



March 14, 2017

The Honorable Diane Black
Chairwoman
House Budget Committee
Washington, DC

The Honorable John Yarmuth
Ranking Member
House Budget Committee
Washington, DC

Dear Chairwoman Black and Ranking Member Yarmuth:

In advance of the House Budget Committee's consideration of the "American Health Care Act" (AHCA), the American Academy of Family Physicians (AAFP) submits the following analysis and recommendations to inform and assist you in your work.

The AAFP continues to have significant concerns with the legislation in its current form. Our concerns are primarily focused on the significant loss of health care coverage that will be experienced by millions of Americans should this legislation become law. Furthermore, we believe those who retain coverage will face escalating premiums and deductibles that will further separate them and their health care needs from the health care system.

These two concerns are supported by the recently released analysis from the Congressional Budget Office (CBO), which found that, if the AHCA were enacted in its current form, 21 million fewer Americans would have health care coverage in 2020 and 24 million fewer in 2026. The CBO analysis also found that as many as 7 million people who currently have employer-based coverage would lose that coverage. Our concerns regarding the financial impact on individuals and families also were supported by the CBO analysis, which found that premiums in the nongroup market would increase by 15 percent to 20 percent more than current law in 2018 and 2019. When CBO's projections on premium increases under current law are factored in, the actual premium increases likely would be greater than 25 percent for individuals in the nongroup market. Furthermore, we are especially concerned with the CBO's projections regarding the impact of new age-rating rules on older adults.

There are several provisions in the AHCA that are consistent with AAFP policy. We strongly support the continuation of protections available under current law that prohibit discrimination in insurance underwriting based on age, gender, race, or an individual's health history. We also appreciate that the proposal takes steps to ensure that individuals with pre-existing conditions are not subjected to draconian medical underwriting practices that would make coverage unobtainable for them. We also appreciate that you acknowledge the poor payment rates that are prevalent in Medicaid, especially for primary care, and offer a policy solution that would allow states to address this long-standing problem, even if just temporarily.

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Despite the inclusion of provisions that extend these important policies, the AAFP has significant concerns with the AHCA as drafted and is deeply troubled by the negative impact it would have on individuals, families, and our health care system writ large. The following are recommendations on how the legislation should be improved by your Committee.

Health Care Coverage

The AAFP first adopted a policy supporting health care coverage for all in 1989. For the past 28 years the AAFP has advanced and supported policies that would ensure a greater number of Americans had health care coverage. In a December 28, 2016 [letter](#) to House and Senate leaders, the AAFP outlined the criteria by which we would evaluate any health care reform proposal introduced in the 115th Congress. In our December 28 letter we stated:

“Currently insured individuals should not lose their health care coverage (public or private) as the result of any action or inaction on the part of the United States Congress and/or the Administration. The AAFP shares your goal of ensuring that currently uninsured individuals have affordable health care coverage, but we believe the expansion in the number of individuals with health care coverage should be pursued in a manner that does not disrupt or destabilize the individual, small group, or employer-based insurance markets.”

The AHCA currently falls short of this objective. As noted in the CBO analysis, the AHCA will result in 24 million people, who are currently covered, losing that coverage by 2026. Furthermore, CBO found that people’s share of medical services paid in the form of deductibles and other cost sharing would increase. Due to this, the CBO predicts that fewer lower-income people would obtain coverage. The negative and consequential impact this legislation would have on low and middle income families, including those with employer-based coverage, should give us all pause. We are equally concerned that the phased-in implementation outlined in the AHCA will destabilize insurance markets over the next three years and directly harm millions of people.

Finally, the AAFP strongly disagrees with suggestions that the AHCA will provide every American “access to health care coverage.” “Access to health care coverage” is distinctly different than “securing health care coverage.” The AAFP’s goal is to ensure that every American “secures health care coverage.”

Affordability

We believe the AHCA does not adequately address the affordability of health care coverage or health care more generally. We are concerned that it would compound the economic strain on a large percentage of individuals and families – requiring them to spend a larger percentage of their income on premiums and deductibles and thus leading to greater financial insecurity. More people – including those with employer-based coverage – will be forced to spend a higher percentage of their income on health care coverage premiums and deductibles if it becomes law.

Our concerns are supported by several independent and non-partisan organizations that have shown the negative impact the AHCA will have on premiums and deductibles. Furthermore, their analyses also show that low and middle income families – especially those with family members above the age of 45 – would experience substantial increases in the cost of their health care coverage.

We also are concerned that the AHCA does not propose policies that would foster greater competition in the insurance market, especially in predominantly rural communities. The combination of the AHCA's policies seems to discourage competition, not foster it.

Clearly there is work that needs to be done to improve the affordability of health insurance coverage and health care services. The AHCA, in our opinion, prioritizes the elimination of coverage and premium support while failing to address the real-life economic challenges Americans have with health care. The AAFP has proposed a policy that would assist individuals and families with these challenges through a policy that would afford them access to primary care physicians independent of cost-sharing requirements such as deductibles. We outline this proposal below.

Medicaid

The AAFP and our members are committed to ensuring that all individuals, regardless of their socio-economic status, have access to health care coverage. This commitment is acutely focused on those individuals and families who do not have access to employer-based health insurance and/or are economically unable to secure health care coverage through the individual market. Our commitment to low-income individuals and families is reflected in family physicians' participation in the Medicaid program. Currently, more than two-thirds (68%) of family physicians participate in the Medicaid program and accept new patients into their practices. Participation in Medicaid by family physicians is at its highest level since the AAFP began monitoring the issue in 2004.

