Alliance
FOR AGING RESEARCH

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March 3, 2017

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

The Honorable Paul Ryan
Speaker
United States House of Representatives
Washington, DC 20515

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

The Honorable Nancy Pelosi
Minority Leader
United States House of Representatives
Washington, DC 20515

Dear Majority Leader McConnell, Minority Leader Schumer, Speaker Ryan, and Minority Leader Pelosi,

On behalf of the Alliance for Aging Research, we are writing to respectfully ask you to reconsider proposed repeal and replacement provisions for the Patient Protection and Affordable Care Act (ACA) that will have an adverse impact on the health and well-being of America's seniors and near-seniors, and to permanently repeal two existing provisions in the ACA that have concerned us. The Alliance for Aging Research is the leading non-profit organization dedicated to accelerating the pace of scientific discoveries and their application to improve the experience of aging and health, and we support healthcare legislation that maintains and improves access to quality care for our rapidly aging population.

"Access to Coverage" and "Continuous Coverage" Won't Protect People with Pre-Existing Conditions

Prior to 2014, health plans could deny coverage to people with a pre-existing condition, charge those individuals higher premiums, and refuse to cover expenses related to pre-existing conditions. Individuals diagnosed with a serious illness could also have their coverage rescinded. More than half of non-elderly and near-elderly Americans have conditions that would have precluded them from coverage under the pre-existing condition and medical underwriting rules that existed in most states. See the table below from the Kaiser Family Foundation for a sample list of conditions that were used by insurers to exclude coverage prior to 2014.

Examples of Declinable Conditions in the Medically Underwritten Individual Market, Before the ACA	
AIDS/HIV	Lupus
Alcohol abuse/ Drug abuse with recent treatment	Mental disorders (severe, e.g. bipolar, eating disorder)
Alzheimer's/dementia	Multiple sclerosis
Arthritis (rheumatoid), fibromyalgia, other inflammatory joint disease	Muscular dystrophy
Cancer within some period of time (e.g. 10 years, often other than basal skin cancer)	Obesity, severe
Cerebral palsy	Organ transplant
Congestive heart failure	Paraplegia
Coronary artery/heart disease, bypass surgery	Paralysis
Crohn's disease/ ulcerative colitis	Parkinson's disease
Chronic obstructive pulmonary disease (COPD)/emphysema	Pending surgery or hospitalization
Diabetes mellitus	Pneumocystic pneumonia

Epilepsy	Pregnancy or expectant parent
Hemophilia	Sleep apnea
Hepatitis (Hep C)	Stroke
Kidney disease, renal failure	Transsexualism
SOURCE: Kaiser Family Foundation review of field underwriting guidelines from Aetna (GA, PA, and TX), Anthem BCBS (IN, KY, and OH), Assurant, CIGNA, Coventry, Dean Health, Golden Rule, Health Care Services Corporation (BCBS in IL, TX) HealthNet, Humana, United HealthCare, Wisconsin Physician Service. Conditions in this table appeared on declinable conditions list in half or more of guides reviewed. NOTE: Many additional, less-common disorders also appearing on most of the declinable conditions lists were omitted from this table.	

Patient protections for pre-existing conditions under the ACA prohibit exclusions, guarantee issue, restrict premium ratings, ban annual and lifetime benefit limits, and prohibit coverage rescissions.

Current proposals to create "access to coverage" through state-based high-risk pools are not a suitable alternative. State-based high-risk pools that existed prior to 2014 had common features which limited enrollment of eligible individuals and weakened coverage for the most disadvantaged:

- Premiums were usually 150-200% higher than standard non-group market rates;
- Nearly all excluded coverage of pre-existing conditions for medically eligible enrollees for around 6-12 months;
- Thirty-three pools imposed lifetime dollar limits on covered services, most ranging from $1 million to $2 million, totals easily exceeded by those with serious illness ranging from cancer, to rare diseases, to those needing complicated procedures such as bone marrow or organ transplants.
- Most pools offered a choice of plan option with different deductibles—in 25 programs, the plan option with the highest enrollment had a deductible of $1,000 or higher.

Additionally, the concept of "continuous coverage" would subject people with pre-existing conditions whom experience a lapse in coverage, to an increased rate penalty the next time they apply for coverage in the individual market—at an estimated 130% of the standard rate for the first year of coverage. Both of these proposals would make healthcare unaffordable for millions of Americans with pre-existing conditions.

