Thirty-five states plus the District of Columbia would likely lose funding.

Not hospitals. More than one-in-five U.S. hospitals are already running in the red, while more than half are losing money on the administration of care. The decreased Medicaid funding in Graham-Cassidy will threaten the financial viability of hospitals nationwide.

And certainly not the American people. Under Graham-Cassidy, it's likely that fewer people will be covered by health insurance, while those with pre-existing medical conditions may pay more, if they can secure coverage at all.

At least we think this could be some of the fallout of Graham-Cassidy, but it's difficult to know for sure, because the bill is being rushed to a vote. It was only

unveiled last week and will be voted on next week, without a score from the Congressional Budget Office and with no chance to fully vet the bill's side effects.

What we do know, though, is not comforting.

We know that between 2020 and 2026 the bill will end direct support for purchasing coverage in the marketplace, including tax credits and federal support for states like Ohio that have expanded their Medicaid program.

We know that it will convert funds that would have been spent on federal support for coverage into block grants distributed to states, allowing each state to decide how these plans are administered. While per-capita cap allocations under Medicaid, done the right way, may make sense, a block grant for everything would force states to build 50 separate administrative infrastructures – a highly inefficient model.

We also know that Graham-Cassidy will allow states to set aside the ACA's Essential Health Benefits – which require all insurance plans to cover 10 healthcare categories (such as doctors' services, hospital care, prescription drugs, pregnancy and childbirth, mental health services, and more) – including

restrictions on charging higher premiums for those with pre-existing medical conditions.

It's true that the amendment requires insurers to offer "adequate and affordable" coverage to people with pre-existing conditions. However, it does not define what "adequate and affordable" means. So while a cancer survivor, for instance, may have access to the health insurance marketplace, it's not true access if the coverage is unaffordable – as it often is in high-risk pools.

According to a recent Kaiser Family Foundation poll, nearly 70 percent of Americans want Congress to fix the ACA by stabilizing the insurance market. At a minimum, legislation should do just that, while also supporting widespread insurance coverage for Americans, maintaining coverage for pre-existing conditions and improving access to affordable coverage and care.

The Graham-Cassidy bill fails to deliver on any of those priorities. In fact, it actively pursues the opposite, which is why the medical community – doctors, hospitals, insurers, pharmaceutical companies, and patient advocacy groups – is universally opposed to this latest effort to "repeal and replace" the ACA.

Healthcare in the United States should be of the highest quality, affordable and accessible to all Americans. At Cleveland Clinic, it is our mission to deliver the best possible care to all the patients we serve. The proposed Graham-Cassidy healthcare bill does not support what our organization thinks healthcare in America should be, therefore we oppose the pending legislation. As an organization, we will continue to communicate with our policymakers to implement changes that have a positive impact on our nation's healthcare system.

Carlos Jackson

Executive Director, Government Relations

Cleveland Clinic

216-448-1200 – direct

216-314-2857 – mobile

jacksoc7@ccf.org

25875 Science Park Drive AC-121

Beachwood, Ohio 44195

Statement as testimony for:

Senate Finance Committee

Hearings to examine the Graham-Cassidy-Heller-Johnson proposal

Monday, September 25, 2017

Submitted by the following organizations:

National Latina Institute for Reproductive Health

In Our Own Voice: National Black Women's Reproductive Justice Agenda

National Asian Pacific American Women's Forum

National Partnership for Women & Families

Washington, DC

ATTACKS ON THE AFFORDABLE CARE ACT, PLANNED PARENTHOOD AND MEDICAID ARE ATTACKS ON REPRODUCTIVE JUSTICE FOR WOMEN OF COLOR

UPDATED SEPTEMBER 2017 | FACT SHEET

Reproductive justice will be attained when all people have the economic, social and political power and means to make decisions about their bodies, sexuality, health and families. Because of the Affordable Care Act (ACA), millions of women of color have gained access to affordable coverage and critical health care. The ACA is working — in the majority of states, more than 80 percent of women of color ages 18–64 are now insured.[1] Conservative lawmakers are gambling with the health and economic stability of Black, Latina and Asian and Pacific Islander (AAPI) women, families and communities. Women of color will be disproportionately impacted by proposed rollbacks to health care coverage and stand to lose the most if current protections and policies are eliminated. Our health and lives are on the line.

REPEAL OF THE ACA WOULD PUSH COVERAGE OUT OF REACH FOR WOMEN OF COLOR, EXACERBATING HEALTH DISPARITIES.

The ACA led to significant coverage gains for women of color,[2] but rolling back the ACA's financial assistance and coverage expansions will lead to women of color losing health coverage. If women lose coverage, this means cutting off access to one of the ACA's most important advancements for women's health: the guarantee of no-cost-sharing coverage of preventive services. Women of color would lose access to the types of services that combat pervasive health disparities, such as contraceptives, screening for breast and cervical cancer and well-woman visits.

- Fifteen million Black people now have coverage for preventive services without cost sharing.[3] Between 2012 and 2014, the uninsured rate among Black women fell by nearly seven percent.[4]
    - Black women have higher breast cancer mortality rates compared to other racial and ethnic groups.[5] In 2010, the Centers for Disease Control and Prevention reported that the breast cancer death rate for Black women aged 45–64 was 60 percent higher than that for white women.[6] Coverage for preventive services without cost sharing removes barriers to care, enabling Black women to access essential health care such as breast cancer screenings.
- Seventeen million Latinos/as now have coverage for preventive services without cost sharing, and between 2012 and 2014, the uninsured rate among Latinas fell by nine percent.[7]
    - Cervical cancer is highly preventable, but Latinas have the highest rates of cervical cancer in the United States.[8] Coverage for preventive services without cost sharing removes barriers to care, enabling Latinas to access essential health care like cervical cancer screenings.
- Eight million Asian-Americans now have coverage for preventive services without cost sharing.[9] Between 2010 and 2015, the uninsured rate among Asian-Americans and Pacific Islanders (AAPI) fell by more than seven percent.[10] Over 2 million Asian-Americans gained coverage under the ACA, giving more AAPI women coverage for preventive services without cost sharing.[11]

- Cancer is the leading cause of death for AAPI communities[12], and the cervical cancer incidence rate is higher in several Asian-American, Native Hawaiian and Pacific Islander (AANHPI) subgroups than in non-Hispanic whites. For instance, the incidence rate is twice as high in Cambodians as in non-Hispanic whites, and 40 percent higher among Vietnamese women.[13] Coverage for preventive services without cost sharing removes barriers to care, enabling AAPI women to access essential health care like cancer screenings.

ATTACKS ON THE ACA'S IMPORTANT PROTECTIONS FOR PEOPLE WITH PRE-EXISTING CONDITIONS WOULD FURTHER EXACERBATE HEALTH DISPARITIES FOR WOMEN OF COLOR.

Under the ACA, marketplace plans are not able to deny coverage or increase premiums based on prior health conditions or medical history, including for pregnancy and childbirth.[14] Without such protections, already existing health disparities for women of color and their families could be exacerbated. An estimated 133 million Americans have pre-existing conditions,[15] any of whom could have been denied coverage or subject to increased cost without the current ACA protections. Proposals for repealing and replacing the ACA would allow states to waive two ACA protections that are vital to people with preexisting conditions: the Essential Health Benefits and the prohibition against insurers charging higher premiums for those with preexisting conditions.[16] This would open the door for insurance companies to charge individuals with pre-existing conditions astronomically higher premiums, thereby denying them access to affordable coverage.

Prior to the ACA, insurance companies could define pre-existing conditions to include conditions such as asthma, menstrual irregularities, obesity, diabetes, or if someone has ever received mental health treatment, had cancer or been pregnant.[17] Rolling back these protections could allow insurers once again to discriminate against women by allowing them to consider pregnancy, having a C-section or even receiving medical treatment for prior domestic violence as pre-existing conditions.

Repeal of the ACA would put the health of millions of women of color at stake.

- African American women are twice as likely to develop diabetes as white women.[18] And Black women have a 14 percent higher death rate from cancer than non-Hispanic white women, despite a six percent lower incidence rate.[19]
- Hispanic women are twice as likely to develop diabetes as white women.[20] Diabetes affects more than 1 in 10 Hispanics. Among Hispanic women, diabetes affects Mexican-Americans and Puerto Ricans most often.[21] Compared to non-Hispanic whites, cervical cancer incidence rates are 44 percent higher for Latinas, and liver and stomach cancer incidence rates are about twice as high.[22]
- Other health conditions, like the Hepatitis B virus (HBV), were also considered pre-existing conditions prior to the ACA.[23] Chronic HBV affects about 1.3 million people in the United States, and AAPIs account for over half of the chronic hepatitis B cases and resulting deaths.[24] AAPI women are 20 percent more likely to die from viral hepatitis as compared to non-Hispanic whites.[25]

DEFUNDING PLANNED PARENTHOOD FROM THE MEDICAID PROGRAM JEOPARDIZES WOMEN OF COLOR'S ACCESS TO CRITICALLY IMPORTANT HEALTH CARE.

Defunding Planned Parenthood further threatens women of color's access to essential preventive health services, including reproductive health care such as sexually transmitted infection (STI) testing and treatment, contraceptives and counseling and cancer screenings.[26] Planned Parenthood health centers provide high-quality primary and preventive health care to many women of color who otherwise would have nowhere to turn for care. Defunding Planned Parenthood would unravel the safety net that our communities rely on for trusted care.

- In 2014, 15 percent of Planned Parenthood patients were Black,[27] 23 percent were Latino/a[28] and four percent were AAPI.[29]
- Planned Parenthood health centers are a lifeline for quality health care for underserved communities. Fifty-four percent of Planned Parenthood health centers are in underserved areas. In 21 percent of counties with a Planned Parenthood health center, Planned Parenthood is the only safety-net family planning provider, and in 68 percent of counties with a Planned Parenthood health center, Planned Parenthood serves at least half of all safety-net family planning patients.[30]

ADDITIONAL RESTRICTIONS ON ABORTION COVERAGE WOULD FURTHER COMPROMISE WOMEN OF COLOR'S ABILITY TO MAKE REPRODUCTIVE HEALTH DECISIONS WITH DIGNITY AND WITHOUT POLITICAL INTERFERENCE.

Attempts to repeal the ACA also include harsh abortion restrictions, which have the adverse effect of tightening restrictions on those who receive health care tax credits, prohibiting them from purchasing health care plans that include abortion coverage and disincentivizing insurance companies from offering plans that cover abortion care.[31]

- Women of color experience disproportionately high rates of unintended pregnancy and[32] are more likely to live in poverty,[33] and thus less likely to be able to afford abortion care (or other health care) out of pocket.
- When politicians restrict insurance coverage of abortion care, low-income families, people of color, immigrant women and young people are hardest hit. A recent study found that a woman who seeks but is denied abortion care is three times more likely to fall into poverty than a woman who is able to get the care she needs.[34]

ATTACKS ON THE MEDICAID PROGRAM WOULD TAKE AWAY HEALTH CARE FROM MILLIONS OF WOMEN OF COLOR.

Ending the ACA's Medicaid expansion and slashing billions in federal funding would leave millions of women and families[35] without health care coverage and increase health and economic disparities for communities of color. Medicaid is integral to women's health. Medicaid finances more than half of all births in the United States, and accounts for 75 percent of all public dollars spent on family planning.[36] One in five women of reproductive age, and nearly half (48 percent) of all low-income women of reproductive age, are enrolled in the Medicaid program.

Under these same proposals, new mothers who are enrolled in Medicaid could be forced to return to work within 60 days after giving birth in order to keep their Medicaid coverage. These harsh work requirements are unnecessary and are an attack on women of color's ability to make thoughtful decisions about their health and the way they choose to raise their children. Work requirements such as these prey on stereotypes that stigmatize mothers of color. Rather than provide incentives to work, these requirements can further push women of color and their children into poverty by eliminating health care coverage when they need it most. Medicaid is particularly important for women of color.[37]

- Nearly one-third (31 percent) of Black women of reproductive age are enrolled in the Medicaid program. [38]
- More than one quarter (27 percent) of Latinas of reproductive age are enrolled in the Medicaid program.[39]
- Nearly one-fifth (19 percent) of AAPI women are enrolled in the Medicaid program. The program is particularly important for Southeast Asian and Pacific Islander women.[40] For example, 62 percent of Bhutanese women, 43 percent of Hmong women and 32 percent of Pakistani women currently receive their insurance through Medicaid.[41]

INCREASING COST SHARING AND PREMIUMS HITS WOMEN OF COLOR HARDEST BECAUSE OF GENDER- AND RACE-BASED WAGE GAPS.

The ACA provides financial assistance that low- to middle-income families need to afford coverage. Repealing the law and replacing it with substantially lower financial assistance would result in millions losing coverage.

Repeal of the ACA would put health care coverage out of reach for many, but for those who can retain coverage, the erosion of Essential Health Benefits standards could drastically increase cost sharing. By gutting the Essential Health Benefits provision, coverage for maternity and newborn care, mental health services, and certain pediatric services, among other benefits that women of color depend on, could be denied. Approximately 13 million women who gained access to maternity coverage under the ACA[42] would stand to lose their coverage.

Possible replacements could include a continuous coverage provision that would allow companies to charge exorbitant penalties for those who have experienced a gap in coverage. Increasing premiums, higher cost sharing and soaring penalties would hit women of color harder because they already earn less due to pervasive racial and gender inequalities. If the ACA were repealed, additional burdens would be placed on low- to middle-income women of color as quality, comprehensive health coverage is pushed out of reach. This would also exacerbate the already high rates of poverty experienced by Black,[43] Latina[44] and AAPI women.[45]

- Black women are typically paid 63 cents for every dollar paid to white, non-Hispanic men.[46]
- Latinas are paid 54 cents for every dollar paid to white, non-Hispanic men.[47]
- While Asian-American women as a whole earn 87 cents for every dollar paid to white, non-Hispanic men,[48] Southeast Asian and Pacific Islander women experience some of the widest wage gaps compared to other racial and ethnic groups. For example, Burmese and Marshallese women make only 44 cents for every dollar paid to white, non-Hispanic men.[49]

Attacks on the ACA, on Planned Parenthood, or on our nation's Medicaid Program would have a devastating, long-term impact on women of color's health, economic security and progress.

These are attacks on reproductive justice.

