AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

A Proposal to

Establish a Standard Primary Care Benefit for Individuals with High-Deductible Health Plans (HDHP)

In an effort to maximize the proven benefits of health care coverage and a continuous relationship with a primary care physician, the American Academy of Family Physicians (AAFP) proposes the establishment of a standard primary care benefit for individuals and families with high-deductible health plans (HDHP).

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Establishment of a Primary Care Benefit

- Individuals with a high-deductible health plan, as defined by the Internal Revenue Service (IRS)*, 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:
    - Evaluation & Management (E&M) codes for new and existing patients 99201-99215
    - Prevention & Wellness codes 99381-99397
    - Chronic care management codes (CCM)
    - Transition care management (TCM) codes

- Primary care, for the purposes of this proposal, is defined as those eligible clinicians enrolled in Medicare via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 37 Pediatric Medicine; and 38 Geriatric Medicine.
    - Patients would designate their primary care physician and that physician would be the site of service for this benefit for the enrollment period.
    - If a patient fails to designate a primary care physician, the insurer issuing the HDHP would be responsible for assigning a primary care physician to the patient.

* The IRS defines any insurance product that requires a deductible of $1,300 for an individual or $2,600 for a family as a high-deductible health plan (HDHP).

Background

The Value of Primary Care

It is well-recognized that the two most influential indicators of health are continuous health care (insurance) coverage and a usual source of care, typically through a continuous relationship with a primary care physician. Our nation has undertaken many efforts to ensure continuous health care coverage, but we have not fully advanced policies that create a continuous relationship with a primary care physician despite its proven impact on health, patient satisfaction, and costs. Barbara Starfield, MD, MPH, in her research, found that:

> *"Robust evidence shows that patient care delivered with a primary care orientation is associated with more effective, equitable, and efficient health services. Countries more oriented to primary care have residents in better health at lower costs."*[1]

In an effort to maximize the proven benefits of health care coverage and a continuous relationship with a primary care physician, the American Academy of Family Physicians (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 high-deductible health plans and serve as a guardrail against disease progression that leads to more costly care.

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. A recent study conducted by the University of Portland found that every $1 invested in primary care, resulted in $13 in savings in other health care services, including specialty, emergency room, and inpatient care.[2]

Despite its proven efficacy, utilization of primary care remains relatively low among insured patients. According to research conducted by the Robert Graham Center,[3] primary care visits per year ranged from a low of 1 to a high of 3. Higher utilization was common among children (0-4), older adults (45-64) and Medicare eligible seniors (>65). Utilization among adolescents, teens, and young adults were low, below 1.5 visits per year. When you consider that the average cost of a visit to a primary care physician is $160,[4] you begin to see the value of stronger investment in the primary care function both from a health and economic perspective. This investment in primary care is even more important when you consider the cost of the alternatives. By comparison, the median charge for outpatient conditions in the emergency room is $1,233[5] and the average hospital stay is $10,000[6]. Based on these indicators, you could see your 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 those patients whose medical problems are considered "avoidable" or "non-urgent" were to take advantage of primary or preventive health care and not rely on emergency rooms for their medical needs.[7]

When you consider the costs of a primary care visit, the utilization rates, and dollar value of higher utilization of primary care versus other care settings; it is apparent that this policy would be valuable to the individual and a smart investment for the insurer.

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[1] N Engl J Med 2008; 359:2087-2091 November 13, 2008 DOI: 10.1056/NEJMp0805763 http://www.nejm.org/toc/nejm/359/20/
[2] https://www.oregon.gov/oha/pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf
[3] http://www.annfammed.org/content/10/6/503.full
[4] http://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html
[5] http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491
[6] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb168-Hospital-Costs-United-States-2011.pdf
[7] https://www.debt.org/medical/emergency-room-urgent-care-costs/

High-Deductible Health Plans

Health care coverage policies enacted into law over the past twenty years, including the Children's Health Insurance Program, the Medicare Modernization Act, and the Affordable Care Act have increased access to coverage for millions of adults and children, but have not relieved the financial pressures on individuals, families, and employers.

Over the past seven years, the nation's uninsured rate has reached a historic low. In fact, the uninsured rate decreased from 15.7 percent in 2009 to 9.1 percent in 2015.[8] Over this same time period we have experienced a rapid growth in the number of individuals and families who have a high-deductible health plan (HDHP) in both the employer-based group and individual markets.

