American College of Physicians Statement for the Record

Senate Finance Committee Hearing

The Graham-Cassidy-Heller-Johnson Proposal

September 25, 2017

As the Senate Finance Committee considers the merits of the Graham-Cassidy-Heller-Johnson (GCHJ) proposal to repeal and replace the Affordable Care Act (ACA), the American College of Physicians (ACP) would like to take this opportunity to provide our view that the Senate should not move forward with this bill. We outlined our opposition to the initial version of this legislation in our September 13th letter that detailed many of the reasons why it would undermine or eliminate health care coverage, benefits, and consumer protections for millions of people. Based on the most recent version of this legislation that was released on September 25, we reaffirm our strongest possible opposition to the new draft of the bill as it would make it even more harmful to our patients by creating new and perhaps insurmountable coverage barriers for Medicaid enrollees, and patients with pre-existing conditions and for the many millions of Americans who will be priced out of coverage, or will pay more for less coverage.

We are dismayed that the revised bill is an even more blatant violation of regular order because it was released just hours ago, with a vote possible in the Senate by Friday. As a result, the Congressional Budget Office (CBO) will have no time to do a complete cost and coverage estimate of GCHJ's impact by the time a vote is taken, there will be no committee mark ups, no time for other independent analyses and stakeholder input, and just a single, cursory hearing today that does not even allow time for the public to offer testimony that reflects a thorough review of the latest revised bill.

ACP urges the Finance Committee to move forward with the development of bipartisan legislation to stabilize the health insurance marketplace, create competition among insurers, and lower the cost of health care for all Americans. We believe that the bipartisan hearings that occurred earlier this month in the Senate Finance Committee on health care issues impacting cost and coverage and in the Senate HELP Committee on ways to stabilize and lower premiums in the individual insurance market offer a good starting point for the consideration of such health reform proposals.

ACP is the largest medical specialty organization and the second largest physician group in the United States, representing 152,000 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.

ACP has developed criteria, ten key questions that should be asked to ensure that any legislation that would alter the coverage and consumer protections under current law "first, do no harm" to patients and ultimately result in better coverage and access to care for essential medical services. We remain concerned the GCHJ legislation falls well short of meeting the criteria that we have established to ensure that the health of patients is improved rather than harmed by changes to current law.

Medicaid

The GCHJ legislation would eliminate or weaken coverage for individuals insured through Medicaid by eliminating the enhanced federal match provided under the ACA for states that opt to expand the Medicaid program starting on January 1, 2020. It would allow states to re-determine Medicaid eligibility for individual's eligible every six months or more frequently for individuals eligible for Medicaid through the ACA expansion or the state option for coverage for individuals with income that exceeds 133 percent of the federal poverty level. This change would result in a substantial number of citizens who reside in states that expanded their Medicaid population that would lose coverage under this legislation, with no assurance that they would be covered under a state plan or in the marketplace. It would put at risk the gains that we have made under the ACA in ensuring that low income individuals would have coverage and a regular source of care to maintain their well-being or treat illness when they are sick.

It would also 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 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 GCHJ 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, and non-expansion adults. 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.

The GCHJ 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 work requirements because 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 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.

The bill requires all states to establish their own system for financing health care by 2020, or risk losing all federal block grant funding. This would be highly disruptive and nearly-impossible task for most states to accomplish in that timeframe. It would also authorize massive redistribution of funding from states that expanded Medicaid coverage to the most vulnerable to those that did not, resulting in billions of dollars in cuts to Medicaid expansion states. In addition, all federal Medicaid funding to the states will sunset in 2027, when all states would lose federal block grant funding unless funding is reauthorized.

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, ACP 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.