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[1] National Women's Law Center. (2017, February). *Affordable Care Act Repeal Threatens the Health and Economic Security of 5.1 Million Women of Color Who Recently Gained Insurance Coverage.* Retrieved 17 March 2017, from http://nwlc.org/wp-content/uploads/2017/02/WOC-Health-Coverage-by-State.pdf

[2] Ibid.

[3] Garrett, B., & Gangopadhyaya, A. (2016, December). *Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?* Urban Institute Health Policy Center. Retrieved 17 March 2017, from http://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf; U.S. Department of Health and Human Services. (2015, May). *The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans.* Retrieved 9 February 2017, from https://aspe.hhs.gov/sites/default/files/pdf/139221/The%20Affordable%20Care%20Act%20is%20Improving%20Access%20to%20Preventive%20Services%20for%20Millions%20of%20Americans.pdf

[4] U.S. House of Representatives Committee on Energy and Commerce, Democratic Staff Report. (2016, December). Turning Back the Clock: Republican Plans to Repeal the Affordable Care Act Will Reverse Progress for Women at 10. Retrieved 19 September 2017, from http://democratsenergycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/ACA%20Womens%20Health%20FINAL.pdf

[5] Black Women's Health Imperative. *Breast Cancer.* Retrieved 20 March 2017 from http://www.bwhi.org/issues/breast-cancer/breast-cancer/

[6] Ibid.

[7] U.S. House of Representatives Committee on Energy and Commerce, Democratic Staff Report. (2016, December). *Turning Back the Clock: Republican Plans to Repeal the Affordable Care Act Will Reverse Progress for Women at 10.* Retrieved 16 December 2016, from http://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/ACA%20Womens%20Health%20FINAL.pdf; U.S. Department of Health and Human Services. (2015, May). *The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans.* Retrieved 9 February 2017, from https://aspe.hhs.gov/sites/default/files/pdf/139221/The%20Affordable%20Care%20Act%20is%20Improving%20Access%20to%20Preventive%20Services%20for%20Millions%20of%20Americans.pdf

[8] Centers for Disease Control and Prevention. (2016, June 16). *Cervical Cancer Rates by Race and Ethnicity. 2015.* Retrieved 16 March 2017, from http://www.cdc.gov/cancer/cervical/statistics/race.htm

[9] U.S. Department of Health and Human Services. (2015, May). *The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans.* Retrieved 9 February 2017, from https://aspe.hhs.gov/sites/default/files/pdf/139221/The%20Affordable%20Care%20Act%20is%20Improving%20Access%20to%20Preventive%20Services%20for%20Millions%20of%20Americans.pdf

[10] U.S. Census Bureau. (2010 and 2015). *American Community Survey 1-Year Estimates,* Table S0201. Retrieved 21 February 2017, from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S0201&prodType=table

[11] Chu, R., Wong, D., Robinson, W., & Fingold, K. (2012, April 1). *The Affordable Care Act and Asian Americans and Pacific Islanders.* Office of the Assistant Secretary for Planning and Evaluation. Retrieved 22 March 2017, from https://aspe.hhs.gov/report/affordable-care-act-and-asian-americans-and-pacific-islanders

[12] American Cancer Society. (2016). *Special Section: Cancer in Asian Americans, Native Hawaiians, and Pacific Islanders at 26.* Retrieved 16 March 2017, from https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2016/special-section-cancer-in-asian-americans-native-hawaiians-and-pacific-islanders-cancer-facts-and-figures-2016.pdf

[13] American Cancer Society. (2016). *Special Section: Cancer in Asian Americans, Native Hawaiians, and Pacific Islanders* at 34. Retrieved 16 March 2017, from https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2016/special-section-cancer-in-asian-americans-native-hawaiians-and-pacific-islanders-cancer-facts-and-figures-2016.pdf

[14] Health Care.Gov. *Health Coverage for Pre-Existing Conditions.* Retrieved 10 May 2017, from https://www.healthcare.gov/coverage/pre-existing-conditions.

[15] Department of Health & Human Services. (2017, January 5). *Health Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act.* Retrieved 10 May 2017, from https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

[16] Hayes, Tara O'Neill. (2017, May 10). *Fact Versus Fear: The AHCA and Pre-Existing Conditions.* Retrieved 10 May 2017 from, https://www.americanactionforum.org/insight/fact-versus-fear-ahca-pre-existing-conditions/

[17] Henry J. Kaiser Family Foundation. (2016, December). *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA.* Retrieved 10 May 2017, from http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/

[18] Office on Women's Health. (2016, July 13). *Diabetes and African Americans.* U.S. Department of Health and Human Services. Retrieved 10 May 2017, from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18

[19] American Cancer Society Inc. (2016). *Cancer Facts and Figures 2016.* Retrieved 10 May 2017, from http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-047079.pdf

[20] Office on Women's Health. (2017, June 12). *Diabetes: Do women of color need to worry about diabetes?* U.S. Department of Health and Human Services. Retrieved 19 September 2017, from https://www.womenshealth.gov/a-z-topics/diabetes

[21] Ibid.

[22] American Cancer Society Inc. (2016). *Cancer Facts and Figures 2016.* Retrieved 10 May 2017, from http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-047079.pdf

[23] Gordon, E. (2017, April 15). *U.S. Health Care Wrestles With the 'Pre-Existing Condition.'* National Public Radio. Retrieved 10 May 2016, from http://www.npr.org/sections/health-shots/2017/04/15/523577871/u-s-health-care-wrestles-with-the-pre-existing-condition

[24] Do, T.N., & Nam, S. (2014, August 20). *Knowledge, Awareness and Medical Practice of Asian Americans/Pacific Islanders on Chronic Hepatitis B Infection.* Pogon Sahoe Yongu *31*(3): 341-364. Retrieved 10 May 2017, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4139091/pdf/nihms440000.pdf

[25] Kochanek, K., Murphy, S. et al. (2016, June 30). *National Vital Statistics Reports: Deaths: Final Data for 2014.* Centers for Disease Control and Prevention. *65*(4): 1-122. Retrieved 15 May 2017, from https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf

[26] Planned Parenthood. (2016). *Fact Sheet: This is Who We Are.* Retrieved 16 March 2017, from https://www.plannedparenthood.org/files/6814/6833/9709/20160711_FS_General_d1.pdf

[27] Planned Parenthood. (2016, December 7). *The Urgent Need for Planned Parenthood Health Centers.* Retrieved 16 March 2017, from https://www.plannedparenthood.org/files/4314/8183/5009/20161207_Defunding_fs_d01_1.pdf

[28] Ibid.

[29] Planned Parenthood. (2015). Unpublished raw data.

[30] Planned Parenthood. (2016, December 7). *The Urgent Need for Planned Parenthood Health Centers.* Retrieved 16 March 2017, from https://www.plannedparenthood.org/files/4314/8183/5009/20161207_Defunding_fs_d01_1.pdf (citing Letter from Jennifer J. Frost, Principal Research Scientist, Guttmacher Institute, to Lisa Ramirez-Branum, Analyst, Congressional Budget Office (CBO). (2015, August 14)).

[31] National Partnership for Women and Families. (2017, March). *House Republicans' Repeal Bill Would Harm Women and Families.* Retrieved 16 March 2017, from http://www.nationalpartnership.org/research-library/health-care/aca-fact-sheets/house-republicans-repeal-bill-would-harm-women-and-families.pdf

[32] Guttmacher Institute. (2016, February 29). *Despite Recent Declines, Unintended Pregnancy Rates in the U.S. Remain High Among Women of Color.* Retrieved 16 March 2017, from https://www.guttmacher.org/infographic/2016/despite-recent-declines-unintended-pregnancy-rates-us-remain-high-among-women-color

[33] National Women's Law Center. (2015, September). *National Snapshot: Poverty Among Women & Families, 2014.* Retrieved 16 March 2017, from http://nwlc.org/wp-content/uploads/2015/08/povertysnapshot2014.pdf

[34] Foster, D., Dobkin, L., & Upadhyay, U. (2013, January). Denial of Abortion Care Due to Gestational Age Limits. *Contraception, 87*(1). Retrieved 16 March 2017, from https://www.ncbi.nlm.nih.gov/pubmed/23122688

[35] Congressional Budget Office. (2017, March 13). *American Health Care Act.* Retrieved 10 May 2017, from https://www.cbo.gov/publication/52486.

[36] Sonfield, A. (2017). Why Protecting Medicaid Means Protecting Sexual and Reproductive Health. *Guttmacher Policy Review, 20,* 39-40. Retrieved 16 March 2017, from https://www.guttmacher.org/sites/default/files/article_files/gpr2003917.pdf

[37] Sonfield, A. (2017). Why Protecting Medicaid Means Protecting Sexual and Reproductive Health. *Guttmacher Policy Review, 20,* 39-40. Retrieved 16 March 2017, from https://www.guttmacher.org/sites/default/files/article_files/gpr2003917.pdf

[38] Ibid.

[39] Ibid.

[40] NAPAWF calculations based on American Community Survey (ACS) 2015 1-year using Ruggles, S., Genadek, K., Goeken, R., Grover, J., & Sobek, M. (2015*). Integrated Public Use Microdata Series: Version 6.0* [dataset]. Minneapolis: University of Minnesota. Retrieved 16 March 2017, from https://usa.ipums.org/usa/

[41] Ibid.

[42] National Women's Law Center. (May 2013). *Fact Sheet: Women and the Health Care Law in the United States.* Retrieved 10 May 2017, from https://nwlc.org/resources/women-and-health-care-law-united-states/.

[43] Guerra, M. (2013, November 7). *Fact Sheet: The State of African American Women in the United States.* Center for American Progress. Retrieved 16 March 2017, from https://www.americanprogress.org/issues/race/reports/2013/11/07/79165/fact-sheet-the-state-of-african-american-women-in-the-united-states/

[44] Jackson, M. (2013, November 7). *Fact Sheet: The State of Latinas in the United States.* Center for American Progress. Retrieved 16 March 2017, from https://www.americanprogress.org/issues/race/reports/2013/11/07/79167/fact-sheet-the-state-of-latinas-in-the-united-states/

[45] Ramakrishnan, K., & Ahmad, F. (2014, July 21). *Income and Poverty.* Center for American Progress. Retrieved 16 March 2017, from https://cdn.americanprogress.org/wp-content/uploads/2014/08/AAPI-IncomePoverty.pdf

[46] National Partnership for Women & Families. (2017, September). *Fact Sheet: Quantifying America's Gender Wage Gap by Race.* Retrieved 21 September 2017, from http://www.nationalpartnership.org/research-library/workplace-fairness/fair-pay/quantifying-americas-gender-wage-gap.pdf

[47] Ibid.

[48] Ibid.

[49] National Asian Pacific American Women's Forum. (2017). *Fighting Invisibility, Closing the Gap.* Retrieved 16 March 2017, from https://napawf.org/wp-content/uploads/2017/03/FIGHTING-INVISIBILITY_FINAL.pdf

ALPHA-1 FOUNDATION

September 22, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

I am writing on behalf of the Alpha-1 Foundation to express our opposition to the Graham-Cassidy-Heller-Johnson (Graham-Cassidy) health reform legislation. The Alpha-1 Foundation is committed to finding a cure for Alpha-1 Antitrypsin Deficiency (Alpha-1) and to improving the lives of people affected worldwide.

Alpha-1 affects about 1 out of every 2,500 people in the US or more than 100,000 people in sum, equally affecting men and women in all races and ethnicities. An estimated 19 million people in the U.S. have one normal and one defective gene and are Alpha-1 carriers, who may pass the defective gene to their children. Alpha-1 may result in serious lung disease in adults and/or liver disease at any age. Individuals with Alpha-1 (Alphas) who are lung-affected depend on a biologic augmentation therapy to protect their health and prevent further deterioration. This treatment is extremely effective, allowing Alphas to lead full and productive lives, but also very expensive, with average annual treatment costs of $100,000. Alpha-1 is the most common genetic risk factor for COPD and Alpha-1-related lung disease is commonly called "genetic COPD."

The Foundation has long advocated for policies to ensure that Alphas have high-quality insurance that provides access to the specialists and therapies needed for them to manage their condition and lead healthy, productive lives. The most generous health insurance plan is only as good as an Alpha's ability to purchase it, so we support efforts to further improve affordability and access to health insurance. The Foundation supports the array of private insurance market reforms that were included in the ACA as these work together to ensure that Alphas, and all individuals with rare, expensive and chronic conditions have adequate insurance.

We oppose the Graham-Cassidy legislation, since it would invalidate all four of our key patient protection priorities:

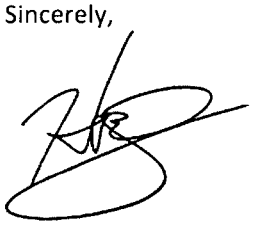
- **No pre-existing conditions restrictions:** States could allow plans to charge people more for premiums based on having a pre-existing condition. Moreover, allowing states to define the essential health benefits (EHBs) allows plans to remove coverage for treatments needed by Alphas or others with high-cost, chronic conditions.
- **No annual or lifetime limits on EHBs:** States could remove the essential health benefit requirements, making the ban on annual and lifetime caps meaningless, since it only applies to services defined as EHBs.
- **A reasonable limit on out-of-pocket expenses:** Likewise, the limit on out-of-pocket expenses only applies to EHBs, so this is also significantly weakened if states narrow the definition EHBs.

- **Insurance coverage up to age 26 on a parent's plan:** Plans could charge parents much more to cover a child affected by Alpha-1 or stop covering Alpha-1 treatments, undermining this protection, too.

We ask that you reject the Graham-Cassidy proposal and restart bipartisan negotiation to implement changes to protect and enhance coverage for Alphas and all Americans living with chronic diseases. Many of the insurance reforms included in the ACA have positively impacted our community, but many Alphas continue to struggle with the high cost of insurance coverage comprehensive enough to meet their complex health care needs. We urge you not to implement policies that will limit patient access to care, particularly for Alphas and other patients with chronic conditions.

Thank you for your consideration. Your efforts to reform our health insurance markets will have profound effects on our community and many others. We would be pleased to serve as a resource to you. If we may be of further assistance, please contact me at hmoehring@alpha1.org.