HDHPs are insurance plans with a minimum deductible and maximum out-of-pocket limit as defined by the Internal Revenue Service (IRS). In 2015, the deductible threshold was $1,300 for an individual and $2,600 for a family. Under a HDHP, all medical care must be paid for out of pocket until this minimum deductible is met. HDHPs were first offered by employers in 2001, but didn't experience large growth until after creation of health savings accounts (HSA) through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[9]

Many of the newly insured population have secured coverage through a HDHP. According to a report in Health Affairs, approximately 90 percent of enrollees in the individual marketplace have a deductible beyond the qualifying threshold for an HDHP.[10] According to the same report, the average silver plan deductible nationally is more than $2,500 for an individual. The average bronze plan deductible is more than $5,300 for an individual.[11]

The expansion and utilization of HDHPs, however, are not limited to the individual marketplace. They are increasingly popular in the employer-based group market as well. Employers spend, on average, $5,179 and $12,591 on health care premiums for their employees in the individual and family plans respectively.[12] With cost continuing to rise, employers are seeking insurance products that lessen the financial impact on their businesses while still providing employees coverage. One of the solutions becoming more popular with employers is HDHPs–often coupled with a health savings account (HSA). In 2015, more than half of all employers offered a HDHP to their employees.

The popularity of HDHPs has increased among consumers as well. In 2006, 4 percent of employees enrolled in an employer-sponsored HDHP. In 2015, 24 percent of employees were enrolled in such a plan.[13] HDHP are especially appealing to younger workers. When given a choice, over 40 percent of younger workers chose a HDHP.[14]

The challenge is that HDHPs often provide a disincentive for individuals to seek primary and preventive care due to the associated out-of-pocket expenses. Recent academic literature shows that individuals with HDHPs delay or prolong seeking health care services as a result of the out-of-pocket financial obligations that exists with HDHPs.[15][16] [17]Delays in seeking care, lapses in maintenance, or adherence to treatment protocols lead to a worsening of an individual's health. Ultimately, providing needed care will cost the individual, their insurer, and the health care system significantly more money. Under our proposal, individuals with a HDHP would have access to their primary care physician independent of the financial obligation.

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[8] https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf
[9] http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf
[10] http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf
[11] http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf
[12] http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf
[13] http://kff.org/report-section/ehbs-2015-summary-of-findings/
[14] http://go.benefitfocus.com/insights/report/2016-state-of-employee-benefits/pr?utm_source=wire&utm_medium=press_release&utm_campaign=report_2016_soeb_mid
[15] Journal of General Internal Medicine 27, no. 9 (2012):1105–11
[16] Health Affairs 30, no. 2 (2011):322–31
[17] American Journal of Managed Care 19, no. 12 (2013):400–7

Cost – Individuals

Our success in expanding health care coverage to millions of previously uninsured individuals and families has not, in many cases, lessened the economic strain on individuals and families. According to the Kaiser Family Foundation, the average annual out-of-pocket costs per patient rose almost 230 percent between 2006 and 2015.[18] The same Kaiser Family Foundation study found employee deductibles on average increased 67 percent from 2010 to 2015. In addition, greater than half of all individuals with an employer-based insurance plan have a deductible of at least 1,000.[19] Out-of-pocket costs are higher and more problematic for individuals with HDHPs. For an individual with an employer-sponsored HDHP, the average deductible for their coverage was $2,196 in 2015.

Compounding the economic strain on individuals and families is the fact that growth in health care costs is outpacing wages. Between April 2014 and April 2015, wages increased 1.9 percent while out-of-pocket medical expenses increased 9 percent.[20] As a result, more and more individuals and families are challenged to pay for their health care services. In fact, in a recent Kaiser Family Foundation survey, 20 percent of Americans under the age of 65 who have insurance claimed to have had problems paying their medical bills.[21]

These trends are concerning since many studies have shown that individuals with HDHP are more likely to delay or prolong seeing a physician due to their deductible. According to Kaiser Family Foundation, 43 percent of insured patients said they delayed or skipped physician-recommended tests or treatment because of high associated costs. Even individuals with health savings accounts report that they have delayed seeing a physician due to the out-of-pocket costs. Patients' ability to afford medical services decreases significantly depending on how their deductible stacks up to their household income. For patients whose deductibles equaled 5 percent or more of their annual income, 40 percent said they chose not to see a physician, get a medical test or visit a specialist, according to a survey by Commonwealth Fund.

