ENDOCRINE SOCIETY
Hormone Science to Health

March 20, 2017

The Honorable Mitch McConnell
Senate Majority Leader
U.S. Capitol Building, S-230
Washington DC 20510

The Honorable Paul Ryan
Speaker of the House
U.S. Capitol Building, H-232
Washington, DC 20515

Dear Leader McConnell and Speaker Ryan:

On behalf of the Endocrine Society, the oldest and largest global professional membership organization representing the field of endocrinology, I would like to share our comments and concerns about specific provisions in the American Health Care Act (AHCA). Our more than 18,000 members care for patients and are dedicated to advancing hormone research and excellence in the clinical practice of endocrinology, focusing on diabetes, obesity, osteoporosis, infertility, rare cancers and thyroid conditions. We promote policies to help ensure that all individuals with endocrine diseases have access to high quality, specialized care and adequate, affordable health insurance, and believe strongly that no person who currently has health insurance should lose their coverage because of the repeal of the Affordable Care Act (ACA).

Affordable access to health insurance - We appreciate your commitment to maintain important insurance market reforms, including the guarantee of health insurance with no annual or lifetime caps or pre-existing condition exclusions, and the opportunity for a young adult to be covered by their parents' insurance until the age of 26. The ACA has allowed many of these people to obtain affordable insurance coverage; the cost of care for endocrine conditions such as diabetes, which averages $13,700 per year[1], is beyond the ability of most people to afford without insurance coverage. Alleviating some of the financial burden through insurance coverage allows those people with diabetes to follow the care plan developed with their physician and avoid costly complications.

We do have concerns, however, with the potential cost that patients with pre-existing conditions will have to pay for their health insurance according to the AHCA. The individual mandate established through the ACA was designed to expand the insurance pool to balance the costs of coverage of a person with a pre-existing condition or multiple chronic diseases with the low costs of coverage of a young, healthy person. Without the requirement for

[1] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2012. *Diabetes Care.* April 2013.

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everyone to maintain continuous coverage, insurance providers will need to charge significantly more for their enrollees with pre-existing conditions or multiple chronic diseases, making the coverage options beyond the means of many of these individuals. These costs will be even harder to bear as these individuals age because of the AHCA provision that increases the age rating from 3:1 to 5:1. **We appreciate that the legislation includes the Patient and State Stability Fund that can be used by states to offset the cost for high-risk individuals to enroll in a plan, but urge you to include a provision that limits insurers' ability to charge significantly higher prices to these individuals.**

Elimination of the Prevention and Public Health Fund (PPHF) – The Society opposes the elimination of the PPHF. The Fund has allowed the Centers for Disease Control and Prevention to expand effective prevention programs such as the evidence-based Diabetes Prevention Program (DPP), which saves Medicare $2,650 per enrollee. Approximately 12 percent of the agency's budget, and approximately 80 percent of CDC's diabetes programing, is funded through PPHF, which goes to support critical evidence-based prevention and public health programs that lower the incidence of diseases and prepares the country for public health emergencies. In this budget environment, this funding shortfall will not be able to be filled through the appropriations process. Preventive health care improves the health of Americans while also reducing costs to the health care system. **We urge you to maintain the PPHF.**

Access to women's health care services – Ensuring that all women, regardless of their socioeconomic status, have continued access to health services, contraception, and preventive screenings is a top priority for the Society.

We strongly oppose provisions in the ACHA that prevent Americans from choosing to receive care from physicians and other qualified providers based on site-of-service, such as Planned Parenthood clinics. These clinics provide vital health care services to women who are uninsured or unable to afford care at hospitals or physicians' offices. 97 percent of the services provided are for basic health care, preventive services, cancer screening, and sexually transmitted disease screening[2], largely to low-income and under-served populations. Texas provides a real-world example of the impact of defunding health care providers like Planned Parenthood. Analysis shows that there was a 25 percent average decrease in number of women served by clinics within the Texas Women's Health Program[3], an increase in the rate of childbirth covered by Medicaid[4], and a significant increase in maternal mortality rates[5] in the

[2] Analysis of Planned Parenthood Services Provided. https://www.plannedparenthood.org/files/3814/5756/0903/PP_Services.pdf
[3] Weinberg, A. Planned Parenthood was Defunded by Texas: Here's What Congress Can Learn. *ABC News Online.* August 3, 2015
[4] Stevenson, A. et al. Effects of Removal of Planned Parenthood from the Texas Women's Health Program. *N Engl J Med* 2016; 374:853-860.
[5] MacDorman MF, et al. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. *Obstet Gynecol* 2016;128:447-52

years after the defunding of Planned Parenthood. **Protecting women's health, including ensuring access to care and preventive services, including contraception free of charge, is critical to ensuring the public's health. We urge you to remove Section 103 from the AHCA.**

