AMERICAN OSTEOPATHIC ASSOCIATION

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May 23, 2017

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

Dear Chairman Hatch:

On behalf of the American Osteopathic Association (AOA) and the nearly 130,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to share recommendations on ways to provide patient-focused reforms that address the increasing costs of healthcare while giving American families greater control of their healthcare coverage decisions. We recognize the many challenges our current health care system faces and are supportive of efforts to improve it.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. As such, we recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families will have access to coverage and care when and where they need it. At the start of the year, the AOA shared with Congressional leadership and the incoming Administration its Priorities for Health Care Reform, which highlighted four key needs when considering changes to our health care system:

- Foundation based on prevention and care coordination
- Preservation of the patient-physician relationship
- Development of a strong physician workforce is critical
- Ensured coverage and access to care

As such, the AOA unequivocally believes that the primary focus of any policy and/or operational changes should be to expand or at least maintain access to comprehensive, affordable coverage and care. With that said, we are also concerned about the growing potential for market instability and the deleterious effect that a collapse would have on patients' access to insurance coverage and health care services. The AOA urges the Committee to consider policy changes to our existing healthcare system that would ensure unimpeded access to high-quality care at the appropriate time and in the appropriate setting, while providing stability and sustainability in the marketplace.

Access to Care and Continuity

Osteopathic medicine values preventive care as a foundational element of health care. As such, we strongly urge that coverage of evidence-based, preventive services without cost-sharing to patients should be not just preserved, but emphasized, as a requirement of insurance plans. Increased access to screening for diabetes, cancer, depression, and other chronic conditions, and counseling to address behavioral risk factors have the potential to reduce disease and prevent exacerbations of conditions that can be medically managed when caught early. Improved health will reduce the use of avoidable hospital and other high-cost care and could significantly reduce Medicaid spending. For example, smoking can cause heart disease and other

chronic illness that one study estimated may be responsible for more than $75 billion in Medicaid costs. Medicaid coverage of smoking cessation services, including telephone quit lines and medications, has the potential to mitigate both health and cost impacts of smoking. Obesity, a major driver of preventable chronic illness and health care costs, affects about two-third of low-income adults. Findings from one study indicate that severe obesity in adults cost state Medicaid programs almost $8 billion in 2013.[1]

Appropriate and timely clinical interventions are vital to favorable patient health outcomes. The AOA believes the advancement of policies that promote continuous enrollment in health insurance coverage and discourage individuals from waiting until illness occurs to become enrolled are critically important to achieving a more stable and sustainable marketplace. With that said, the AOA does not support adoption of continuous coverage standards that would create additional barriers for consumers to access care. We believe that the imposition of pre-existing condition exclusions, health status underwriting allowances, waiting periods, and/or enrollment penalties or premium surcharges as contemplated under a continuous coverage approach would conflict with the Committee's stated goal of giving American families greater control over their healthcare decisions.

Medicaid

The AOA supports ensuring access to care for the most vulnerable in our nation of all ages, including those who lack the resources to directly access it themselves. We are concerned that the changes being considered for the Medicaid program as part of health care reform discussions will significantly impact coverage for these Americans.

The House-passed American Health Care Act (AHCA) would repeal the enhanced federal funding for the Medicaid expansion to low-income adults and repeal the federal essential health benefit requirements for Medicaid adults. The AOA has grave concerns that such large losses in Medicaid coverage for adults, as well as a reduced set of benefits for those who do remain covered, would further exacerbate healthcare spending by allowing preventable disease to manifest to full blown chronic conditions.

The bill also implements a per capita cap that is "one-sided," in that it would provide states with a reduced federal matching fund if their spending is above the AHCA cap in a given year, but would not provide them with additional federal funding if their spending is below the cap. After 2020, the cap would be adjusted based on changes in the Consumer Price Index for Medical Care (CPI-M), as well as changes in the share of enrollees in a set of specified eligibility categories.

The AOA is concerned that this will leave states with insufficient funds to provide care to the most vulnerable in our society. Medical inflation does not capture many of the factors that affect overall health care spending trends, such as trends in health care utilization. The current structure of the per-capita cap in AHCA leaves states at risk of cuts that are significantly larger than expected if utilization increases due to demographic changes, changes in resident's health status, public health emergencies, or the arrival of new pharmaceuticals and technologies on the market.