Our nation has extended health security to low-income individuals and families for more than 50 years. We have more work to do to ensure health equity among all individuals and populations, but ensuring affordable health coverage for all Americans is a critical first step toward this goal. Today, more than 70 million people rely on the Medicaid program for their health care coverage. The AAFP believes that these individuals and families should not face discontinuation of that coverage as a result of any action or inaction on the part of the United States Congress or the Administration. Furthermore, we believe that the basic functions of Medicaid should be universal, meaning regardless of the state of residency, low-income individuals are guaranteed health care coverage that is equitable with coverage in any of the other states.

In our opinion, the AHCA would take steps backward from meeting these standards. In fact, the sudden elimination coverage for millions of currently eligible beneficiaries, coupled with the proposed financing mechanism that cuts federal funding, would essentially create a race to the bottom among the states in the name of flexibility. Medicaid has always been a partnership between the federal government and the states. We urge the federal government to continue to ensure guaranteed accessibility and accountability for patients in this important health care program.

In addition, we are concerned that certain provisions included in the AHCA will not only change the structure of Medicaid, but create an administrative morass that will expose both beneficiaries and health care providers to unnecessary and costly proceedings. Section 116 seems overly aggressive and, potentially, exposes physicians and other providers to penalties for care provided to a beneficiary that unbeknownst to them, was not an eligible beneficiary. We

support fraud prevention, but this provision goes well beyond commonsense and is not appropriate in our opinion.

Access to Primary Care

The value of primary care to the health and wellbeing of individuals has long been acknowledged and understood. The existence of a continuous relationship with a primary care physician helps prevent illness and death, and it is associated with a more equitable distribution of health in populations. Primary care is also associated with enhanced access to health care services and better health outcomes, as well as lower costs through changes in utilization, such as lower rates of hospitalization and emergency department visits.

In our December 28, 2016 letter, we called on Congress to pursue policies that would increase access to primary care physicians – especially for individuals with high-deductible health plans (HDHP). We also suggested that insurance companies should be prohibited from excluding primary care physicians from their networks. Access to primary care physicians should be encouraged, not de-incentivized by restrictive networks. Requiring that all primary care physicians be considered “in-network,” for all insurance products, encourages the establishment of a continuous relationship between patients and their primary care physician. The AHCA, in its current form, does not include a single provision that would facilitate greater connection between individuals and a primary care physician.

We view this connectivity to primary care as an essential policy objective, especially for those with HDHPs. This is why we have proposed a true “patient-centered” reform that would maximize the proven benefits of health care coverage and a continuous relationship with a primary care physician through the establishment of a standard primary care benefit for individuals and families with high-deductible health plans (HDHP). Under this proposal, individuals would be exempt from cost-sharing requirements such as deductibles (and perhaps co-payments) for visits to primary care physicians in an ambulatory office setting.

Ensuring connectivity to the health care delivery system through continuous comprehensive primary care is not only solid health policy; it also is sound economic policy for individuals and employers. For example, the average cost of a visit to a primary care physician is \$160¹. By comparison, the median charge for outpatient conditions in the emergency room is \$1,233² and the average hospital stay is \$10,000³. Based on these indicators, a patient could see a primary care physician 7.7 times for the cost of a single visit to the emergency room and 62.5 times for a single hospital admission. Furthermore, it is estimated that more than \$18 billion could be saved annually if patients whose medical problems are considered “avoidable” or “non-urgent” took advantage of primary or preventive health care as opposed to emergency rooms for their medical needs.⁴

Mental Health & Addiction

In its current form, the AHCA eliminates the federal guarantee of access to mental health and addiction services for millions of low and middle income individuals. At a time when many states are facing a crippling public health crisis resulting from widespread opioid and heroin

¹ <http://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html>

² <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491>

³ <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb168-Hospital-Costs-United-States-2011.pdf>

⁴ <https://www.debt.org/medical/emergency-room-urgent-care-costs/>

addiction, reducing access to mental health and addiction services is inappropriate. We question how an epidemic that is resulting in thousands of deaths per year can be classified as anything other than a national epidemic deserving of a national solution.

Women's Health

The AAFP continues to be deeply concerned with ongoing efforts, at all levels of government, that seek to hinder access to legal, safe, and effective health care services for women. We are equally concerned with efforts that seek to limit and, in some cases prohibit, the ability of physicians, other qualified health care professionals, and health care facilities to deliver these legal health care services, as appropriate, to individual patients.

We view Section 103 of the AHCA as an inappropriate intrusion into the patient-physician relationship and outside the scope of legislative bodies. We urge all elected officials to pause and reflect on the negative consequences these and similar actions have on our health care system and, more importantly, the health and well-being of patients. The patient-physician relationship needs to exist in an environment of honesty and transparency and it should be unencumbered by any legislative and/or regulatory interference except in matters clearly related to overall public health.

In closing, thank you for the opportunity to share these opinions and recommendations with you. As previously stated, we have significant concerns with the "American Health Care Act," in its current form, but we recognize that the legislative process is ongoing. We hope the recommendations provided in this letter assist you in modifying the legislation in a manner that will protect the progress we have made as a nation over the past two decades.

However, **if major changes are not made to the AHCA by your Committee to fully address the recommendations and concerns noted above, the AAFP will consider opposition to its passage.** The AAFP stands ready to work with you to identify and implement policies that will continue to decrease the number of uninsured in our country, establish a competitive private insurance market, and make health care more affordable for all. For more information, please contact Robert Hall, JD, AAFP Director of Government Relations at rhall@aafp.org.

Sincerely,



Wanda Filer, MD, MBA
Board Chair

C: Members, House Budget Committee