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United States Senate

COMMITTEES

ARMED SERVICES
COMMERCE, SCIENCE, AND TRANSPORTATION
ENVIRONMENT AND PUBLIC WORKS
VETERANS' AFFAIRS

Dear Alaskan,

Thank you for contacting me regarding the Affordable Care Act (ACA) and its recent reform efforts.

I'd like to begin by sincerely thanking the thousands of Alaskans – like you – who have written me regarding health care reform, those who have participated in my numerous town halls and health care roundtables across the state, and those who have called and visited my offices in Washington, D.C. and in Alaska. Your input, insight, and personal stories weighed heavily on my role in crafting legislation to help Alaskans and my decisions on how I voted regarding the repeal and repair of the ACA.

First and foremost, health care is an issue that I genuinely care about, for all Alaskans. Alaska faces the highest health care premiums in the country – with premiums skyrocketing 203 percent since the ACA was implemented. Alaska's individual market is in chaos with one insurer remaining in our state, and thousands of Alaskans not able to afford ruinously expensive health insurance – an average of almost $1,100 per month for an individual plan. As of 2014, when the numbers were last available, about 23,000 Alaskans – and about 6 million Americans – either could not afford health insurance under the ACA, or bristled at the individual mandate requiring them to purchase coverage, choosing to opt out and pay a penalty to their own federal government.

Alaskans are hurting because of the lack of affordable health insurance, therefore taking no action was not acceptable to me. For the past seven months, my staff and I have focused on this issue, attending countless meetings with both Republican and Democratic Senators, health care experts, and Alaskans; working relentlessly to educate members of the House and Senate leadership and the Trump Administration on Alaska's unique challenges; and proposing and obtaining provisions in the Senate proposed Better Care Reconciliation Act (BCRA) to address many of Alaska's unique challenges.

Unfortunately, as the Senate was set to vote on the BCRA in July, Alaskans did not get the full story on how legislative language obtained in the bill would have helped Alaskans. I would not have voted for a bill that would have resulted in thousands of Alaskans losing their insurance coverage. As I've stated before, I would not have voted for a bill that would have made Alaskans worse off, period.

I believe that it's important that you understand the key provisions that were included in the proposed legislation that would have protected Alaskans' health care coverage while providing relief to those who are unfairly hurt by the ACA. Health care reform is not an issue that will go away, and these are provisions I will continue to fight for and protect, if and when the Senate moves forward to address continuing challenges in our health care system. The BCRA included the following provisions, many of which my staff and I played a key role in obtaining:

ANCHORAGE
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SUITE 750
ANCHORAGE, AK 99501
(907) 271–5915

FAIRBANKS
101 12TH AVENUE
SUITE 328
FAIRBANKS, AK 99701
(907) 456–0261

JUNEAU
800 GLACIER AVENUE
SUITE 101
JUNEAU, AK 99801
(907) 586–7277

KENAI
805 FRONTAGE ROAD
SUITE 101
KENAI, AK 99611
(907) 283–4000

KETCHIKAN
1900 FIRST AVENUE
SUITE 225
KETCHIKAN, AK 99901
(907) 225–6880

MAT-SU
851 EAST WESTPOINT DRIVE
SUITE 309
WASILLA, AK 99654
(907) 357–9956

- Retaining key ACA protections, including continuous coverage for those with preexisting conditions. Allowing dependents to stay on their parents' insurance plan until they are 26 years old and continuing to not allow lifetime or yearly caps on coverage.
- Repealing the ACA's onerous mandates, like the individual and employer mandates, and burdensome taxes, like the so-called Cadillac tax which will go into effect in 2020.
- Providing more flexibility to Alaska to design its own health care system and bring down premium costs, while supporting such state-based innovations and efforts with billions of dollars of federal support, including specific federal funding set-asides for states, like Alaska, with the highest premiums in the country.
- Establishing a $45 billion fund to help states, like Alaska, that are struggling with mental health and drug addiction epidemics, like opioids and heroin. Alaska would have received tens of millions of dollars from this BCRA provision.
- Dramatically increasing funding for Community Health Centers throughout the country—160 of which are in Alaska, serving more than 100,000 Alaskans per year and constituting 10 percent of America's community health centers.
- Protecting the significant advances made by the Alaska Native health care delivery system, which has been a bright spot for health care in our state.
- Finally, the BCRA would have begun the important process of putting our nation's Medicaid system on a sustainable and equitable path for Alaska, protecting our most vulnerable citizens and future generations who need this vital program. My team and I worked for months on this important and complicated topic. I was confident that any final health care reform bill would have protected Alaska's disabled, blind, low income, and expansion populations under Medicaid.

