American College of Physicians
Leading Internal Medicine, Improving Lives

**American College of Physicians Statement for the Record**

**Senate Finance Committee Hearing**

**Health Care: Issues Impacting Cost and Coverage**

**September 12, 2017**

The American College of Physicians (ACP) is grateful for the opportunity to share our views regarding the hearing in the Senate Finance Committee on Health Care: Issues Impacting Cost and Coverage. We applaud the Chairman of the Committee, Senator Orrin Hatch, and Ranking Member Ron Wyden for convening this hearing and hope that it will provide a platform to act on bipartisan solutions impacting the cost and coverage of health care. Although the health care debate has turned more partisan in recent years, we believe that common ground can be reached on a pathway forward on policies that share bipartisan support. To that end, in May of this year, ACP released a forward looking document that provides a prescription for Congress to implement a broad array of bipartisan solutions to improve the quality of health care. The intent of this statement is to provide a guide for Congress to work together on solutions that will lower cost and improve coverage of health care for our citizens.

**EXPAND ACCESS TO COVERAGE**

We urge Congress to act to sustain gains in coverage from the Affordable Care Act (ACA) rather than working to repeal and replace the current law. ACP has submitted letters of opposition to legislation to repeal and replace the ACA such as, the Better Care Reconciliation Act (BCRA), or the most recent legislation unveiled in September by Senators Lindsey Graham and Bill Cassidy that would take our country a step backward by vastly increasing the number of uninsured citizens and rolling back consumer protections on existing health insurance plans. We know that the Graham-Cassidy proposal is gaining some traction in the Senate and we urge you to set aside this legislation and instead allow the Senate to follow the pathway forward on health reform through a more deliberative process of regular order, in which hearings are held to solicit the advice of health care experts and stakeholders, with any such improvements considered in a bipartisan manner in which both parties may offer amendments. This process will allow the Senate to ensure that any changes to current law, first, do no harm, to patients and build upon the gains in coverage provided by current law.

As outlined in detail below, ACP believes that there are steps that Congress can take now to build upon current-law coverage, including: stabilizing the insurance market, continuing cost sharing reduction payments, encouraging reinsurance programs, promoting ACA enrollment, preserving and strengthening the Medicaid program, and allowing individuals to buy into

Medicare coverage. It is also vitally important that Congress extend funding for critical programs that will soon expire, such as the Children's Health Insurance Program (CHIP), the Title VII Health Professions Program, the National Health Service Corps (NHSC), and Teaching Health Centers Graduate Medical Education (THCGME). Finally, to further aid in driving down costs while also improving the quality of care, Congress must address ways to improve care for those with chronic illnesses, reduce the cost of prescription drugs, and promote value-based care.

**Enact Reforms to Stabilize the Market**

We are also encouraged that a bipartisan process for considering improvements to the ACA has also been started by the Senate, Health, Education, Labor and Pensions (HELP) Committee as it recently hosted hearings on ways to stabilize premiums and help individuals in the individual insurance market for 2018. ACP offered the following statement to the HELP committee on reforms that could be enacted to lower premiums and stabilize the individual insurance market. We urge the Senate Finance Committee to work with the Senate HELP Committee to enact the following reforms to stabilize the insurance market, improve coverage, and lower costs.

**Ensure Cost Sharing Reduction Payments**

ACP believes that Congress must make a clear, immediate and unambiguous commitment to preserve the ACA's cost-sharing reduction (CSR) payments to insurers at least through 2019, 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 up to 23 percent to make up the shortfall according to preliminary insurer rate filings for plan year 2018.[1] Insurers are deciding now whether they will be able to offer insurance through the exchanges for the 2018 enrollment cycle and several have already announced substantial premium increases because of the uncertainty over whether the CSR payments will continue. The Congressional Budget Office (CBO) has determined that gross silver plan premiums would increase by 20 percent in 2018 and 25 percent in 2020 compared to the March 2016 baseline if CSRs are not continued after 2017.[2] While enrollees who receive premium tax credits would be largely insulated from rate fluctuations, individuals who do not qualify for subsidized plans would be forced to pay the higher premiums or switch to less-expensive, off-marketplace plans. However, eliminating CSR payments would in fact cost the federal government $194 billion *more* over ten years according to the CBO.[3] Therefore, it is imperative that CSRs be preserved into the future.