We are currently facing an opioid epidemic, and Medicaid plays a vital role in addressing this epidemic. In 2015, over 2 million people were addicted to prescription opioids and 591,000 addicted to heroin. Medicaid provides coverage to over 650,000 non-elderly adults with opioid addiction and covers range of treatment services. As of May 2017, 32 states have expanded Medicaid, with enhanced federal funding, to cover adults up to 138% of the federal poverty level. By broadening coverage of adults, the Medicaid expansion has been able to reach many low-income adults with opioid addiction who were previously ineligible for coverage and facilitated access to treatment.[2]

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[1] Kaiser Family Foundation; Data Note: Medicaid's Role in Providing Access to Preventive Care for Adults; May 2017.

[2] Kaiser Family Foundation; 6 Things to know About Uninsured Adults with Opioid Addiction; May 12, 2017.

Substance use disorders have a ripple effect that continues far from just the patient. The opioid epidemic has societal costs that go far beyond health care expense -- there are workplace costs (lost earnings, reduced productivity, lost employment, reduced tax revenues), criminal justice costs (correctional facility and police resources), and public sector costs (social support services for dependents of impacted patients, survivor benefits for those left behind in the case of fatal overdoses, of which there were 15,000 in 2015 alone). One study estimated these aggregate costs at $78.5 billion for the United States in 2013 dollars[3]. Therefore, investing into such care for as many Americans as possible can lower costs for both states and the federal government in the long-term. But more importantly, ensuring such access will reduce untold amounts of pain and suffering for millions of Americans and their families.

Consumer Protection

The healthcare system must support consumers and provide high-value options for their healthcare coverage. While the AHCA preserves many of the consumer protections for insurance coverage that are part of current law, such as guaranteed issue requirements and prohibitions against direct discrimination in underwriting based on gender, race, or previous health history, we have strong concerns that other provisions of this legislation would still leave many Americans without adequate access to affordable care, and would still impact many based on their gender or pre-existing conditions due to reductions in the minimum benefits. In addition to states having the option to waive out of requirements to cover all of the essential health benefit categories, actuarial value requirements and cost-sharing subsidies are also being repealed. Combined with a shift to basing tax credits for purchasing coverage largely on age rather than income, many Americans could be left in a position of being able to perhaps obtain so-called coverage, but given its more limited value, will be unable to afford their actual care.

There have been discussions of implementing an Invisible Risk-Sharing Program (IRSP) as part of healthcare reform legislation. While the AOA supports providing guaranteed access to coverage and protecting patients with pre-existing conditions, we urge the Committee to make certain that the funds dedicated to the IRSP are maintained by an independent non-profit organization. We encourage such independence to ensure the funds managed by the program are used solely for their intended purpose. Such a system will provide certainty for health insurance providers that the program will remain solvent as they will have to prospectively cede individuals into the program and cede those individuals' premiums to help pay for the risk sharing. Such stability in the system will also help to alleviate the high rates of health insurance premiums from year to year.

The AOA agrees with the Committee's stated goal to provide "patient-focused reforms." Partnering with our patients in their care is at the heart of our whole-person collaborative approach to medicine. To this point, we emphasize to the Committee the role that increased health literacy plays in improving health outcomes for patients and reducing costs for the entire healthcare system. According to the Agency for Healthcare Research and Quality Report, low health literacy is linked to higher risk of death and more emergency room visits and hospitalization.[4] This holds particularly true for vulnerable populations including older adults, minority, and low income populations.[5] In addition to poorer health outcomes, low health literacy has an economic consequence. It is estimated that the cost of low health literacy to the U.S. economy is between $106 billion to $238 billion annually, representing between 7 and 17 percent of all health care expenditures.[6]

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[3] Curtis S. Florence, Chao Zhou, Feijun Luo, Likang Xu. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Medical Care*, 2016; 54 (10): 901 DOI: 10.1097/MLR.0000000000000625

[4] Agency for Healthcare Research and Quality; Health Literacy Interventions and Outcomes: An Updated Systematic Review; March 2011.

[5] Institute of Medicine and Nielsen-Bohlman, L., Penzer, A. M., Kindig, D.A., Health Literacy: A Prescription to End Confusion

[6] Vernon, J.A., Trujillo, A, Rosenbaum, S, (2007). Low Health Literacy: Implications for National Health Policy

Choosing the proper health insurance with the correct in-network physicians, specialists, and hospital can be overwhelming enough. As consumer-driven healthcare plays an increasing role in health reform discussions, patients could face even more complexity as they would need to identify and compare options for the care they seek, often with little to no information accessible to them with which to make these comparisons. This further highlights the need and importance to improve health communication, education, and consumption of healthcare to reduce costs and improve access to high-quality care.