The Alliance for Aging Research supports the current ban on pre-existing conditions and exclusions on annual or lifetime limits, opposes high-risk pools and "continuous coverage" penalties, and urges members of Congress to do the same.

Medicaid Block Grants and Caps Will Kick the Most Vulnerable Seniors Out of Medicaid

Medicaid is a lifeline for older adults, covering more than one in seven (6 million) older Americans in 2015 Calling the program a "lifeline" is not an exaggeration. Medicaid beneficiaries are individuals who cannot afford viable insurance through the private market. Most of these beneficiaries are frail, have dementia, and suffer from three-or-more chronic conditions requiring regular medical appointments, medications, and assistance with daily self-care activities to live independently. These are many of the most vulnerable older adults in our communities.

For many Medicare beneficiaries, Medicaid covers services that Medicare does not, such as long-term care in nursing homes, assisted living, and at home care. In some states vision, dental, and hearing care is also available for adult Medicaid beneficiaries. Medicaid also covers premiums, deductibles, co-payments, and out-of-pocket costs for acute care services, which are often cost prohibitive for seniors with low incomes.

Proposals to change Medicaid financing by limiting federal funding to states through block granting or per capita caps, would be devastating to seniors. Those changes would force states to cut eligibility, reduce benefits, and lower provider reimbursement, particularly for high cost enrollees—such as older adults with Alzheimer's disease—who need substantial services under the program. Medicaid is already a lean program, with spending per beneficiary

considerably lower than private insurance and growth in spending per beneficiary slower than private insurance—and expected to grow even more slowly in coming years.

The bottom line is that proposed block grants and caps will kick many older adults out of Medicaid, not only putting their physical and financial health in jeopardy, but also likely *increasing* costs to states for senior-related care. Research clearly shows that when basic assistance for the needs of daily life is not available, frail elders wind up in high-cost settings—notably hospitals and nursing homes—and overall costs increase.

The Alliance for Aging Research opposes Medicaid block grant or per capita cap provisions, and urges members of Congress to stand up for a robust Medicaid program as a vital safety net for America's seniors.

Premium Age Limit Increases Will Put Coverage Out of Reach for Near-Seniors

Currently, nearly 3.3 million Americans aged 55-64 ("near seniors") rely on Marketplace coverage, and represent the largest share (26%) of people reliant on individual Marketplace plans. Premiums are made more affordable for these individuals because insurers may charge older vs. younger enrollees to no more than three times the premium of younger enrollees. This 3:1 limit on age rating specifically protects older adults between 55-64, allowing them access to affordable health coverage until they become eligible for Medicare.

Plans to increase the limit insurers can charge older adults, or to eliminate age rating limits altogether, would put coverage financially out of reach for those age 50-64 and likely increase federal spending for treatment of unmanaged health conditions. According to the Urban Institute, more than 4.5 million Americans aged 55-64 could lose their health insurance coverage by 2019 under proposed age rating increases.

Additionally, current tax credits for the purchase of individual health insurance are based on income, with those who earn less getting more assistance. Proposals to shift these tax credits based on age in order to help those who are older (and who will presumably be charged higher premiums) seem helpful in theory, but in reality could only cover one quarter to one third of the cost of even the most bare-bones plans, leaving them financially out of reach for many near-seniors.

The Alliance for Aging Research supports the current 3:1 limit on age rating, and tax credits based on income, and strongly urges members of Congress to retain both.

Essential Health Benefits Really are Essential

Marketplace health insurance plans currently have to include ten Essential Health Benefits (EHBs):

1. Outpatient care
2. Emergency room visits
3. Hospital inpatient care
4. Before and after birth care
5. Mental health and substance abuse services
6. Prescription drugs
7. Services and devices to help in recovery after an injury, or in cases of disability or chronic condition, including physical and occupational therapy, speech-language pathology, and more
8. Lab tests
9. Preventive services including screenings, vaccines, and care for chronic disease management
10. Pediatric services, including dental and vision care

In the past, many health plans did not cover these services and treatments so patients had to pay out-of-pocket or in many cases, go without them.

A proposed alternative to the current EHBs is to allow states to decide which benefits are "essential." This choice would likely result in some states opting for less generous benefit packages to allow insurers to cut benefits.. This is beneficial for healthy people but would send the cost of more comprehensive plans—the plans sicker people need—skyrocketing. And it could leave someone who chooses a less robust plans and then experiences an unexpected injury or illness, completely out of luck.

