May 23, 2017

Senator Richard Burr
217 Russell Senate Office Building
Washington, DC 20510

Dear Senator Burr:

North Carolina's Community Health Centers are united in our commitment to work with policymakers at all levels of government to move our health care system toward one that is more affordable, accessible and equitable for all patients in our state. We deeply appreciate the support and leadership you've shown on behalf of health centers in North Carolina and nationwide during your time in the Senate.

Health centers are bound, both by our mission and by federal statute, to care for any patient who walks through our doors, regardless of insurance status. Also, by statute, health centers must be located in underserved and low-income urban and rural areas with few other options for care -- and must provide a broader range of comprehensive primary and preventive health care services. Health centers have a solid and long track record of improving health outcomes in these areas while at the same time lowering costs for the nation's overall health system. In 2015, our network of 38 health center organizations provided high-quality, comprehensive primary and preventive care at almost 200 locations, to more than 483,000 North Carolinians, including 113,000 children and 6,300 veterans. Since then, our health center network has grown to 41 health centers and 220 locations across the state. On behalf of our patients, we offer below both our concerns with the health-related legislation that passed the House in May, and our recommendations and principles for health reform moving forward.

We urge you to take these recommendations into the coming deliberations with your colleagues, and ask that you work together with us in the coming weeks and months to ensure any and all legislation considered by the Senate meets these principles.

Concerns with the American Health Care Act

On May 4th, the U.S. House of Representatives passed H.R. 1628, The American Health Care Act, by a very narrow margin. Like health centers nationwide, we have significant concerns about the potential impact of the House legislation on our patients, and on our capacity to deliver care. In particular, we are most concerned about the following aspects of the House bill:

1. **Medicaid Per-Capita Cap/Block Grant.** In North Carolina, 26% of health center patients are covered by Medicaid. The House legislation would put that coverage at risk for a significant number of our patients by capping the federal portion of Medicaid spending. Regardless of whether the cap is determined on a per-capita basis or on a statewide basis, this change represents an enormous shift of risk to state governments already hamstrung by significant budget challenges. More importantly, because federal Medicaid contributions would grow more slowly than health care costs, states would be forced to either to raise taxes or to make increasingly dramatic cuts to covered benefits, beneficiary eligibility, and provider payments. Furthermore, North Carolina periodically experiences natural disasters including floods,

hurricanes, and tornados and Medicaid would be less able to respond to assist victims under a per-capita cap or block grant funding model.

2. **Rollback of Medicaid Expansion.** While North Carolina has not adopted the Medicaid expansion available since 2014, we are concerned by the precedent set by rolling back the federal commitment to this newly-insured population in other states. Not only does this add to the uncertainty facing individuals, providers and state governments, but it represents an additional step backward from our shared policy goal of expanding coverage to all individuals in need. More than 11% of all North Carolinians remain uninsured and 41% of North Carolina health center patients lack insurance coverage. For adults who don't have dependent children and make less than $12,060 each year, there is no financial help to buy insurance coverage that could cost them as much as half their annual income. An analysis by Manatt Health found that non-Medicaid Expansion states like ours could see lower funding allowances under the House bill proposal to cap Medicaid funding. Currently, North Carolina has the 10th lowest Medicaid per capita spending in the country. However, our state experienced higher than average annual per enrollee spending growth between 2000-2011. As a result, the House bill could put our state in a very financially dangerous position where we are locked into a relatively low per capita rate despite the fact that our Medicaid per capita costs are growing at a rate higher than average, we have a higher proportion (and number) of uninsured than most other states, and our population growth rate is above average.[i]

3. **Change in Tax Credits for Purchase of Private Insurance.** Both the Affordable Care Act and the House-passed AHCA legislation call for tax credits to individuals to assist in the purchase of private insurance. We are concerned that the AHCA would shift this credit away from one based on income and geography toward one based almost exclusively on age. For the low-income, elderly and/or rural patients who represent the bulk of those we serve, this would pose a major barrier to the affordability of coverage, which would lead inexorably to poorer health outcomes for our patients and increased costs for the system. More than 90% of North Carolinians with Federal Marketplace plans receive financial help. Estimates indicate that the House bill proposal to shift tax credits would hit North Carolinians particularly hard. In fact, consumers in our state would see the second greatest increases in plan costs compared to all other states. Estimates suggests plan costs would increase by an average of $5,360 for North Carolina consumers.[ii]

