



May 22, 2017

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
U.S. Senate
Washington, DC 20510

Dear Senator Hatch:

On behalf of the American College of Physicians, I would like to express our gratitude for this opportunity to share our thoughts regarding the American Health Care Act of 2017 that was passed by the House earlier this year, and our recommendations on how the Senate can move forward concerning legislation to improve our health system. We remain strongly opposed to the American Health Care Act (AHCA) and urge the Senate to set aside this inherently flawed bill that would rollback coverage and consumer protections millions of Americans, including radical changes in how Medicaid is financed. We hope the Senate will take this opportunity to work with us to improve the Affordable Care Act (ACA) and achieve real bipartisan solutions to increase access, coverage, and consumer protections for all Americans.

As Congress started the process of considering changes to the ACA, we established [criteria](#) that any reforms to current law should first do no harm to patients. We developed 10 key questions that should be asked of any legislation that would alter the coverage and consumer protections available under the ACA, and we encourage the Senate to consider these questions as they debate potential improvements to the current law. We have already expressed our [view](#) that the AHCA violates the do no harm principle as it will erode coverage and essential consumer protections for the most vulnerable patients: those who are older, sicker, and poorer.

The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We remain concerned that the continued polarization and partisanship over the future of the Affordable Care Act is standing in the way of making progress on a range of issues that are essential to improving our health care system. That is why ACP believes that it is time to move away from the rhetoric concerning repealing the ACA and instead urge Congress to implement [a forward-looking agenda](#) to improve American health care.

ACP offers the following suggestions for a forward-looking agenda to improve health care:

Expand Access and Coverage

1. Sustain gains in coverage from the ACA and close coverage gaps. Congress should ensure that any legislation sustains and improves on existing coverage programs and consumer protections rather than rolling them back. Action is also needed to stabilize insurance markets and offer individuals more options for coverage.

- a. Put aside efforts to repeal the ACA and instead work to improve it.** Congress should drop the effort to repeal and replace the ACA, and more specifically, the American Health Care Act (AHCA). The AHCA would reverse the historic gains in coverage that have occurred under current law, and would have caused 14 million to lose coverage in 2018 and 24 million over the next 10 years, according to the Congressional Budget Office. Specifically, ACP calls on Congress to reject proposals to cut, cap or block grant the federal contribution to Medicaid; to end the higher federal match for Medicaid expansion; to replace progressive income-based premium and cost-sharing subsidies with regressive age-based tax credits; and to repeal or weaken the ACA's Title I protections, including community-rated premiums, guaranteed issue, and Essential Health Benefit (EHB) requirements by allowing states to obtain waivers to opt-out of such requirements. Read [ACP's letter](#) to the Senate on why the Senate should put aside the AHCA and start over to achieve consensus on needed improvements.
- b. Take immediate action to stabilize the market for insurance sold through the exchanges.**
 - i. The Trump Administration and Congress must make a clear, immediate and unambiguous commitment to preserve the ACA's cost-sharing reduction (CSR) payments to insurers at least through 2018, and better yet, for the long-term.** In 2016, about 6 million enrollees relied on CSR payments to help reduce the burden of co-payments, deductibles, and co-insurance. Without a guarantee that the CSR payments will be continued, many insurers will have no choice but to leave the exchanges or to raise premiums by 20 percent or more to make up the shortfall. Many insurers are deciding now whether they will be able to offer insurance through the exchanges for the 2018 enrollment cycle and the proposed premiums should they opt to stay in the exchange markets. Several have already announced substantial premium increases because of the uncertainty over whether the CSR payments will continue. It is imperative that CSR be preserved. Read the [letter](#) to Congress and the administration, signed by over 20 organizations, including ACP, which explains why the CSR payments must be maintained.
 - ii. The administration should take additional actions to reduce uncertainty that could result in more insurers choosing not to offer plans in the 2018 enrollment cycle.** It should commit to actively promote 2018 enrollment especially of younger people; to lengthen the 2018 enrollment period; to enforce existing requirements that people purchase qualified insurance; and to work with insurers, consumers, clinicians, and consumer advocates on additional measures that could be taken to stabilize the markets and encourage more insurers to participate in them. More intensive outreach and enrollment efforts will be vital as the open enrollment period for 2018 has been shortened. In 2017, marketplace enrollment declined after the U.S. Department of Health and Human Services (HHS) prematurely ended its open enrollment publicity and outreach campaign. Evidence [suggests](#) that enhanced television advertising can increase enrollment. Further, many uninsured people remain [unaware](#) of marketplace-based coverage options and subsidies. The administration must expand efforts to promote the marketplace awareness and attract more people to shop and purchase the right coverage for them.