The Alliance for Aging Research supports EHBs to ensure that patients, regardless of what health insurance plan they choose, can receive the care and treatment they depend on now or may need in the future, and strongly urges members of Congress to retain them.

Preserve the Prevention and Public Health Fund

The Prevention and Public Health Fund (PPHF) was established to ensure that agencies such as the Administration for Community Living (ACL), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA) are able to provide expanded and sustained investments in prevention and public health. The use of evidence-based, effective public health efforts like the ones supported by PPHF can result in health care savings of as much as $5.60 per every health dollar spent. PPHF resources have helped millions of older adults avoid debilitating and costly falls and strokes, better manage their multiple chronic conditions, avoid deadly infections, receive immunizations, learn how to identify symptoms of Alzheimer's disease, and more. Many of these conditions are costly, disabling, and deadly in the older adult population.

The Alliance for Aging Research supports the PPHF because it has helped to improve health outcomes and enhance health care quality, and we strongly urge members of Congress to preserve it.

Keep Seniors Healthy by Maintaining Improvements to Medicare

It makes both clinical and financial sense to encourage seniors to follow prevention and wellness recommendations. Currently, seniors incur no cost-sharing for almost all of the preventive services covered by Medicare, including an annual "Wellness Visit" benefit for beneficiaries. These improvements to Medicare have had a meaningful impact on the overall health of beneficiaries and their care coordination. According to CMS almost 40 million beneficiaries have received at least one preventive service at no cost.

The annual wellness visits build on the "Welcome to Medicare" visit beneficiaries are entitled to receive within 12 months of enrolling in Medicare Part B. During the wellness visit, a physician or other healthcare provider establishes or updates the patients' medical history, creates a list of the patient's providers and suppliers (including current prescription medications), takes routine and vital measurements, and looks for cognitive impairment. Wellness visits can also include health education or preventive counseling for disease self-management, weight loss, falls prevention, smoking cessation, improved nutrition, and physical activity. This education and counseling is designed to reduce risk factors that have been identified during the visit. In addition, providers establish or update screening schedules for 5-10 years based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP). These services include mammograms, cancer screenings (colorectal, cervical, and prostate), immunizations (against flu, pneumonia, and hepatitis B), diabetes and cardiovascular screenings, bone mass assessment, and HIV testing.

Even with improved wellness interventions, health education, and screening for disease prevention, older adults still face barriers to access for prescription medications to manage often comorbid conditions. Most Medicare Part D plans have a coverage gap or "donut hole" where beneficiaries are required to pay the full cost of their medications, even while they continue to pay premiums. This coverage gap is significant. The current "donut hole" phase-out helps older adults who fall into this coverage gap, by reducing copayments required for brand-name and generic

drugs and increasing discounts from brand-name drug manufacturers. To date, this impactful program has saved Medicare beneficiaries as much as $20 billion on prescription drugs.

The Alliance for Aging Research supports the current Medicare prevention and wellness benefits and cost-saving phase-out of the Part D "donut hole" for beneficiaries, and we strongly urge members of Congress to keep these programs high on the agenda.

PCORI and CMMI Improve Patient Care

The Patient-Centered Outcomes Research Institute (PCORI) is a non-governmental organization created by Congress and charged with comparative clinical effectiveness research (CER), which is the direct comparison of multiple existing health care interventions to determine which treatment works best, for whom, and under what circumstances to help patients, family caregivers, clinicians, employers, insurers, policy makers and others make better-informed health and healthcare decisions. More than 570 PCORI-funded projects have taken place and focused on the needs of patients suffering from cancer, cardiovascular disease, neurological diseases, mental and behavioral health issues, and multiple chronic conditions. Additionally, PCORI is the only organization mandated by law to place a priority on studies aimed at the concerns of the elderly, who are high-utilizers of healthcare but often excluded from research.

PCORI receives resources from three funding streams: appropriations from the general fund of the Treasury, transfers from CMS trust funds, and a fee assessed on private insurance and self-insured health plans. Repeal and replacement efforts put PCORI funding at risk, which will ultimately compromise research on health outcomes.

Another initiative that seeks to improve patient care, the Center for Medicare & Medicaid Innovation (CMMI) was established to support the development and testing of innovative health care payment and delivery models. CMMI allows Medicare and Medicaid to test models that improve care, lower costs, and better align payment to support patient-centered practices. CMMI evaluates reform efforts widely used in the private sector, develops provider-proposed approaches, and quickly adjusts models in response to feedback from healthcare providers and patients.

