Gary M. Reedy
Chief Executive Officer

May 23, 2017

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

Dear Chairman Hatch,

Thank you for your recent letter outlining your plans for considering health reform legislation in the Senate Finance Committee. I very much appreciate your inviting the American Cancer Society's views and recommendations in this process, and want to assure you that we are committed to working with you in crafting legislation that is responsive to the needs of cancer patients, survivors and their families.

The Society is a science-based organization and our view on patient access to health insurance coverage is informed by our own research findings that patients with insurance coverage, which includes no-cost preventive cancer screenings and the full range of curative therapies, have better outcomes. Their cancers are diagnosed at an earlier stage and they have an overall improved chance of survival. For cancer patients, access to adequate and affordable coverage can be the difference between economic security or bankruptcy and even life and death.

PROTECTING PATIENTS

There is no question that current law needs improvement, but its greatest achievement is enabling most patients with pre-existing conditions, including the more than 15 million cancer survivors living today, to buy insurance that covers their treatment. Prior to 2010, individuals who needed health insurance were often precluded from purchasing coverage on the individual market. Keeping the patient protections now in the law, which guarantee issue without underwriting, abolish annual and lifetime caps, prevent policy rescissions, and guarantee access to essential health benefits, is the most important decision you could make for patients in your deliberations.

KEEPING COVERAGE AFFORDABLE

We also want to make sure that health coverage is affordable to the most people. The premium tax credits, cost-sharing reductions, and the Medicaid expansion in 31 states made coverage more affordable for millions of people in the lower-income ranges. But low-income patients in the 19 non-expansion states don't have the opportunity to be covered in Medicaid, and premium tax credits are not generally available to middle-income families in the marketplaces. This has resulted in key coverage gaps and policies with prohibitive out-of-pocket costs that result in patients losing access to care.

The flat tax credit proposed in the American Health Care Act (AHCA) would help young and early middle-age individuals, but older individuals between the ages of 50 and 65 would face dramatically

increased premiums due to AHCA's new 5:1 age rating scenario. Unlike the current premium tax credit, the flat credit would not adjust for greater premium and out-of-pocket costs.

MEDICAID

AHCA's proposed phase-out of the Medicaid expansion covering childless low-income adults would, over time, erode the coverage they now have in the 31 expansion states. This policy change, together with proposed cuts in overall Medicaid funding, accounts for much of the CBO's projected reduction in the number of Americans who would become uninsured. Medicaid coverage is vital in providing key public health and disease prevention services in rural and urban areas throughout the country, and plays a major role in the fight against cancer. National Program of Cancer Registries data collected over the fourteen-year period from 1999-2013, found that nearly one-third of childhood cancer patients were covered by Medicaid at the point of their diagnosis. In 2015, 1.52 million individuals aged 18 to 64 with a history of cancer relied on Medicaid for their insurance. Even so, the Society's nationwide call center often receives calls from low-income cancer patients, the majority are from Medicaid non-expansion states, who are seeking and unable to find coverage. Many of these individuals are working poor or have had to quit work due to illness and lost coverage.

AMERICAN CANCER SOCIETY RECOMMENDATIONS

We agree that reforms to the current law are needed. Changes should focus on providing coverage that is as good or better than consumers now have. To that end, we offer the following recommendations:

1. **PRE-EXISTING CONDITION EXCLUSIONS AND ESSENTIAL HEALTH BENEFITS (EHB):** We do not support a statutory waiver or other mechanism that would allow insurance plans to medically underwrite on the basis of health status or to waive minimum essential health benefits. The current law limits the out-of-pocket costs that patients pay for EHB services, and plans are not allowed to impose lifetime and annual limits on those services. The EHB standards are particularly important for cancer patients because treatment is expensive. Before lifetime and annual limits were prohibited, many patients – even in employer-sponsored plans – reached these limits and were left with the choice of pursuing further treatment while facing financial ruin or in many cases delaying or foregoing recommended treatment altogether.

2. **MANDATES AND CONTINUOUS COVERAGE:** Assuming that the employer and individual mandates will be repealed, a continuous coverage provision could encourage enrollment in the marketplace. But punitive measures imposed on people who drop coverage create a disincentive to re-enroll, thus acting against the overall purpose of the continuous coverage provision. A moderate, time-limited financial penalty is acceptable, but individuals (or their caretakers) who lose coverage because they become sick (or are caring for a loved one) and stop working should be allowed to enroll or re-enroll without penalty. Patient lock-outs or

requiring patients to pay past premiums for periods of time in which coverage was dropped are also punitive and create a disincentive to re-enroll.

3. **PREMIUM SUBSIDIES, COST SHARING REDUCTIONS (CSR's), FLAT SUBSIDIES AND AGE-RATING:** These subsidy/affordability issues all work in concert, and adjusting one to improve affordability on one demographic has the opposite effect on the other. To provide what we believe is the most important element, which is universal access to affordable care, we recommend the preservation of sufficient revenue streams that exist in the current law to finance a subsidy that is graduated to income for all non-Medicaid eligible, pre-Medicare adults and allows purchase of coverage that covers EHB.

4. **MEDICAID:** Medicaid remains the nation's critical health safety-net for millions of Americans with cancer, as well as for children, the elderly and persons with disabilities. AHCA would reduce Medicaid funding by $880 billion, which in the absence of some yet to be discovered efficiencies, would jeopardize health care coverage for millions of low-income Americans by forcing states to limit enrollment and cut access to life-saving treatments. We urge you to preserve revenue streams in current law to assure sufficient funding to expand Medicaid to cover very low-income Americans in all fifty states.

Again, we very much appreciate your reaching out to the American Cancer Society, and having the opportunity to share our views on the health care legislation. We are eager to participate in this process and look forward to being of assistance to you and the committee during the weeks and months ahead. Please do not hesitate to contact me at gary.reedy@cancer.org or my policy and advocacy team at the American Cancer Society Cancer Action Network, chris.hansen@cancer.org or dick.woodruff@cancer.org for further follow-up.

Sincerely,

Gary Reedy
Chief Executive Officer

cc: Chris Hansen
Dick Woodruff