- iii. **Explore options for an effective re-insurance program and other initiatives to stabilize the market.** HHS' March 13, 2017 [letter](#) and subsequent checklist encouraging states to seek Section 1332 waivers for reinsurance programs was a step in the right direction. Reinsurance can help to ensure that patients get to keep the coverage they have while protecting insurers from high costs. Alaska has implemented a successful reinsurance program and Minnesota has set up its own reinsurance and premium relief program. The administration should cooperate with state officials to stabilize their insurance markets and actively work to attract insurers to enter or maintain activity in underserved states. Such efforts [have been fruitful](#) to encourage insurer participation in underserved regions. Congress can embrace initiatives that have [proven effective](#) in the Medicare Part D program by establishing permanent reinsurance and risk corridor programs as well as emergency fallback protections to provide coverage when no plans are available in an area.

- c. **Preserve the federal government's contribution to Medicaid including the higher match for expansion states.** In the 32 states and the District of Columbia that have agreed to expand Medicaid to persons with incomes up to 138 percent of the federal poverty level (FPL) an estimated 11.2 million [people](#) have gained coverage who otherwise would not have been eligible for coverage prior to expansion. Studies [show](#) that they have gained access to care and financial security as a result, and initial data also show that expansion is associated with improvements in measures of self-reported health status. Yet because 19 states have not yet expanded Medicaid, an [estimated](#) 2.6 million fall in a "coverage gap" because they have incomes at or below 100% of the FPL, making them ineligible for the ACA's premium and tax credit subsidies to purchase private insurance through the exchanges. For them, Medicaid expansion may be the only option to obtain coverage. States that have not yet expanded Medicaid should do so. Congress should ensure that higher federal match for Medicaid expansion is not eliminated or phased out, and that non-expansion states can continue to join the program at their own option; the AHCA regrettably would sunset the higher federal match for expansion starting in 2020 and prohibit states from joining the program effective on enactment.

2. Consider additional policies to encourage state innovation and bring more choice and competition into insurance markets without rolling back current coverage, benefits and other consumer protections guaranteed by the ACA and other federal laws and regulations.

- i. **Use existing 1332 waiver authority to allow states to adopt their own innovative programs to ensure coverage and access, provided that the coverage and benefits available in the state would be no less than under current law.** Section 1332 waivers offer states the opportunity to test innovative ways to expand insurance coverage while ensuring that patients have access to comprehensive insurance options. As long as a state's waiver program meets the ACA's standard of comprehensiveness at the same cost and level of enrollment, it can test a more market-based approach, a single-payer model, or make minor revisions to continue existing state initiatives. States like Alaska, Vermont, and Massachusetts have filed 1332 waiver applications and many more are developing proposals.

- ii. **Improve the Medicaid waiver process.** As proposed in a 2011 position paper, [ACP reaffirms](#) its recommendation that the Medicaid waiver process should be improved and streamlined to facilitate the establishment of approved plans, encourage public input, and improve coordination between federal and state agencies.