4. **Weakening Covered Benefits and Consumer Protections.** The late addition of the so-called Meadows-MacArthur amendment to the House bill would allow insurers to once again discriminate against individuals with pre-existing conditions, by allowing state waiver of so-called "community rating" requirements that no patient be charged more for insurance based on health status. This will cause our patients who are most in need of coverage to face the greatest challenge in affording it. The bill would also allow waivers of the Essential Health Benefits package, meaning insurers could offer plans that don't cover many basic services, including many which health centers are required to provide. Health centers already encounter many patients who we would consider "underinsured"—as providers open to all, this leads to significant strain on the federal investments Congress and the Administration make in our system of care. The Meadows-Macarthur provisions would only make this problem worse.

5. **Overall Impact on Coverage.** The Congressional Budget Office has estimated that the original version of the House bill would cause 24 million Americans to lose coverage within ten years. Yet every health center clinician and staff member can attest to the difference having health insurance makes in the lives of our patients—in terms of their personal and family security, access to specialty care, and likelihood to seek the cost-saving, primary and preventive care services we offer. Our nation can do better.

Principles and Recommendations for Health Reform

North Carolina's health centers serve on the front lines of a changing health care system. We share your belief that our system can be improved dramatically—specifically toward becoming a more equitable, accessible and affordable one for all patients in need, while driving efficiency and promoting high-quality, high-value care. To that end, we offer the following principles and recommendations to help guide your work on any effort to reform the health care system moving forward.

1. **First, do no harm – do not eliminate coverage for any American in your proposal.** This should be the guiding principle of your work – to at least sustain both the number of people covered by insurance and to maintain the accessibility, affordability and quality of that coverage for every American.

2. **Maintain a strong and viable safety net through Medicaid.** Medicaid and health centers work synchronously to ensure that our patients have access to affordable, high-quality care and reliable and predictable coverage. Health reform legislation should build on successes within Medicaid, not simply shift the burden of operating and financing the program to the States. Specifically, we cannot support proposals to place caps on the federal share of Medicaid payments or to institute broad block grants, or attempts to roll back the federal commitment to Medicaid expansion.

3. **Strengthen Medicaid's connection to health centers.** Medicaid not only covers nearly half of health center patients, but it is also the largest revenue source, accounting for 44% of health center revenue nationwide. Yet health centers deliver significant return on investment. Within Medicaid, this is especially true – a recent 13-state study found that health center Medicaid patients had 24% lower total costs of care when compared to similar patients cared for in other settings. This record of success is due largely to the unique Federally Qualified Health Center Prospective Payment System (FQHC PPS)— a payment structure you were instrumental in developing with a member of the US House. The FQHC PPS ensures health centers can fully treat the whole patient, while not diverting other federal investments intended to support care for the uninsured. Congress has since implemented similar payment systems for health centers in Medicare, CHIP, and Exchange coverage, and replicated it for other key safety net providers. Any proposals related to Medicaid must preserve and build upon this successful system.

4. **Strengthen tax credits, minimum benefits and consumer protections in the individual marketplace.** Several Senators have already indicated a desire to enhance the system of tax credits called for in the House bill to improve affordability for low-income patients. We strongly

support changes in this direction. Further, it is critical that any final legislation ensure individual market plans cover a minimum set of essential health benefits, and either maintain or strengthen protections afforded to the millions of patients with pre-existing conditions.

5. **Sustain and grow direct investments in health centers and the primary care workforce.** For decades and through bipartisan administrations, Congress has consistently seen the value in growing the federal investment in the health center system of care. The Trump administration has continued that support, calling investment in health centers one of the "highest priorities" in its March budget document. Yet, a crisis looms for every health center in North Carolina and around the nation with the scheduled expiration of the Health Centers Trust Fund at the end of September. We strongly urge you to sustain and grow this and other key federal investments in primary care on a long-term basis, by acting well ahead of the September deadline to extend funding for Health Centers, the National Health Service Corps and the Teaching Health Centers Graduate Medical Education program for at least five years.

