



October 6, 2016

Andrew M. Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS–1654–P  
Mail Stop C4–26–05  
7500 Security Boulevard  
Baltimore, MD 21244–1850

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I am responding to the [proposed rule](#) titled, “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018” as published by the Centers for Medicare & Medicaid Services (CMS) in the September 6, 2016, *Federal Register*. Lack of competition in health plans could be a serious concern during the 2017 enrollment period. The AAFP believes this proposed rule could provide the Exchanges with needed flexibility and encourage continued participation by Qualified Health Plans (QHPs). Ultimately, the AAFP wants more choices available for patients, who too often raise concerns to their family physician about plans, premiums, benefits, and seeing the doctor they want to (provider networks).

**Risk Adjustment.** The AAFP supports CMS’ proposal to allow for partial-year risk adjustment. The goal of risk adjusting should be to make it more predictable, accurate, and effective at spreading risk for QHPs, ultimately benefitting patients’ choices. Estimating the risk associated with enrollees who are not enrolled for a full 12 months will better identify, quantify, and mitigate the effects of those who gain coverage with limited medical history and/or those who have sudden, high-cost acute episodes of care or a qualifying life event that drives them to enroll. The AAFP urges CMS to extend this logic to risk adjustment methodologies for providers and better estimate the risk associated with patients who have not had prior health insurance coverage for a full 12 months.

**Prescription Drug Information.** The AAFP maintains that the family physician is the patient’s best advocate. As described in the AAFP’s [policy](#) on “Patient-Centered Formularies,” the AAFP believes that QHPs and pharmacy benefits managers (PBMs) should provide drug utilization and cost information to physicians in clear and understandable reports. CMS should also use prescription drug data to update the predictive ability of its risk adjustment models since the use of prescription drug utilization data is previously-untapped information on the health condition or status of individuals. Drug prescribing information can be useful in enhancing risk adjustment to better identify patients who utilize a disproportionate share of health services and to better establish the severity of conditions already identified by the current model. However, that information should be used as a

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supplemental data source—in conjunction with data obtained from a patient’s physician. While identifying a patient’s condition is aided by drug prescribing information, many drugs may be used for both high- and low-cost conditions and could lead to incorrectly identifying a patient diagnosis. For example, if a patient is using Topiramate, it would be difficult to determine if that drug is being used to treat and prevent seizures or to prevent migraine headaches. The AAFP believes CMS should institute effective data sharing mechanisms for obtaining the actual patient diagnoses from a patient’s medical home that will not increase the administrative burdens on physicians. In addition, the risk adjustment models should incorporate factors that, while directly unrelated to risk, may indirectly affect risk. For example, drug utilization will vary based on access to pharmacies, whether a drug is too high-cost for a patient, and the cost-sharing structure of the patient’s policy. This is another reason not to rely too heavily on utilization patterns and to attain the actual patient diagnoses from physicians.

QHP Competition and Medical Loss Ratio Calculations. Over several years, the AAFP has strongly supported applying the medical loss ratio (MLR) to Medicare Advantage (Part C), the Medicare Prescription Drug Benefit (Part D), Medicaid Managed Care, and Exchange plans. The AAFP continues to support implementation of MLR requirements since it helps ensure health care resources are focused on patient care rather than insurer profits. We support CMS’ proposal to defer reporting of policies until those policies have a full 12 months of experience in the MLR reporting year. Since MLRs are calculated on a three-year rolling average, QHPs can game the system by reporting high and low MLRs over this period by allowing them to pay lower overall rebates. New QHP entrants, however, do not have three-years of premium and claims data and are disadvantaged by this provision. In addition, QHPs that are new or have rapid enrollment growth within the Exchanges may be required to pay rebates based on excess premiums over claims for these policies. Therefore, the AAFP believes this proposal should encourage entry of new QHPs, provide smooth enrollment growth with financial stability, and allow QHPs to defer reporting newly issued policies. Modifying the MLR calculations to defer newly issued reporting policies with less than 12 months of experience would provide much needed time for QHPs to gain data on their newly enrolled member population in order to make sound risk, actuarial, and reimbursement calculations. Having at least 12 months of data on enrollees would enable QHPs to analyze and predict costs for those with chronic conditions and enable them to spread those costs more evenly over time. The proposed rule should give new QHP entrants and QHPs with rapid enrollment growth a level playing field with incumbent QHPs that use the three-year averaging MLR calculation. Eventually, the premiums and claims of those deferred policies should be reported in the following calendar year.

Requirement for QHPs to List Full-Year Plans. The AAFP continues to support efforts to expand patient access to affordable health insurance coverage through the Exchanges and improve open and special enrollment periods. CMS proposes requiring QHP issuers on an Exchange to participate for a full plan year (unless a basis for suppression applies) as a QHP certification requirement. The AAFP supports this position and believes this would help ensure that individuals enrolling through special enrollment periods and newly qualified members of group plans have access to a range of plans; which is generally comparable to the range of plans that can be accessed by those who enroll during the open enrollment period. Requiring QHPs to participate on the Exchanges for a full plan year ensures fairness, stability, and certainty for enrollees who seek out coverage during special enrollment. QHPs with commercial lines of business often offer the same coverage to those who want to enroll during the plan year due to a change in employment, the birth of a child, or other special/qualifying circumstances. This would align Exchange offerings with health insurance offered in commercial lines of business.