- iii. Encourage states to adopt patient-centered delivery models.** ACP supports continued administrative and financial support to Medicaid programs to develop and implement innovative patient-centered delivery system models like the medical home. [26 states](#) are actively testing Medicaid Medical Homes to better serve patients with chronic health conditions, integrate behavioral health and primary care, and [address](#) the opioid epidemic.
- iv. Improve network adequacy and patients’ ability to choose their own physician and hospital.** ACP strongly supports robust provider network adequacy laws that ensure patients have access to their preferred physician. However, in an effort to trim costs, insurers are offering fewer plans with a broad choice of physicians, hospitals, and other providers, potentially restricting patients from seeing the high-quality health care professionals they value most. A [report](#) by the Robert Wood Johnson Foundation found that 41 percent of 2014 silver qualified health plan (QHP) networks were small (they include 10-25 percent of office-based participating providers in the area) or extra small (less than 10 percent included in network). By specialty, 36 percent of primary care networks and 23 percent of internal medicine specialty networks were small or extra small. ACP recommends that CMS and state regulators continue to provide robust oversight of qualified health plan provider networks, use quantitative standards to evaluate network adequacy, approve networks prior to going to market, improve provider directory accuracy, and take other actions to ensure that provider networks provide access to high-quality physicians and not just low-cost providers.
- v. Consider enacting legislation to offer individuals aged 55 through 64 the option to buy into Medicare.** ACP supports the development of a Medicare buy-in option for people age 55-64. By doing so, older adults will have an opportunity to enroll in the popular Medicare program, potentially improving both the Medicare and marketplace risk pools and driving down premiums. Specifically, ACP recommends:
- A Medicare Buy-in Program must include financing that assures that premiums and any subsidies are sufficient to fully cover expenses without further undermining the solvency of the Medicare trust funds;
 - A Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate;
 - Eligibility for a Medicare Buy-in Program should include adults age 55-64 regardless of their insurance status; and
 - Enrollment in a Medicare Buy-in program should be optional for eligible beneficiaries and should include the full range and responsibilities of Medicare benefits (Parts A, B, Medicare Advantage and Part D).
- vi. States could use existing law authority to allow sale of insurance across state lines among states that have agreed to enter into a regulatory compact to protect consumers.** The evidence suggests that selling insurance across state lines will not likely result in significant cost-savings and could cause a “race to the bottom,” absent a regulatory structure that ensures that such plans meet existing essential benefit, community-rating, network adequacy standards, prompt claims payment and other consumer protections. Rather than pursuing new statutory authority to sell insurance across state lines absent such a regulatory agreement among the states, the administration should work with states to promote and support the development of interstate health insurance compacts as authorized under Section 1333 of the ACA. This could

potentially broaden choice of insurance options while maintaining crucial insurance regulations, benefit requirements, and other protections that characterize marketplace-based QHPs.

3. Adopt and implement policies to address the impact of high-deductible plans on access to services and out-of-pocket costs. Evidence shows that cost sharing, particularly deductibles, may cause patients to forgo or delay care, including medically necessary services. To address this, ACP recommends that high-value health care services, like preventive screening and chronic care management services, be provided without a co-payment and exempt from deductibles. The value-based insurance design concept is embedded in the ACA, since evidence-based preventive care highly-rated by the U.S. Preventive Services Task Force is not subject to cost sharing. We also recommend enhancing the affordability of marketplace-based QHPs by expanding eligibility for CSRs and increasing the generosity of premium tax credits and cost-sharing subsidies. Further, as health insurance becomes more complex, stakeholders must conduct outreach and education efforts to enhance health insurance literacy because many people do not understand health insurance concepts like provider networks, how to calculate out-of-pocket costs or their right to appeal health insurer decisions.

4. Ensure continued access for women's health services. ACP opposes any sort of legislative or regulatory restrictions that prevent patients from obtaining evidence-based services, like contraception, preventative health screenings, vaccines, and sexually transmitted infection testing and treatment, from women's health clinics that are qualified under existing federal law, including providers like Planned Parenthood. Moreover, the College opposes the use of gender rating in insurance pricing which results in women having to pay more for their coverage simply for being a woman. Any reform to the ACA must uphold the coverage of health benefits essential to women's well-being, including the coverage of maternity care and preventative screenings.

5. Reauthorize the Children's Health Insurance Program. The Children's Health Insurance Program is a federal-state financed program that provides health insurance to about 9 million children in families who are ineligible for Medicaid and unable to purchase private coverage. Since signed into law 20 years ago, the [program](#) has played a vital part in reducing the percentage of uninsured kids to an all-time low of just 5% and has [succeeded](#) in alleviating health care-related financial burden and stress related to children's health care. Since CHIP has proven to be an immensely beneficial program, we strongly urge Congress to pass a long-term funding extension before current funding expires in September 2017. Failing to act could endanger coverage for millions of children.

We believe that the implementation of the recommendations in our forward-looking agenda not only include critical measures to stabilize the insurance market to ensure access to affordable coverage, but also can attract the bipartisan support necessary to reduce the divide and excessive partisanship associated with efforts to repeal and replace the ACA.

ACP's Concerns Regarding the AHCA

As you mentioned in your letter to stakeholders, when considering reforms to the ACA "*it is critically important that expectations be managed and everyone remains willing to work toward the art of the doable.*" We believe that the AHCA should not be used as a starting point for discussion of reforms to current law and that the changes in this legislation are not feasible since:

- **The AHCA would make [radical changes](#) to the Medicaid program's structure and financing, resulting in the rollback of coverage for many millions of the most vulnerable Americans.** Specifically, we oppose capping, block granting and cutting the federal contribution to Medicaid,

ending federal funding for Medicaid expansion, and eliminating the requirement that Medicaid cover essential health benefits.

