

May 22, 2017

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

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

Dear Leader McConnell and Minority Leader Schumer:

The undersigned organizations share a commitment to protecting and strengthening the Medicare and Medicaid programs for today's beneficiaries and for future generations. We strongly oppose provisions in the American Health Care Act (AHCA) that would undermine the Medicare program's finances and threaten access to needed services for people dually eligible for Medicare and Medicaid. We urge the Senate to reject the AHCA and to engage in a transparent, bipartisan dialogue on needed reforms to enhance health care access and affordability for older adults, people with disabilities, and their families.

Starting in 2023, the AHCA would repeal the Affordable Care Act (ACA) payroll tax increase on the wealthiest Americans, which currently amounts to a 0.9% increase for individual workers with incomes of more than \$200,000 and for couples earning more than \$250,000. The elimination of this tax increase is estimated to reduce federal revenues by \$59 billion over the next ten years. This reduction in funds would lead to the insolvency of the Medicare Hospital Insurance (Part A) Trust Fund two years earlier than projected, from 2028 to 2026.¹ Millionaires would benefit substantially from these regressive tax cuts. In 2025, nearly two-thirds (64%) of this tax windfall would go to workers earning more than \$1 million, amounting to an average of \$137,000 each.²

As you know, insolvency is not an indicator of the Medicare program's bankruptcy or demise. Should Trust Fund depletion proceed, the Medicare program could still cover 87% of the cost of inpatient care.³ Further, Congress has always acted to ensure adequate funding is available to prevent the Trust Fund from becoming insolvent.⁴ It alarms us that Congress would knowingly undercut the availability of these resources through the AHCA—merely to provide tax breaks to the wealthiest Americans. That the U.S. House of Representatives ultimately passed legislation delaying this tax repeal, rather than implementing it immediately, in no way mitigates the resulting harm to Medicare and the families who rely on it.

Similarly, we are concerned by reports, based on estimates from the Centers for Medicare & Medicaid Services' independent actuary, that the AHCA repeal of a tax on pharmaceutical manufacturers would increase Medicare Part B premiums by \$8.7 billion in aggregate over the next decade. This effectively

¹ P. Van De Water, "House-Passed Health Plan Would Speed Medicare Trust Fund's Depletion by Two Years," (Center on Budget and Policy Priorities: May 2017), available at: <http://www.cbpp.org/blog/house-passed-health-plan-would-speed-medicare-trust-funds-depletion-by-two-years>

² Tax Policy Center, "Repeal 0.9 Percent Additional Medicare Tax by Expanded Cash Income Level, 2025," (Urban Institute & Brookings Institution: December 2016), available at: <http://www.taxpolicycenter.org/model-estimates/distribution-affordable-care-act-taxes-dec-2016/t16-0303-repeal-09-percent>

³ P. Van De Water, "To Repeat: Medicare Isn't Going 'Bankrupt'" (Center on Budget and Policy Priorities: December 2016), available at: <http://www.cbpp.org/blog/to-repeat-medicare-isnt-going-bankrupt>;

⁴ The Boards of Trustees, "2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds," (2017; pg. 26), available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf>

amounts to a premium hike on older adults and people with disabilities to fund a tax break for pharmaceutical companies.⁵

The AHCA fundamentally changes the structure and financing of Medicaid, by essentially eliminating the Medicaid expansion and by radically restructuring the program through per capita-caps. According to available Congressional Budget Office estimates, these changes would cut \$839 billion in federal funding from Medicaid over the next ten years.⁶ One in five (11 million) 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.⁷ These cuts would reduce the affordability and availability of needed care for people enrolled in Medicare and Medicaid.

Medicaid covers many services and supports not covered by Medicare, including home and community-based long-term services and supports and nursing home care, which would otherwise be altogether unaffordable for low-income older adults and people with disabilities. Two in three nursing home residents on Medicare are also enrolled in Medicaid and two-thirds of all Medicaid spending for people on Medicare is for long-term services and supports.⁸

Federal cuts to Medicaid brought about by per-capita caps—which have nothing to do with the ACA—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 services. We are concerned, for example, that home and community-based services would be targeted for cuts because they are optional while nursing home coverage is mandatory. Indeed, Moody's Investor Services concluded that the AHCA's Medicaid proposals would harm state finances and be a credit negative.⁹

Even with an enhanced growth rate—which could too easily be dialed down when additional federal savings are desired—the caps would fail to adjust for increasing longevity and significant state differences due to an aging population and the fact that older adults aged 85+ have 2½ times higher Medicaid costs than those aged 65-74.¹⁰ Caps would also undermine state innovation and efforts to improve integration of Medicare and Medicaid. Many states have implemented Medicaid managed care programs and financial alignment demonstrations that use capitated payment models. Federal funding caps, however, are not the same as capitation in managed care. Under managed care arrangements, states are required to ensure that rates are “actuarially sound” to ensure the delivery of contracted services and supports. States also typically tie managed care capitated rates to quality measures to incentivize desired outcomes that improve health and

⁵ U.S. Senate Finance Committee Ranking Member and U.S. Energy & Commerce Committee Ranking Member, “Press Release: TrumpCare's Tax Gift to Pharma Raises Premiums By Billions in Medicare Part B,” (March 2017), available at: <https://www.finance.senate.gov/ranking-members-news/trumpcares-tax-gift-to-pharma-raises-premiums-by-billions-in-medicare-part-b>