Sincerely,



Henry R. Moehring
Chief Executive Officer

CC: Members of the United States Senate

Ohio State Medical Association

Bringing physicians together for a healthier Ohio

September 21, 2017

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

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

Dear Majority Leader McConnell and Democratic Leader Schumer:

On behalf of the 16,000 members of the Ohio State Medical Association (OSMA), our state's largest physician-led organization, I wish to commend you for seeking efforts to improve the American healthcare system. We recognize that the Cassidy-Graham-Heller-Johnson Amendment to H.R. 1628, the "American Health Care Act of 2017", represents the most recent proposal to address some of the challenges posed by the Affordable Care Act (ACA).

However, as we have stated with previous attempts earlier this year to overhaul our nation's healthcare system, we remain deeply concerned about the potential negative impact this measure will have on patients and access to quality medical care. We are encouraged by the bi-partisan conversations that have begun at the state level and are now reaching the halls of Congress. We encourage you to continue your deliberations to seek ways to improve, and not harm, our nation's healthcare system.

As we stated before, our focus remains on seeking ways to improve our healthcare system without diminishing access to quality care for so many who presently have coverage today, thanks in part to the ACA. We also wish for insurance market reforms that allow for situations, such as, coverage for pre-existing conditions, to remain in place. And if the goal is to alleviate the reliance on government-funded healthcare programs like Medicaid then any such plan must not have the unintended effect of eliminating coverage for many low-income families or disabled individuals who need this assistance.

Unfortunately, the American Health Care Act of 2017 fails to provide safeguards for preventing any of these scenarios from occurring and thus likely harming millions of Ohioans.

The OSMA opposed the ACA when it was first implemented in 2009 and continues to understand that there are needed reforms and changes to make the national healthcare system more efficient. But such changes should not come at the expense of Ohioans and other Americans who desperately need access to quality medical care. If you have any questions regarding our position, please contact Reginald Fields, the OSMA's director of external and professional relations at RFields@osma.org. Thank you for the consideration given to our concerns.

Sincerely,

Robyn F. Chatman, MD MPH CPE FAAFP CPHIMS CHEP
President
Ohio State Medical Association

Visit www.OSMA.org

5115 Parkcenter Avenue • Suite 200 • Dublin, OH 43017
ph (614) 527-6762 • (800) 766-6762 • fax (614) 527-6763
info@osma.org

CC:

The Honorable Steve Chabot
U.S. House of Representatives
Ohio, 1st District

The Honorable Joyce Beatty
U.S. House of Representatives
Ohio, 3rd District

The Honorable Robert Latta
U.S. House of Representatives
Ohio, 5th District

The Honorable Bob Gibbs
U.S. House of Representatives
Ohio, 7th District

The Honorable Marcy Kaptur
U.S. House of Representatives
Ohio, 9th District

The Honorable Marcia Fudge
U.S. House of Representatives
Ohio, 11th District

The Honorable Tim Ryan
U.S. House of Representatives
Ohio, 13th District

The Honorable Steve Stivers
U.S. House of Representatives
Ohio, 15th District

The Honorable Sherrod Brown
U.S. Senate
Ohio

The Honorable John R. Kasich
Office of the Governor
Ohio

The Honorable Brad Wenstrup
U.S. House of Representatives
Ohio, 2nd District

The Honorable Jim Jordan
U.S. House of Representatives
Ohio, 4th District

The Honorable Bill Johnson
U.S. House of Representatives
Ohio, 6th District

The Honorable Warren Davidson
U.S. House of Representatives
Ohio, 8th District

The Honorable Michael Turner
U.S. House of Representatives
Ohio, 10th District

The Honorable Patrick Tiberi
U.S. House of Representatives
Ohio, 12th District

The Honorable David Joyce
U.S. House of Representatives
Ohio 14th District

The Honorable James Renacci
U.S. House of Representatives
Ohio, 16 district

The Honorable Robert Portman
U.S. Senate
Ohio

September 22, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, D.C. 20510

Dear Leader McConnell and Leader Schumer:

On behalf of the women and men served by Susan G. Komen, I am writing you to express our opposition to the Graham-Cassidy-Heller-Johnson (Graham-Cassidy) health reform proposal. As you know, Komen takes a multifaceted approach to addressing issues related to breast cancer diagnosis, management and treatment, and barriers to access. Our work includes supporting patients, funding breast cancer research, and advocating on behalf of patients and families.

We expressed concern about previous health care efforts in this Congress that would have significantly impeded our patients' access to insurance due to pre-existing conditions, led to them paying more for less coverage and made key patient protections optional. Unfortunately, the Graham-Cassidy proposal is just as concerning since it would jeopardize access to public and private insurance coverage for millions of individuals and have devastating effects on women and men with breast cancer and survivors.

Graham-Cassidy will lead to breast cancer patients paying more for less coverage. Premiums will increase for millions of sicker Americans, including those with breast cancer, since plans could set premiums based on health status. While insurers would still be required to offer plans to breast cancer survivors and those with pre-existing conditions, the plans offered are not required to cover the cancer care, including chemotherapy or "no-cost" screening mammography and other elements of treatment. Mandatory annual and lifetime cap protections would be eliminated for millions of people. In addition, the repeal of the Medicaid expansion and reduction in federal spending for Medicaid will lead to coverage losses. A recent study concluded that decreases in Medicaid availability are associated with later-stage disease at the time of a breast cancer diagnosis for low-income women.

We use our Breast Cancer Bill of Rights to guide all of our advocacy efforts, and hope that this guideline of issues will be helpful to you as you consider reforms to our health care system:

- **ACCESS**: Breast cancer patients and survivors have a right to affordable, quality and accessible health insurance coverage, including those with pre-existing conditions.
- **CLINICAL TRIALS**: Breast cancer patients should be educated about clinical trial opportunities and patients who participate in a clinical trial have a right to coverage of routine health care costs.
- **EARLY DETECTION**: Every woman has a right to access the most effective, evidence-based breast cancer screening and diagnostic tools.

- **FINANCIAL STABILITY**: Breast cancer patients have a right to fight the disease without fear of bankruptcy.
- **HIGH QUALITY**: Every woman has a right to high-quality care, no matter where she seeks medical services.
- **INNOVATION**: All Americans have a right to a government that makes investment in cancer research a national priority.
- **PATIENT EDUCATION**: Every woman has a right to make informed decisions and control her own health.
- **RECONSTRUCTION**: Breast cancer survivors have a right to insurance coverage for full mastectomy care, including reconstruction or prosthesis.
- **STRONG SAFETY NET**: Uninsured and underinsured women have a right to a strong breast health care safety net.
- **TIMELY CARE**: Every woman who has an abnormal mammogram has a right to a diagnosis and treatment, if needed, without delay.

Thank you for your consideration. In accordance with the Breast Cancer Bill of Rights, we seek to ensure that all breast cancer patients and survivors have access to quality, affordable health insurance. We urge you to reject this proposal and restart bipartisan discussions to implement policies that empower patients, improve patient access, and increase affordability. Please do not hesitate to reach out to Molly Johnson, mjohnson@komen.org, with any additional questions.

Sincerely,

Ellen D. Willmott, Esq.
Interim President & Chief Executive Officer
Susan G. Komen

Cc: Members of the United States Senate

BECAUSE OF YOU MOUNT CARMEL | NATIONWIDE CHILDREN'S | OhioHealth | THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

September 22, 2017

The Honorable Sherrod Brown
713 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Robert Portman
448 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Brown and Senator Portman:

On behalf of the hospital systems in Central Ohio, we are writing to express our opposition to the Graham-Cassidy-Heller-Johnson (GCHJ) bill. While we are aware that passage of the bill will likely result in Ohio losing significant federal funding over the next decade and beyond, the pillar upon which our opposition rests is the access to care for the patients we serve. Now more than ever, it is vital to preserve current levels of health coverage to ensure the welfare of our state's economic and physical health.

The GCHJ bill would dramatically change the financing structure for the traditional Medicaid population and end Medicaid expansion in 2020. Those two provisions alone have the potential to greatly harm our most vulnerable patients by impeding their access to care.

Ending Medicaid expansion coupled with the drastic reductions in Medicaid funding for children as well as GCHJ's other repeals of premium tax credits, cost sharing reduction (CSR) payments, and the individual and employer mandates has the grave potential to erode patient protections. For example, the bill creates a block grant program open to all states and utilizing money that otherwise would have continued funding Medicaid expansion. Applying for and receiving this money would allow Ohio to waive the current patient protections for anyone receiving coverage through the grant program. Therefore, potentially jeopardizing Medicaid coverage for hospital care, behavioral health services, maternity care and other common services. Additionally, Ohio could allow insurers to charge individuals with pre-existing conditions any amount in premiums, effectively pricing many individuals out of coverage.

As leaders of central Ohio's major health care systems, we certainly recognize that opportunities exist to strengthen and improve the Medicaid program, while also managing health care costs. We are also actively aware of the unique needs of our communities, many of which have been devastated by the opioid epidemic. The Medicaid program is central to fighting that crisis; reducing Medicaid support for Ohio would significantly impede our ability to fight this battle. We stand ready to work with you and your colleagues in Congress on this issue.

Our request today is the same one we expressed earlier this summer. We encourage the Senate to go back to the drawing board. Bring together all of the interested parties across the health care spectrum and lead a thoughtful and deliberate bipartisan discussion on how to improve Medicaid, the individual marketplaces, and access to care for all Ohioans. We respectfully ask for you to

look beyond politics and oppose the GCHJ bill and concentrate on preserving the access to healthcare for all Ohioans.

Sincerely,

Edward H. Lamb, FACHE
President and Chief Executive Officer
Mount Carmel Health System

David P. Blom
President and Chief Executive Officer
OhioHealth

Steve Allen, M.D.
Chief Operating Officer
Nationwide Children's Hospital

David McQuaid, RPh, MBA, FACHE
Chief Operating Officer, The Ohio State University Wexner Medical Center
Chief Executive Officer, The Ohio State University Health System

September 22, 2017

Senator Brown:

As the health care debate continues in Washington, it is important that we express our concerns with the Graham-Cassidy bill and its potential impact on our residents, particularly babies, mothers, people with chronic health conditions, the poor, and those with mental health and addiction issues.

To protect vulnerable residents, a quality health care reform bill must include:

- Prevention and Public Health Fund
- Requirement to cover mental health and addiction services
- Prohibition on charging higher premiums for those with pre-existing conditions
- Requirement to cover pre-natal, maternity and post-natal care
- Marketplace subsidies that reduce monthly premiums and out of pocket costs to assist low income and older adults
- Medicaid eligibility for individuals up to 138% of FPL

This bill will directly affect our ability to address two public health crises in our country that are hitting Ohio particularly hard – opiate addiction and infant mortality. In Columbus, 1.7 people die every day of an overdose. And of the

702,000 Ohioans covered under Medicaid expansion in 2016, nearly 25,270 had an opioid use disorder. The cost of treating Medicaid recipients with an addiction in Ohio amounts to nearly $280 million per year. This bill would impact Ohio's ability to pay for prevention and treatment, and increases the burden on families, foster care and law enforcement on the front lines of the epidemic. As communities across our state are struggling to deal with this epidemic, now is not the time to reduce or eliminate the money we need to combat this deadly crisis.

Babies in our community also are dying at alarming rates, and accessing prenatal care as early as possible is one of the most important things a mom-to-be can do to ensure her baby is born healthy. Rolling back coverage and protections puts women and their babies at risk and limits our ability to reduce infant mortality. By allowing states to change what qualifies as an "essential health benefit," insurers could refuse to cover maternity care. Medicaid today covers about half of all pregnancies in the U.S., and nearly 50% of moms served through CelebrateOne are covered under Ohio's Medicaid program. These families must be able to count on their health insurance to get the timely pre-natal care that will help more babies live until their first birthday and thrive every year beyond.

Additionally, repeal of the Prevention and Public Health Fund will greatly reduce our ability to affectively and quickly respond to disease outbreaks and threats such as Ebola and Zika to protect the public's health. In fact, more than 40% of the CDC's immunization program is allocated through the Prevention and Public Health Fund which will impede the ability of our community – and communities all across Ohio -- to prevent disease outbreaks.

Finally, any legislation should ensure that more people are covered by health insurance at a lower cost. Anything that prices more people out of the health insurance system and leaves them uninsured is unacceptable. Access to care is critical for vulnerable people – and all residents -- to live a healthy and productive life.

Columbus Public Health is committed to protecting the health and improving the lives of all residents – and we need your help. We urge you to vote no on the Graham-Cassidy bill to protect the health and safety of all Ohio residents.

Yours in good health,

Teresa Lazo MD

Teresa C. Long, MD, MPH
Health Commissioner
Columbus Public Health

240 Parsons Avenue Columbus, OH 43215 . T (614) 645.7417 | F (614) 645.7633 | health@columbus.gov www.publichealth.columbus.gov

OFFICE OF THE MAYOR

September 22, 2017

Senator Sherrod Brown
U.S. Senate
713 Hart Senate Office Building
Washington, DC 20510

Senator Rob Portman
U.S. Senate
448 Russell Senate Office Building
Washington, DC 20510

Dear Senators:

In Central Ohio, we know how to come together and make solutions work. We have collectively come together to win the Smart Cities Challenge, we are working to end infant mortality and just a few months ago we released our Opiate Action Plan. We know how to use local tools and other resources to solve some of the most destructive issues facing our community. Medicaid is a very necessary resource to combat these issues.

As you know, the City of Columbus joined with Franklin County, public health and social services agencies, first responders, law enforcement, healthcare organizations and businesses to address our opioid crisis with a comprehensive action plan. We've just begun this extremely important work, and the passage of Graham-Cassidy would bring our efforts to a halt; in addition to the Medicaid cuts, this bill also lacks funding for opioid treatment.

Furthermore, our community has one of the highest infant mortality rates in the country. Our focus has been on providing resources to support mothers and infants to ensure every child born in our community has the opportunity to thrive. I am happy to report, we are seeing the results we need! Infant mortality is starting to decline, and the passage of this legislation would end this precious progress.

The statewide outlook is even more devastating. Under this new plan, Ohio's Medicaid per capita loss would be $10.2 billion by 2027, and $161 billion by 2036. Ohio would not be able to recover from these losses. Ohioans deserve better. I encourage you to oppose this, and any healthcare bill that rolls back Medicaid expansion, weakens coverage for pre-existing conditions, or allows any reduction in mental health and substance abuse parity.