- **The AHCA replaces income-based premium and cost-sharing subsidies with regressive age-based tax credits that result in higher premiums and deductibles for millions of patients, with persons aged 50 and over being most at risk of having to pay thousands of dollars more out-of-pocket.** For many of them, insurance would simply become unaffordable.
- **The AHCA will allow states to obtain waivers to opt-out of federal requirements that insurers cover [essential health benefits](#) and that premiums be based on [community rating](#) rather than an individual's health status.** As a consequence, insurers in waiver states would also once again be able to charge more to people with pre-existing conditions who are unable to maintain continuous coverage.

ACP's concerns regarding AHCA cuts to Medicaid

Medicaid is an essential part of the health care safety net. Studies show that reductions in Medicaid eligibility and benefits will result in many patients having to forgo needed care, or seek care in costly emergency settings and potentially have more serious and advanced illnesses resulting in poorer outcomes and even preventable deaths. As an organization representing physicians, we cannot support any proposals that would put the health of the patients our members treat at risk. We believe though that improvements can and should be made in Medicaid, including more options for state innovation, without putting the health of millions of patients at risk.

The changes to the Medicaid program included in the AHCA are not feasible as they would rollback coverage for many millions of the most vulnerable Americans.

- **For states that expanded their Medicaid programs under the ACA,** the enhanced federal match will be discontinued as of January 1, 2020, except for those who are already enrolled and maintain continuous coverage; the bill also requires states to stop enrolling additional persons after that date. These changes would result in those states losing the enhanced federal match for the expansion population over time; it would also result in many of those currently enrolled under the expansion policy losing coverage as they cycle out of Medicaid. Because many Medicaid enrollees have fluctuating incomes, applying the enhanced federal funding match only to those who do not have a break in eligibility could lead to drastic funding cuts and reduced enrollment. These changes will also force states to reduce beneficiary eligibility or benefits starting in 2020, reversing much of the progress made by the ACA in driving down the uninsured rate to historic lows.
- **For non-expansion states that may have been considering expansion,** the House-passed AHCA would prohibit them from receiving any enhanced federal funds as of March 1, 2017. This provision would effectively make it impossible for additional states to expand Medicaid to persons with incomes up to 138% of the Federal Poverty Level, as allowed under current law, because it would immediately terminate (retroactively to March 1, 2017) the higher federal contribution available to states that opt for expansion. Continued support for Medicaid expansion is essential to ensuring that low-income Americans have access to affordable coverage. Under the original language, the CBO already expected that no states would expand

Medicaid eligibility and determined that its effect would be that 5 million less people would have Medicaid coverage by 2026. We also oppose the bill language to eliminate the option for expansion states to cover persons with incomes above 133% of the FPL.

ACP opposes provisions in AHCA that would cap future federal contributions to Medicaid either through a per-enrollee cap or a block grant option:

- **The AHCA will convert the shared federal-state financing structure for Medicaid that has been in effect for more than half a century to one that would cap the federal contribution per enrollee, resulting in a loss of coverage and benefits for many of the 74 million enrolled in Medicaid.** Because most states are required by law to balance their budgets, a reduction in and/or a cap on federal matching funds will necessarily require them to greatly reduce benefits and eligibility and/or impose higher cost-sharing for Medicaid enrollees, most of whom cannot afford to pay more out of pocket—or alternatively and concurrently, reduce payments to physicians and hospitals (including rural hospitals that may be forced to close), enact harmful cuts to other state programs or raise taxes. The CBO’s March 23, 2017, report estimates that per capita caps, combined with the phase-out of funding for Medicaid expansion states, would result in the federal contribution to Medicaid being slashed by \$839 billion over the next 10 years, an unprecedented and unsustainable reduction in support of health care for the most vulnerable patients.
- **We also oppose AHCA provisions to provide states with a block grant financing option because it would result in even worse outcomes than the AHCA as originally drafted,** likely leading to even greater [losses in coverage](#). Along with the phasing out of the ACA’s Medicaid expansion beginning in 2020 and a radical restructure of the program’s financing to a per-enrollee cap-structure, the CBO’s March 23, 2017, report estimates that 14 million fewer Americans would be covered by Medicaid in 2026; the number of people without coverage will likely increase with a block grant option. Under block grants, because the states do not get any additional payment per enrollee, strong incentives would be created for states to cut back on eligibility, resulting in millions of vulnerable patients potentially losing coverage. Block grants also will not allow for increases in the federal contribution should states encounter new costs, such as the availability of new expensive prescription drugs. Under either block grants or per capita spending limits, states would be forced to cut off enrollment, slash benefits, or curb provider reimbursement rates.