**Encourage Reinsurance and Other Stabilization Efforts Through State Waivers**

[1] http://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/

[2] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf

[3] Congressional Budget Office. The Effects of Terminating Payments for Cost-Sharing Reductions. August 2017. Accessed at https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf

The College believes that the Department of Health and Human Services' (HHS) March 13, 2017 letter encouraging states to seek Section 1332 waivers for reinsurance programs was a step in the right direction. There is ample evidence that reinsurance can help to ensure that patients retain the coverage they have while protecting insurers from high costs. The ACA's temporary reinsurance pool ended in 2016 and was proven to be effective by HHS' June 30, 2017 report on transitional reinsurance payments and risk adjustment transfers for plan year 2016. That report showed that the ACA's transitional reinsurance program stabilized insurers with a substantial amount of high-cost enrollees, and, in concert with the risk adjustment program, reduced the risk of adverse selection.[4] Alaska's reinsurance program has successfully reduced premium costs,[5] containing premium hikes to just seven percent, down from a projected 42 percent increase. Minnesota has also applied for a section 1332 waiver to help finance its reinsurance program. Congress can also 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.[6]

Congress should 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**.** Provided that coverage and benefits available in a particular state would be no less than under current law, Congress should encourage the use of existing section 1332 waiver authority to allow states to adopt their own innovative programs to ensure coverage and access. 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. However, ACP believes that Congress should *not* weaken or eliminate the current-law guardrails that ensure patients have access to comprehensive essential health benefits and are protected from excessive co-payments and deductibles. If existing requirements were removed (e.g. that waivers provide comprehensive, affordable coverage that covers a comparable number of people as would be covered under current law), a backdoor would emerge for insurers to offer less generous coverage to fewer people and to make coverage unaffordable for patients with preexisting conditions. 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, or make other, more targeted revisions to continue existing state initiatives.

[4] Centers for Medicare and Medicaid Services. Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year. June 30, 2017. Accessed at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf
on July 6, 2017.

[5] Alaska Department of Commerce, Community, and Economic Development Division of Insurance. Alaska 1332 Waiver Application. December 7, 2016. Accessed at https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=106061

[6] http://www.commonwealthfund.org/publications/blog/2017/apr/shoring-up-the-health-insurance-marketplaces

**Enhance Enrollment Through Promotion and Engagement**

ACP supports robust outreach to patients to encourage patient enrollment in health coverage. Congress should support and properly fund this outreach and other education efforts to avert declining enrollment that could lead to higher premiums and market destabilization. The administration's recent actions to cut marketing funding for advertising by 90 percent and cut navigator program grant funding by about 41 percent are steps in the wrong direction and are counter to the available evidence. Distressingly, the administration has also interrupted the current funding for the navigator program and it is unclear when the funding will resume.[7] With open enrollment starting November 1st and the administration already stating that the funding will *not* be retroactive, Congress must step in with its oversight authority to properly ensure that the navigator programs are properly funded.

ACP strongly believes that *more* intensive outreach and enrollment efforts will be needed because the open enrollment period for 2018 was considerably shortened. Many uninsured people remain unaware of marketplace-based coverage options and subsidies[8] and in 2017 marketplace enrollment declined after HHS prematurely ended its open enrollment publicity and outreach campaign. Evidence suggests that efforts such as enhanced television advertising can increase enrollment.[9] Curtailing funding for such advertising, as the administration is planning to do, will not only reduce overall enrollment, leading to more uninsured persons, but also lead to adverse selection (and higher premiums and federal premium subsidies) if younger and healthier persons do not get the information needed to encourage and help them enroll. Therefore Congress must encourage the administration to redouble efforts to promote marketplace awareness and attract more people to shop and purchase the right coverage for them.

