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ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

July 3, 2013

Dr. Joseph W. Thompson
Surgeon General, State of Arkansas
Director, Arkansas Center for Health Improvement
1401 Capitol Avenue, Suite 300, Victory Building
Little Rock, AR 72201

Dear Dr. Thompson:

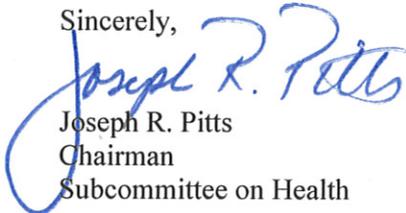
Thank you for appearing before the Subcommittee on Health on Wednesday, June 12, 2013, to testify at the hearing entitled "The Need for Medicaid Reform: A State Perspective."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Friday, July 19, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Attachment—Additional Questions for the Record

The Honorable Michael Burgess

1. Your state has reached a preliminary agreement with the U.S. Department of Health and Human Services (HHS) to use Medicaid dollars to pay for private coverage sold on the insurance marketplaces that are being created by the ACA, correct?
2. Do you believe your state has enough providers to support coverage of additional beneficiaries?
 - a. Do you believe that, had Arkansas chose to undergo a standard Medicaid expansion under the ACA, there would have been enough providers to support such an expansion?
 - b. How does your state's plan insure access to a sufficient number of providers?
3. Last year CBO estimated that private insurance plans cost nearly 50 percent more than Medicaid. In Arkansas' own actuarial analysis, it was found that the difference in provider rates between the private market and Medicaid is less than 25%. The report also indicated that there may be actual cost-savings associated with the Medicaid proposal.
 - a. What evidence is there that placing Medicaid beneficiaries into the private insurance marketplace will achieve cost-savings?
 - b. Will the "actuarial soundness" certification regulations which apply to Medicaid managed care plans also apply to the exchange plans offered to Medicaid beneficiaries?
 - c. How will the state address the vast difference in provider rates that will likely occur between Medicaid provider rates and qualified health plan provider rates?
4. In a recent memo to states from HHS, Secretary Sebelius stated "beneficiaries must remain Medicaid beneficiaries and continue to be entitled to all [Medicaid] benefits and cost-sharing protections." It seems HHS is actually eliminating the benefits of the state hoped to achieve through the private insurance market and thus make the state Exchange look more like Medicaid.
 - a. How will the private plans offered to Medicaid beneficiaries in the Exchange compare to Medicaid, in terms of cost-sharing and benefits provided?
 - b. Will Medicaid continue to provide wrap-around services for those services that are not covered in the standard set of benefits?
 - c. Will these wrap-around benefits include the cost-sharing portion of the plans?

- d. Under the ACA, the federal government established new provisions to stabilize the cost of insuring beneficiaries through the Exchange: reinsurance, risk corridors, and risk adjustment. Will the Medicaid population enrolled in Exchange health plans be included in these programs?
 - i. If YES – how will these additional costs be distributed to other beneficiaries within the Exchange?
 - ii. If NO – will these provisions be applicable in just the Medicaid pool? If so, how will costs be distributed among Medicaid beneficiaries?
 - e. What flexibilities does Arkansas require from HHS to provide true consumer-driven, market-based insurance?
5. Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statute, is the “payor of last resort”. The Deficit Reduction Act of 2005 worked to ensure Medicaid is the payer of last resort by requiring states to amend their Medicaid programs with certain provisions.
 - a. Are you aware of what challenges states continue to face in recovering third-party payments?
 - b. What impediments prevent third-party payers from following through on their payments?
 6. How does the recent increased use of managed care in Medicaid influence third-party liability issues?
 7. The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?

The Honorable Gus Bilirakis

1. Can you talk about you work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?
2. The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?