ACP opposes provisions in the AHCA that would eliminate Essential Health Benefits for Medicaid expansion enrollees:

- We oppose repeal of the current law requirements that Medicaid cover 10 categories of essential services including physician and hospital visits, prescription drugs, cancer screening tests and other preventive services, mental health treatment, and many others. Further, we are opposed to leaving it up to states to define the essential health benefit package for private market plans because the need for crucial services like cancer screenings and innovative prescription drugs does not respect state boundary lines. We are particularly concerned that any reduction in Medicaid coverage for substance use disorder treatments would exacerbate the grave opioid epidemic that is devastating individuals, families and communities across the country. Women’s access to health care would particularly be at risk, because the AHCA as passed by the House could undermine coverage for maternity care and contraception.

Our nation is in the midst of an opioid epidemic that is taking thousands of lives and devastating communities across the country. Medicaid is the largest provider of behavioral health services, including substance use disorder treatment, and demand is rising. Over a million people who need substance use disorder treatment gained coverage as a result of the Medicaid expansion and over a million more people with substance use disorders would be eligible for such coverage if all states expanded [Medicaid](#). If the essential health benefits package is repealed and mental health and substance use disorder benefits are taken with it, thousands of people who are in treatment could see their path to recovery blocked.

ACP opposes provisions in the AHCA that would impose work or job search requirements on certain Medicaid enrollees:

- Medicaid is not a cash assistance or job training program; it is a health insurance program and eligibility should not be contingent on whether or not an individual is employed or looking for work. While an estimated 80 percent of Medicaid enrollees are working, or are in working families, there are some who are unable to be employed, because they have behavioral and mental health conditions, suffer from substance use disorders, are care-givers for family members, do not have the skills required to fill available positions, or there simply are no suitable jobs available to them. Skills- or interview-training initiatives, if implemented for the Medicaid population, should be voluntary, not mandatory. Our Ethics, Professionalism and Human Rights Committee has stated that it is contrary to the medical profession's commitment to patient advocacy to accept punitive measures, such as work requirements, that would deny access to coverage for people who need it.

ACP's concerns regarding AHCA Tax Credits

The AHCA's regressive age-based tax credits, combined with changes that will allow insurers to charge older people much higher premiums than allowed under current law, will make coverage unaffordable for poorer, sicker, and older persons, as well as for persons who live in high health care cost regions.

We strongly believe that the value of premium and cost-sharing subsidies should not be reduced compared to current law:

- Replacing income-based premium and cost-sharing subsidies, with age-based advance refundable tax credits worth only \$2,000 to \$4,000 for an individual, could put especially vulnerable persons at risk, including low-income families and children; children and adults with special health care needs, and older persons with chronic illnesses who are not yet eligible for Medicare. Indeed, a [study](#) based on the value of these tax credits determined that only 34 percent of a beneficiary's medical costs would be covered. This is much less than the ACA which ranges from about 60% to 94%, depending on the level of plan.
- In addition, by repealing the current law cost-sharing subsidies for persons with incomes up to 250% of the FPL, the AHCA would make out-of-pocket costs too high and health care unaffordable, for many poorer patients. Without cost-sharing reductions, enrollees will be exposed to higher deductibles, co-payments and other cost sharing, potentially discouraging patients with limited financial means from seeking medically necessary care.

- The AHCA establishes a set amount for the tax credits per individual, without any adjustment for differences in the cost of care by locality. This will result in the tax credits being insufficient to make coverage affordable for patients in high health care cost areas, especially older, poorer and sicker ones.
- We acknowledge the House-passed AHCA includes a provision to allow eligible persons to deduct more of their health care expenses above a specified percentage of income from their income taxes, which will mainly benefit higher-income persons with large medical bills. The apparent intent is to allow the Senate to use such funds instead to reduce out-of-pocket costs for older and lower-income persons buying coverage in the individual insurance market. While we support that goal of increasing the value of the premium subsidies (and continuing the ACA's cost-shifting subsidies, which would be repealed by the bill), the AHCA offers no guarantee that the reserve fund will result in the tax credits being fundamentally restructured to eliminate their regressive nature, which benefits wealthier persons at the expense of poorer ones and results in older, sicker and poorer patients paying substantially more out-of-pocket for coverage in the individual market than under the ACA. Nor would it repeal the "age tax" on older persons created by a provision in the AHCA that allows insurers to charge older persons five times more than younger ones, compared to no more than three times more under the ACA.