Going forward, I will continue to advocate for many of these provisions included in the BCRA. I will also be examining other ways to address the ever-increasing cost of health care in America, including lowering pharmaceutical prices, dis-incentivizing the practice of excessive defensive medicine, medical malpractice reform, and continuing my focus on addressing our mental health and drug addiction challenges.

Again, thank you for taking the time to provide me with your insight on this important and complex issue. Knowing of your concern about health care and what needs to be done to better address Alaska's unique health care challenges, I've attached an in-depth summary discussing the recent health care reform legislative process, and the key elements of the BCRA legislation with an explanation of the challenges, opportunities, and ACA problems that the BCRA was intended to address. I hope you have the time to review this more detailed response.

Sincerely,

Dan Sullivan

United States Senator

A Health Care Message to Alaskans

I. Introduction

Thank you for contacting me regarding the Affordable Care Act (ACA) and its recent reform efforts. I appreciate your views on this issue, and welcome the opportunity to respond. I also want to apologize if it has taken some time for you to receive this letter. The last several months have been an intense period of debate and legislative activity culminating in Senate votes on July 25-28 to repeal and repair different elements of the ACA, in which I have been actively involved.

I wanted to provide you with a very detailed response of what has transpired, the key elements of legislation focused on addressing those challenges, and my reasons for voting to repeal and repair the ACA.

Although lengthy, I encourage you to read this entire letter and continue to stay engaged on this critically important issue.

II. The Legislative Process and Input from Alaskans

Much has been written and said about the legislative process over the past several months that led to the amendments and votes that took place from July 25-28. I'd like to begin by sincerely thanking the thousands of Alaskans who have written me regarding health care reform, those who have participated in my numerous town halls and health care roundtables across the state, and those who have called and visited my offices in Washington, D.C. and across Alaska. Your input, insight, and personal stories weighed heavily on my role in crafting legislation to help Alaskans and my decisions on how I voted regarding the repeal and repair of the ACA.

I will be the first to admit that over the past several months the health care reform legislative process in the Senate was not perfect. I agreed with calls for more transparency as well as for open hearings in congressional committees. That being said, Senators had a choice to become fully engaged in the process that was set forth, or not. I thought it was clearly in the best interest of Alaskans that I be fully engaged in all aspects of the Senate health care debate, even if somewhat flawed. As such, my staff and I spent the past seven months attending countless meetings, including with Democratic Senators and health care experts, with one purpose in mind: relentlessly educating members of the House and Senate leadership, as well as the Trump Administration, on Alaska's unique challenges, and proposing and obtaining legislative language to address many of these challenges.

Your insights and input allowed me to make the best case for addressing Alaska's challenges during this debate. As noted below, we were able to positively impact the Senate legislation in numerous ways that I believe would have significantly benefitted Alaska. I also took very seriously my role of reading, revising, and understanding the legislation that was being crafted, debated, and voted on. I did not want to make the mistake of previous members of Congress who did not read or know what they were voting on during the 2009-2010 ACA debate due to a lack of due diligence on their part.

III. The Better Care Reconciliation Act (BCRA) was Focused on Addressing Many of Alaska and America's Health Care Challenges

Given the complexity and personal nature of health care, any legislation to address present health care challenges will be complex and likely controversial. Nevertheless, taking no action was not an acceptable alternative for me, particularly given the thousands of Alaskans who are not faring well under the current health care system. After months of engaged debate, Senate Republicans began to coalesce around a health care reform proposal called the Better Care Reconciliation Act (BCRA).

My staff and I were deeply involved in this process, focusing particularly on the following areas:

1. Relentlessly educating leaders in the House, Senate, and Trump Administration on Alaska's unique health insurance and medical care challenges, and advocating for specific provisions in the BCRA to help us address them.
2. Repealing onerous ACA mandates that have driven up health insurance premiums and have stifled small business growth, while maintaining critical ACA side boards such as guaranteed coverage of preexisting conditions, young adults ability to stay on their parents' insurance until 26 years of age, and no lifetime or yearly insurance caps.
3. Ensuring significant federal resources and support to help Alaska address our unique health care challenges.
4. Providing Alaska's Governor and State Legislature more flexibility and authority to address our challenges in an Alaska specific way—not with a one-size-fits-all mandate from Washington D.C., which was a hallmark of the ACA—all with an overriding goal to help reverse the trend in spiking premiums in Alaska.
5. Supporting longer term structural reforms to Alaska and America's Medicaid system to ensure that this critical program for the poor and disabled is on a sustainable and equitable path for future generations.

The version of the BCRA on which the Senate voted on July 27th, while certainly not perfect, contained these and other provisions that sought to address many of the health care challenges facing Alaskans and our fellow Americans. What follows is a summary of some of the key elements of this BCRA legislation and an explanation of the challenges, opportunities, and ACA problems that the BCRA was intended to address.

