National Health Council

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May 23, 2017

The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Hatch:

The NHC is the only organization that brings together all segments of the health community to provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient advocacy organizations, which control its governance and policy-making process. Other members include professional and membership associations, nonprofit organizations with an interest in health, and representatives from the pharmaceutical, generic drug, insurance, medical device, biotechnology, and communications industries.

The NHC strives to ensure access to affordable, quality health care coverage for people with chronic diseases and disabilities. The patient protections created by the Patient Protection and Affordable Care Act (ACA) have led to new opportunities for more Americans to purchase and maintain meaningful health insurance. However, we understand the need to make modifications to ensure that the needs of people with chronic conditions are balanced with the need to create a competitive, sustainable insurance market.

As the Senate undertakes legislation impacting health care access, it is imperative that all stakeholders have an opportunity to provide their perspective, expertise, and feedback. Therefore, we appreciate the opportunity to respond to this Request for Information and hope to continue working with you and your colleagues on this very important issue.

National Health Council's Guiding Principles:

The NHC has outlined the following guiding principles for health care reform:

1. Ensure meaningful and affordable access:
   - Ensure access to affordable coverage, including for those with pre-existing and chronic conditions and the financially disadvantaged through the use of subsidies.
   - Maintain current – and increase future – levels of access to Medicare, Medicaid, employer-sponsored, and individual market insurance.

- Ensure health plans offer comprehensive coverage options, including mental health care, preventative services, long-term and end-of-life care, robust provider networks, and formularies with affordable and predictable out-of-pocket costs.
- Create appropriate mechanisms to pool and spread insurance risk across broad groups of people to promote affordability and stability of premiums and ensure access for high-risk people with chronic conditions.

2. Provide coverage for pre-existing conditions:
   - Guarantee continuity of health care access and ban limitations on coverage of pre-existing conditions.
   - Prohibit wrongful termination of an individual's health insurance coverage for having or developing any condition.
   - Prohibit medical underwriting and rating schemes that discriminate on the basis of health status, age, or gender.
   - Eliminate adverse selection through plan design elements such as high cost-sharing and utilization management.

3. Eliminate annual and lifetime benefit caps:
   - Ban lifetime limits on health insurance coverage and annual limits on all benefits.
   - Include a reasonable cap on annual out-of-pocket expenses that is spread throughout the calendar year.

Above all, **the NHC insists that we cannot allow insurance markets to exclude patients with pre-existing conditions, charge them more, or exclude coverage for health care services to treat these conditions.**

Specific Recommendations:

After using our principles to analyze the American Health Care Act (AHCA) as passed by the House of Representatives, it is clear that the bill does not meet the needs of people with chronic diseases and disabilities. Thus, we are opposed to the House-passed AHCA. **We are most concerned that the bill will have a particularly detrimental impact on people with chronic conditions by reintroducing medical underwriting and high risk pools and weakening the essential health benefits, out-of-pocket costs caps, and lifetime and annual limit protections. Furthermore, we are troubled by the loss of coverage for millions of Americans and increased costs for older, poorer Americans.** While this letter focuses on issues that are within the Senate Finance Committee's jurisdiction, we have additional concerns.

The Medicaid Cuts Will Lead to the Loss of Health Care Access for Millions of Americans

We have serious concerns with the Medicaid provisions of the AHCA. Medicaid serves as a vital lifeline for our nation's most vulnerable. The AHCA would deny access to necessary medicines and services by ending Medicaid expansion and instituting a per capita system.

While we appreciate that the AHCA will keep the enhanced expansion match rate for those currently enrolled, the Medicaid population is particularly volatile and experiences a great amount of turnover between types of insurance coverage. This will likely create a very quick loss of coverage for many

enrollees. Furthermore, seven states have laws that would effectively end Medicaid expansion immediately or soon thereafter when the expansion match rate is eliminated.

We are equally concerned with the proposal to transition the Medicaid program to a per capita cap system. In an effort to reduce federal spending for the Medicaid program, the per capita caps are set to grow more slowly than current Medicaid costs. As the difference between federal funding and the cost of Medicaid programs widens, states will be forced to decide between increasing their contribution to the program or cutting them by restricting the number of people they serve and the benefits they receive. While we are opposed to the proposal to cap federal Medicaid financing, if the Congress does move forward with this proposal, we recommend that the growth of caps more closely represents the growth of actual Medicaid spending than the methodology of the AHCA. Additionally, we recommend including protection for states in the case of significant increases in costs due to unforeseen circumstances such as natural disasters, epidemics, changes in medical treatments, or similar circumstances.

