



November 27, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma:

The American College of Physicians appreciates the opportunity to comment on the 2019 Benefit and Payment Parameters proposed rule. ACP is the largest medical specialty organization and the second largest physician group in the United States, representing 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Navigator Program

ACP supports enhanced efforts to provide outreach and enrollment assistance to consumers. The College has developed a toolkit to help our members guide their patients to Navigators and other entities that provide education, enrollment, and other assistance during open enrollment and throughout the year. The educational role of Navigators (and marketplace advertising and promotion initiatives) remains vital; a recent survey found that 40% of uninsured adults were unaware of Healthcare.gov or their state's marketplace (i). A survey of uninsured individuals and public or private insurance enrollees found that although most respondents could identify terms such as premiums and appeal, fewer understood the terms step therapy (37%) or medically necessary (60%) (ii). Twenty-three percent could name the characteristics of a preferred provider organization. Only 21% could accurately calculate out-of-pocket costs involving a deductible, a copayment, and coinsurance. As health insurance becomes more complex, Navigators offer objective education that other entities may not provide. We concur with the statement in the proposed rule that "(b)ased on HHS's experience with Navigator programs in federally facilitated exchanges (FFE) and other public programs, we believe entities with a physical presence and strong relationships in their FFE service areas tend to deliver the most effective outreach and enrollment results." Therefore, we oppose the proposal to amend the requirement that a FFE need only to contract with one Navigator in the state. Because insurance markets vary widely, we support the existing requirement that Navigators and other entities maintain a physical presence in the area.

Essential Benefits Package

ACP policy strongly supports the Affordable Care Act's requirement that qualified health plans cover an essential health benefits (EHB) package. The EHB requirement has proven to be a powerful tool to reduce underinsurance. College policy supports the benchmark coverage concept; in its 2012 letter to HHS regarding the proposed rule on essential health benefits, actuarial value, and accreditation, the College stated that benchmark coverage should have benefits not less than, and out-of-pocket cost-sharing not greater than a variety of health plan options available *in that state*.

We are concerned that the proposed changes to the EHB benchmark policy would permit states to select benchmark plans or categories in states with less comprehensive benchmark plans, potentially leading to an erosion of coverage generosity and allowing insurers to circumvent state benefit mandates. The policy also seems to undermine the spirit of the law's requirement that the essential health benefit package reflect coverage offered by employer-based health insurance offered in the state.

The benchmark model is imperfect, but it allows states to base the EHB package on existing health insurance coverage offerings that reflect the needs of patients and unique market conditions of the state. Because of this flexibility, items and services covered within the 10 EHB categories vary dramatically from state to state. Some states have substantial coverage gaps, including the mental health and substance use disorder services category. According to a National Center on Addiction and Substance Abuse report, about half of 2017 essential health benefit benchmark plans did not comply with the law's requirement for coverage of prescription drugs for addiction treatment (iii). None of the benchmark plans reviewed provided comprehensive coverage for substance use disorders that included methadone maintenance and residential treatment without treatment limitations, and 88% of plan documents for essential health benefit benchmark plans lacked sufficient detail to determine compliance or adequacy of benefits for substance use disorder. Autism, infertility, and hearing aid coverage also varies widely among EHB benchmark plans (iv). Should the proposed rule be finalized, states with comprehensive benchmark coverage of substance use disorder treatment or other services could select another state's benchmark category that includes strict limits on necessary items and services, potentially resulting in less valuable coverage and higher out-of-pocket costs for patients. The proposed rule would also allow states to develop their own EHB benchmark plan provided it meets a number of requirements, including that new EHB benchmark plan not exceed the generosity of the most generous among a set of comparison plans including the State's 2017 EHB-benchmark plan used for the 2017 plan year. This option may further encourage some states to develop limited benchmarks that skimp on primary care, maternity care, prescription drug coverage, and other crucial services. Further, this proposal will also affect the annual and lifetime limits for large group plans on which EHBs are based.

Provision of EHB

ACP is very concerned about the proposal to allow substitutions between essential health benefit categories especially if coverage of services used by complex-need patients is diluted. Without strong oversight of insurance issuer practices, insurers may substitute benefits they deem too expensive or preferred by sicker patients, in favor of less costly services or products. HHS and state regulators should consider only permitting substitutions if the procedure or service to be replaced is proven to be of limited clinical effectiveness or low value. Health plans seeking to substitute benefits should also be required to report the potential effect of the revised benefit package on complex-need, high-risk patients.