Columbus' families are counting on all of us to get this right. That can only happen with an open, transparent process that fully vets a Senate bill before the American people. As our Senators, you have a right to ask tough questions, thoughtfully consider the costs and benefits of this plan, and vote for reform that is true to our values as Ohioans. With that in mind, I also encourage you to oppose any bill that has not received a full, fair hearing in the Senate.

Thank you in advance for your thoughtful consideration.

Sincerely,

Andrew J. Ginther
Mayor

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

90 W. Broad Street | 2nd Floor | Columbus OH 43215 | T (614) 645.7671 | F (614) 645.5818 | 311@columbus.gov

COLUMBUS WOMEN'S COMMISSION

September 22, 2017

U.S. Senator Sherrod Brown
713 Hart Senate Office Building
Washington, DC 20510

Dear Senator Brown,

With the recent announcement of the Graham/Cassidy/Heller/Johnson bill, we want to share with you the considerable negative impact the proposed bill has on women, particularly low-income women, in our state and in our community. Like you, we are committed to the people of the great state of Ohio, and we want to emphasize how important retaining quality, affordable health care is to our residents. Therefore, **we respectfully request that you oppose this bill.**

As you know, more than 700,000 people in Ohio – 100,000 in Franklin County -gained health care through the Medicaid expansion enabled by the Affordable Care Act. Adoption of this new bill threatens access to health care and ultimately the well-being of our neighbors here in central Ohio.

Medicaid is a cost-effective program that serves vulnerable residents in our community, including the disabled, the elderly and children. It acts as a high-risk pool for the population with high rates of disease and disability. That helps make private health insurance more affordable – which is something we all want. Reducing the Medicaid benefit shifts the costs and the risks to states like Ohio that would then ultimately make beneficiaries responsible for the cost of health care with no controls on skyrocketing costs.

The changes proposed in this bill disproportionately affect women. Many of our nation's poorest women have no pathway to coverage if federal funds for Medicaid expansion are reduced and/or eliminated. In states like Ohio, Medicaid expansion helped reduce the national percentage of uninsured women from 17 to 11 percent. Medicaid is a key source of coverage for 15 to 19 percent of women in Ohio.

Moreover, today, pregnant and postpartum women have a greater range of protections and benefits than they did prior to the Affordable Care Act. These range from mandatory maternity and newborn coverage, to no-cost prenatal screenings, and breastfeeding support.

Sadly our community is currently struggling to address one of the highest infant mortality rates in the country. Our focus is on providing evidence-based resources to support mothers and infants to ensure every child born in our community has the opportunity to thrive. Today in Franklin County, 150 babies each year die before their first birthdays. The Affordable Care Act ensures vitally important resources are available to support improvement in our community's birth outcomes. This bill eliminates these protections and benefits.

This bill also allows states to waive coverage for preventive services and award insurers unlimited ability to consider pre-existing conditions to set premiums, basically returning us to the policies of a decade ago when insurers could deny a consumer coverage based on a pre-existing condition, leaving residents without any access to affordable healthcare coverage. Moreover, it provides no dedicated funding for substance abuse treatment, including opioid addiction treatment, at a time when opioids are literally destroying entire communities in our great state. We can do better.

We are committed to the women, men and children in our community. Health care is a basic human need. **We are asking you to stand with the residents of central Ohio and oppose this bill, thereby preserving Ohioans' access to safe, affordable health care coverage.**

Sincerely,

Shannon L. Ginther

Shannon Ginther
Chair of the Columbus Women's Commission
First Lady of Columbus

Elizabeth Brown
Executive Committee Member

Jeff M. Myers
President and CEO

Medicaid Health Plans of America

September 21, 2017

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

Dear Majority Leader McConnell:

As you know from our discussions with you and your staff, MHPA and our member plans are committed to exploring ways to guarantee that Medicaid is on firm financial footing to ensure its long-term viability for beneficiaries that count on this extremely important program and for the taxpayers who provide the resources to pay for these much-needed services. We have been open to discussing alternative financing models as well as structural reforms which, if implemented, would drive better care for Medicaid enrollees while bending the cost curve. While we understand and accept the limitations that are placed on you and your colleagues using a reconciliation-driven model, we are alarmed at both the size of the federal funding reductions you are proposing and its timing, as well as the impact that moving to a block grant mechanism would have on the overall integrity of the Medicaid program.

In our view, the Cassidy/Graham proposal would reduce federal participation in Medicaid to such an extent that it would create significant challenges for the states to adequately fund services to beneficiaries. Indeed, according to an independent analysis from Avalere Health consulting, the Cassidy/Graham bill might reduce federal support for the program even more than what was proposed by the ***Better Care Reconciliation Act*** (BCRA), which the Senate wisely rejected. One of the first principles that MHPA has consistently reiterated to policymakers is the need to provide adequate funding and a reasonable timeframe for any financing changes to ensure program stability. In our view Cassidy/Graham fails that test.

The transition from the current funding mechanism to a fundamentally different design must allow sufficient time for states, MCOs and provider networks to adapt. A transition period should be no less than three years, and preferably five, to curtail disruptions and the increase in associated expenses. Graham/Cassidy specifies that the *per capita* funding mechanism will go into effect in 2020. This timeframe is far too short. State procurement processes, contracting and negotiating terms for new program changes for a complex program like Medicaid averages two years. With state legislative and budget approvals also required, a minimum of three years is essential.

In the Graham/Cassidy proposal, the *per capita* model, unlike the block grants which are discussed below, ties each state's allocation to a per-person capitated rate within four different populations and, going forward, sets up a funding structure based on national trends and costs per population. While this mitigates some of the shortcomings of a block grant, the inadequate annual update factor and the absence of rebasing in the current *per capita* model make it

suboptimal and can be viewed only as a starting point to a true discussion on comprehensive Medicaid reform.

Furthermore, the removal of enhanced Federal Medicaid Assistance Program funds (FMAP) for the expansion population by placing the funds into the so-called "Market Based Healthcare Grant Program" penalizes those states that expanded the program to the near poor by simultaneously reducing funding and combining it into a block grant. MHPA supported (and continues to support) the expansion provisions because they encouraged states to provide care in an integrated, capitated fashion instead of a fragmented and inefficient charity care model that drives high costs to the states and the federal government paid for via disproportionate share hospital (DSH) and supplemental payments.

We have also consistently reminded policymakers that the block grant mechanism ignores the complexity and purpose of the Medicaid program. While we support additional "state flexibility" in designing Medicaid services to address the needs of their citizens, MHPA does not believe that the funding or design of a block grant will ensure that enrollees get the services they need in an actuarially sound manner over time. Block grants do not accommodate the counter cyclical nature of Medicaid and the inability of States to shoulder increased financial stress during economic downturns. They do not take into account changes in population health, demographics, and unanticipated events (like hurricanes or public health emergencies like the opioid addiction crisis). Block grants are simply not a suitable mechanism for Medicaid.

We know and appreciate your interest in finding ways to address the challenges that Medicaid faces; unfortunately, in our view, significant reductions in funding over a short period of time combined with a fundamental restructuring of the federal commitment to our nation's poor will dramatically destabilize the program. As you and your colleagues consider redesigning the federal and state partnership implicit in this program, we would strongly encourage you to consider the views of the plans that provide the care to nearly three fourths of beneficiaries. We are committed to doing all that we can to provide ideas that make the program more robust and address well founded concerns about Medicaid's cost growth, and we look forward to continuing to work with you and other members of the U.S. Senate who share this commitment.

Best regards,

Jeff M. Myers

1150 18th Street NW Suite 1010 Washington, DC 20036
TEL (202) 857-5720 FAX (202) 857-5731 jmyers@mhpa.org www.mhpa.org

CELEBRATEONE.INFO

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

September 22, 2017

U.S. Senator Sherrod Brown
713 Hart Senate Office Bldg.
Washington, DC 20510

Dear Senator Brown,

Our community has one of the highest infant mortality rates in the country. In Franklin County, 150 babies each year do not reach their first birthdays. CelebrateOne is the collective community impact initiative created to address Columbus and Franklin County's unacceptably high infant mortality rate. Our focus is on providing resources to support mothers and infants to ensure every child born in our community has the opportunity to thrive.

With the recent announcement of the Graham-Cassidy bill, I want to share with you the considerable impact the proposed bill has on mothers and infants in Columbus and Franklin County. Like you, I am committed to improving the lives of people in our community and I want to emphasize how important health care is to the families we serve.

Today, pregnant and postpartum women have a greater range of protections and benefits than they did prior to the Affordable Care Act. These range from mandatory maternity and newborn coverage, to no-cost prenatal screenings and breastfeeding supports. The Affordable Care Act ensures vitally important resources available to pregnant women which lead to better birth outcomes.

Addtionally, more than 700,000 people in Ohio – 100,000 in Franklin County -- gained health care through the Medicaid expansion enabled by the Affordable Care Act. Adoption of the Graham-Cassidy bill will reduce and cap Medicaid funding. Over 50% of families we serve are enrolled in Medicaid. The Medicaid cuts would result in a significant number of pregnant women, mothers and infants without health care, threatening the well-being of our neighbors here in central Ohio.

We are committed to the mothers and infants in our community. CelebrateOne is focused on reducing the infant mortality rate by 40% and cutting the racial disparity rate in half by 2020.

We are asking you to stand with the residents of central Ohio to preserve their health care coverage.

Sincerely,

Erika Clark Jones
Executive Director, CelebrateOne

1111 East Broad Street Suite 203 A | Columbus OH 43205 | www.celebrateone.info

Celebrate One Partners
Columbus Public Health Central Ohio Hospital Council Columbus Department of Development Franklin County Board of Commissioners Franklin County Families and Children First Council Ohio Department of Medicaid Columbus City Council Franklin County Department of Job and Family Services Ohio Better Birth Outcomes Collaborative Partners for Kids

National Council of
Urban Indian Health
Policy & Legislation

September 21, 2017

In re: concerns of urban Indian patients and providers about the Graham-Cassidy-Heller-Johnson measure to repeal and replace the Affordable Care Act

Dear Senator:

On behalf of the National Council of Urban Indian Health (NCUIH), which represents over forty urban Indian health programs (UIHPs) across the nation, I urge you not to support the Graham-Cassidy-Heller-Johnson measure to repeal and replace the Affordable Care Act (ACA) until the measure is reformed to ensure it is consistent with the federal government's Trust Responsibility to provide American Indian/Alaska Native (AI/AN) people with health care. This obligation has been reaffirmed, repeatedly, by all three branches of the federal government, one which cannot be passed on to the states, and one which follows AI/AN people off of reservations and into urban areas.

NCUIH represents the interests of UIHPs, as well as its patients and providers, before the legislative and executive branches and serves as a resource center for the education and training of UIHPs' management and staff. An integral part of the Indian Health Service's (IHS) I (direct care) /T (Tribal) /U (urban) system, UIHPs are public-private partnerships which employ their own staffs. UIHPs receive slightly more than 1% of IHS' budget, but still manage to provide high-quality, culturally-competent health care to urban Indians, i.e., the more than two-thirds of American Indian/Alaska Native (AI/AN) people who live off of reservations, either because of the federal government's forced relocation policy or they seek greater economic and educational opportunities. Urban Indians experience health conditions and outcomes that are comparable to those of AI/AN people who live on reservations and markedly worse than non-AI/AN people who also live in urban environments.

1. **Mandates**

NCUIH supports the measure's repeal of the ACA's penalties for employers which don't provide insurance it with respect to their application to AI/AN people and employers because the ACA's employer mandate are inconsistent with the federal government's Trust Responsibility.

924 Pennsylvania Ave. SE
Washington, DC 20003
Phone (202) 544-0344
Fax (202) 544-9394
www.ncuih.org

2. Block Grants

Medicaid is a program that has served AI/AN people very well, and it is vital in mitigating against the Congress' chronic underfunding of IHS. The block granting of Medicaid would result in a significant reduction in the federal contribution to the program, culminating in the elimination of funding after 2026. The measure ostensibly exempts IHS and Tribal facilities from its Medicaid cuts; significantly, it would leave UIHPs fully exposed.

States would gut their Medicaid programs to offset the lost federal contributions: reducing the benefits available, narrowing eligibility for the remaining benefits, and slashing payments to providers. Significant numbers of AI/AN people would inevitably lose access to Medicaid and be forced to fall back on an IHS that has historically been resourced by Congress at well below capacity. Even if assuming arguendo ending any federal role in Medicaid constitutes good public policy, the federal government, consistent with the Trust Responsibility, would be obligated to work with Indian health care providers to exempt reimbursements for services received through I/T/U facilities from the resulting state-imposed limitations.

3. Medicaid Expansion

Medicaid Expansion has been an unqualified success in Indian Country, playing a key role in reducing the number of uninsured AI/AN people and increasing Medicaid revenues in the I/T/U system that can then be reinvested in Indian health care. NCUIH appreciates that the measure attempts to preserve Medicaid eligibility for AI/AN people enrolled in expansion states before 2020. However, we are uncertain such an exception for AI/AN people would even be viable because of the adverse impacts on states of reducing and then eliminating federal contributions to Medicaid as well as ending the expansion effort generally. Even if assuming arguendo ending Medicaid Expansion constitutes good public policy, the measure should be changed to ensure that Medicaid Expansion is preserved for all AI/AN people, regardless of their states of residence.

4. Federal Medical Assistance Percentage

NCUIH appreciates that the measure would extend a Federal Medical Assistance Percentage (FMAP) of 100 to UIHPs. This is a long overdue reform. It makes no sense, either as a matter of law or policy, to treat UIHPs differently from IHS and Tribal facilities, both of which already receive 100% FMAP. However, section 128 would also extend 100% FMAP to non-IHS providers without adequate consultation with Tribes or any consideration of how the increased savings to states of $3.5 billion over ten years,

924 Pennsylvania Ave. SE
Washington, DC 20003
Phone (202) 544-0344
Fax (202) 544-9394
www.ncuih.org

according to the Congressional Budget Office, can be invested in Indian health care. Tribes, urban Indians, Republicans, and Democrats all agree that 100% FMAP for UIHPs is sound public policy and consistent with the Trust Responsibility, so this option should be implemented without delay. However, no such consensus exists with respect to non-IHS providers, so NCUIH urges lawmakers to consult further with Indian Country health care providers before proceeding any further.