**Preserve and Strengthen Medicaid**

Medicaid is another program that provides a foundation for low-income children and adults to obtain quality affordable coverage. We remain opposed to attempts in this Congress to enact substantial cuts to Medicaid by converting the current federal financing formula for this program to a per capita cap or block grant model. Legislation to repeal and replace the Affordable Care Act, such as the Graham-Cassidy legislation, would significantly decrease federal funding for the Medicaid program by converting the current federal financing formula to a per capita cap model. The proposed per capita cap on federal funding would be devastating to coverage and access to care for many of the 72 million people currently enrolled. 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

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[7] Cliff, Sarah. "This is the most brazen act of Obamacare sabotage yet." *Vox*, September 8, 2017. Accessed at https://www.vox.com/platform/amp/policy-and-politics/2017/9/8/16268572/trump-obamacare-navigators

[8] http://www.commonwealthfund.org/publications/blog/2016/jan/better-outreach-critical-to-aca-enrollment-particularly-for-latinos

[9] Karaca-Mandic P, Wilcock A, Baum L, Barry CL, Fowler EF, Niederdeppe J, Gollust SE. The Volume of TV Advertisements During The ACA's First Enrollment Period Was Associated With Increased Insurance Coverage. Health Affairs. 2017; 36(4):747-754. Accessed at http://content.healthaffairs.org/content/36/4/747 on June 13, 2017.

hospitals (including rural hospitals that may be forced to close), enact harmful cuts to other state programs or raise taxes.

The Graham-Cassidy proposal would also allow states the option to participate in a Medicaid Flexibility block grant program beginning in Fiscal Year 2020. Under the Medicaid Flexibility Program, states would receive block grant funding instead of per capita cap funding for non-elderly, non-disabled, adults who are not eligible for the Medicaid expansion. We remain opposed to this block grant funding structure as we believe it would be devastating to coverage and access to care especially under this legislation as overall federal funding for Medicaid would be reduced from current law. Under block grants, because 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 will not allow for increases in the federal contribution should states encounter new costs, such as devastating hurricanes, flooding or tornadoes that may injure their residents or destroy health care facilities. Under either block grants or per capita spending limits, states would be forced to cut off enrollment, slash benefits, or curb provider reimbursement rates.

We are also concerned that the substantial cuts to Medicaid included in the Graham-Cassidy legislation will threaten coverage and treatment of individuals with substance abuse disorders. ACP supported the bipartisan-enacted provisions to address the opioid crisis through the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act. However, those laws are simply not a replacement for the comprehensive, continuous coverage furnished through the Medicaid program, which not only covers substance-use disorder-treatment but also a host of services to prevent and manage other chronic illness, including those that disproportionately affect opioid users, like HIV and hepatitis C. Medicaid also plays a crucial role in financing treatment for people in recovery, funding counseling services and vital medications like buprenorphine and naltrexone. Medicaid has also has greatly expanded access to life-saving naloxone, which all states cover in their Medicaid programs. Unfortunately, the Graham-Cassidy legislation will cap and cut Medicaid as well as phase out the Medicaid expansion, endangering comprehensive insurance coverage for patients and their families as well as the Medicaid beneficiaries with mental illness and substance use disorder conditions who were covered as a result of the Medicaid expansion

We urge the Committee not to restructure the Medicaid program to impose punitive work requirements as a condition for the receipt of Medicaid medical assistance. The Graham-Cassidy legislation would also permit states, effective October 1, 2017, to require non-disabled, non-elderly, non-pregnant individuals to satisfy a work requirement as a condition for the receipt of Medicaid medical assistance. We oppose this work requirement because Medicaid is not cash assistance or a 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 caregivers 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.

There is a substantial body of research that shows that the Medicaid program has improved access and outcomes to patients who depend on it for their care. 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.

**Support Medicare Buy-In Option**

Currently, some exchanges have difficulty attracting enough insurers and some patients may have only one insurer from which to obtain coverage. Congress should enact a public option that would provide more options and increase competition. Several avenues exist to achieve a range of public options including a buy-in program for traditional Medicare and Medicare Advantage, Medicaid, and other publically funded health programs to offer real competition to private insurers in the marketplaces.

For instance, ACP supports the development of a Medicare buy-in option for people age 55-64. Older adults would have the opportunity to enroll in the popular Medicare program while potentially improving both the Medicare and ACA marketplace risk pools and driving down premiums. Specifically, ACP recommends that: 1) 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; 2) a Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate; 3) Eligibility for a Medicare Buy-in Program should include adults age 55-64 regardless of their insurance status; 4) 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); and 5) Reimbursement for services, including evaluation and management services, should be no less than under the traditional Medicare reimbursement rates.