Premium Tax Credits
This proposal would repeal the ACA premium tax credits as of January 1, 2020 and allocate some of the funds that were used for that purpose to a new Market Based Health Care Grant Program. States would be able to use payments allocated from the program for one or more of the following activities:

- To establish or maintain a program or mechanism to help high-risk individuals purchase health benefits coverage, including by reducing premiums for such individuals, who have or are projected to have high health care utilization (as measured by cost) and who do not have access to employer-sponsored insurance;
- To establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting market participation and plan choice in the individual market;
- To provide payments for health care providers for the provision of services specified by the CMS Administrator;
- To provide health insurance coverage by funding assistance to reduce out-of-pocket costs (such as copayments, coinsurance, and deductibles) for individuals with individual health insurance coverage.

We remain concerned that this formula provides less funding than currently in place for individuals to purchase health insurance in the individual market and that states could use these funds for a broad range of health care purposes, not just coverage, with essentially no guardrails or standards to ensure affordable meaningful coverage.

The estimates from the bill's sponsors and/or administration showing that many states will receive more federal dollars under the GCHJ Market Based Health Care Grant Program does not appear to take into consideration the impact of the Medicaid per-capita limits and reduction in the federal contribution to Medicaid. Even in the select states that the sponsors (questionably) assert will experience short-term gains in funding, all states are expected to experience reductions when the impact of Medicaid caps and cuts, and the expiration of funding in 2027, are taken into account. Any temporary increase in funding to a few states does not make up for the damage that will be done to their residents, and those of other states, resulting from eliminating essential patient protections and capping and cutting Medicaid. GCHJ would plunge the country back to the pre-ACA days when people 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.

Rather than grant states large sums of funding to use on the options listed in this legislation that offer no assurance of increased access to coverage, we wish to work with you to enact meaningful reforms to strengthen the individual market and build on the gains in health care coverage ensured by the ACA. ACP has offered a forward looking document that provides our prescription for meaningful reforms to accomplish these goals.

Elimination of Essential Health Benefits and Other Consumer Protections

We are alarmed that the most recent changes to the GCHJ legislation would do even more harm to individuals with pre-existing conditions by making it even easier for states to opt out of essential health benefits (EHBs) and could also allow annual and lifetime limits on patient coverage, resulting in bare-bones coverage. States will only have to submit to the Department of Health and Human Services a broad, undefined statement that they "shall" provide access to affordable coverage with insufficient or non-existent guardrails of what that is or requirements to ensure that such coverage is truly affordable. States could offer plans with lower or no "actuarial equivalent" standards, meaning higher deductibles and out-of-pocket costs for patients.

We believe that 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. The waiving of essential benefits would undermine the assurance that insurance policies would cover essential health care services such as physician and hospital benefits, maternity care and contraception, mental health and substance use disorder treatments, preventive services, and prescription drugs.

Unfortunately, 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.

Elimination of the Individual and Employer Mandate

The GCHJ legislation eliminates the mandate that requires individuals to pay a penalty if they do not acquire health insurance or employers with 50 or more full time workers to pay a fine if they do not provide health insurance for their employees. We are concerned that the elimination of this mandate would allow individuals to wait until they are ill to purchase insurance and that insurers would need to increase premiums to compensate for the resulting sicker risk pool and the destabilization of the insurance market. Maintaining effective adherence to the mandate helps balance the market's risk pool, attract healthier employees, and avoid dramatic premium rate increases. In addition, Congress should not enact any legislation to weaken or repeal the individual insurance requirement absent an alternative that will be equally or more effective.

Conclusion

In July of this year, the Senate failed to garner the necessary votes in the process of moving forward with legislation to repeal and replace the Affordable Care Act in a budget reconciliation bill. Rather than continue with an effort to repeal and replace the Affordable Care Act, we urge you to set aside this legislation and instead, focus on bipartisan efforts to improve coverage and lower costs based on the hearings that were held in the Senate Finance and HELP Committee earlier this month. We also urge that any legislation to amend current law should be developed through regular order, with hearings, debate, and committee mark-ups, and with sufficient time for comprehensive independent analysis by the Congressional Budget Office (CBO), independent experts, and the clinicians and patients directly affected by the proposed changes. We stand ready to work with you should our expertise be of help.