We are grateful to continue to partner with you as a champion for improving the patient experience of health care and population health and at the same time reducing the per capita cost of health care. Given the urgency of this debate, we would like to discuss these concerns with you in person at your earliest convenience and, ideally, before the end of June. We have asked representatives from the North Carolina Community Health Center Association to work with your office to coordinate that visit, and are willing to meet here in the state or in Washington, DC. We deeply appreciate the opportunity to offer these recommendations and stand ready to work with you and your colleagues to develop health policy proposals that improve both our overall system and the lives and health of those we serve.

Sincerely,

Kim A. Schwartz
Chief Executive Officer, Roanoke Chowan Community Health Center
Board Chair, NC Community Health Center Association

And NC Community Health Center Association Board Members:

Nic Aposteleris, Chief Executive Officer, Appalachian Mountain Community Health Centers

Cheryl Ballance, Chief Executive Officer, Ocracoke Health Center

Reuben Blackwell, President and Chief Executive Officer, OIC Family Medical Center

Dr. Gregory M. Bounds, Chief Executive Officer, Goshen Medical Center, Inc.

Priscilla Bumphus, Chief Executive Officer, Person Family Medical & Dental

Margaret Covington, Chief Executive Officer, Stedman-Wade Health Services

William B. Crumpton, Chief Executive Officer, Caswell Family Medical Center

Darlene Ennett, Chief Executive Officer, Kinston Community Health Center

George Timothy Hall, President and Chief Executive Officer, Robeson Health Care Corporation

Philip Harewood, Chief Executive Officer, Lincoln Community Health Center, Inc.

Brian O. Harris, Chief Executive Officer, Rural Health Group, Inc.

Richard Hudspeth, MD, Chief Executive Officer & Chief Medical Officer, Blue Ridge Health

LaShun Huntley, Chief Executive Officer, United Health Centers

Althea Johnson, Chief Executive Officer, MedNorth Health Center

Dee Johnson, Chief Executive Officer, Carolina Family Health Centers, Inc.

Michelle Lewis, Chief Executive Officer, Triad Adult and Pediatric Medicine, Inc.

Thomas McRary, Chief Executive Officer, West Caldwell Health Council, Inc.

Michael Moore, Executive Director, Metropolitan Community Health Services, Inc.

Shavonda Pugh, Chief Executive Officer, Bertie County Rural Health Association

Alice Salthouse, Chief Executive Officer, High Country Community Health

Teresa Shackleford, Chief Executive Officer, Randolph Family Health Care at MERCE

Chuck Shelton, Chief Executive Officer, Bakersville Community Health

Doug Smith, Chief Executive Officer, Greene County Health Care

Robert E. Spencer, Chief Executive Officer, Gaston Family Health Services

Teresa Strom, Executive Director, Hot Springs Health Program

Johnston Tilghman, Board Chair, and Pam Tripp, Chief Executive Officer, CommWell Health

Brian Toomey, Chief Executive Officer, Piedmont Health Services, Inc

Kim Wagenaar, Chief Executive Officer, Cabarrus Rowan Community Health Centers

Panella M. Washington, Chief Executive Officer, Advance Community Health

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[i] Manatt Health. *Medicaid Capped Funding: Findings and Implications for North Carolina*. Robert Wood Johnson Foundation, April 5, 2017. Available at: http://www.statenetwork.org/wp-content/uploads/2017/04/NC-Fact-Sheet_rev-4.4.17.pdf. Accessed May 15, 2017.

[ii] Aviva Aron-Dine and Tara Straw. *House Tax Credits Would Make Health Insurance Far Less Affordable in High-Cost States*. Center for Budget and Policy Priorities, Revised March 16, 2017. Available at: http://www.cbpp.org/research/health/house-tax-credits-would-make-health-insurance-far-less-affordable-in-high-cost. Accessed May 15, 2017.