One CMMI demonstration project is currently testing a care model that uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with two or more chronic conditions. Home-based primary care allows providers to spend more time with their patients, perform assessments in a patient's home, and assume greater accountability for all aspects of the patient's care. This Independence at Home Demonstration focuses on timely and appropriate services designed to improve overall quality of care and quality of life for patients, while lowering health care costs by delaying the need for institutional care. The Independence at Home Demonstration should be made permanent by CMS.

The Alliance for Aging Research supports PCORI and CMMI because they improve patient care, and we strongly urge members of Congress to continue them.

Clinical Trial Coverage for Near-Seniors with Life-threatening Conditions

As of January 2014, non-grandfathered health plans (i.e. those that were not in place before March 23, 2010) cannot deny a qualified individual, under age 65 and not covered by Medicare, participation in an approved clinical trial, or deny or limit the coverage of routine patient costs in connection with participation in the trial.

In essence, this provision expanded the scope of coverage for most existing health policies and prevented health plans and insurers from excluding clinical trial coverage under most circumstances. This is vital for people under the age of 65 who are not covered by Medicare and are diagnosed with cancer or another life-threatening illness. For example, many of the approximately 200,000 Americans with early onset Alzheimer's disease are in their 40s and 50s. They have families, careers or are even caregivers themselves when Alzheimer's disease strikes.

The amendment contains only a few qualifications and clarifications:

- Qualified individuals are defined as those eligible to participate in an approved clinical trial protocol for treatment of cancer or another life-threatening disease or condition;
- Trials must be "approved" clinical trials;
- Coverage cannot be denied for the routine patient costs for items and services furnished in connection with the trial, but may be restricted to in network providers;
- State laws requiring clinical trials are not preempted.

The Alliance for Aging Research supports clinical trial coverage for those under 65 with cancer or another life-threatening illness, and we strongly urge members of Congress to maintain it.

Repeal the Independent Payment Advisory Board and the Medical Device Excise Tax

The Alliance for Aging Research continues to be concerned about the existence of the Independent Payment Advisory Board (IPAB). The IPAB can single out Medicare for indiscriminate cuts based on arbitrary spending targets that do not adequately take into account system-wide health costs, and has unchecked authority to make decisions about limiting services without public input or the opportunity for administrative or judicial review.

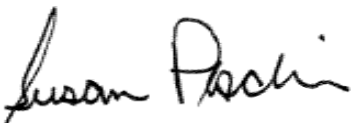
Additionally, the existing 2.3% excise tax on medical device manufactures is draining critical resources away from the development of new medical devices. Delays in new devices that could improve detection and treatment of age-related diseases and conditions, in turn slows down quality of life gains for our aging population. The unmet health challenges older adults face are enormous financial and human burdens that demand increased investment in research and development. This excise tax has had a chilling effect on innovation and we believe that it should be fully repealed as part of the ACA replacement plan.

The Alliance for Aging Research opposes the IPAB and the medical device tax, and we strongly urge members of Congress to permanently repeal both provisions.

Thank You

Thank you for considering the current priorities that we believe have been central to improving the health of America's seniors and near-seniors, as well as the existing provisions that we believe should be permanently repealed. Many of the current coverage programs and structures have provided a degree of security and certainty for older Americans and Americans with serious illness that they now expect and deserve. We stand ready to work with you to develop policies that will ensure seniors and near-seniors have access to a robust health insurance market that provides affordable and comprehensive coverage options. Please do not hesitate to contact us directly: Sue Peschin at 202-688-1246 or speschin@agingresearch.org; or Cynthia Bens, at 202-688-1230 or cbens@agingresearch.org.

Sincerely,



Susan Peschin, MHS
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CC: The Honorable Orrin Hatch, Chairman, Senate Committee on Finance
The Honorable Ron Wyden, Ranking Member, Senate Committee on Finance
The Honorable Lamar Alexander, Chairman, Senate Committee on Health, Education Labor & Pensions
The Honorable Patty Murray, Ranking Member, Senate Committee on Health, Education, Labor & Pensions

The Honorable Susan Collins, Chairman, Senate Special Committee on Aging
The Honorable Bob Casey, Ranking Member, Senate Special Committee on Aging
The Honorable Kevin Brady, Chairman, House Committee on Ways & Means
The Honorable Richard Neal, Ranking Member, House Committee on Ways & Means
The Honorable Greg Walden, Chairman, House Committee on Energy & Commerce
The Honorable Frank Pallone, Ranking Member, House Committee on Energy & Commerce