5. Medicaid Work Requirements

The measure would allow states to impose work requirements on Medicaid recipients. AI/AN people should be exempt from such requirements because of lack of economic opportunities in large parts of Indian Country. Moreover, such requirements could induce AI/AN people to fall back on the already underfunded IHS, simply shifting the cost from one program to another. NCUIH supports job training and counseling, but such programs should not be mandatory for AI/AN people, and the measure should be revised accordingly.

6. Third Party Insurance Reforms

The measure would replace with block grants the cost-sharing protections created by the ACA, including those specifically for AI/AN people which make it possible for them to secure health insurance. Loss of these protections will inevitably induce AI/AN people to fall back on an IHS which the Congress has consistently failed to adequately fund. Whether states, which would be required by the measure to develop their own health care programs, would establish similar cost-sharing protections for AI/AN people is uncertain. What is not uncertain is that the measure would pass off the federal government's Trust Responsibility for Indian health care to the states--which is contrary to treaty, law, and case law.

Please contact NCUIH Executive Director Francys Crevier (fcrevier@ncuih.org) if you have any questions about our views on the measure. Thanks for your consideration.

Sincerely,

Ashley Tuomi

Ashley Tuomi
President

924 Pennsylvania Ave. SE
Washington, DC 20003
Phone (202) 544-0344
Fax (202) 544-9394
www.ncuih.org

UC Health

September 22, 2017

The Honorable Sherrod Brown
SH-713 Hart Senate Office Building
Washington, DC 20510-6321

Dear Senator Brown:

On behalf of University of Cincinnati Health (UC Health), I write to express our strong opposition to the Graham-Cassidy-Heller-Johnson proposal currently being considered, and to urge you to vote against this measure if brought to the Senate Floor.

UC Health is Cincinnati's academic health system. We have been committed to our tri-partite mission of education, research and clinical excellence since our first hospital was founded 200 years ago. With our two inpatient facilities: UC Medical Center and West Chester Hospital, we are the only health system in southwest Ohio caring for the most vulnerable, training future health care professionals, providing comprehensive and coordinated care, providing specialized and lifesaving services and advancing public health. We are the community's *essential health system* and, as such, continue to advocate the following key principles as fundamental cornerstones of any successful health care system:

- All individuals should have access to affordable healthcare coverage.
- Healthcare systems should be free from excessive regulatory burden so that more resources can be devoted to patient care.
- Hospitals should be fully reimbursed for the services provided to patients.
- Healthcare reform efforts must provide hospitals with stable, predictable reimbursement.
- The healthcare delivery system must continue its transformation to value-based care.

The Graham-Cassidy proposal does not meet these principles as it repeals the individual and employer mandates, repeals Medicaid expansion, caps traditional Medicaid funding and dramatically alters the original intent of the Disproportionate Share Hospital program.

This bill completely overhauls the entire health care system, and we strongly advocate for a thoughtful and deliberative process through regular order to address the flaws in our current health care marketplace. We urge the Senate to continue to engage in close collaboration with health care stakeholders and to craft a bipartisan bill that is responsive to the issues.

Thank you for your attention to this letter.

Sincerely,

Richard P. Lofgren, MD
President & Chief Executive Officer
UC Health

SUMMIT COUNTY OPIATE TASK FORCE

1867 West Market Street, Suite B2
Akron, Ohio 44313-6914
330-762-3500
Fax: 330-252-3024
www.summitcountyaddictionhelp.org

Senator Rob Portman
338 Russell Senate Building
Washington, DC 20510

Dear Senator Portman,

I write this letter today on behalf of myself and the Summit County Opiate Task Force to once again commend you on your work in opposition to repealing Obamacare. As you know, Medicaid expansion has saved many families from financial ruin in our state and prevented even more Ohioans from losing their lives. The importance of continuing the programs that have helped thousands of Ohioans get the help they need cannot be over stated. We are very concerned about the setback that will result if the Graham/Cassidy/Heller/Johnson Bill is passed. The current piece of legislation under consideration will ....

- Eliminate Medicaid expansion and federal exchanges along with the associated tax credits and subsidies after 2020; states could apply for a block grant to access the federal funds that otherwise would have been spent on Medicaid expansion and federal exchange monetary assistance from 2021 to 2027: **Impact to Ohioans – major reduction in coverage, reduction in federal funding for Ohio.**
- Reduce the insurance market protections for persons with high-cost diseases with allows states to "waive" essential health benefit requirements: **Impact on Ohioans – will make insurance more expensive for those with pre-existing conditions, may make certain benefits inaccessible (e.g. behavioral health, addiction treatment, maternity services).**
- Restructure the Medicaid program overall by capping overall Medicaid expenditures while seeking to equalize Medicaid payments to states by redistributing the dollars among states that did and did not expand Medicaid. **Impact on Ohioans – significant reduction in funding.**
- **Pulls $161 billion in federal funding out of Ohio over a 20-year period.**

Senator Portman – please vote NO on Graham/Cassidy/Heller/Johnson bill. This bill does not help Ohioans. It does not fix the exchange markets, it guts Medicaid, and it threatens all Ohioans under age 65 – not just our most vulnerable citizens – but all Ohioans who need access to healthcare services.

Thank you for your continued opposition to the repeal bills. God bless America.

Respectfully yours,

Sincerely,

Gerald A. Craig, MSSA LISW-S
Chair, Summit County Opiate Task Force

Summit County Public Health

1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558
www.scphoh.org

Date: **September 21, 2017**

To: **Sherrod Brown, U. S. Senator, Ohio's 13th Congressional Office**

From: **Donna R. Skoda M.S, R.D., L.D., Health Commissioner, Summit County Public Health**

RE: **Medicaid Expansion and Summit County Public Health**

Because Ohio has expanded Medicaid under the ACA, low-income adults without dependent children became eligible for the first time in 2014. The following residents can enroll in Medicaid in Ohio (immigration rules apply):

- Adults with household income up to 133 percent of poverty (138 percent after the built-in 5 percent income disregard).
- Children with household income up to 206 percent of poverty.
- Pregnant women with household income up to 200 percent of poverty.

Individuals above these income guidelines have anecdotally benefited from the ACA on the market place by purchasing insurance at a greatly reduced price even if they were not eligible for subsidies like sole practitioner's veterinarians, dentist that purchased insurance on the marketplace for much less than before. $1,000 compared to $1,500 a month.

Specifically, we have seen:

- 50% more of our dental clients insured resulting in patients getting dental care; 222 received dentures
- 85 oral surgeries
- Individuals who do not receive dental care suffer long-lasting expensive conditions like heart disease, premature birth, etc.

Also, through Medicaid expansion we have been able to treat more individuals that suffer from Substance Use Disorders. We also at the same time test for HIV and Hepatitis C which decreases the spread of the disease by identification. It is a very expensive disease to treat and early identification is essential.

Please feel free to contact me at dskoda@schd.org or 330-926-5654. Thank you in advance for your cooperation.

Respectfully,

Donna R. Skoda

Donna R. Skoda
Health Commissioner

KNOX COUNTY Health Department

11660 Upper Gilchrist Road
Mount Vernon, Ohio 43050

www.knoxhealth.com

Phone 740-392-2200
Fax 740-392-9613

September 21, 2017

To: Honorable U.S. Senator Sherrod Brown

Honorable U.S. Senator Rob Portman

I am writing as the health commissioner of rural Knox County, Ohio to implore you to vote no on the proposed Graham-Cassidy bill intended to come before you for vote next week.

Not only is the Graham-Cassidy bill potentially devastating to many U.S. and Ohio citizens it also would eliminate the Prevention and Public Health Fund, which provides 12% of the funding at the Centers for Disease Control and Prevention (CDC) and which supports our local public health efforts to prevent disease, promote health and protect the environment for our residents.

The Graham-Cassidy Bill as presented is no better than the previously vetoed bills and I feel does not adequately protect the health of Knox County residents nor the remainder of the State's residents. Essentially the bill would:

1) completely eliminate the ACA's expansion of Medicaid, which has extended coverage to 11 million low-income adults and would jeopardize coverage for 500,000 Ohioans by ending the Medicaid expansion and reduce federal funding for traditional Medicaid services that benefit Ohio's children, seniors, and people with disabilities;
2) completely eliminate the ACA's marketplace subsidies, which currently help almost 9 million people afford coverage. Unlike under earlier Republican bills, which substituted highly inadequate tax credits, moderate-income working people buying individual market coverage would no longer be guaranteed any assistance;
3) dramatically redistribute funding across states, meaning that many states - especially Medicaid expansion states, like Ohio and states with high marketplace costs - would see far deeper cuts
4) end completely after 2026 - as if the need to help low- and moderate-income people afford coverage would just disappear overnight – this is an unrealistic goal.

As an Ohio, rural, local public health department we were fortunate to have received county designation as a Medically Underserved Area (MUA) – Medicaid in 2015, and for over 20 years our county has been designated as a Health Professional Shortage Area (HPSA) for Dental Care. These two designations allowed us to apply and receive federal funding to start a Federally Qualified Health Center in early 2017. Knox County has historically had difficulty in providing access to health care for Medicaid recipients due to the former restrictions with the program, with Medicaid expansion in Ohio and the

availability of our center many residents without health or dental care now have a medical home. We already have stories of clients who have gone without health care, now receive Medicaid, visit our center and found to have cancer, diabetes or other chronic disease conditions. Without Medicaid expansion and our FQHC the residents in our jurisdiction will go without health care, or opt not to have insurance over feeding their family and most likely suffer health issues that should not have to occur.

The Graham-Cassidy bill will also cause additional burden to our community partners who, like us, must serve individuals regardless of insurance or ability to pay. Our local hospital will most likely see their "charity/uncompensated care" costs increase significantly, after seeing it reduced and being able to place those savings back in the community. This bill is detrimental to our nation, state and to our local OHIO community.

This bill also includes a block grant that provides a fixed amount of funding for states each year, which will leave Ohio responsible for any and all unexpected costs from recessions, natural disasters, public health emergencies, or prescription drug price spikes. These unexpected costs are public health costs and Ohio already stands as one of the most poorly funded states in the nation for public health services. So, I ask you, who will pay for the next measles outbreak in Ohio, such as the one Knox County suffered in 2014?

It is also my understanding that the Congressional Budget Office has not had time to assess the loss of coverage that would result or the impact on the federal deficit. Governor John Kasich has been clear that reform is necessary -- Ohio is a national leader in health care reforms that control costs -- but the current effort in Congress to rush a reform that is not yet fully understood is risky and in the wrong direction.

Please consider the very detrimental costs to Ohio residents if this bill should pass. Consider the costs economically but more importantly to Ohio's health. And need I remind you that Ohio ranks poorly in a multitude of health issues in contrast to most other states. I strongly encourage you to vote no on the Graham-Cassidy bill.

Thank you for your service and your consideration of my request.

Respectfully,

Julie Miller, RN, MSN

Health Commissioner, Knox County General Health District

Akron
Children's
Hospital

William E. Considine
Chief Executive Officer

September 22, 2017

The Honorable Orrin G. Hatch
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Graham-Cassidy Legislation

Dear Chairman Hatch and Ranking Member Wyden:

In 1890, Akron Children's Hospital was founded for the purpose of improving the health of children in our community. While health care and the world itself has changed in ways that were unimaginable 127 years ago, this mission remains true and the reason we must speak up when the health of children is in jeopardy.

Over the last nine months America has watched as Republican Congressional leaders have attempted to fundamentally alter the federal government's commitment to funding Medicaid coverage for children. Of the 70 million individuals covered by Medicaid nationwide, 30 million are children - children, who with few exceptions had this coverage prior to the Affordable Care Act (ACA). In Ohio alone, 1.3 million children rely on Medicaid for health coverage. Under the Graham- Cassidy legislation, the per capita cap funding structure, federal support for Ohio Medicaid is estimated to fall by $51 billion to $86 billion by FY 2030.

If such cuts were to occur, children would lose coverage or the network they rely on for care would be damaged resulting in poor access to care. Proponents of the legislation have falsely claimed that children on Medicaid will not be harmed by this legislation. This claim does not stand up to independent analysis nor will is stand up when the bill is scored by the Congressional Budget Office. The staggering loss of federal support cannot be overcome by the promise of increased flexibility it would be more accurate to promise states the flexibility to make disastrous decisions that will destroy families and children.

Lost in the abstract messaging and talking points used by the proponents of this legislation are the lives at stake. One such life is Benjamin Dworning, a beautiful and outgoing 10-year-old boy, who traveled to Washington earlier this year to share his story with members of Congress and ask them to protect Medicaid for kids. Benjamin, along with his parents Paul and Nikki shared their

journey, from Benjamin's diagnosis with Down syndrome and achondroplasia, through multiple surgeries and the ongoing care necessary to keep Benjamin healthy. During this visit Benjamin and his parent met with Senators Rob Portman and Sherrod Brown to ask for their renewed commitment to keeping Medicaid strong for kids. The coming days will test every member's commitment to the health and wellbeing of our nation's children.

The 30 million children on Medicaid were not beneficiaries of Medicaid expansion, or most provisions of the ACA and they should not be victims of its repeal, repair or revision. The Graham-Cassidy legislation puts the future health of all children in great jeopardy, and for this reason I ask that the members of the Senate Finance Committee oppose the legislation.

Sincerely,

William H. Considine

William Considine
CEO, Akron Children's Hospital

CC: Senator Rob Portman
Senator Sherrod Brown

Summa Health

1077 Gorge Blvd
Akron, Ohio 44310
234.312.5259
summahealth.org

Senator Rob Portman
448 Russell Senate Office Building
Washington, DC 20510

Senator Sherrod Brown
713 Hart Senate Office Building
Washington, DC 20510

Dear Senators Portman and Brown:

We write today to express our deepest concern with the Graham-Cassidy-Heller-Johnson legislation that the Senate intends to vote on next week to repeal and replace the Affordable Care Act (ACA). In short, this legislation does not fix the challenged exchange marketplaces in Ohio, and will reduce federal support for Ohio's Medicaid program and for Ohio's exchange marketplace enrollees by an estimated $161 billion over a 20-year period from 2020-2036.[1]

As leaders of Summa Health in Akron, Ohio, our institutions serve patients everyday who rely on the Medicaid program and exchange marketplace coverage to access care and services they need to live productive, healthy lives. The health insurance market changes made by the ACA outlawing medical underwriting and protecting those with health conditions from substantial increases in insurance premium costs have benefited the health and wellbeing of our communities. Study after study confirms that having health coverage leads to better treatment access and more prevention. We are deeply concerned that Graham-Cassidy-Heller-Johnson will needlessly reverse the coverage increases Ohio has gained thanks to the ACA, which moves Ohio in the wrong direction.