ACP's concerns regarding AHCA changes to Essential Health Benefits

The AHCA will allow states to obtain waivers to opt out of federal requirements that insurers cover essential health benefits and that premiums be based on community rating rather than an individual's health status. A new [analysis](#) by the non-partisan Brookings Institution shows that the AHCA, "would allow states to effectively eliminate community rating protections for all people seeking individual market coverage, including people who had maintained continuous coverage. . . As a result, community rating would be eviscerated—and with it any meaningful guarantee that seriously ill people can access coverage." [Emphasis added in italics].

The AHCA would remove the mandate that all health insurance plans must cover essential health benefits including: coverage for physician hospital services and prescriptions, mental health and substance use disorder treatment, primary care services, preventive services at no out of pocket cost to insured individuals, contraception and other women's health preventive services, and maternity care, and ensure that parity between medical/surgical benefits and mental health/substance disorder benefits is appropriately maintained.

By eliminating the national requirement that all plans offer 10 categories of essential benefits, not only would patients find that needed care isn't covered, but that the ACA's prohibition on annual and lifetime limits on coverage would no longer apply to services that a waiver state determines are not essential. To illustrate, a waiver state might decide that insurers are not required to cover chemotherapy as an essential benefit, meaning that a cancer patient's insurer could impose a dollar limit on how much chemotherapy they will pay for in a year or lifetime, putting the patient at risk of bankruptcy or having to forgo life-saving treatment. This weakening of consumer protections would adversely affect not only people who obtain coverage through the ACA marketplace plans, but also those who obtain coverage through their employers.

These harmful changes would return the country to the pre-Affordable Care Act (ACA) days when persons with pre-existing “declinable” medical conditions in most states were priced out of the market and the insurance products available in the individual market did not cover medically-necessary services.

While the AHCA attempts to cover individuals with pre-existing conditions through high risk pools or reinsurance programs, the pre-ACA experience with high risk pools is that they do not provide adequate coverage and protection. Prior to the ACA, according to the Kaiser Family Foundation, many states had [high risk pools](#) that typically charged premiums above standard nonmarket rates, had pre-existing condition exclusions, lifetime and annual limits, and high deductibles; many states also limited enrollment, directly or indirectly, to limit costs. While an amendment to the House-passed AHCA included an additional \$8 billion over five years to help fund high-risk pools in waiver states, this inadequate increase will not make coverage affordable for sick people. A [recent analysis found](#) that the AHCA, prior to this amendment being adopted, would leave a \$20 billion annual shortfall in the amount of funding that would be needed for such pools to be sustainable. The amendment’s addition of an average of \$1.6 billion per year doesn’t come close to providing the resources needed. Another new [report by Avalere](#) found that the AHCA's high-risk pool funding will cover just five percent of the total number of enrollees with pre-existing chronic conditions in the individual market today. A [study](#) by the Kaiser Family Foundation estimates that in 2015, 27.4 million non-elderly adults had a gap in coverage of at least several months, including 6.3 million people with a pre-existing condition whose premiums would increase substantially if the House passed AHCA were enacted.

Simply put, high risk pools are no substitute for maintaining the ACA’s prohibition on insurers charging more to people with pre-existing conditions.

The College strongly believes in the principle that we must first, do no harm to patients. Therefore we continue to urge that the Senate move away from the fundamentally flawed and harmful policies that would result from the American Health Care Act as passed by the House and urge the Senate to reject this legislation and start anew on policies that will improve the current law, expand coverage, and ensure that essential consumer protections such as essential health benefits are maintained. We appreciate your reaching out to solicit our ideas as you consider health reform and hope this this correspondence will be the first step in the process of a meaningful dialogue with you and your staff to create policies that will improve the health care system for our patients.

Sincerely,

A handwritten signature in black ink, appearing to read "Jack Ende", with a long horizontal flourish extending to the right.

Jack Ende, MD, MACP
President