A. The ACA's Burdensome Taxes and Mandates Are Penalizing Many of Alaska's Working Families

The Challenge: According to the U.S. Department of Health and Human Services (HHS), more than 23,000 Alaskans—and more than 6 million Americans—declined to buy health insurance that was viewed as too expensive, instead opting to pay a fine to the federal government as required by the ACA for the privilege of not buying health insurance. This penalty often hits those with the lowest incomes the hardest, many making $25,000 a year or less. This is unfair and unacceptable.

High health insurance costs in Alaska are exacerbated by these mandates and by burdensome taxes and regulations that stifle economic growth, especially for Alaska's small businesses. Nationally, the ACA placed roughly $1 trillion in taxes and a myriad of burdensome regulations on our economy. For example, the ACA's so-called "Cadillac Tax", set to go into effect in 2020, amounts to a 40 percent excise tax on employee health benefits whose costs exceed a specific threshold. This will dramatically increase health insurance costs for all Alaskans. Estimates are that the vast majority of Alaska-based health plans will be hit by the Cadillac Tax in 2020, or soon thereafter. Due to the high cost of care—and insurance premiums—in Alaska, this tax will hit our state's

businesses and citizens harder than any other state. Every dollar that is paid in federal excise tax is a dollar that is not spent on salaries or business development in Alaska. It is likely that employers will either reduce benefits to a lower level or drop health coverage for their employees altogether once the ACA's Cadillac Tax goes into effect. Additional taxes stemming from the Affordable Care Act include the Health Insurance Tax (HIT) and the Medical Device Tax. These taxes, paired with the Cadillac Tax, disadvantage America's hard-working middle class families and small businesses the most.

I have heard story after story from hundreds of Alaskans who have been negatively impacted by these onerous ACA taxes and mandates. One man from Eagle River is paying more than $30,000 per year in premiums with a $10,000 deductible for coverage. Another woman, a small business owner, is making too much for a subsidy, but is being forced to pay $32,000 in premiums per year for coverage. She is also supporting a disabled husband and two sons. Another constituent, a chiropractor in Soldotna, is losing customers because of his high cost of insurance. His family of five is paying nearly $3,000 a month in premiums with a $6,500 deductible *per person*. A small business owner wrote to tell me that she was going to have to lay off employees because of the high cost of insurance. Another long-time Alaskan family is considering leaving the state because they can't afford the insurance options available to them.

While it's true that more Alaskans are insured now than before the ACA, it's also true that many Alaskans now cannot afford the very limited insurance options that are available to them. It is these kinds of stories that illustrate the urgency in which reforms are needed, and why my staff and I have been so focused on health care reform over the last eight months.

The BCRA Solution: A repeal of the individual and employers mandates was the solution to ending the penalty for those who choose not to buy coverage they cannot afford. These mandates were the top ACA problems that I heard from Alaskans while traveling the state over the past three years. They negatively impact middle-class families and America's main street businesses. The BCRA removed these onerous employer and individual mandates.

The BCRA also repealed or delayed many of the onerous taxes that stemmed from the ACA. This includes a significant delay in the implementation of the Cadillac Tax, the Health Insurance Tax (expected to cost working families an additional $5,000 over a decade), and the Medical Device Tax (which is a 2.3 percent excise tax on each medical device product sold in the United States). These taxes take money out of the pockets of Alaskans and put it into the hands of the government. It continues to be a priority of mine to repeal as many of these burdensome taxes as possible.

B. The Individual Market for Health Insurance in Alaska and Across the Country is in Chaos with Premiums Spiking and Insurers Dropping Out

The Challenge: Alaska's individual market, made up of roughly 20,000 of our citizens, has been described by Alaska's Director of the Division of Insurance as being in "complete chaos." Before the ACA, there were five insurers in Alaska's individual market. Today, that number unfortunately stands at just one. There are four other states that are now left with only one insurer, and the average number of insurers per state participating in the marketplace has fallen from 5.4 in 2016 to 3.9 in 2017. In fact, one-third of counties in the entire country are now left with only one insurer on their health insurance exchange.

According to the U.S. Department of Health and Human Services, premiums in Alaska have gone up 203 percent since the implementation of the ACA with an average cost of almost $1,100 per month for an individual plan. The rest of the country has also been negatively affected with

premiums going up an average of 105 percent nationwide. Alaska is at the forefront of the challenges the ACA has presented throughout the country, with the highest health insurance premiums in the country by far.

But there is some relief in sight in this very difficult area for Alaska. Despite our state's current challenging fiscal situation, the Alaska State Legislature voted to stabilize the insurance market with a $55 million reinsurance package last year that helped drive yearly insurance price increases from 40 percent down to a little more than 7 percent. Without this, Alaska's premiums would have gone up by 250 percent since implementation of the ACA.

