November 21, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9930–P
P.O. Box 8016
Baltimore, MD 21244–8016

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the HHS Notice of Benefit and Payment Parameters for 2019 proposed rule that was published by the Centers for Medicare & Medicaid Services (CMS) in the November 2, 2017 *Federal Register*.

Additional state flexibility in the definition of essential health benefits

Summary

CMS proposes to provide states with additional flexibility in how they select their essential health benefits (EHBs) benchmark plans for benefit years 2019 and beyond, and outlines potential future directions for defining EHBs. CMS proposes to allow states to select a new EHB-benchmark plan on an annual basis, which would allow states to update their EHB-benchmark plan on a schedule that works for the state, rather than one set by HHS.

CMS also proposes to provide states with substantially more options in what they can select as an EHB-benchmark plan. Instead of being limited to 10 options, states would be allowed to: 1) choose from the 50 EHB-benchmark plans that other states used for the 2017 plan year; 2) replace one or more EHB categories of benefits under its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or 3) select a set of benefits to become its EHB-benchmark plan, provided that the new EHB-benchmark plan does not provide more benefits than a set of comparison plans and is equal to the scope of benefits provided under a typical employer plan, as required by the *Affordable Care Act*.

AAFP Response

The proposed rule states that a state's benchmarks must be "equal to the scope of benefits provided under a typical employer plan." CMS proposes to define typical employer plan as "an employer plan within a product (as these terms are defined in §144.103 of this subchapter) with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more States, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more States." This language defines typical in reference to the number of people who are covered by a single plan. **The AAFP is concerned that a single outlier plan with minimum benefits could now count as typical, even if it's much less generous than other**

plans in the market. Under the proposed definition, if a large employer had an unusually narrow health plan, states could use this plan to scale down their EHBs.

The AAFP is further concerned that under the rule, insurers could reduce or eliminate certain EHBs to avoid vulnerable, expensive patients by excluding specific services. For instance, if an insurer wanted to scale back prescription drug coverage, it could do so, as long as it ramped up coverage in another category at a comparable level. In doing so, insurers could potentially make plans less valuable for people with long-term chronic conditions.

While relaxing EHB requirements could decrease cost, and thus attract younger and healthier consumers who could improve the balance in the risk pool and stabilize premiums, it could also endanger coverage for a more vulnerable population. Inadequate benefits could leave this population with too little coverage to meet their health care needs. While ratcheting down EHBs may reduce upfront premium costs, it could have devastating financial implications for families with the sickest patients whose insurance coverage may not cover medically necessary services.

In addition, the AAFP is increasingly concerned with the escalation in deductibles that has occurred in the employer-sponsored, small group, and individual insurance markets. Higher deductibles create a financial disconnect between individuals, their primary care physician, and the broader health care system. **Therefore, in an effort to maximize the proven benefits of health care coverage and a continuous relationship with a primary care physician, the AAFP proposes the establishment of a standard primary care benefit for individuals and families with high-deductible health plans (HDHP). Under our proposal, individuals would be able to connect with the health care system through visits with their primary care physician or their primary care team.** These visits would be exempt from cost-sharing requirements such as deductibles and co-payments. The establishment of a standard primary care benefit would guarantee connectivity to the health care system for individuals with HDHPs and serve as a guardrail against disease progression that leads to more costly care.

Individuals with a HDHP, as defined by the Internal Revenue Service, would have access to their primary care physician, or their primary care team, without the cost-sharing requirements (deductibles and co-pays) stipulated by their policy.

The company issuing the HDHP to the individual or family would be responsible for providing full coverage of primary care services for the plan year. Covered services would include primary care, prevention & wellness and care management services. Plans would pay primary care physicians for the following services at the contracted rate:

1) Evaluation & Management (E&M) codes for new and existing patients 99201-99215;
2) Prevention & wellness codes 99381-99397;
3) Chronic care management codes (CCM); and
4) 4) transition care management (TCM) codes.

Ensuring connectivity to the health care delivery system through continuous access to a primary care team is not only efficient health policy, it also is sound economic policy for individuals, families and employers. A recent study conducted by the University of Portland found that every $1 invested in primary care resulted in $13 in savings for other health care services, including specialty, emergency room, and inpatient care.

The AAFP believes that adequate EHB coverage of primary care services will lead to higher utilization of primary care. Increased primary care utilization will then lead to better outcomes for patients and lower costs for individuals, employers, and government health care programs. Given that more and more Americans have HDHPs, it is even more important that we incentivize and prioritize primary care.

About Family Medicine
Family physicians are dedicated to treating the whole person. These residency-trained, primary care specialists provide a wide variety of clinical services. They treat babies with ear infections, adolescents with depression, adults with hypertension, and seniors with multiple chronic illnesses. With a focus on prevention, primary care, and overall care coordination, they treat illnesses early and, when necessary, refer their patients to the right specialist and advocate for their care.

One out of every five office visits in the United States are made with family physicians. More than 192 million office visits are made to family physicians each year. This is 66 million more than the next largest medical specialty. More Americans depend on family physicians than on any other medical specialty.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,

John Meigs, Jr., MD, FAAFP
Board Chair