All told, this bill will pull an estimated $4 trillion out of the US healthcare system by 2036[2], and has the potential to devastate the patients we serve here in Akron, along with the financial health of our integrated delivery system.

Thus, we respectfully request you vote "no" on this bill, and instead voice support for moving forward with deliberate, thoughtful bipartisan efforts to stabilize the insurance

[1] http://avalere.com/expertise/managed-care/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta
[2] Ibid.

markets. We also encourage the continued pursuit of reforms across all healthcare segments that focus on getting better value for our healthcare dollars spent.

Graham-Cassidy-Heller-Johnson is not the answer – it does not protect Ohio's patients, the healthcare professionals who serve them, and will create instability for healthcare employers in Ohio that so often serve as economic engines in our communities.

Thank you.

Dr. T. Clifford Deveny
Interim President and CEO, Summa Health

Robert Gerberry
SVP and General Counsel, Summa Health

Dennis Pijor
President, SummaCare

Sung Lee ACA Story

Dreams of a new life brought Sung Lee and his wife to Akron, Ohio where he was offed a six-figure career. Upon arrival, Sung Lee and his wife lived a successful and happy life, however, things took a turn when he was sent back to Korea. After working several months in Korea for his job site, Sung Lee was able to return to the US and continue working, however, he was shortly let go from his position. Sung Lee is currently in transition of finding a new job to build the American dream for him and his young family, however, he quickly realized that he would need health care during his job transition, however, he quickly realized how expensive health insurance will cost in the United States. Like so many in Ohio and across the country, Sung Lee would have risked facing detrimental health care costs from an unexpected illness or accident. Sung Lee soon realized he could go on the Marketplace and apply for an insurance plan that would temporarily cover him and his wife while he was job searching. If it were not for the Affordable Care Act (ACA) and the assistance Lee was able to receive from certified Navigators, Sung Lee and his family would be without health insurance, something a man who wants to take care of his family would never want to face.

Ms. Fanyun Wu Story

In March 2016, Ms. Fangyun Wu from Toledo, Ohio found herself in the middle of a life changing situation that many often go through in silence. After years of marriage, five beautiful children, and overcoming the rollercoaster of setting up a once-thriving business, Fangyun was filing for divorce. Fangyun came from Taiwan to the United States to pursue higher education. A year later, her spouse also came from Taiwan and united with her, and soon started his own business in California. Finishing education, raising children, and assisting her spouse's business, Fangyun lived a very busy life. After eighteen years of fast paced California life, the couple decided to move to Toledo, Ohio. Life in Toledo, Ohio was good for Fangyun and her children. However, her spouse's business had been struggling since the economy collapsed. The whole family felt the impact, the stress, and went through a depressive phase, while the children in particular suffered from anxiety. In May 2016, Fangyun was legally divorced and became a single mother, living with four children (two college kids, two on the autism spectrum), striving hard for her new career in real estate, while her ex-husband moved with their eldest son to California, striving hard for his new business plan.

Fangyun turned to the Marketplace to find a health insurance plan for her and her family to ensure that they would continue having the health care coverage that they needed. When Fangyun first went onto the Marketplace, she found the website relatively easy to use due to her ability to speak and read English as a second language. Prior to the Marketplace, Fangyun's original health insurance plan with her family cost an average of $1,300 per month. Due to her new financial situation, Fangyun found that two of her children qualified for Medicaid, which never crossed her mind. Fangyun was also able to purchase a Marketplace plan for her and her two college kids that covered their primary care provider and psychiatrist. The Marketplace plan had a monthly premium of $760, however, with the tax subsidy; Ms. Fangyun was able to receive $570 as a tax credit and only paid $190 per month.

Although Fangyun did not ever think that the Affordable Care Act would impact her life as a self-sufficient immigrant and business woman, she quickly found that through the ACA, she was able to receive health care coverage with peace of mind. Fangyun was able to continue her therapy sessions and recover from depression. She transitioned from seeing her psychiatrist once a week, to once a month, and now, it has been 3 months since her last appointment. Without the ACA, Fangyun would not have been able to afford the health insurance premium, whereas now, she can focus on being a mother and building her real estate business.

At the end of May 2016, Fangyun attended an Asian Leadership Roundtable Meeting hosted by Asian Services in Action (ASIA) where she learned about how to become civically involved in the Toledo area. It was at that time she got connected with Tiffany Budzinski who coordinated with ASIA to bring the ACA workshop to the Toledo Asian communities. Fangyun offered to work with Tiffany and her partner (who is a certified Navigator) to conduct outreach and education events throughout Toledo to educate the Chinese community about the Affordable Care Act. Fangyun helped to conduct and coordinate three ACA workshops as the Chinese interpreter to ensure that others knew the benefits of the Marketplace. It was open-enrollment time, and with the Navigator's assistance Fangyun was able to acquire a new, more fitting health plan.

Ms. Fangyun hopes that as elected officials make decisions this week on the future of the Affordable Care Act, that they step into the shoes of those affected by the ACA and to really think about what they would do if they could no longer afford health insurance. She asks that they ask themselves, "If I am a hard working individual and going through a hard time in life right now, how would I want the government to help me in a time of need?" Fangyun believes that with this mindset, elected official can make decisions that would lessen the burden and maximize the benefit to the people who need it the most.
When asked to reflect on Fangyun's experience with the Marketplace and how it has impacted her life, Fangyun quotes, "Because of the subsidy, I can afford the Health Insurance I need to cover my family. It has helped me a lot. I have less to worry about and feel much better. Now I am able to focus on being a mom, building my business, and enjoying my new beginning."

Ms. Mary story

Mary wants to share her story about how important the ACA and Medicaid is to her. She recently became enrolled in the Medicaid adult program which was made possible by President Obama's Affordable Care Act. Currently, her sole source of income is her monthly Social Security Disability Income. She has a number of chronic health issues which has become debilitating and will continue to worsen, leading to her eventual demise. She is scheduled to start chemotherapy within the next 3 months, which will just be the beginning of an ongoing process. She is the poster child of "pre-existing conditions." Without the ACA, she would be a dead man walkin. Mary believes that the idea of "high risk pools" is a joke. These would shut out all but the very wealthy with exorbitant premiums, deductibles, and co-pays. To say that the ACA has literally saved her life is no "covfefe." She also believes that the bottom line is that losing the ACA will cause people far more harm than any extremist group or any terrorist group, or any refugees, or immigrants- which our current administration sees as being such a threat. Losing the ACA means losing lives, all because we will no longer have access to Healthcare. How does that make American Great Again?

UACT Urges U.S. Senators to Protect Patients

By: UACT Staff On: September 22, 2017

Today, Manon Ress, Founder and Acting Director of the Union for Affordable Cancer Treatment, delivered a letter to 17 Republican Senators, urging them to vote no on the Graham-Cassidy "health care" bill.

UACT visited Senate leadership, including Majority Leader Sen. Mitch McConnell (R-KY) and Majority Whip John Cornyn (R-TX), as well as the original authors of the bill, Bill Cassidy (R-LA) and Lindsey Graham (R-SC). Additional letters were delivered to the GOP members of the Senate Committee on Health, Education, Labor and Pensions, and to key Senators who could stop this bill.

The full copy of UACT's letter can be found copied below and is available as a pdf here.

The Graham-Cassidy health care bill is not a plan for providing healthcare to millions of Americans, but rather would deny affordable coverage to individuals when they need it most. While the Republican leadership pushes for a vote before the Congressional Budget Office has even assessed the impact on Americans, independent analyses have found that the bill would be disastrous for cancer patients.

The Center for American Progress estimated a premium surcharge of $142,650 for individuals with metastatic cancer if the legislation were to be enacted. The same analysis found an estimated increase in premium of $72,980 for lung and brain cancers and $28,660 for colorectal, kidney, and breast cancers in individuals younger than 50.

Sen. Rand Paul (R-KY) and Sen. John McCain (R-AZ) have announced publicly that they will not support this plan. Under Senate budget reconciliation rules, the Republicans can pass this legislation through September 30th with a simple 51 vote majority. If any one more Republican makes the moral and responsible choice in voting no on this legislation, the bill will fail.

To: GOP Members of US Senate

Re: Graham-Cassidy Health Care Bill

Date: September 22, 2017

Dear GOP Senators:

I am addressing this only to GOP Senators because apparently you are the only ones who are considering to vote for the Graham-Cassidy health care bill.

I am a stage 4 breast cancer patient. I am alive and doing well now because I have insurance through the Affordable Care Act, and access to a drug that is keeping me alive. The insurance premiums are high, mostly because there are insufficient cost control measures for health care, including the insane prices for new cancer drugs.

If the Graham-Cassidy bill passes, patients like me who have prior medical conditions are highly likely to be confronted with even higher premiums and gaps in coverage.

This is a life and death issue for me and probably for your own constituents and extended family members if you bothered to check.

I would like you to kill the Graham-Cassidy bill, so the Graham-Cassidy bill does not kill me.

Sincerely,

Manon Anne Ress. PhD.

Acting Director and Co-founder, Union for Affordable Cancer Treatment

--

Kim Treanor

Knowledge Ecology International

kim.treanor@keionline.org

tel.: +1.202.332.2670

United States Senate
Washington, D.C. 20510

September 25, 2017

Dear United States Senators,

On behalf of YWCA USA, I write to urge you to oppose the efforts that are currently underway to repeal the Affordable Care Act (ACA). The proposed "Graham-Cassidy Proposal," much like the Better Care Reconciliation Act of 2017 (BRCA), the House-passed American Health Care Act (AHCA), the so-called "skinny repeal," and other proposals to repeal the ACA that came before it, would lead to the same outcome: Americans losing coverage, loss of critical protections, and rising costs.

eliminating racism
empowering women
ywca

YWCA USA
1020 19th Street NW, Suite 750
Washington, DC 20036
P 202.835.2362
F 202.467.0802
ywca.org

As we have emphasized throughout the year, the ACA provides a healthcare lifeline for 9.5 million women who could not otherwise afford health insurance, and has been particularly beneficial for women of color, whose uninsured rates have dropped dramatically. Many survivors of domestic and sexual violence and childhood trauma—who need health care immediately after an assault and may also need longer-term care to address physical and mental health problems caused by an attack, abuse in childhood, or by a partner's ongoing violence—have been able to get the care they need, when they need it, since the ACA was enacted. As one of the largest providers of domestic violence services in the country, preserving the ACA's protections for survivors is of utmost concern to us.

YWCA USA is deeply concerned that the latest effort to repeal and replace the ACA would still lead to significant losses of coverage and threaten many provisions that are critical to women's health, including essential health benefits, coverage for pre-existing conditions, access to reproductive health services, and a strong Medicaid program. There is too much at stake—for women, communities of color, and survivors of gender-based violence—for Congress to move forward with repealing the ACA, or with replacing it with the Graham-Cassidy proposal.

YWCA USA continues to maintain that any health care legislation must uphold—and states must not be allowed to waive—key provisions of the ACA, including:

- **Coverage for the full array of essential health benefits**—preventive care (like mammograms, cervical cancer screenings, and domestic violence screenings), pregnancy and childbirth coverage, pediatric care, outpatient care and hospitalization, mental health and substance abuse services, chronic disease management, emergency services, lab services, and prescription drugs—that the ACA mandates for low income people in the Medicaid program, and for people who have health insurance through the healthcare exchanges, or have certain other individual and employer plans.
- **Protections for survivors of domestic violence** so that they are not penalized if their abusers block their access to health coverage.
- **A structurally sound, well-funded Medicaid program** that is available to all individuals who meet established income levels, including people who gained health coverage through their state's expansion of Medicaid eligibility. This also means a strong Medicaid program that maintains both the expansion and the current financing structure, without block grants or per-capita caps.

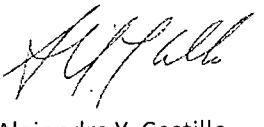
- **The full range of reproductive health services for women and girls,** including continued Medicaid funding for Planned Parenthood, which is often the only women's health provider in many communities.
- **Full and affordable coverage for people with pre-existing conditions,** so that they can get the care they need without fear of being denied or cut off from coverage when the costs for surgery, cancer, diabetes, or other health conditions run high.

Beyond the impact of this legislation on health care coverage, affordability, and accessibility, we remain alarmed by the Senate's "behind closed doors" process that continues to prevent bipartisan collaboration to address policy issues of such significant importance. Legislators on both sides of the aisle must have both the time and opportunity to participate in a meaningful, open, and transparent process of multiple committee hearings to fully vet the impact of this proposal. Constituents must have the opportunity to understand how legislation would affect their access to and quality of care, *before* legislation is brought to a vote.

The Senate Finance Committee's hearing scheduled for September 25 does little to allay these concerns, particularly in light of Senator Alexander's announcement this week that he was terminating bipartisan negotiations with Senator Murray to find an agreeable deal to stabilize markets and strengthen the existing ACA structure. Ending bipartisan negotiations to rapidly push through another proposal designed behind closed doors, with little time for input from the public, is not the open and transparent process that democracy demands. Moreover, sound policy decisions cannot be achieved without a final Congressional Budget Office (CBO) score, which will not be available prior to the vote on this legislation.

YWCA USA believes that repeal of the Affordable Care Act, especially without a viable replacement plan that has been fully and publicly vetted through a bipartisan process, is incredibly harmful to the women and girls across the country who are at the heart of our mission. Accordingly, **we urge you to vote against the Graham-Cassidy proposal**, any other repeal efforts currently under consideration in the Senate, and any amendments that would undermine the gains for women and girls in health care coverage, affordability, and accessibility that have been achieved under the ACA.