Related to this action, Alaska was the first state to be approved by the Trump Administration for a 1332 waiver for reinsurance from the federal government. This includes the potential for over $300 million of federal support over the next five years to stabilize the individual market. This waiver will allow the state to better offer affordable and comprehensive coverage in the individual market while granting the state flexibility to better address its individual health care needs. Alaska's 1332 waiver will also offer relief to the state budget by increasing federal funds to the state and helping Alaskans get the quality care they need at a lower cost. It is also expected to increase the size of Alaska's small individual market by about ten percent, or an additional 2,000 people, and reverse the trend in spiking premiums in Alaska.

I commend the Alaska Legislature for its action as well as the Trump Administration's 1332 waiver action, which I have been pressing for months, but overall, Alaska still has the highest health insurance premium market in the country. More needs to be done.

The BCRA Solution: Similar to the 1332 waiver granted to Alaska, the BCRA focused on providing a significant influx of federal funding accompanied by flexibility granted to states to design to their specific state individual market needs, with a major goal of bringing down skyrocketing premiums.

The BCRA included the establishment of two stability funds to provide long-term federal resources to give states more control and flexibility to stabilize their individual markets, as well as short-term support to insurance companies as they implement changes. The short-term funding for the country over the next four years would have been $15 billion dollars in 2018 and 2019, as well as $10 billion in 2020 and 2021—a total of $50 billion. Long-term funding would have included an additional $8 billion in 2019, $14 billion in 2020 and 2021, and $19.2 billion each remaining year until 2026—a total of $62 billion. This could have given Alaska at least $500 million from the short-term stability funding and over $1.3 billion from the long-term stability funding.

As we have seen, a one-size-fits-all approach from Washington does not work in Alaska. The effort to create a stability fund on the federal level was to provide resources, monetary and administrative support, to give states the latitude to best provide a stable individual market for their constituents. These stability funds would incentivize innovative behavior through less mandates and requirements from Washington. Alaska has always had to be innovative and recreate systems and programs to make them work for the Last Frontier.

In that spirit, I crafted language that was included in the BCRA that created a safety valve for states that have very high health insurance costs. This language gave at least 1 percent of each stability fund to states with premiums 75 percent higher than the national average. Currently, only Alaska qualified for such a set aside. Provisions such as this allow for relief to states most in need. At current premium rates, our state would have received well over $1 billion in critical funds in the

next ten years that would have helped stabilize our volatile insurance market, decreased premiums, and encouraged other insurance companies to re-enter our insurance market.

Another provision of the BCRA allowed non-ACA compliant plans, like catastrophic plans, to be sold on state individual insurance markets. Similar to a bill that I authored last year, this proposal would have allowed both comprehensive ACA plans to be sold as well as more limited plans. The point of this provision was to allow consumers to make a choice on what type of health insurance they want to purchase and at what price. This would have allowed for more affordable health care plans to be offered that would have benefitted younger and healthier populations. It would have also expanded the health insurance pool which would have likely driven insurance costs down in the state. HHS estimated that these provisions would have had a very positive impact on reducing premiums nationwide.

Health savings accounts (HSAs) were also strengthened under the BCRA. HSAs allow patients to set aside pre-tax money to pay for certain medical expenses tax free. They offer several tax advantages, however they can only be used alongside a high deductible plan. There has been recent growth in the popularity of HSAs, with nearly 60 percent of large employers offering compatible health plans and total national assets of more than $40 billion. Under the BCRA, contribution limits were nearly doubled and the penalty for non-medical use was reduced. Overall, this would have provided patients with more flexibility to choose HSAs and could have expanded their use in Alaska even more.

C. Some Key Provisions of the ACA Have Benefitted Alaskans and Remained in the BCRA

The Opportunity and the BCRA Response: During my roundtables and town halls across the state of Alaska, I heard from countless Alaskans about the need to protect those with preexisting conditions, the need to keep their children on their insurance until the age of 26, and not to implement lifetime or yearly caps on insurance expenses. I committed to protecting these ACA "sideboards," most importantly those with preexisting conditions.

The BCRA kept these valued portions of the ACA, these federal "sideboards." These provisions have allowed some people to obtain and maintain coverage for the first time in their lives, maintain coverage while looking for a job after college, and afford coverage without fear of hitting a coverage ceiling, which would mean thousands more in out-of-pocket expenses.

