United States Senate
WASHINGTON, D.C.

October 23, 2012

Via Electronic Submission

The Honorable Mary Fallin
Office of the Governor
Oklahoma State Capitol
2300 N. Lincoln Blvd., Room 212
Oklahoma City, OK 73105

Dear Governor Fallin:

As you know, in June of this year the Supreme Court ruled that the massive expansion of the Medicaid program mandated under President Obama's health care law was unconstitutional. As a result, states have the option to expand their Medicaid program under the law, but are now not required to do so.

I was pleased to hear you say in recent weeks that for the time you are delaying any decision regarding expanding Oklahoma's Medicaid program (i.e. SoonerCare). Like you, many governors and state legislators have noted the great uncertainty facing states considering expanding the program.

Today I am writing to convey my concerns over any decision that would expand Oklahoma's Medicaid program in the manner prescribed under the federal health care law. I do not think expanding the Medicaid program in Oklahoma is in the best interest of the taxpayers and patients in Oklahoma. Such an expansion raises a number of serious policy concerns.

First, some of the cost of expanding Medicaid in Oklahoma will be borne by Oklahoma taxpayers. Under the law, the federal government would fully fund the cost of insuring newly eligible Medicaid enrollees from 2014 through 2016. After that point, the federal contribution would be 95 percent in 2017 for the expansion population, 94 percent in 2018, 93 percent in 2019, and 90 percent for each year following. Some analysts have suggested expansion would somehow be a good deal for Oklahomans, since the federal government will pick up the bulk of the tab for the newly expanded population. However, there is only one set of taxpayers and some portion of federal contribution would still be borne by Oklahomans –whether through their federal or state taxes. Moreover, if all states expanded their Medicaid programs, the Congressional Budget Office estimated this would increase federal expenditures by $931 billion from FY2012 to FY2022. That constitutes nearly $1 trillion increase in spending that would be borne by taxpayers.[1]

Second, options for expanding Medicaid under the health care law assume the federal matching rate is continued at current levels, even though the federal government has a poor track record of upholding promises to American citizens. While the federal government may initially fulfill their promised matching rate, what will happen when politicians face reality and decide the federal government can no longer afford to pay the rate as promised? Politicians in Washington, DC have already begun to consider reducing the federal contribution as part of broader deficit reduction talks, and applying a single "blended" matching rate to Medicaid was even part of President Obama's most recent budget proposal. This would place the cost burden back on our state. Expanding Medicaid would inherently take the chance for our state that the federal government will follow through and keep its promises. This seems highly unlikely. With increasing pressure on the federal budget from the looming

[1] Figure reflects average annual enrollment. Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012.

insolvency of the Medicare and Social Security programs, politicians are increasingly aware that the federal government cannot honor its current promises.[2] A future Congress is likely to push expansion costs onto the states, leaving state governments with the unenviable position of picking up the tab for Medicaid's unsustainable fiscal future.

Third, expanding Medicaid under the health care law could effectively reduce private health insurance options for Oklahomans. In fact, research has found that "high rates of crowd-out for Medicaid expansions aimed at working adults (82%), suggesting that the Medicaid expansion provisions of [the President's health care law] will shift workers and their families from private to public insurance without reducing the number of uninsured very much."[3] Additionally, expanding Medicaid in Oklahoma dramatically surpasses the original intent of the program. Medicaid was originally designed as a safety net program for low-income and disabled individuals and families – not as an entitlement for single, working age adults.

Fourth, expanding Medicaid under the President's health care law further perpetuates federal bureaucrats' control of Oklahoma's Medicaid program. As you well know, one of the problems with Medicaid today is that states have too little control over the program, while bureaucrats in Washington, DC have too much control. We need Oklahoma to design a program that best fits our states needs, rather than be subject to the whims and dictates of federal bureaucrats. Our state already manages our Medicaid program effectively compared to many states, but we need more state control, not an expansion of the status quo. So, rather than expand the program based on its current parameters, our state needs to be given more flexibility to modernize eligibility determination, provide long-term care benefits that promote cost-effectiveness and self-directed services, and partner with the federal government in providing more coordinated care for beneficiaries eligible for both Medicare and Medicaid. When states are able to better manage their programs, have stronger negotiating power with health care providers, and perform more coordinated care, patients will see quality increased and costs reduced.