The benefits of a Medicare Buy-in program, according to the American Academy of Actuaries, may expand patient access to providers and enhance the continuity of care for individuals changing over to Medicare while at the same time helping to reduce premiums for individuals in the marketplace exchanges.[10]

[10] http://election2016.actuary.org/sites/default/files/Medicare-Buy-In-Option.pdf

**Extend funding for the Children's Health Insurance Program (CHIP)**
One of the first steps that Congress could take to ensure that individuals continue to maintain affordable quality health care insurance would be to reauthorize the CHIP program. We commend the Finance Committee Chairman Orrin Hatch and Ranking Member Ron Wyden for recently introducing legislation, S. 1827, the Keep Kids Insurance Dependable and Secure Act of 2017, that will extend funding for the CHIP program for the next five years. This legislation would ensure that the nearly 9 million children who are currently insured through the CHIP program will not lose coverage. ACP was pleased to offer a statement of support for the legislation and we urge Congress to act quickly on the consideration and passage of this legislation before the CHIP program expires at the end of the month.

**The Title VII Program**
It is also imperative that Congress continues to provide adequate funding for a primary care workforce to ensure that individuals who have insurance coverage have access to a physician to meet their health care needs. ACP strongly supports increasing funding for Title VII, a critical resource as it is the only federal program dedicated to funding and improving training of primary care physicians. We urge Congress to provide $71 million in funding for Fiscal Year 2018.

**The National Health Service Corps (NHSC)**
We urge Congress to continue funding for the NHSC that provides scholarships and loan forgiveness to encourage primary care physicians to work and care for patients who live in underserved communities. This College requests the Congress to provide $380 million for the NHSC for fiscal year 2018.

**Teaching Health Centers Graduate Medical Education (THCGME)**
The THCGME program was established by the ACA to provide funding for primary care residents in community settings. This program enriches the training of primary care residents by allowing them to see a wide variety of patients in an office based setting rather than solely in the hospital. The College recently signed on in support of reauthorization of the THCGME program to ensure stable funding. ACP supports the Training the Next Generation of Primary Care Doctors Act, H.R. 3394 and S. 1754 that would fund THCGME at $116.5 million each year for three fiscal years until 2020.

**STEPS CONGRESS CAN TAKE TO LOWER THE COST OF HEALTH CARE**
As Congress considers proposals to expand health insurance coverage, it must also move forward with the consideration and passage of legislation that will lower the cost of health care for all Americans. ACP has been supportive of bending the cost curve of medicine and urges Congress and the administration to enact the following measures to reduce health care costs to preserve access to affordable health care.

**The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017**

ACP commends the Senate Finance Committee for a commitment to advancing legislation to improve the quality and lower the cost of treating patients with multiple chronic illnesses. In April of this year, we submitted a letter of support to the sponsors of the legislation Senators Orrin Hatch, Ron Wyden, Johnny Isakson, and Mark Warner, that also included our recommendations to improve the bill. This legislation reforms Medicare to give physicians additional incentives to treat patients with chronic diseases in their homes, through advancements in telemedicine, and provides additional flexibility for Medicare beneficiaries to receive care through Accountable Care Organizations (ACOs).

This bill has been approved by the Senate Finance Committee and is now pending consideration by the Senate. We urge the Senate to move forward with debate on this legislation and ask Senators to offer the following amendments to strengthen the bill:

**ACP Recommendation**

We urge the Senate to add an amendment to the CHRONIC Care Act, that would require CMS to establish two new codes (perhaps initially as G codes) that would recognize the value of care for clinicians who treat patients with chronic conditions between 20-40 minutes and 40-60 minutes.

**ACP Recommendation**

We urge the Senate to add an amendment to this legislation that would move chronic care management services to the preventive services category under Medicare Fee-For-Services(FFS) to eliminate any beneficiary cost sharing associated with these services. Alternatively, a provision could be added that would allow CMS to give physicians the option of routinely waiving the copay for chronic care management codes for patients with chronic conditions.

**Lower the Cost of Prescription Drugs**

ACP recognizes that ensuring and improving patient access to prescription drugs and biologics is a growing need. Over the past several years, we have seen a dramatic rise in the cost of prescription drugs in this country. These increases apply not only to specialty drugs that treat life-threatening illnesses like cancer, but also common drugs like antibiotics that treat bacterial infections. Our internists see first-hand how the impact of rising prescription drug costs threatens the health of their patients. Approximately, 18 percent of retail prescription drugs were paid for out of pocket in 2012, and patients used various techniques to reduce costs, including not taking a medication as prescribed (7.8 percent), asking the doctor for a lower-cost medication (15.1 percent), purchasing drugs from another country (1.6 percent), or using alternative therapies.