Best Regards,



Alejandra Y. Castillo
CEO, YWCA USA

YWCA USA is on a mission to eliminate racism, empower women, stand up for social justice, help families, and strengthen communities. Our more than 50,000 employees and volunteers in 47 states and the District of Columbia help over 2 million women, girls, and their families each year at YWCAs across the country. To read more about YWCA USA, visit www.ywca.org.

eliminating racism
empowering women
ywca

YWCA USA
1020 19th Street NW, Suite 750
Washington, DC 20036
P 202.835.2362
F 202.467.0802
ywca.org

September 25, 2017

Dear Senate Majority Leader McConnell, Senate Minority Leader Schumer, House Speaker Ryan, and House Democratic Leader Pelosi,

As current and former state insurance commissioners, we urge you to oppose the health care repeal legislation that has been proposed by Senators Bill Cassidy and Lindsey Graham. Instead, we ask that you work toward a bipartisan bill that would improve market stability. At a time when state insurance markets urgently need greater stability and predictability, this bill would go in the wrong direction.

The Cassidy-Graham bill would increase the number of people without health coverage and severely disrupt states' individual insurance markets, with sharp premium increases and insurer exits likely to occur in the short term and over time. The bill would immediately (in fact, retroactively) eliminate the individual mandate, which serves as a key incentive for healthier people to enroll in coverage, and would put no alternative incentives in place. In 2020, the Cassidy-Graham bill would eliminate both federal subsidies that help people afford private plans in the individual market and funding for expanded Medicaid, replacing them with a reduced block grant that would fail to keep up with growing costs and needs. All 50 states and the District of Columbia would have to set up their own coverage programs and make significant changes to insurance market rules by January 1, 2020 – an unreasonable timeline that hampers states' review of premium rates and insurers' efforts to price and plan for the future.

Many states would weaken or eliminate core protections that consumers in the individual market have come to rely on, such as the requirement to cover the essential health benefits and the ban on charging people higher premiums because they have pre-existing medical conditions. Instead of insurers competing based on the price and quality of their plans, they would vie to avoid the sickest enrollees and cover as few benefits as possible. Few if any states would be able to afford to offer the robust subsidies that are needed both to make coverage affordable and to ensure a stable risk pool. After 2026, the block grant funding would evaporate under Cassidy-Graham, leaving states to figure out how to fill giant holes in their budgets.

This series of disruptions – over the short, medium, and longer terms – would batter state insurance markets and the consumers that they serve. While we are strong supporters of state flexibility and state regulation of health insurance, the Cassidy-Graham bill puts states in an impossible position.

In just six weeks, open enrollment for individual-market coverage is scheduled to begin. Certainty, not further disruption, is what's needed now. We urge you to reject the Cassidy-Graham proposal and instead focus on efforts to pass bipartisan legislation that would help to stabilize the individual market.

Signed,

Current Commissioners

Jessica Altman, Acting Insurance Commissioner, Pennsylvania

John G. Franchini, Insurance Superintendent, New Mexico

Marie Ganim, Health Insurance Commissioner, Rhode Island

Gordon I. Ito, Insurance Commissioner, Hawaii

Dave Jones, Insurance Commissioner, California

Mike Kreidler, Insurance Commissioner, Washington

Mike Rothman, Commissioner, Minnesota Department of Commerce

Marguerite Salazar, Colorado Insurance Commissioner

Jean Straight, Oregon Insurance Director, Acting Director, Dept. of Consumer and Business Services

Stephen C. Taylor, Commissioner, District of Columbia

Maria T. Vullo, Superintendent of Financial Services, New York

Former Commissioners

Joel Ario, Oregon and Pennsylvania

Brian Atchinson, Maine

Jane L. Cline, West Virginia

John Garamendi, California

Steven M. Goldman, New Jersey

Jorge Gomez, Wisconsin

Thomas E. Hampton, District of Columbia

J. Robert Hunter, Texas

Alessandro Iuppa, Maine

Mila Kofman, Maine

Christopher F. Koller, Rhode Island

Steven B. Larsen, Maryland

Monica Lindeen, Montana

Sally McCarty, Indiana

Michael McRaith, Illinois

Teresa D. Miller, Oregon and Pennsylvania

Lawrence Mirel, District of Columbia

John Morrison, Montana

Earl Pomeroy, North Dakota

Sandy Praeger, Kansas

Beth Sammis, Maryland

Kathleen Sebelius, Kansas

Karen Weldin Stewart, Delaware

Susan E. Voss, Iowa

William P. White, District of Columbia

The Leadership Conference
on Civil and Human Rights

1620 L Street, NW
Suite 1100
Washington, DC
20036

202.466.3311 voice
202.466.3435 fax
www.civilrights.org

September 25, 2017

Oppose the Graham-Cassidy Plan
Which Will Destroy Medicaid, End the Medicaid Expansion, and Defund Planned Parenthood

Dear Senator:

On behalf of The Leadership Conference on Civil and Human Rights, the National Health Law Program, the National Partnership for Women & Families, and the undersigned 234 organizations, we urge you to oppose the Graham-Cassidy proposal (Graham-Cassidy). This proposal will eliminate affordable quality health care for millions of Americans by gutting the Affordable Care Act (ACA); slash federal funding and destroy Medicaid by turning its funding into per capita caps; eliminate the Medicaid expansion; and defund Planned Parenthood health centers. Graham-Cassidy would leave tens of millions of people in the United States significantly worse off than under current law. Without a full score from the Congressional Budget Office (CBO), we do not yet have a complete understanding of the full devastation that Graham-Cassidy would bring, but what we do know is more than enough for all our organizations to unequivocally oppose this bill. We strongly urge you to oppose the Graham-Cassidy proposal and urge Congress to instead move forward with bipartisan efforts on market stabilization and other critical issues to improve access to affordable health care for all people in the United States.

The ACA and Medicaid are critical sources of health coverage for America's traditionally underserved communities, which our organizations represent. This includes individuals and families living in poverty, people of color, women, immigrants, LGBTQ individuals, individuals with disabilities, seniors, and individuals with limited English proficiency.

The ACA has reduced the number of people without insurance to historic lows, including a reduction of 39 percent of the lowest income individuals.[i] The gains are particularly noteworthy for Latinos, African Americans, and Native Americans. Asian Americans, Native Hawaiians and Pacific Islanders have seen the largest gains in coverage. The nation and our communities cannot afford to go back to a time when they did not have access to comprehensive, affordable coverage. Further, due to the intersectionality between factors, such as race and disability, or sexual orientation and uninsurance, and issues faced by women of color, many individuals may face additional discrimination and barriers to obtaining coverage if the ACA is weakened as a result of this bill.

Medicaid is also critically important, as it insures one of every five individuals in the United States, including one of every three children, 10 million people with disabilities, and nearly two-thirds of people in nursing homes. Medicaid coverage, including the Medicaid expansion, is particularly critical for underserved individuals and especially people of color, because they are more likely to be living with certain chronic health conditions, such as diabetes, which require ongoing screening and services. People of color represent 58 percent of non-elderly Medicaid enrollees.[ii] According to the Kaiser Family Foundation, African Americans comprise 22 percent of Medicaid enrollment, and Hispanics comprise 25

percent.[iii] Medicaid also serves as a crucial program for Asian Americans, 17 percent of whom receive Medicaid, and Native Hawaiian and Pacific Islanders, 37 percent of whom receive Medicaid.[iv]

People of color are more likely than White non-Hispanics to lack insurance coverage and are more likely to live in families with low incomes and fall in the Medicaid gap.[v] As a result, the lack of expansion disproportionately affects these communities, as well as women, who make up the majority of poor uninsured adults in states that did not expand Medicaid. For people of color who experienced some of the largest gains in health coverage since the implementation of the ACA and Medicaid expansion, the Graham-Cassidy proposal could mean vastly reduced access to needed health care, increased medical debt, and persistent racial disparities in mortality rates.[vi] Further, Medicaid provides home and community-based services enabling people with disabilities to live, work, attend school, and participate in their communities. The proposed cuts would decimate the very services that are cost-effective and keep individuals out of nursing homes and institutions. Finally, one in five people with Medicare rely on Medicaid to cover vital long-term home care and nursing home services, to help afford their Medicare premiums and cost-sharing, and more.

Despite the common myth that all low-income people could enroll in Medicaid, the Medicaid program had previously only been available to certain categories of individuals (e.g., children, pregnant women, seniors, people with disabilities) who had little to no savings or assets. Parents of children and childless adults were often excluded from Medicaid or only the lowest income individuals in these categories were eligible. For example, the Medicaid expansion greatly expanded coverage for LGBTQ individuals who previously did not fit into a traditional Medicaid eligibility category and for working people struggling in jobs that do not offer health insurance and pay at or near the minimum wage. Yet the Graham-Cassidy proposal repeals Medicaid expansion and cuts billions from Medicaid itself which will force states to cut eligibility and services.

We do not yet have a full CBO score that tells us how many people would have Medicaid or marketplace coverage taken away from them under the Graham-Cassidy bill, and we will not have that estimate before legislation may come up on the Senate floor. But the analysis that is already available provides a stark picture, one in which Graham-Cassidy would decimate the Medicaid program as we know it, end the Medicaid expansion, defund Planned Parenthood health centers, and rescind tax credits and cost-sharing reductions currently available to low-income individuals to purchase private coverage.

The Graham-Cassidy bill makes fundamental changes to both the Medicaid expansion and the traditional Medicaid program, as well as dismantling ACA's reforms to the individual market. Graham-Cassidy destroys the Medicaid program, ending the federal-state partnership and dramatically altering the structure of the program by implementing a per capita cap. The bill would cut billions of dollars of funding to states, limiting the federal contribution to states based on a state's historical expenditures, which would be inflated at a rate that is projected to be less than the annual growth of Medicaid costs.[vii] Any costs above the per capita caps would be the sole responsibility of states, regardless of the cost of care. As a result, per capita caps will cause deep cuts in care for people with disabilities, seniors, women, and people of color who qualify for Medicaid. Women, who comprise the majority of Medicaid adult enrollees, would be particularly harmed, with women of color disproportionately impacted. Thirty percent of African-American women and 24 percent of Hispanic women aged 15-44 are enrolled in Medicaid.[viii] The move to per capita caps would also disproportionately harm people with disabilities, with home- and community-based services likely targeted for cuts by many states. The move to per capita caps may also give states the option to turn the entire Medicaid program into a block grant.

With regard to the Medicaid expansion, under the Graham-Cassidy plan, ACA tax credits and Medicaid expansion funding would be converted into block grants to states. The Medicaid expansion would effectively end at the beginning of 2020, and the block grants would end entirely in 2026. Graham-Cassidy would cut funding for the expansion under the new block grant system, with funding for the block grants set at 17 percent less than current funding, providing insufficient funds to maintain ACA coverage levels. Beginning in 2021, Graham-Cassidy would also redistribute this reduced federal funding stream across states based on their share of low-income residents instead of their actual spending needs, punishing states that have enrolled more low-income people. Furthermore, and deeply troubling, the legislative language describing what purposes the block grants could be used for is very broad, with no requirement that block grant funds even be used to aid low or moderate-income people.

As the Center on Budget and Policy Priorities has noted, once the block grant funding stops in 2026, Graham-Cassidy would effectively repeal the ACA's major coverage provisions without a replacement. CBO has previously estimated that this approach would result in 32 million more people being uninsured.[ix] Graham-Cassidy is even more harmful than prior repeal approaches however, in part because states could not continue to cover Medicaid expansion enrollees in Medicaid with less federal funding.

Furthermore, we are very concerned that Graham-Cassidy gives states the option to impose a work requirement as a condition of eligibility under the Medicaid program. Such a requirement not only fails to further the purpose of providing health care but also undermines this objective. Among adults with Medicaid coverage, nearly 8 in 10 live in working families and a majority are working themselves.[x] This work requirement would include penalizing any woman who does not meet work requirements just 60 days after the end of her pregnancy.

In addition, Graham-Cassidy would single out Planned Parenthood by blocking federal Medicaid funds for care at its health centers. The "defunding" of Planned Parenthood would prevent more than half of its patients from getting affordable preventive care, including birth control, testing and treatment for sexually transmitted diseases, breast and cervical cancer screenings, and well-women exams at Planned Parenthood health centers, often the only care option in their area. This loss of funds will have a disproportionate effect on low income families and people of color who make up 40 percent of Planned Parenthood patients.[xi] Seventy-five percent of Planned Parenthood patients are at or below 150 percent of the federal poverty level and half of their health centers are in rural or underserved areas.[xii] One in five women in the United States have relied on Planned Parenthood for healthcare in her lifetime.

Lastly, we are seriously concerned about the lack of transparency of the discussions leading to Graham-Cassidy, and the rush now to vote on the bill without adequate time for analysis, hearings, and a full CBO score, which would provide opportunity for both lawmakers and the public to understand the proposed legislation and participate in this discussion in which their very access to health care for themselves and their families is at stake. It is unconscionable to even contemplate dramatically altering one-sixth of the U.S. economy and taking away health care from millions of people without a full CBO score in hand, along with adequate time to review the CBO's findings and debate the Graham-Cassidy bill with all the facts.

We urge you to oppose passage of the Graham-Cassidy bill and instead focus on moving forward with bipartisan efforts on market stabilization and other critical issues to improve access to affordable health care for all people in the United States. If you have any questions, please feel free to contact The Leadership Conference Health Care Task Force Co-chairs Katie Martin at the National Partnership for Women & Families (kmartin@nationalpartnership.org), Mara Youdelman at the National Health Law

The Leadership Conference

Program (youdelman@healthlaw.org), or Emily Chatterjee at The Leadership Conference (chatterjee@civilrights.org).

