

Congress of the United States
Washington, DC 20515

October 27, 2015

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Slavitt:

We write today in response to the estimated costs of the newly-eligible adult Medicaid expansion population recently made public by the Centers for Medicare and Medicaid Service's (CMS) actuary in the *2014 Actuarial Report on the Financial Outlook for Medicaid*. We want to better understand the degree to which CMS is conducting robust oversight over federal dollars.

In recent years, some States have expanded their Medicaid programs to cover nearly all adults with incomes at or below 138 percent of the federal poverty line. Under such expansions, the federal government is paying 100 percent of the costs for the newly eligible population through next year, after which the federal portion eventually decreasing to 90 percent by 2020 under current law.

According to the CMS Office of the Actuary (OACT), State's Medicaid expansions under the Patient Protection and Affordable Care Act (PPACA) are estimated to have added 4.3 million newly eligible adults to Medicaid during the nine months the rules were in effect for fiscal year 2014. OACT estimated that expenditures for newly-eligible adults amounted to \$23.7 billion in 2014 and would total \$460 billion through 2023, with the federal government paying 93 percent of those costs (\$430 billion). According to *the 2014 Actuarial Report on the Financial Outlook for Medicaid*:

“In 2014, the average benefit costs of newly-eligible adult enrollees are expected to have been substantially greater than those for non-newly eligible adult enrollees in the program. Newly eligible adults are estimated to have had average benefit costs of \$5,517 in 2014, 19 percent greater than non-newly eligible adults' average benefit costs of \$4,650. These estimates are significantly different from those in previous reports, in which average benefit costs for newly-eligible adults in 2014 were estimated to be 1 percent lower than those of non-newly eligible adults.”

The report explained that a key reason for cost differences between newly-eligible and non-newly eligible adult enrollees is that most States expanding eligibility used managed care plans to cover newly-eligible adults. OACT noted that capitation rates for these individuals were, on average, significantly greater than the projected average costs previously calculated.

According to the report, the capitation rates included significant adjustments to reflect a higher level of acuity or morbidity among newly eligible adults, as well as adjustments such as for pent-up demand and adverse selection.

While the increase in estimated costs for the newly eligible may be explained by incorrect assumptions in the original modeling, the double-digit increase in costs is potentially concerning. Under the current matching rate, States effectively lack economic incentives to be prudent purchasers for the newly-eligible population, because the federal government pays 100 percent of the cost of care for this population. Under current law, the lack of incentive is only slightly diminished over time since the federal government is still on track to pay for at least 90 percent of the costs associated with this population for the foreseeable future.

Accordingly, we respectfully ask for responses to the following questions:

1. What steps did CMS take to ensure that 2014 capitation rates for the newly-eligible adults were appropriate? Related, how did CMS assess the adjustments States included in their managed care rates for this population?
2. What proportion of States that provided newly-eligible adults with coverage through managed care included risk-sharing arrangements in managed care contracts that would return excess payments to federal taxpayers? To what extent are the risk-sharing arrangements specific to certain populations or rate cells, such as the newly eligible, versus for the contract as a whole?
 - a. For contracts that include risk-sharing arrangements specific to the newly eligible population, does the federal government recoup all of the payments returned to the state by the managed care entity?
 - b. If the risk-sharing arrangements are for the contract as a whole, how do states and CMS determine what proportion of returned payments should go to the federal government given the higher federal matching rates for the newly eligible population?
3. How did CMS ensure that States were not shifting costs to the federal government by making generous assumptions and setting higher payment rates for newly eligible adults while offering lower rates for the non-newly eligible? For example, did CMS assess where in the actuarially sound rate range States set rates for the newly-eligible compared to other populations in managed care?
4. In the June 2015 proposed managed care rules, it states that “payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.” Since actuaries generally deem rates within a certain range to be actuarially sound, how does CMS plan to ensure that inappropriate cross-subsidizing from one population to another does not occur?

Thank you for your attention to this important matter. We respectfully request your response to this letter no later than 45 days upon receipt of this letter. Should you have any questions regarding this letter, please contact Josh Trent or Michelle Rosenberg with the House

Letter to The Honorable Andy Slavitt
Page 3

Committee on Energy and Commerce at (202) 225-2927 or Kim Brandt with the Senate Finance
Committee at (202) 224-4515.

Sincerely,



Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives



Orrin G. Hatch
Chairman
Committee on Finance
U.S. Senate

cc: The Honorable Frank J. Pallone, Jr., Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives

The Honorable Ron Wyden, Ranking Member
Committee on Finance
U.S. Senate