Fifth, a general concern with Medicaid expansions under the health care law is the issue of Medicaid patients' reduced access to health care because of the program's low reimbursement rates for health providers. While Oklahoma's provider reimbursements are currently well above the national average, across the country many Medicaid programs do not adequately reimburse physicians for seeing Medicaid patients. The Congressional Budget Office has previously noted that "studies indicate that [Medicaid's] payment rates for physicians and hospitals were about 40 percent and 35 percent lower, respectively, than private rates."[4] Moreover, Medicaid payments to health care providers are often an attractive budget line item for state legislators seeking to reduce spending. So, over time, reductions in provider reimbursements would reduce the ability of physicians and others to see Medicaid patients. In fact, across the country, on average it is estimated that 30-40 percent of Medicaid patients do not to have timely access to a primary care physician. For example, the 2011 National Ambulatory Medical Care Survey Electronic Medical Records Supplement found that nationally 31 percent of physicians were unwilling to accept any new Medicaid patients. In New Jersey, the percentage of physicians unwilling to accept new Medicaid patients was the highest, at 60 percent.[5] If Oklahoma were to expand its Medicaid program, I worry that inevitable budgetary reductions would result in reduced access to care for patients in deed.

Sixth, another general concern about the Medicaid program is that essential medical care is not equally available to patients on the program. Again, while Oklahoma may be an exception in many ways, for too many low-income Americans, Medicaid proves that access to a government program is not access to health care. For the sake of Oklahomans depending on Medicaid, the state should focus on continuing to manage the program well – not expand it. The data for Medicaid patients helps clarify this policy choice. Research shows that many patients on Medicaid may have poorer outcomes than Americans with no insurance at all. A 2010 study performed at the University of Virginia showed the effects of health insurance on medical outcomes. An analysis

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[2] Avik Roy, "Why States Have a Huge Fiscal Incentive to Opt Out of Obamacare's Medicaid Expansion," Forbes, July 13, 2012, http://www.forbes.com/sites/aroy/2012/07/13/why-states-have-a-huge-fiscal-incentive-to-opt-out-of-obamacares-medicaid-expansion/

[3] Steven D. Pizer, Austin Frakt, and Lisa Iezzoni. "The Effect of Health Reform on Public and Private Insurance in the Long Run," March 9, 2011. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1782210

[4] Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," December 18, 2008. http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

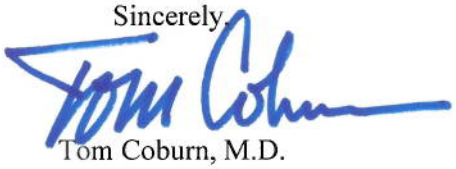
[5] Sandra L. Decker, "In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," Health Affairs, August 2012, vol. 31 no. 8, 1673-1679. http://content.healthaffairs.org/content/31/8/1673.abstract

of the study concludes that Medicaid patients were more likely to die than those with private insurance, and their hospital stays were more than 40 percent longer, costing a quarter more.[6] Moreover, medical research also shows that Medicaid patients experience lower health outcomes in a number of areas and have higher rates of infant mortality.[7] Expanding this program in its current form seems neither responsible nor compassionate.

For these reasons and more, I believe Oklahoma should not expand its Medicaid program. Focusing on managing the current program –rather than expanding it—is more responsible and compassionate than increasing spending and ceding more control to the federal government. I do believe our state Medicaid's program can help Oklahomans who qualify for the program, but at a time when our national debt is $16 trillion and Congress is running trillion-dollar annual deficits, it is unlikely that federal promises of stable Medicaid funding are anything more than a mirage.

Thank you for your commitment to ensuring patients and taxpayers in our state are well served by our state government. I appreciate your consideration of my comments and will continue to advocate for you and every governor to have increased authority and flexibility in overseeing individual Medicaid programs.

Sincerely,



Tom Coburn, M.D.
U.S. Senator

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[6] Avik Roy, "UVa Study: Surgical Patients On Medicaid Are 13% More Likely To Die Than Those Without Insurance," The Apothecary, July 17, 2010, http://www.avikroy.org/2010/07/uva-study-surgical-patients-on-medicaid.html and http://www.americansurgical.info/abstracts/2010/18.cg

[7] Elayne J. Heisler, "Infant Mortality Rates," Congressional Research Service, October 14, 2009, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=5d0b18f4-af13-4d84-85fd-b44c58895933.