⁶ Congressional Budget Office, “Congressional Budget Office Cost Estimate, American Health Care Act” (March 2017), available at: <https://www.cbo.gov/publication/52486>; Congressional Budget Office, “Comparison with Previous Estimate,” (March 2017), available at: <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf>

⁷ Jacobson, G., Neuman, T., and MB, Musumeci, “What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?,” (Kaiser Family Foundation: March 2017), available at: <http://files.kff.org/attachment/Issue-Brief-What-Could-a-Medicaid-Per-Capita-Cap-Mean-for-Low-Income-People-on-Medicare>

⁸ Ibid

⁹ Moody's Investor Services, “Moody's: Proposed American Health Care Act would be credit negative for most healthcare companies,” (March 2017), available at: https://www.moody.com/research/Moodys-Proposed-American-Health-Care-Act-would-be-credit-negative--PR_363716

¹⁰ Jacobson, G., Neuman, T., and MB, Musumeci, “What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?,” (Kaiser Family Foundation: March 2017), available at: <http://files.kff.org/attachment/Issue-Brief-What-Could-a-Medicaid-Per-Capita-Cap-Mean-for-Low-Income-People-on-Medicare>

quality of life. Federal funding caps simply limit funding without actuarial soundness, consumer protections, or incentives to improve outcomes for beneficiaries.

Federal Medicaid payments for the Medicare Savings Programs (MSPs), which provide assistance with Medicare Part B premiums and cost-sharing for the lowest income people with Medicare, are exempt from the per-capita cap payments established through AHCA. Nevertheless, we are concerned that per-capita caps could lead some states to scale back this critical assistance. Twelve states and the District of Columbia opted to exercise existing flexibilities to increase eligibility for these vital programs.¹¹ Heightened budgetary pressure resulting from capped Medicaid funding overall could limit access to Medicare cost-sharing support for the nearly 2.4 million low-income older adults and people with disabilities living in these states and Washington, D.C. who rely on MSPs.¹²

Our organizations are united in opposition to proposals in the AHCA that weaken Medicare's financial standing as well as those that risk access to essential long-term services and supports, premium and cost-sharing assistance, and other vital care for people with Medicare and Medicaid. As the dialogue on health reform proceeds, we urge you to reject these policies, for the sake of the older adults, people with disabilities, and families who rely on Medicare and Medicaid and for the taxpayers now contributing to their earned Medicare benefits for the future. Thank you.

Sincerely,

AFL-CIO

Aging Life Care Association

AMDA – The Society for Post-Acute and Long-Term Care Medicine

American Association on Health & Disability

American Congress of Obstetricians and Gynecologists

American Federation of State, County & Municipal Employees (AFSCME)

American Federation of Teachers

American Society on Aging

Association For Gerontology and Human Development in Historically Black Colleges and Universities

Association of Asian Pacific Community Health Organizations (AAPCHO)

B'nai B'rith International

Bread for the World

Cancer Support Community

Caring Across Generations

Center for Medicare Advocacy, Inc.

Center for Popular Democracy

Center for Public Representation

Community Catalyst

Compassion & Choices

¹¹ See Medicare-Medicaid Coordination Office (MMCO), "Dec/2016-Release of Medicare-Medicaid Enrollee State and County Monthly Enrollment Snapshots, Updated Quarterly (March 2016 Data) – EXCEL," (Last Accessed March 2016), available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Analytics.html>

¹² Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC), "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," (January 2017), available at: http://www.medpac.gov/docs/default-source/publications/jan17_medpac_macpac_dualdatatobook.pdf?sfvrsn=0

Congregation of Our Lady of Charity of the Good Shepherd, US Province Leaders
Consumers Union
Doctors for America
Epilepsy Foundation
Families USA
God's Love We Deliver
Health Care for America Now (HCAN)
HIV Medicine Association
Human Rights Campaign
International Union, UAW
Justice in Aging
Lakeshore Foundation
LeadingAge
Lutheran Services in America
Medicare Rights Center
MoveOn.org
NACBHDD – The National Assn of County Behavioral Health and Developmental Disability Directors
NARMH – The National Assn for Rural Mental Health
National Active and Retired Federal Employees Association (NARFE)
National Adult Day Services Association (NADSA)
National Advocacy Center of the Sisters of the Good Shepherd
National Alliance on Mental Illness (NAMI)
National Association for Home Care and Hospice
National Association of Area Agencies on Aging (n4a)
National Association of Perinatal Social Workers (NAPSW)
National Association of Social Workers (NASW)
National Caucus and Center on Black Aging (NCBA)
National Center for Transgender Equality
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Consumers League
National Council of Jewish Women
National Council on Aging (NCOA)
National Disability Rights Network
National Health Law Program (NHeLP)
National Hispanic Council on Aging (NHCOA)
National Hispanic Medical Association
National Multiple Sclerosis Society
National Partnership for Women & Families
National Patient Advocate Foundation
National Physicians Alliance
National Women's Health Network
NETWORK Lobby for Catholic Social Justice
PHI (Paraprofessional Healthcare Institute)
Public Citizen

Raising Women's Voices for the Health Care We Need

RESULTS: The Power to End Poverty

SEIU

Social Security Works

Southern AIDS Coalition

Special Needs Alliance

The Arc of the United States

The Center for Closing the Health Gap

Third Way

Union for Reform Judaism

United Methodist Church- General Board of Church and Society

Universal Health Care Action Network (UHCAN)

Young Invincibles

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