When patients delay primary or preventive medical care, they often end up in an emergency room. According to a poll conducted by the American College of Emergency Physicians, about 80 percent of emergency physicians said they are treating insured patients who have sacrificed or delayed medical care due to unaffordable out-of-pocket costs, co-insurance or high deductibles.[22] A 2013 study found that HDHP led to decreased adherence to pharmaceutical treatments for patients with chronic conditions.[23] The decrease in pharmaceutical adherence contributes to poor control of chronic conditions, which leads to the probability of more intensive and expensive health care treatments at some future date.

These findings further support the need to ensure that individuals with a HDHP have connectivity with the health care system through a continuous relationship with a primary care physician. The cost of not ensuring continuous primary care is substantial. For example, the average cost of a visit to a primary care physician is $160.[24] By comparison, the median charge for outpatient conditions in the emergency room is $1,233[25] and the average hospital stay is $10,000.[26] Based on these indicators, you could see your 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 those patients whose medical problems are considered “avoidable” or “non-urgent” were to take advantage of primary or preventive health care and not rely on emergency rooms for their medical needs.[27]

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[18] http://kff.org/report-section/ehbs-2015-summary-of-findings/
[19] http://kff.org/report-section/ehbs-2015-summary-of-findings/
[20] http://www.nytimes.com/2015/09/23/business/health-insurance-deductibles-outpacing-wage-increases-study-finds.html?version=meter+at+7&module=meter-Links&pgtype=article&contentId=&mediaId=&referrer=https://www.google.com/&priority=true&action=click&c
[21] http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/
[22] https://www.acep.org/uploadedFiles/ACEP/advocacy/ACEP%20Fair%20Coverage%20Report.pdf
[23] http://www.ajmc.com/journals/issue/2013/2013-1-vol19-n12/medication-utilization-and-adherence-in-a-health-savings-accounteligible-plan
[24] http://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html
[25] http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491
[26] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb168-Hospital-Costs-United-States-2011.pdf
[27] https://www.debt.org/medical/emergency-room-urgent-care-costs/

Our Health Care System

There are many misconceptions about our health care system and these misconceptions lead to policy decisions that actually drive higher utilization of high cost services and therefore higher costs for individuals and payers. Our health care system was built on an "open access" philosophy, meaning that patients do not have limitations on the amount of services they can seek and receive. This philosophy has been curbed, but the general concept remains prevalent in our current health care system.

Many efforts have been made to demonstrate health care utilization. The first meaningful effort took place in 1961 when Kerr White, MD published the *Ecology of Medical Care: Monthly Prevalence of Estimates of Illness in the Community*.[28] Dr. White's research found that of any 1,000 people, in any given month, the following would occur:

- 750 would report one or more illness
- **250 would see a physician**
- 9 would be admitted to the hospital
- 5 would be referred to an additional physician
- 1 would be referred to an academic or university hospital

In 2001, this study was recreated and published in the New England Journal of Medicine.[29] The researchers found that of any 1,000 people, in any given month, the following would occur:

- 800 would report one or more symptom
- 327 would consider seeking medical care
- **217 would see a physician**
- **113 would see a primary care physician**
- 65 would see a complimentary or alternative medical care provider
- 21 would visit a hospital outpatient clinic
- 14 would receive home health care
- 13 would visit an emergency department
- 8 are hospitalized
- Less than 1 is hospitalized in an academic or university hospital

These two studies show that, despite being conducted more than 40 years apart, the overwhelming percentage of health care services are provided by ambulatory physicians, usually primary care physicians. If this is the preferred source of care for patients, why would we not prioritize access to their preferred source of care? Especially since the source of care they prefer is the most efficient?

It is well known that the United States, as compared to other OECD countries, spends a greater percentage of our GDP on health care, yet we have a significantly lower life expectancy. Many researchers have pointed to various reasons why this occurs in the United States, but one common finding is the fact that the United States spends far less on primary care and prevention than other OECD countries. Currently, the United States spends about 6 percent of its total health care resources on primary care. By comparison, we spend 27 percent on inpatient hospitalization, 28 percent on outpatient hospital services, 30 percent on non-primary care professional procedures, and 16 percent on pharmaceuticals.

Higher utilization of primary care would lead to better outcomes for patients and lower costs for individuals, employers, and government health care programs. Given that a greater percentage of individuals have a HDHP, it is even more important that we incentivize and prioritize primary care.

[28] http://www.nejm.org/doi/10.1056/NEJM196111022651805
[29] http://www.nejm.org/doi/full/10.1056/NEJM200106283442611