Sincerely,

The Leadership Conference on Civil and Human Rights
National Health Law Program (NHeLP)
National Partnership for Women & Families
ACCESS
Access Living
ADAP Advocacy Association (aaa+)
Advocates for Youth
AFL-CIO
African Coalition
AFSCME
AIDS Foundation of Chicago
American Academy of Nursing
American Association of Colleges of Pharmacy
American Association of People with Disabilities (AAPD)
American Association of University Women (AAUW)
American Atheists
American Civil Liberties Union
American Federation of Teachers
American Nurses Association
American Public Health Association
American-Arab Anti-Discrimination Committee
Amida Care
Amnesty International USA
APLA Health
APSE--Association of Persons Supporting Employment First
Asian & Pacific Islander American Health Forum
Asian & Pacific Islander Caucus for Public Health (APIC)
Asian American Drug Abuse Program, Inc.
Asian Americans Advancing Justice | AAJC
Asian Americans Advancing Justice-Los Angeles
Asian Law Alliance
Asian Pacific American Labor Alliance, AFL-CIO (APALA)
Asian Pacific Policy and Planning Council
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Programs for Rural Independent Living
Association of Reproductive Health Professionals
Association of University Centers on Disabilities
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Bend the Arc Jewish Action
Black Women's Blueprint
Black Women's Health Imperative
Black Women's Roundtable

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Black Womens Roundtable, National Coalition on Black Civic Participation
Black Youth Vote!
Breast Cancer Action
Cascade AIDS Project
Center for American Progress
Center for Community Change Action
Center for Law and Social Policy (CLASP)
Center for Medicare Advocacy
Center for Popular Democracy
Center for Reproductive Rights
Children's Defense Fund
Children's Health Fund
Chinatown Service Center
Coalition for Disability Health Equity
Coalition of Labor Union Women
Coalition on Human Needs
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Commission on the Public's Health System
CommonHealth ACTION
Communications Workers of America (CWA)
Community Access National Network (CANN)
Council for Native Hawaiian Advancement
Council of Mexican Federations in North America (COFEM)
Crescent City Media Group
Disability Rights Education & Defense Fund
Drug Policy Alliance
EMILY's List
Empowering Pacific Islander Communities
Equal Justice Society
Equal Rights Advocates
Equality California
Equality Federation
Families USA
Family Equality Council
Family Voices
Farmworker Justice
Feminist Majority
Friends of the Earth
GLMA: Health Professionals Advancing LGBT Equality
Global Justice Institute
Guam Communications Network
Health & Medicine Policy Research Group
Health Care for America Now (HCAN)
Health Justice Project
Healthy House Within A Match Coalition
Heartland Alliance for Human Needs & Human Rights
Hepatitis B Foundation and Hep B United
Hispanic Health Network

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HIV Medicine Association
Human Rights Campaign
Human Rights Watch
Illinois Public Health Association
Indivisible
International Association of Official Human Rights Agencies
International Association of Women in Radio and Television, USA
International Institute of the Bay Area
Japanese American Citizens League
Jewish Council for Public Affairs
Jewish Women International
Justice in Aging
Korean Community Services of Metropolitan NY
La Cooperativa Campesina de California
Labor Council for Latin American Advancement (LCLAA)
Lambda Legal
Latino Commission on AIDS
Latinos in the Deep South
Lawyers' Committee for Civil Rights Under Law
LBGT PA Caucus of the American Academy of Physician Assistants, Inc.
League of United Latin American Citizens
League of Women Voters of the United States
LEAnet, a national coalition of local education agencies
LPAC
Main Street Alliance
Matthew Shepard Foundation
Medicare Rights Center
Metropolitan Community Churches
Mi Familia Vota
MomsRising
Movement Advancement Project
MoveOn.org Civic Action
NAACP
NAPAFASA
NARAL Pro-Choice America
NASTAD
NASW-NYC Committee on Health
National African American Drug Policy Coalition Inc.
National Asian Pacific American Women's Forum (NAPAWF)
National Association of County and City Health Officials
National Association of County Behavioral Health and Developmental Disability Directors & National Association for Rural Mental Health
National Association of Human Rights Workers
National Association of Social Workers (NASW)
National Association of Social Workers New York City Chapter
National Black Justice Coalition
National CAPACD
National Center for Law and Economic Justice

National Center for Learning Disabilities
National Center for Lesbian Rights
National Center for Transgender Equality
National Coalition on Black Civic Participation
National Collaborative for Health Equity
National Congress of American Indians
National Council of Asian Pacific Americans (NCAPA)
National Council of Asian Pacific Islander Physicians
National Council of Churches
National Council of Jewish Women
National Council on Independent Living
National Disability Rights Network
National Domestic Workers Alliance
National Down Syndrome Congress
National Education Association
National Employment Law Project
National Fair Housing Alliance
National Family Planning & Reproductive Health Association
National Hispanic Media Coalition
National Hispanic Medical Association
National Immigrant Justice Center
National Immigration Law Center
National Institute for Reproductive Health
National Latina Institute for Reproductive Health
National LGBTQ Task Force Action Fund
National Low Income Housing Coalition
National Network for Arab American Communities (NNAAC)
National Network to End Domestic Violence
National Organization for Women
National Urban League
National Women's Health Network
National Women's Law Center
National Women's Political Caucus
NETWORK Lobby for Catholic Social Justice
NICOS Chinese Health Coalition
NOBCO: National Organization of Black County Officials
OCA - Asian Pacific American Advocates
OneAmerica
Organizing for Action
Organizing for Action-Springfield
Out2Enroll
People for the American Way
PFLAG National
Philadelphia Unemployment Project
Planned Parenthood Federation of America
PolicyLink
Population Connection Action Fund
Population Institute

Positive Women's Network - USA
Presbyterian Church (USA) member
Presbyterian Feminist Agenda Network
Presbyterians Affirming Reproductive Options (PARO)
Prevention Institute
Prism Health
Progressive Leadership Alliance of Nevada
Project Inform
Public Citizen
Raising Women's Voices for the Health Care We Need
Resource Center
San Francisco AIDS Foundation
Service Employees International Union (SEIU)
Sexuality Information and Education Council of the U.S. (SIECUS)
SisterSong: National Women of Color Reproductive Justice Collective
SiX Action
Slow Roll Chicago
South Asian Bar Association of North America Health Law Section
South Asian Network (SAN)
Southeast Asia Resource Action Center
Southern Poverty Law Center
TASH
The AIDS Institute
The Alliance
The Arc of the United States
The National Campaign to Prevent Teen and Unplanned Pregnancy
The Trevor Project
The United Methodist Church -- General Board of Church and Society
The Voter Participation Center
Trust for America's Health
UCHAPS: Urban Coalition for HIV/AIDS Prevention Services
UMOS Inc
UnidosUS
Union for Reform Judaism
United Church of Christ, Justice and Witness Ministries
URGE: Unite for Reproductive & Gender Equity
US Women and Cuba Collaboration
Venas Abiertas
Voices for Progress
West Pinellas National Organization for Women (NOW-FL)
Wisconsin Alliance for Women's Health
Women Employed
Women's Action Movement
Women's Intercultural Network (WIN)
Women's Media Center
Women's Missionary Society African Methodist Episcopal Church
Women's Voices Women Vote Action Fund
Woodhull Freedom Foundation

The Leadership Conference

Working America
Young Invincibles
YWCA USA

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[i] U.S. Department of Health and Human Services, Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage, pp. 2, 4 (Sept. 29, 2016), available at https://aspe.hhs.gov/sites/default/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf.

[ii] Kaiser Family Foundation, Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity: 2015, available at http://kff.org/medicaid/state-indicator/rate-by-raceethnicity-3/?currentTimeframe=0.

[iii] Kaiser Health Foundation, Medicaid Enrollment by Race/Ethnicity, available at http://kff.org/medicaid/state-indicator/medicaid-enrollment-by-raceethnicity/.

[iv] Summary Health Statistics: National Health Interview Survey, 2015, Table P-11a, Age-adjusted percent distributions (with standard errors) of type of health insurance coverage for persons under age 65 and for persons aged 65 and older, by selected characteristics: United States, 2015, ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-11.pdf.

[v] Kaiser Family Foundation, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[vi] Center on Budget and Policy Priorities, African Americans Have Much to Lose Under House GOP Health Plan, available at http://www.cbpp.org/blog/african-americans-have-much-to-lose-under-house-gop-health-plan.

[vii] National Health Law Program, Top 10 Changes to Medicaid Under the Graham-Cassidy Bill (Sept. 14, 2017), available at http://www.healthlaw.org/issues/medicaid/medicaid-expansion-toolbox/issues-a-advocacy/top-10-changes-to-medicaid-under-graham-cassidy-bill.

[viii] Guttmacher Institute, Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters (July 14, 2016), available at https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters.

[ix] Center on Budget and Policy Priorities, Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market (Sept. 18, 2017), available at https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.

[x] Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work, available at http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[xi] Planned Parenthood, This is Who We Are, (July 11, 2016), available at https://www.plannedparenthood.org/files/6814/6833/9709/20160711_FS_General_d1.pdf

[xii] Planned Parenthood, The Urgent Need for Planned Parenthood Health Centers (Dec. 7, 2016), available at https://www.plannedparenthood.org/files/4314/8183/5009/20161207_Defunding_fs_d01_1.pdf.

SEIU
Stronger Together

September 25, 2017

The Honorable Orrin G. Hatch
Chairman
U.S. Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Graham-Cassidy-Heller-Johnson Legislation

Dear Chairman Hatch, Ranking Member Wyden, and Members of the Senate Finance Committee:

On behalf of the two million members of the Service Employees International Union ("SEIU"), I voice our categorical opposition to the Graham-Cassidy-Heller-Johnson ("Graham-Cassidy") legislation, and all amendments and legislation that would repeal the Affordable Care Act ("ACA") and destroy the Medicaid program. The supporters and authors of Graham-Cassidy claim it provides "state flexibility," but in reality the legislation will severely hinder the ability of states to provide adequate care and coverage to their residents. As a result of the severe cuts, states will have massive budget shortfalls resulting in cuts to care and services. Millions of people across the country, including health care workers, have come together to make clear that they do not support this or other damaging proposals put forth by the Republican Caucus. It is reprehensible to put the health, lives, and financial security of millions at risk, simply for a political win.

Once again, Senators are pushing towards a vote without clearly understanding the impact of legislation that will touch one sixth of the US economy and could literally mean life or death for people. A sham "congressional hearing" held one day before the Senate will potentially begin consideration of Graham-Cassidy without any debate is not an honest effort to educate the American people about the implications this bill. In fact, the Congressional Budget Office ("CBO") has already stated that they will not be able to provide a full analysis of the Graham-Cassidy proposal before the reconciliation instructions are set to expire on September 30th. The bill's authors are using this deadline to coerce their colleagues into voting on this legislation, and that is irresponsible by any measurement, including their own previous stances just this year.

While the CBO will not have time to properly analyze the impact of the legislation, preliminary analysis by the Center for American Progress, partially derived from past CBO data, demonstrates that under Graham-Cassidy, an estimated 32 million people stand to lose coverage. Graham-Cassidy replaces Medicaid expansion and payments that help people afford their premiums in the health insurance marketplaces with a capped and temporary block grant to states. According to *Avalere*, from 2020-2027 states would face cuts of $326 billion, or 21% less in federal funding, compared to what the ACA would have

SERVICE EMPLOYEES
INTERNATIONAL UNION
CTW, CLC

1800 Massachusetts Ave., NW
Washington, DC 20036

202.730.7000

www.SEIU.org

provided. Even worse, the Graham-Cassidy bill ends these policies completely after 2027, creating a scenario that could be very similar to repeal without replace proposals, leaving tens and millions with no coverage at all.

In addition, the legislation allows states to opt out of ACA protections, like those that prevent insurance companies from discriminating against people based on age or pre-existing conditions. This means that people with pre-existing conditions or people who are older could pay significantly more out of pocket for their coverage compared to current law. This issue is compounded by the fact that under the proposal, states may choose not to require that plans cover essential health benefits, such as maternity care, prescription drugs, and mental health services, which are now ensured under the law. This will leave those affected on the hook for the complete cost of care for the uncovered categories of benefits.

Furthermore, the bill would transform the traditional Medicaid program to a per-capita cap structure under which federal Medicaid funding would be capped irrespective of states' actual costs. According to an analysis by *Avalere,* the result would be deep cuts of nearly $164 billion by 2027. When combined, the cuts included in the per capita caps and Medicaid block grants reduce federal spending by $490 billion, or by 10.1%, compared to the ACA. Cutting hundreds of millions from the Medicaid program will put at risk health-related services for 74 million low-income individuals, children, people with disabilities, and seniors. For many of these individuals, specifically the aged and disabled populations, the ability to live with dignity and remain in their communities rather than institutions is contingent on their access to health care and services through Medicaid. In addition, states—which must balance budgets and already face fiscal pressures—will not be able to make up the lost federal dollars and will be forced to deny coverage. We also have serious concerns that hospitals, especially those that serve communities that may not have access to many providers, could be forced to close or cut back services, further reducing access to care in underserved areas. The inevitable result will be that Graham-Cassidy will make it much harder for people to get the care they need and for families to support their loved ones.

Every day, we hear from our members and others who are increasingly alarmed about their patients' and their families' futures not only because they rely on ACA and Medicaid coverage for healthcare, but because their jobs and ability to support their families are being put at risk by politicians who refuse to listen to their constituents. Decimating federal healthcare funding, most significantly through Medicaid cuts, will have a broad impact on local economies. These cuts will likely put a damper on future growth in healthcare jobs, which according to the Bureau of Labor Statistics (BLS) are among the fastest growing jobs in the country. And the effect on workers and jobs is not limited to the health care sector alone – multiple analyses demonstrate that significant cuts to health care funding like those included in Graham-Cassidy will stymie job creation in industries throughout the economy.

Finally, the bipartisan effort in the Senate Health, Education, Labor, and Pensions ("HELP") Committee to improve the ACA offered a chance for Congress to move meaningful legislation through regular order with input from the American people and stakeholders, and to arrive at a bipartisan compromise. The Graham-Cassidy legislation has sabotaged Senate HELP's negotiations in order to pressure Senate Republicans to vote for a proposal that has not been fully analyzed, and has had no input from anyone but the Senators who authored the bill behind closed doors. These partisan efforts to change or repeal the law have repeatedly failed, primarily due to Americans coming together, making their voice heard and standing up to protect their care. It is grossly inappropriate for Congress to treat health care like a

political football while Americans are facing greater uncertainty in their lives. There is still time to drop this effort and return to regular order to develop bipartisan legislation to improve the ACA. We stand ready to work with you on real improvements that make care more affordable and available for all. The message the American people are sending is clear: Congress should come together, work to find a bipartisan solution to improve the ACA and stop trying to repeal the law and destroy Medicaid.

For these reasons, SEIU opposes Graham-Cassidy or similar proposals. For additional information please contact Ilene Stein, Assistant Legislative Director, at Ilene.Stein@seiu.org or (202)-730-7216.

Sincerely,

Mary Kay Henry
International President

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afl-cio, clc

cc: Members of the U.S. Senate Finance Committee