D. Mental Health and Substance Abuse Challenges are Reaching Crisis Levels in Alaska and Across America

The Challenge: Last August, I hosted the "Alaska Wellness Summit: Conquering the Opioid Crisis" at the Mat Su College. The goal was to bring attention to the spike in opioid and heroin addiction in Alaska and to examine policies for treatment and recovery. In this regard, Alaska is not alone; much of the nation is suffering from an opioid epidemic. But Alaska presents unique challenges and severely lacks the treatment and support systems needed for those wanting to detox, those in beginning stages of recovery, and those in long-term recovery. I have made addressing the mental health and opioid addiction crisis in Alaska one of my top priorities in the Senate.

In a response to the crisis, Congress passed the Comprehensive Addiction and Recovery Act, which I co-sponsored, as well as the 21st Century Cures Act. Both laws provided for better resources and support for states and local communities to respond to the crisis. Earlier this year, the State of Alaska received $2 million as part of payments to states from this legislation.

I also was invited to meet with Governor Chris Christie, who is the leader of the President's Commission on Combating Drug Addiction and the Opioid Crisis. I raised with him and other Commission members the need for more federal funding to address this crisis which took the lives of more than 50,000 Americans last year.

The BCRA Solution: I have relentlessly raised Alaska's unique challenges of treatment and recovery directly with the President, Vice President, Senate and House Leadership, as well as many of my colleagues. As part of the BCRA legislation, Senators Rob Portman of Ohio, Shelley Moore Capito of West Virginia, and I secured an additional $45 billion to go to states to fight the mental health and opioid crisis. Alaska would have received tens of millions of dollars from this fund.

This summer I met with the Mat-Su Opioid Task Force. I heard stories of recovering addicts eligible for Medicaid and receiving medication-assisted treatment (MAT) through those benefits, who faced the difficult situation of taking a job the salary of which would make them ineligible for Medicaid, and therefore the MAT, or staying in their current situation to stay in treatment. This story reinforced my efforts in Washington, highlighting the need for treatment services to not be based upon income but on the need for long-term recovery. People should not be trapped in poverty to receive treatment. This $45 billion fund over ten years could have provided much more resources to help Alaskans in need and support their recovery efforts.

E. Delivering Health Care to Rural Alaska is Challenging and Very Expensive

The Challenge: Access to medical care throughout our great state is not easy. Rural Alaska presents more difficulties than even rural locations in the Lower 48, but having community health centers and our tribal health system helps significantly. Alaska has more than 160 community health centers which account for more than 10 percent of all community health centers in the nation. These health centers serve over 100,000 Alaskans annually, and are an integral part of our overall state health care system providing vital services where access to primary care is needed but limited.

The BCRA Solution: Throughout the Senate process, I spent considerable time advocating and pressing for more resources for community health centers, similar to a bill I cosponsored last Congress. In the end, the BCRA provided a boost in funding of $422 million for these important entities in 2018. More than any other state, Alaska would have benefitted from this significant increase in funding for community health centers.

F. The Alaska Native Health Care System is a Critical Part of Our Health Delivery System That Has Been Working Well

The Opportunity: The federal government has a trust responsibility to provide for the health and education of the American Indian and Alaska Native (AI/AN) population. Through one statewide Alaska Tribal Health Compact (ATHC), signed in 1994 with the federal government, 25 tribal entities in the state of Alaska have entered into separate funding agreements with the Indian Health Service (IHS) to carry out all of the health services that the IHS would otherwise provide for AI/ANs in Alaska. The ATHC gives Alaska Native people much greater control and flexibility over their health care system. As a result, Alaska has created one of the most effective, efficient, and responsive tribally run health systems in the nation that provides health services to members of all of Alaska's 229 tribes and more than 158,000 AI/AN people.

In 2010, the passage of the ACA served as the vehicle for permanently reauthorizing the Indian Health Care Improvement Act (IHCIA), bringing the tribal health system into the 21st century with essential updates and authorizations widely used in modern health care delivery that had been previously unavailable to the IHS and its tribes.

In addition to the reauthorization of the IHCIA, there were three other Indian-specific provisions within the ACA, outside the IHCIA title, which helped to increase access to care and fill unmet needs for AI/ANs: exemption from the individual mandate; exemption from cost sharing in ACA marketplace plans; and a monthly enrollment option in the marketplace. These three provisions have allowed for more efficient payment models and essential exemptions for AI/ANs and Alaska's tribal health system.

In light of the overall strength of Alaska's tribal health system and the central role reauthorization of the IHCIA has played, I've worked to educate my colleagues and to protect the successful system Alaskans have created and continue to successfully administer.

The BCRA Response: Last December, I attended a meeting with members of the Alaska Native Health Board, where I had to opportunity to hear their priorities for a Senate bill directly from the leaders themselves. Their top priorities were: do not alter the permanent reauthorization of the IHCIA, IHS as the payer of last resort, IHS's permanent authority to bill Medicare Part B, or the exclusion of Indian health benefits from taxation. Throughout the BCRA legislative process, I worked to ensure these priorities were met for this important Alaska population.