Income Must Be a Consideration of Premium Tax Credits

While we were very pleased to see that the AHCA continued to provide assistance for people to purchase insurance, we are concerned about the level and structure of the tax credits. The financial assistance included in the ACA has been one of the most beneficial provisions to help people, who were previously unable to afford insurance, gain access to the insurance marketplace. In fact, many studies have shown that the subsidies have been a greater driver of enrollment than the individual and employer mandates.

The AHCA tax credits are not based on income and do not consider the cost of insurance in a specific geographic region; therefore, poorer, rural Americans will face significantly higher premiums than they do under the ACA. When combined with the provision that broadens the age-rating band from 3 to 1, to 5 to 1 (or wider if a state applies for an age-rating waiver), older Americans will also pay significantly more for their insurance. We strongly urge the Senate to continue considering income and geography when determining the amount of tax credit enrollees receive.

Financial Assistance for Out-of-Pocket Costs Must be Maintained to Help People with Chronic Conditions Afford Their Care

People with chronic conditions face much higher out-of-pocket costs. These costs are a combination of payment for services before reaching a deductible, copays, and coinsurance. The ACA attempts to eases this burden through cost-sharing reduction plans (CSRs). These plans, which can be purchased by exchange enrollees with incomes between 100 percent and 250 percent of the federal poverty level, helped many people afford their out-of-pocket costs. However, the NHC has been concerned about the way they are applied. Exchange enrollees must actively select these plans, and 2.2 million people who were eligible in 2015 unknowingly selected other plans when they may have greatly benefited from a CSR.[1] While we are concerned with functionality of the CSRs, we are far more concerned with the AHCA's repeal of them with no replacement of financial assistance for out-of-pocket costs.

[1] http://avalere.com/expertise/managed-care/insights/more-than-2-million-exchange-enrollees-forgo-cost-sharing-assistance

Additional Funding May Help Create Market Stability

The NHC generally supports the concept behind the AHCA's creation of the Patient and State Stability Fund. Providing federal funding to states may be the best way to ensure long-term viability of their insurance markets and lower premiums. We are particularly interested in the option to use the Stability Fund for an invisible high-risk pool, which would operate similar to a reinsurance program by providing funding to insurers whose enrollees have health care costs that are higher than other plans. Because the population enrolling in the exchanges has been generally sicker than predicted, the risk adjustment program has not worked. Unlike Medicare Advantage and Medicare Part D, the ACA's risk adjustment does not include additional federal funding to offset high utilization. This has led to increased premiums and out-of-pocket costs. Congress now has an opportunity to fix the flawed methodology and help lower costs for all enrollees while stabilizing the market. One potential way for the Senate to strengthen the Stability Fund would be to provide a mechanism for stronger federal oversight of how the states plan to spend their funding to ensure it meets its intended goals.

It is important to note the distinction between an invisible high-risk pool and a traditional high-risk pool. **While the NHC supports invisible high-risk pools, we remain strongly opposed to the reintroduction of traditional high-risk pools.** Traditional high-risk pools, which were used in states prior to the ACA, have a long history of creating challenges for enrollees such as waiting periods, high premiums and cost-sharing, utilization management, and lifetime and annual limits. Segmenting people with pre-existing conditions into high risk pools does not meet the NHC's principles or Congress and President Trump's stated goals of providing access to people with pre-existing conditions.

As the united voice for those with chronic diseases and disabilities, the NHC believes that broad patient protections in the health care statute make for a better market, improving care and access for vulnerable patient populations. As you draft new legislation, the NHC strongly encourages the Senate to reconsider many of the problematic provisions of the House-passed legislation, prioritize the above-referenced level of patient protections, and view the NHC and our members as a resource to understand the impact these policies will have on people with chronic conditions.

Please do not hesitate to contact Eric Gascho, our Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org.

Sincerely,

Marc Boutin, JD
Chief Executive Officer