There are several bills that we support and that Congress should approve to lower the cost and increase access to prescription medication. We urge Congress to enact the following measures to reduce the cost of these live saving medications:

***The Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act of 2017***
ACP supports S. 974, the CREATES Act of 2017, that aims to prevent anti-competitive practices by brand names drugs to prevent or delay other companies from developing other companies from developing alternative lower-cost products. This bill would allow lower cost manufacturers to bring a cause of action in federal court for injunctive relief if a brand name company deliberately uses FDA protocols to deny samples of their product in a manner that prevents the development of lower-cost alternatives, thereby decreasing patient access to lower-cost medications.

***The Medicare Prescription Drug Price Negotiation Act***
We urge Congress to approve S. 41, the Medicare Prescription Drug Price Negotiation Act that will empower the Secretary of Health and Human Services to negotiate with pharmaceutical manufacturers the prices that may be charged for prescription drugs covered under Medicare Part D. The ACP has long standing policy in support of this legislation as a way to lower the cost of prescription drugs purchased by the federal government.

**Promote Value Based Care**
One of the most effective ways to reduce cost and improve the quality of care provided to patients is to accelerate the transition from FFS payment systems toward a more value based payment system. We urge the Senate Finance Committee to use its oversight authority to encourage and work with the Centers for Medicare and Medicaid Innovation (CMMI) to develop test and expand Alternative Payment Models that promote value based care authorized by MACRA, as well as in the broader context of value-based payment and delivery system reform.

**Support Funding for CMMI**
The College strongly supports CMMI and its essential role in developing, financing, implementing, evaluating, and expanding innovative physician-led Advanced APMs as authorized by MACRA, as well as in the broader context of value-based payment and delivery system reform. ACP encourages CMS to fully use its authority under CMMI and the Physician-Focused Payment Model Technical Advisory Committee (PTAC) process to expand the availability of Advanced APMs and other models. The creation of additional APMs, including those that are specialist/subspecialist-focused, would provide additional pathways for practices to transition from traditional FFS to more valued-oriented payment approaches. It is also imperative that CMMI continues to have adequate funding to support its critical role in MACRA/QPP and the movement toward value-based payment.

**Encourage and Promote the testing of Accountable Care Organizations, the Patient Centered Medical Home, Bundled and Capitated Payments**
The College strongly supports the movement from traditional FFS toward a more value-based payment system. This should be achieved by testing a variety of payment models, such as accountable care organizations (ACOs), PCMH and patient-centered specialty practice models, bundled payments, capitated payments, and others. These models

should include risk adjustments including adjustments for socioeconomic status, to the extent possible. In recognition that all clinicians are not willing or able to move directly into models with significant payment at risk, there should be pathways to help clinicians transition to models with increasing levels of risk at stake. In order to accelerate the movement toward value-based payments, ACP encourages CMS to develop an expedited process for CMMI to develop, test, and expand APMs. This should include a pathway for testing models recommended by PTAC, as well as models from other payers including Medicaid and private payers. Accelerated implementation of models should prioritize APMs for clinicians who currently lack opportunities, such as specialists/subspecialists and clinicians who are unable to participate in current models such as those in regions where models are not being tested and those who are unable to participate due to limitations in the model design. Additional options for PCMH models and patient-centered specialty practice models should also be prioritized, including models that do not require physicians to bear more than nominal financial risk.

**Conclusion**

We appreciate the opportunity to provide our thoughts on the pathway forward on enhancing coverage and reducing the cost of health care. We remain concerned that rushing through any legislation to repeal and replace the Affordable Care Act, without following regular order, securing complete cost estimates, and inviting stakeholder input, would only destabilize the insurance marketplace and increase the number of uninsured in our country. Instead, we urge you to work with your colleagues, in a bipartisan fashion, to improve coverage and reduce cost through a more deliberative process. ACP stands ready to assist in that effort and to provide feedback on any policies that impact the medical profession and patients.