Additionally, the BCRA also exempted AI/AN from the Medicaid per-capita caps discussed more fully below. Beyond those aforementioned priorities, I continued to hear from the Alaska Native community about other issues with the BCRA. As a result, I worked with Senator John Thune of South Dakota to ensure language included within the final version of the BCRA would not adversely affect the tribal health system in Alaska. Also, during the health care debate at the end of July, as part of the open amendment process, I introduced two amendments: one to continue cost sharing protections for lower income AI/ANs, and the other to exempt AI/ANs from optional state Medicaid work requirements due to the federal trust responsibility of health care.

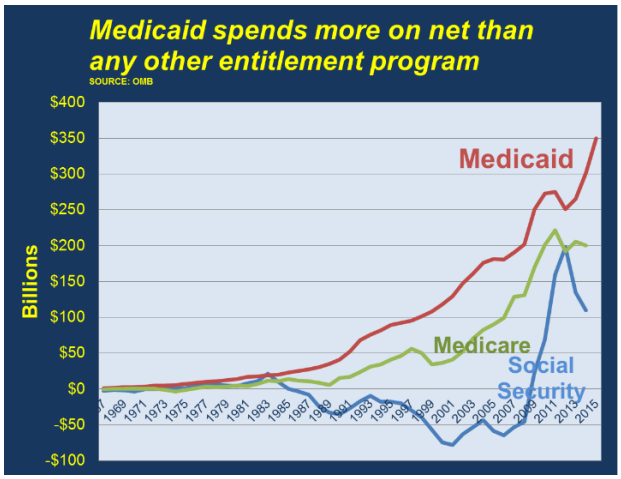
G. Medicaid is a Critically Important Program That Must be Put On a Sustainable and Equitable Path for Alaska and America

The Challenge: Medicaid has been a critical federal program for more than 50 years. It operates as a shared state and federal system where both entities share costs based on the average state per capita income compared to the average national income, resulting in a federal medical assistance percentage (FMAP) as low as 50 percent and as high as 83 percent depending on the state. At 50 percent FMAP, Alaska has the lowest match rate in the country, meaning the federal government contributes less to Alaska's Medicaid program than any other state. Medicaid is a means-tested federal program that traditionally covered low-income families and children, pregnant women, the elderly, and the blind and disabled. The federal government pays the set percentage of the state's Medicaid costs without any cap on how much the states can spend. This effectively means that the states are provided with an open ended entitlement from the federal government with no technical limit. The only limit is based on what a state can afford to pay. Since the 1990s, both Democrats and Republicans have voiced concern about the fiscal sustainability of the Medicaid program.

I believe that one of the most important, but also most difficult, things public officials can do is take into account future concerns when making present day decisions. Our young children and future generations cannot vote, but we still must make sure that critical programs, like Medicaid, are solvent when they need them and our nation's finances are sustainable for their future. Right now that is not happening in Washington. Senator Ron Johnson of Wisconsin said it best, "We are $20 trillion in debt. The Congressional Budget Office projects an additional $129 trillion of

accumulated deficits over the next 30 years. A truly moral and compassionate society does not impoverish future generations to bestow benefits in the here and now."

Since the 1990s, when President Bill Clinton proposed Medicaid reform ideas due to his concerns about the program's solvency, Medicaid spending has tripled. Medicaid is now the third largest domestic program in the federal budget following Medicare and Social Security, and the only one of the three without a dedicated funding source. Medicare and Social Security are deducted from the paychecks of American workers and are placed into a trust, while Medicaid funds come from the general fund of the United States. As such, Medicaid comes from the same funds that pay for additional safety net programs and things like transportation. As you can see in the chart below, Medicaid is far outspending both Medicare and Social Security. This will only continue unless something is done to rein in costs.



As this chart also shows, the ACA took federal Medicaid spending levels to new heights, undermining this critical program's solvency and sustainability for future generations. These significant increases in spending helped drive the doubling of our national debt to $20 trillion over the past decade.

The ACA allowed states to expand their Medicaid programs to able-bodied individuals making up to 138% of the Federal Poverty Level. Alaska expanded its Medicaid program, which has covered an additional 35,000 Alaskans, resulting in about 185,000 people total on Medicaid. When the ACA was implemented in 2014, the FMAP for the "expansion population" was 100 percent, meaning the federal government was responsible for 100 percent of the costs for those enrolled in Medicaid expansion. Starting in calendar year 2017, the expansion FMAP became 95 percent, which means states that have expanded are responsible for a five percent matching rate for the expansion population. Under the ACA, the expansion FMAP will continue to decrease each year until 2020; the expansion FMAP will be 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent in calendar years 2020 and beyond.

