January 25, 2018

John R. Graham, Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 415F
Washington, DC 20201
Submitted by email to: CompetitionRFI@hhs.gov

Re: Request for Information - Promoting Healthcare Choice and Competition Across the United States

Dear Acting Assistant Secretary Graham:

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 request for information titled, "Promoting Healthcare Choice and Competition Across the United States," as posted by the U.S. Department of Health & Human Services on its website.

The AAFP encourages HHS to expand opportunities for physicians and physician-led groups to take financial responsibility for their patients. Physicians – especially independent physician practices– are the lynch pin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. They are the most powerful tool we have to foster an affordable, accessible system that puts patients first. With that in mind, we strongly encourage HHS to prioritize physician-led advanced alternative payment models (AAPMs), including physician-led accountable care organizations (ACOs) and other approaches to achieve improved outcomes for patients, greater value, and the preservation of independent clinical practice.

The AAFP appreciates that HHS is actively working to promote choice and competition, and reduce regulatory burden, in healthcare markets. The AAFP also appreciates and applauds HHS interest in the impact of current laws and regulations on competition in the health care marketplace. However, we do not agree that competition and public safety are of equal importance. Many, if not all, of the applicable professional regulations at the state and federal level are designed to assure the competency of those individuals providing health care services to patients and to protect the safety of individuals seeking health care services. While competition is important and serves as a tool to increase the availability and affordability of services, we do not think greater competition should come at the expense of patient safety.

Both federal and state governments have an obligation through their oversight responsibilities, to ensure that individuals providing health care services have met an acceptable level of academic

achievement, completed the necessary training, and are periodically evaluated for both competence and performance. Each of these steps should be measured against national standards that have been determined to ensure that the individuals seeking to provide care services are competent to do so. Once this public safety threshold is achieved, examining how competition among qualified individuals may be achieved is appropriate. Consequently, regulations that require the successful completion of a rigorous academic program, prescribed years of post-graduate training, national certification, and continuous certification of both academic and performance competencies are not anti-competitive. Instead, they are pro- public safety and necessary to ensure that individuals seeking health care services can have confidence the individual providing such care is competent.

While all health care professionals – physicians and non-physicians – play an important role in providing quality health care to consumers, they are not the same, and their skills are vastly different based on their levels of education and training. We should not disguise or diminish these differences in the name of competition. Instead, we should acknowledge the differences and work to establish team-based models that allow each health care professional to provide care that is safe and appropriate based on the professional's education and training.

The AAFP is deeply troubled by the explosion of mergers between hospitals and health systems. These mergers, in our opinion, are driving up costs, decreasing competition, and creating an escalating arms race in medical technology and costly, low-value medical services. No evidence exists that these mergers are decreasing prices in those marketplaces where they occur. In fact, these mergers appear to decrease access and destabilize the health care delivery system by economically inducing physicians into employed relationships due to imbalanced market power consolidated by hospitals and health systems. We recommend that HHS and/or other branches of the federal and state governments devote significant resources to these issues, and we strongly believe that this is an area where greater competition would benefit patients, physicians, and other health care providers. Allowing hospitals and health systems to expand their stranglehold on the marketplace is harmful for patients, physicians, employers, and federal and state health care programs.

The AAFP is equally concerned about the shrinking number of commercial insurers and the expanded role of the large insurance plans into government health care programs. While there are many benefits related to commercial insurers' entry into the management aspects of Medicare and Medicaid, the trend does present challenges that may limit access and allow insurers to control certain markets. More concerning is the consolidation of plans offered, which allows insurers to narrow their networks by only contracting with those physicians who are willing to accept the lowest levels of payments for their services. We have witnessed this trend for several years, but are more concerned today as health insurers expand into the Health Insurance Marketplaces and roll out fewer Medicaid managed care products. For example, according to a 2017 Kaiser report, 33% (19 million) people are enrolled in a Medicare Advantage (MA) plan. According to this same report Humana and UHC accounted for 41% of enrollment in 2017. BCBS of Alabama controls 85% of the individual market and 93% of the large group market in Alabama. In 2015, UHC and Anthem accounted for 20% of the MA market share. This situation allows insurers to control, if not manipulate, the physician workforce in those marketplaces. This control is anticompetitive, and we encourage HHS and other federal and state government regulators to both examine and prevent such actions by insurers.

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, 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.

We encourage HHS to review the AAFP's policy on "Value-based Insurance Design" to reduce and eventually eliminate financial barriers to high-value health care services. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

The AAFP actively supports family physicians who choose to practice in a delivery and payment model in which they contract directly with patients, typically referred to as Direct Primary Care (DPC). Under the DPC model, the patient pays a monthly or annual fee directly to the practice for a defined set of primary care services. These services typically include increased access to a personal physician, extended visits, electronic communications, in some cases home-based medical visits, and highly personalized, coordinated, and comprehensive care administration. Although a majority of DPC practices offer a common set of primary care services, each DPC practice is unique as it looks to meet the needs of its community. DPC physician practices prosper on being fully transparent and consistent with their costs that the patient can access at any time. The AAFP has seen DPC practices nationwide negotiate substantially lower prices with local imaging and diagnostic centers, because their patients are paying out of pocket for the services.

Although this model represents a small portion of our membership, the AAFP sees continued growth and interest in family physicians adopting this practice model in all settings types, including rural and underserved communities. The AAFP encourages HHS to work with DPC organizations who have experience in designing and implementing this type of payment model under Medicare Advantage and with self-funded employers. We also encourage HHS to seek guidance from independent DPC practices that have typically chosen this practice model to free themselves from the administrative burdens of public and private insurers. Participation in any demonstration model should be voluntary and open to all physicians interested in participating. Direct primary care thrives on removing the administrative requirements that are found in the current fee-for-service system. Any model to test DPC should evaluate decreased cost and increased quality.

We urge HHS to remove legal barriers that currently prevent patients with health savings accounts (HSAs) from receiving care from family physicians practicing in a DPC. Under existing interpretation of the Internal Revenue Code, patients with HSAs are prohibited from engaging in DPC arrangements with a family physician or other primary-care physician. The *Primary Care Enhancement Act of 2015* (HR 365), which the AAFP supports, removes this barrier by allowing patients with HSAs to freely contract with physicians for DPC services. The Internal Revenue Code also establishes that a patient with an HSA may not use HSA dollars to pay for insurance premiums. This legislation explicitly states that patients may use HSA dollars to pay for monthly DPC payments—clarifying that DPC is not health insurance.

The AAFP welcomes the opportunity to connect HHS with our members practicing in this setting to gain further feedback.

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

About Family Medicine
Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.