Changes to the Medicaid Program – We are concerned that the proposed changes to the Medicaid program – repeal of the Medicaid expansion and change to a per capita allotment – will limit enrollment through more restrictive eligibility requirements and eliminate coverage for many adults who benefited from the Medicaid expansion. In states that expanded Medicaid under the ACA, all those enrolled before December 31, 2019 will be allowed to remain on Medicaid, if they maintain continuous coverage and meet stringent eligibility re-verification requirements. This will mean that adults who gained coverage under the expansion and experience a change in insurance coverage (receiving coverage through a new employer, for instance) will not be able to re-enroll in Medicaid after January 1, 2020 if their circumstances change again. Furthermore, a change to a per capita allotment will force states to make difficult decisions on how to ensure that enrollees receive high-quality care within the amount provided by the federal government. Reduced funding will have many consequences, including limiting access as more health care providers will not accept Medicaid patients due to low reimbursement rates. **Congress must provide assurances that low and moderate income Americans can remain in the Medicaid program after the expansion ends or will be able to secure affordable and adequate coverage in the individual markets. Medicaid, CHIP, and other safety net programs must be maintained and adequately funded**.

The AHCA also eliminates the requirement that Medicaid programs provide a standard set of essential health benefits (EHB). We are concerned that states may be forced to make the choice to provide fewer preventive and primary care services to lower costs. These services have been proven to reduce complications and emergency room visits, thereby saving the health care system money in the long run. **We urge you to maintain the EHB requirement to ensure that Medicaid enrollees have access to and continue to benefit from these services.**

These proposed changes to Medicaid coupled with the repeal of the ACA taxes will disproportionally benefit the wealthy while harming the people who depend on these safety net services.

Cost sharing subsidies – As previously mentioned, we cannot support any provision that would negatively impact an individual's access to care and coverage. By eliminating the cost-sharing subsidy for Silver tier plans established under the ACA, many low and middle-income individuals and families who do not qualify for Medicaid will be unable to pay the out-of-

pocket costs that are required with plans with lower actuarial values. Furthermore, it is expected that the tax credits included in the American Health Care Act will be markedly lower than the subsidies received through the ACA. Eliminating the cost-sharing subsidies on top of the reduced premium support will result in fewer numbers of covered individuals or lower utilization of preventive and primary care services. Having insurance coverage does not benefit the enrollees if they cannot access care due to high cost-sharing requirements. **We ask that you continue the cost-sharing subsidies for individuals or families below 250 percent of the federal poverty level.**

Refundable tax credits – The AHCA eliminates the ACA subsidies and replaces them with refundable tax credits that will be as low as $2,000 for an individual in their 20s to as high as $14,000 for families. These credits will not cover as much of the insurance premiums as the tax credits under the ACA, forcing many individuals or families to drop their health insurance or select a plan that has a high deductible. Older people will be particularly hard hit by this change. The ACA considers family income, local cost of insurance, and age when determining the amount of financial support, while the replacement proposal is based only on age, with a gradual phase out for individuals with incomes above $75,000. A Standard & Poor's analysis estimates that a 64-year-old could see their annual premium increase by 30 percent to $13,100 per year on average, largely due to the provision in the AHCA that would allow insurers to charge an older adult five times as much as a younger person instead of the 3:1 age band rating established by the ACA. A $4,000 tax credit would mean that this individual would be responsible for over $700 per month in premiums – a significant amount for someone with a limited income. **If Congress cannot provide a comparable tax credit to the subsidy received under the ACA, the age band rating must stay at 3:1 and additional factors such as income and geographic location must be considered when determining the amount of the tax credit.**

Thank you for considering our comments. While there may be components of the ACA that could be improved, we are concerned that too many of the provisions that have made it possible for millions of people to gain insurance coverage are being repealed or altered in the AHCA. We are eager to work with members of Congress to develop a plan that guarantees coverage and access to health care for all who currently have insurance and embodies the values of families across our country. Please contact Mila Becker, JD, Chief Policy Officer at mbecker@endocrine.org or Stephanie Kutler, Director of Policy and Advocacy at skutler@endocrine.org if we may help as you move forward.

Sincerely,

Henry Kronenberg, MD
President, Endocrine Society

CC: Senate Minority Leader Charles E. Schumer
Senate Finance Committee Chairman Orrin Hatch
Senate Finance Committee Ranking Member Ron Wyden
House Minority Leader Nancy Pelosi
House Energy and Commerce Committee Chair Greg Walden
House Energy and Commerce Committee Ranking Member Frank Pallone
Secretary of Health and Human Services Thomas Price