The Medicaid expansion provision of the ACA has been controversial throughout the country since it funds able-bodied Americans above the poverty level at a much more generous federal match than populations, such as the blind, disabled, and those below the poverty line, which Medicaid has traditionally covered. For states that chose to expand, the ACA is very generous with the 90 percent expansion FMAP rate in perpetuity. Given that federal Medicaid expenditures have tripled since the 1990s, many states did not choose to expand Medicaid. They believed that at a certain point, the generous 90 percent FMAP for their expansion populations would be dramatically

reduced by the federal government and the states would be financially responsible for the costs of their expansion populations, or expansion would have been taken away altogether.

Despite these concerns, Alaska was one of the states that chose to expand Medicaid under the ACA. At the time, this was a controversial decision. Nevertheless, I have tried to ensure that any reforms to the ACA do not pull the rug out from under Alaska's Medicaid expansion population, or the traditional Medicaid population. As explained more fully below, I believe my efforts within the BCRA would have firmly kept this commitment and kept Alaska's Medicaid on a more sustainable and equitable path for future generations.

The BCRA Solution: The BCRA tried to responsibly address the future of Medicaid, the safety net for many Alaskans and Americans. As stated above, Medicaid reform is not a new issue, nor is it a Republican-only effort. President Clinton, in the 1990s, proposed Medicaid reforms involving a per capita cap for states that were somewhat similar to those proposed in the BCRA.

Within the Medicaid reform portion of the BCRA, there was an attempt at a difficult compromise between the 32 states (including the District of Columbia) that expanded Medicaid, like Alaska, and the 18 states that did not. With some justification, the states that did not expand felt they had chosen a more fiscally prudent route and now were receiving significantly less federal money than the states that did choose to expand Medicaid.

The BCRA would have authorized states that expanded, like Alaska, to continue expansion in perpetuity, meaning that Medicaid could continue to cover people who earned 138 percent above the poverty line, but with different conditions involving a state's matching amount of funds. Under the BCRA, states would still receive the generous 90+ percent expansion FMAP until December 31, 2020. After that date, there would be a five percent step down for three years with 85 percent in 2021, 80 percent in 2022, and 75 percent in 2023, followed by states receiving the same FMAP percentage as their traditional population—50 percent in Alaska's case—starting in 2024. As Medicaid is a shared state-federal program, these changes would have resulted in an equal split of federal and state funding of the newly eligible expansion population and the traditionally eligible populations of low-income families and children, pregnant women, the elderly, the blind, the and disabled.

After 2020, the BCRA allowed states to choose between a block grant or a per capita cap for their Medicaid programs. If a state chose a block grant, they would be given a pre-set amount of money for Medicaid. This would be tied to inflation and would use a base year to determine initial Medicaid spending. If a state chose the per capita cap, federal funding would be capped per Medicaid enrollee. This, like the block grant, would be tied to inflation to account for future growth. It should be noted that states like Rhode Island have successfully block granted their Medicaid programs, achieving significant savings for the state and federal government.

My staff and I worked very closely for months with officials from the State of Alaska, CMS, and HHS on legislative proposals to ensure that Alaska could successfully transition to a per capita cap approach to Medicaid spending that would not negatively impact Alaskans on Medicaid.

The first way in which we did this was, in conjunction with Senator Portman and his staff, to propose language and tens of billions of dollars in additional funding for states to develop programs that would allow them—through the use of Medicaid funding, individual subsidies, and stabilization fund dollars—to transition Alaskans in the Medicaid expansion population into the private insurance market at affordable rates. This could have had the added benefit of bolstering our individual market with thousands of additional Alaskan participants. This concept, a version

of which is working well in Arkansas, was included in the BCRA and would have likely helped thousands of low-income Alaskans and our overall health care system.

The second way in which we were ensuring that the State of Alaska could successfully manage a Medicaid per capita cap transition was to adjust the amount of federal funding received by Alaska under Medicaid. As of now, the formula for Medicaid funds to the states does not account for states with higher medical costs and standards of living in states, like Alaska, in relation to other states, while other federal programs do account for such cost discrepancies. I was working relentlessly to change that—making the case for months to leaders in the House, Senate, and Executive Branch that as we undertook needed, long-term, structural reforms, we also needed to address the issue of Medicaid equity for Alaska. My goal was to allow our state to continue to cover all Medicaid recipients, including the expansion population, if it chose to do so, so that no one would have been forced off of the Medicaid program. Although the provision I was working on did not make it into the BCRA, I was confident that it would have made it into the final health care reform bill resulting from a Senate-House Conference.

