American College of Physicians
Leading Internal Medicine, Improving Lives

July 13, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader McConnell and Minority Leader Schumer:

On behalf of the American College of Physicians (ACP), I am writing to reaffirm our strongest possible opposition to the Better Care Reconciliation Act (BCRA) of 2017, despite the changes released today, as part of a revised bill. We believe these changes, especially Title III, will make the bill even more flawed and therefore even more harmful to our patients **by creating new and perhaps insurmountable coverage barriers for patients with pre-existing conditions and by severely weakening or completely eliminating requirements that insurers cover essential health benefits (EHBs) and abide other patient protections like community rating.** In a June 22nd letter, ACP detailed many of the reasons why the original version of the BCRA will undermine the coverage, the benefits, and consumer protections for millions of people and lead to 22 million losing their coverage entirely, including 15 million of our most vulnerable citizens in Medicaid. The BCRA, with today's revisions, continues to fall far short of meeting the criteria that ACP established that any reforms to current law, including the Affordable Care Act (ACA), the Medicaid program, and the Children's Health Insurance Program should *first, do no harm* to patients.

The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 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.

We are alarmed by the anticipated impact of the new Title III which would allow insurers to sell non-ACA compliant health plans in a state as long as the insurer also offered ACA-compliant plans in that state. This would result in insurance companies having vast discretion as to which ACA requirements and regulations to jettison in their non-ACA compliant plans. This is similar to the MacArthur-Meadows amendment that ACP objected to in the American Health Care Act (AHCA). Title III however is potentially worse because it would split the risk pool and create two markets, one where older and sicker individuals (with pre-existing conditions) would pay (or try to pay) for more expensive ACA-compliant policies, and the other where younger and healthier individuals purchase skimpier and cheaper, non-ACA compliant policies. Insurance companies would decide, if there were no mitigating state laws or regulations, which ACA Title I consumer protections to severely weaken or completely eliminate—specifically, community rating protecting people with pre-existing conditions and EHBs.

This 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.

Pre-existing conditions:

Before the ACA, insurance plans sold in the individual insurance market in all but five states typically maintained lists of so-called "declinable" pre-existing medical conditions—including asthma, diabetes, arthritis, obesity, stroke, or pregnancy, or having been diagnosed with cancer in the past 10 years. Even though Title III requires the ACA's guaranteed issue and community rating protections for people with pre-existing conditions for plans on the exchanges, insurers would charge more for these plans because younger and/or healthier individuals would move to the cheaper, less robust non-ACA compliant plans. The result would be that many patients with pre-existing conditions would be forced to purchase the ACA-compliant plans that cost them thousands of dollars more for the care that they need, and in the case of patients with expensive conditions like cancer, even hundreds of thousands more. While patients receiving premium tax credits would largely be insulated from dramatic price increases, those individuals ineligible for premium subsidies (including people with incomes between 350 percent and 400 percent of the federal poverty level who would be eligible for tax credits under current law) would be forced to pay the full cost of comprehensive coverage.

Essential Health Benefits:

Title III would allow insurers to sell plans without EHBs currently required of all plans sold in the individual insurance market. Prior to passage of the ACA, 62% of individual market enrollees did *not* have coverage of maternity services, 34% did *not* have substance use disorder services, 18% did *not* have mental health services and 9% did *not* have coverage for prescription drugs. A recent independent analysis found that the AHCA's repeal of current law required benefits would result in patients on average paying $1,952 more for cancer drugs; $1,807 for drugs for heart disease; $1,127 for drugs to treat lung diseases; $1,607 for drugs to treat mental illnesses; $4,940 for inpatient admission for mental health; $4,555 for inpatient admission for substance use treatment; and $8,501 for maternity care.