In the immediate term, we support efforts to restore the ability to use Health Saving Accounts to access over the counter (OTC) medications. A provision in the Affordable Care Act limited coverage of OTC medications—by requiring a prescription to use tax-deferred health savings dollars for their purchase. Many physicians encourage patients to use OTC products as a means of addressing their immediate health care needs and long-term health maintenance, and OTC medicines provide patients with an effective, affordable, convenient and accessible means to address their health care needs. Requiring patients to obtain a prescription from their physician in order to receive coverage through their tax-preferred account is burdensome and costly to the patient, the physician, and our health care system. Additionally, the products impacted by this policy have already been deemed safe and appropriate for direct sale to and use by consumers by the Food and Drug Administration (FDA), making the prescription requirement even more onerous and unnecessary.

Cost Containment

We are concerned that costs will become barriers to healthcare access. While we understand the Committee's goal to reduce the cost of qualified health plans in the exchange, we stress that proposals to lift the personal responsibility mandate and allow tax credits to apply to all state approved health plans will adversely impact patients. State-approved plans, by definition, do not meet all the consumer protections required in plans that are in the exchange. While the AOA supports states' ability to regulate their insurance market, we are concerned that the proliferation of state-approved plans such as short-term, fixed-indemnity, and specified disease insurance plans which all can be underwritten for health status, exclude pre-existing conditions, omit essential health benefits, and impose annual and lifetime caps would leave consumers with inadequate coverage and lack of access to high-quality care.

In addition, patients benefit from access to healthcare providers of varied specialties. We have great concerns that the aforementioned plans would have very narrow and limited networks that offer necessary care to beneficiaries, especially for lowest cost-sharing tiers in which there are insufficient numbers or specialties of providers to offer consumers adequate access to covered services. Further, providers in narrow networks are challenged to coordinate patient care and are forced to take on more responsibility for the patient due to lack of other providers in network. This provides a disincentive for physicians to contract with health plans that have narrow networks, potentially creating an increasingly downward spiral. As such, reform in our system should provide incentives for qualified health plans to stay in the marketplace and provide incentives for physicians to contract with qualified health plans.

Market Stability

Physicians and patients benefit from stability in the healthcare system as they partner to address healthcare needs. As such, the AOA believes that immediate action is needed to provide critical stability to the health insurance market, and to ensure those in the individual market can continue to access coverage. Further, we suggest that the most urgent action the Senate may do to stabilize the market is to find a bipartisan solution to ensure continued full funding of cost-sharing reduction payments (CSRs) to qualified health plans for eligible enrollees who have coverage through the exchanges.

CSRs help close to 7 million enrollees access care by defraying their cost-sharing obligations, which include co-payments, co-insurance, and deductibles. Notably, insurers have little time left to finalize their rate filings for the 2018 coverage year, and without certainty as to how long CSR payments will be made – or even if they will be made at all – they may be forced to leave the marketplace. One-third of the counties in our nation have only a single issuer offering coverage to those in the individual market; if more leave the marketplace, the impact will be disastrous. Even in areas where insurers are able to remain in the

marketplace, the Kaiser Family Foundation predicts premiums on benchmark plans are projected to rise on average by almost twenty percent, with even higher increases expected in states that did not expand Medicaid[7]. Not only that, this same analysis indicates that if the CSR payments were stopped, **the federal government would actually spend $31 billion *more*** through increased premium tax credits. Continuation of these payments is the fiscally responsible path forward.

The urgency to solve this issue is bipartisan, and continues to grow. The National Governors Association has stated that "Funding the CSR payments will ensure that 7 million low-income enrollees will continue to have affordable access to services through reduced cost-sharing obligations..."

We strongly urge the Committee to find a bipartisan funding pathway for these payments that is stable and builds in long-term and continuous certainty. Such a mechanism is necessary to avoiding future funding crises that will only further exacerbate market instability and continue to erode access for millions of Americans to high quality, affordable coverage and health care. We firmly believe this is the fiscally responsible solution that will be of the greatest benefit for American patients and their families.

Conclusion

The AOA stands ready to assist you in developing approaches to advance our principles, and remains hopeful you will consider our perspective in the coming days. We reiterate our unequivocal belief that the primary focus of any policy and/or operational changes should be to expand or at least maintain access to comprehensive, affordable coverage and care. For more information, please contact Laura Wooster, MPH, AOA Senior Vice President for Public Policy at lwooster@osteopathic.org.

Thank you,

Boyd R. Buser, DO
President
American Osteopathic Association

[7] Kaiser Family Foundation; The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments; April 25, 2017.