Qualified Health Plan Minimum Certification Standards

The College opposed the changes made to 156.230 in the 2017 Market Stabilization rule regarding network adequacy and we reiterate our concern about the proliferation of narrow provider networks (v,vi,vii). Tight

provider networks coupled with inaccurate provider directories create a frustrating, confusing and expensive experience for patients seeking care from their preferred physicians. Further, narrow networks are often developed as a way to cut costs rather than to direct patients to high-quality physicians. ACP supported the Agency's proposal outlined in the Notice of Benefit and Payment Parameters for 2017, which would have determined that a State's network adequacy assessment methodology is acceptable if it includes quantitative measures. While this proposal was ultimately not adopted, the College continues to believe that CMS can play an important role in ensuring that provider networks serve the needs of patients and limit the need to seek care from out-of-network physicians. States play a crucial role in enforcing insurance regulations, but not all states use quantitative standards to determine network adequacy and significant oversight challenges have been reported (viii). To address these gaps, we urge CMS to continue to use quantitative criteria to assess network adequacy and urge continued federal oversight of provider networks rather relying on the accreditation model proposed in the rule.

Other Considerations

We are concerned that the agency intends to promote high deductible health plans (HDHP) paired with health savings accounts (HSA). The intent to promote HDHPs over other plans, such as standardized health plans, seems to counter the proposed rule's intent to create a level playing field among plan offerings and encourage innovation. Generally, ACP believes that HSAs alone will not achieve the goal of universal health care access nor are they likely to have a dramatic impact on either costs or access to health care. Additional and comprehensive reforms will still be needed. HSAs should be considered as one alternative within an array of reforms intended to increase access to health care services, improve quality, and reduce costs.

Evidence shows that cost sharing, particularly deductibles, may cause patients to forgo or delay care, including medically necessary services (ix,x). The effects are particularly pronounced among those with low incomes and the very sick. Because HSAs must be linked to high-deductible health insurance plans, protective measures should be put in place to ensure that low income patients are not forced to cut back on needed care or suffer severe financial and/or medical hardships. Safe harbor provisions for low-cost preventive and primary care services in HSA-linked high deductible plans should be expanded, as should safe harbors for prescription drugs. The federal government and other groups should continue to monitor the use of HSAs and other consumer-directed health plans on access to health insurance for people with existing health problems and people with low and moderate incomes. The effect such plans have on the ability of vulnerable populations to obtain health insurance and access to health care services should also be monitored to ensure that such groups are not indirectly harmed.

HSAs should provide patients with incentives to select more cost-effective and higher-quality options. ACP does support value-based insurance design strategies that reduce or eliminate out-of-pocket contributions for services proven to offer the greatest comparative benefit, with higher cost-sharing for services with less comparative benefit (xi). Such strategies should be based on rigorous comparative effectiveness research by independent and trusted entities that do not have a financial interest in the results of the research. The goal should be to ensure that high-value cost-sharing strategies encourage enrollees to seek items and services proven to be of exceptional quality and effectiveness and not just on the basis of low cost.

Thank you for the opportunity to comment on the proposed rule. If you have additional questions, please contact Ryan Crowley, Senior Associate for Health Policy at rcrowley@acponline.org.

Sincerely,



Jack Ende, MD, MACP
President

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- ⁱ <http://www.commonwealthfund.org/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage>
- ⁱⁱ https://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf
- ⁱⁱⁱ <https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-review-of-addiction-benefits-in-aca-plans>
- ^{iv} <https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf>
- ^v http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027
- ^{vi} <http://healthcare.mckinsey.com/hospital-networks-perspective-three-years-exchanges>
- ^{vii} <http://jamanetwork.com/journals/jama/fullarticle/2466113>
- ^{viii} https://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states_0.pdf
- ^{ix} https://www.rand.org/pubs/research_briefs/RB9174.html
- ^x <http://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0610>
- ^{xi} https://www.acponline.org/acp_policy/policies/insurance_cost_sharing_2016.pdf