A report by Milliman found that the main drivers of premium costs were ambulatory patient services, hospitalization, and prescription drugs. These are crucial services that form the core of any health insurance plan. Another analysis determined that maternity/newborn care accounted for only 6% and outpatient care for substance use disorder and mental health treatment accounted for 1% of the share of total non-group premiums; removing these categories from the EHB package would do little to cut premiums while forcing patients who need these services to pay several thousands of dollars to purchase care in the segregated insurance market. Such increased costs would make it practically impossible for many patients to avail themselves of the care they need. The result will be delays in getting treatment until their illnesses present at a more advanced, less treatable, and more expensive stage, or not keeping up with life-saving medications prescribed by their physicians.

Allowing insurers to eliminate EHBs will also threaten our nation's fight against the opioid epidemic, despite the increased funding in the bill for substance use disorder treatment, as discussed in more detail below. A study concluded that with repeal of the ACA, "approximately 1,253,000 people with

serious mental disorders and about 2.8 million Americans with a substance use disorder, of whom about 222,000 have an opioid disorder, would lose some or all of their insurance coverage."

Substance-use disorder and opioids:
This revised version of the BCRA provides roughly $45 billion over ten years for states to direct to substance use disorder treatment, but that is woefully insufficient to meet the need nationwide of this epidemic. 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—and the additional $45 billion in the BCRA—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 BCRA 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.

Market stabilization:
While ACP acknowledges that one of the modifications offered today adds more funding for market stabilization efforts in the states with the intent of shoring up insurance markets for individuals who have high medical costs or have lost their Medicaid coverage, we are concerned this funding remains inadequate. According to analysis of the BCRA as released on June 22nd, these market stabilization efforts would only reduce premiums by about 4 percent in 2026. Even with increased stabilization funding, ACP is greatly concerned that with the BCRA's draconian cuts to Medicaid along with much less robust tax credits for people in the individual market—all of which remain in place—no amount of temporary funding would be able to overcome the disruption to the individual market unleashed by the BCRA. Case in point, the cost sharing reductions in the BCRA end in 2020, further destabilizing the individual insurance market, and increasing out-of-pocket costs to low-income persons.

While today's version of the BCRA contains a new fund for health insurers to cover high-risk individuals in the remaining ACA-compliant plans, we are concerned that this funding will be difficult to administer and will be inadequate to insulate those individuals from increased costs. ACP is not alone in this assessment; insurance industry stakeholders have great concerns that Title III would cause unworkable instability in the individual market even with market-stabilization funding.

Medicaid and process concerns:
We also remain strongly opposed to how the BCRA would radically change how Medicaid is financed, would reduce premium and cost-sharing subsidies for people in the individual insurance market, and would significantly weaken essential consumer protections for the most vulnerable patients through waivers—which are still contained in the bill despite today's revisions. And, from a process standpoint, ACP remains deeply concerned about the lack of regular order in drafting the BCRA—which unfortunately continues with the development of the policies in this legislation. The appropriate

vetting of any such comprehensive legislation, through stakeholder input, hearings, and vital cost estimates are all crucial to understanding the impact of these policies, all of which have profound, long-term consequences, and this process has clearly not been observed, either with the BCRA or the House-passed AHCA.

The College strongly believes in the *first, do no harm* principle. The course of the Senate is not pre-determined—there is still time to forge a new path. The BCRA—even with modifications—will not preserve and improve essential coverage, benefits and consumer protections, and access to care for both currently insured and uninsured individuals, children and families. **Therefore, we strongly urge that the Senate move away from the fundamentally flawed and harmful policies that would result from the BCRA.** We urge the Senate to vote down this legislation and instead start over and seek agreement on bipartisan ways to improve and build on the ACA and to make other improvements in patient care, as proposed in *ACP's Prescription for a Forward-Looking Agenda to Improve American Health Care*. The College welcomes the opportunity to share our ideas for bipartisan solutions for improving current law that would help make health care better, more accessible, and more affordable for patients.

Sincerely,

Jack Ende, MD, MACP
President

Cc: Members of the United States Senate