Over time, such a provision would have significantly boosted, by hundreds of millions of dollars, federal funding for Alaska's Medicaid population and would have provided both sustainability and equitable treatment for Alaskans who need the Medicaid program. However, since health care reform legislation failed to advance out of the Senate, this significant and dramatic benefit to disabled and low-income Alaskans was never allowed the opportunity to materialize.

IV. My Votes to Continue to Move Forward on Improving Health Care in Alaska and America

The BCRA included these and many other provisions and was the central bill being debated on the Senate floor at the end of July. It was by no means a perfect bill—no bill ever is. There would have been a lot more work to do had we moved into Conference with members of the House. Nevertheless, I believed that it would have been a significant improvement over the status quo in Alaska and around the country, and had the potential to put our state on a much stronger footing in terms of federal resources, flexibility to the state, and the sustainability of our Medicaid program, to address some of our most unique and pressing health care challenges.

For this reason, on July 27, 2017, I voted for the revised Senate version of the BCRA. During the debate surrounding this legislation, there were many procedural motions and related bills and amendments, including the procedural motion to proceed to the overall health care debate, a version of the 2015 ACA repeal that Republicans had previously passed, and a much more scaled down version of the BCRA that would have been another vehicle to go to a Conference Committee with members of the House to negotiate a more comprehensive bill for a further vote likely along the lines of the BCRA legislation described in this letter. I voted for these bills as well. However, only the motion to proceed to debate passed the Senate. The rest of these amendments did not garner a majority vote in the Senate.

V. Criticisms, Promises, and Next Steps on Health Care Reform

Over the last several months there has been significant criticism regarding the apparent lack of a Republican plan on health care. As outlined in this letter, I believe that the BCRA was a serious plan meant to help Alaskans and Americans address many of their current health care and health

insurance challenges. Nevertheless, it is certainly fair to say that both the White House and Republican members of the Congress did not do an adequate job of explaining this bill to the public, and I certainly take responsibility for that. The length and detail of this letter is partly intended to rectify this.

On the other hand, despite the serious problems plaguing our current health care system in Alaska and America, many of which have been directly caused by the ACA, there have been very few realistic reform ideas suggested by my colleagues across the aisle. Indeed, the only significant proposal offered by my Democratic colleagues in the Senate has been for a "single payer" system of complete government-run health care, like in the United Kingdom. This would likely cost the United States trillions of additional dollars. During our recent health care debate, all Senators were given the opportunity to vote for a bill implementing a single payer system, however no one voted in favor of this bill.

The health care debate over the last nine years has been beset by many promises. When promoting the original ACA legislation, Democrats made extensive promises, including that Alaskans could keep their same doctor, and their health care plan, and that costs and premiums would decrease dramatically. Republicans also made repeated promises to repeal and repair the ACA. As of now, none of these promises have been kept. Breaking such important promises can breed cynicism in the political process, especially in such politically charged times. My promise to Alaska is to continue to work relentlessly for you, educate others about Alaska, listen and take input from all sides, and then act to try to address our significant health care challenges.

I have always been willing to work with anyone in the Senate, regardless of party. In fact, during this health care process, I took part in a number of productive health care meetings with some of my Democratic colleagues. I look forward to continuing these bipartisan discussions.

Going forward, I will continue to advocate for many of the ideas discussed in the BCRA and this letter. I will also be examining other ways to address the ever-increasing costs of health care in America, including lowering pharmaceutical prices, dis-incentivizing the practice of excessive defensive medicine, medical malpractice reform, and continuing my focus on addressing our mental health and drug addiction challenges. I will also continue working with the heads of the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services to encourage them to focus on the specific challenges we have in Alaska and to bring much needed relief to the extent available through the current law and regulations. I am confident that the granting of Alaska's recent 1332 waiver by the Trump Administration, the first of its kind and a model for other states, will bring needed relief to our citizens with a decrease in premiums in the individual market.

I still believe that the best course for Alaska and our nation is to repeal and repair the Affordable Care Act. The BCRA was a serious attempt to do this. Nevertheless, I also remain open to any and all bipartisan ideas and endeavors that positively impact Alaska. I fear that without serious reforms to our health care system, chaos and uncertainty will only continue. This is especially true for the numerous Alaskan pleas for help that are going and those suffering with mental health and addiction issues.

I encourage you to stay engaged in the process by continuing to reach out to me on what is important to you. Working directly with constituents has allowed me the opportunity to fully connect on this sensitive, complex, and vital issue.

Thank you again for contacting me on this issue. If you have any more questions or concerns, please feel free to contact me or my staff. My office can be reached at 202-224-3004, or online at www.sullivan.senate.gov.

Sincerely,

Dan Sullivan

United States Senator