Renewability Regulations. Continuity of care is a hallmark and primary objective of family medicine and is consistent with quality patient care provided through a patient-centered medical home, as described in the AAFP [policy](#) “Definition of Continuity of Care.” CMS’ proposal for guaranteed renewability regulations would address instances where issuers may inadvertently trigger a five-year prohibition on re-entering an applicable market and disrupt the continuity of care for its enrollees. The AAFP supports this proposal, but only insofar as it will benefit patients. Under the proposed rule, a QHP that transfers all of its products to another insurer, under a corporate reorganization for example, and maintains continuity of coverage with its products would not be considered to be withdrawing from the market. The insurance products would be considered the same products for federal rate review requirements and the QHP would also not be required to send discontinuation notices to its members, but rather renewal notices. The proposed rule would enable QHPs to reorganize, while maintaining continuity of coverage for patients, and reduce confusion among patients if their insurer reorganizes. Modifying the circumstances that trigger a five-year prohibition on re-entering an applicable market would provide a much-needed update to how QHPs operate in the Exchanges and allow for stability and certainty for health insurance benefits, networks, and premiums for current and future enrollees.

Standardized Plans. As a fundamental principle detailed in the AAFP’s [policy](#) on “Reasonable Choice,” the AAFP supports patients making reasonable, personal choices regarding their participation in the health care system. This extends to selecting health plans because the AAFP believes patients must be well-informed on the options available and possible effects of each option. CMS proposes six standardized health plan options, now referred to as simple choice plans, one each for the bronze, silver, gold, and silver cost-sharing variation levels of coverage. CMS also proposes to establish three sets of six standardized plans. The first set is a version of the 2017 standardized plans reflecting modifications for 2016 enrollment weighted QHPs. The second set of standardized plans are designed to work in states that:

1. Require that cost sharing for physical, occupational, or speech therapy be not greater than cost sharing for primary care visits;
2. Limit the amount charged for each drug tier; or
3. Require that drug tiers have copayments rather than coinsurance.

The third set of standardized plans are designed for states that have maximum deductible requirements or other cost-sharing standards. While CMS will identify in the final 2018 payment notice which of the three sets of standardized plans will be available in each Federally Facilitated Exchange state. The AAFP urges CMS to consider each state’s market, population, and other applicable socio-demographic factors in its considerations. The AAFP believes standardizing plans offered in the Exchanges would reduce confusion for consumers selecting health insurance, enable consumers to compare costs and benefits of QHPs, and more easily identify which works best for them or their family.

The AAFP believes requiring drug tiers in the second set of standardized plans to have copayments, rather than coinsurance, to be of great benefit for patients who have chronic conditions requiring continual medication. According to a recent [report](#) from the Centers for Disease Control and Prevention, in any given month, about half of all Americans—and 90 percent of seniors—take a prescription drug. In addition, a recent *Health Affairs* [publication](#) showed spending on prescription drugs is now growing at a faster rate than spending on any other health care item or service. Drug prices are rising at a rapid enough rate that they are affecting the overall rate of health care cost

growth. Medicare's Board of Trustees [reported](#), Medicare's costs per beneficiary increased by 2.3 percent during 2014, after two years of no growth, due in large part to the almost 11 percent increase in drug costs for the program. This proposal could alleviate financial burdens for patients purchasing expensive prescription drugs.

CMS also proposes that at least one QHP in the silver and gold coverage level must be offered within the Exchange throughout each service area in which a QHP issuer offers coverage. The AAFP supports this proposal as it would promote consumer choice in health plans. Ensuring consumer choice for silver and gold coverage for each service area in which the QHP offers health insurance, would expand options and increase enrollment. In addition, allowing for greater flexibility in bronze plans should help those who find it difficult to obtain health care coverage or see little value in purchasing health insurance. The Exchanges need young and healthy people to enroll, in order to provide premium stability for QHPs and other enrollees. This change should encourage more young and healthy people to enroll because new options would be available to them that are more affordable.

Cost Sharing. AAFP [policy](#) "Value-based Insurance Design (VBID)" calls for cost-sharing policies to be transparent and easily accessible to physicians and patients. These policies should not restrict access to patient care. Easily understandable educational materials should be made available to explain the incentives and disincentives built into a plan's design. CMS proposes a premium adjustment percentage for 2018, which is used to set the rate of increase for several parameters detailed in the *Affordable Care Act*, including the maximum annual limitation on cost sharing for 2018. CMS also proposes the maximum annual limitations on cost sharing for the 2018 benefit year for cost-sharing reduction plan variations. Cost-sharing should not discourage utilization of medically necessary services. We encourage CMS to review our [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. As with VBID or CMS' current cost-sharing proposals, the AAFP urges CMS to continuously evaluate the levels and parameters it sets on health care services to ensure coverage and costs are updated in accordance with evidence-based data. QHPs in various state Exchanges offer additional preventive services without cost sharing when an enrollee visits a doctor in their network, even if they did not meet their deductible. The AAFP calls on CMS to examine different state models utilizing this VBID model and determine if those models should be expanded throughout the Exchanges to eliminate cost sharing for most primary care services. The AAFP applauds CMS for keeping preventive services at a zero cost sharing level. The AAFP appreciates CMS recognizing and encouraging the value of primary care for patients who would enjoy full coverage for that care before those costs are subject to the deductible. We believe this insurance design feature to be extremely important for patients with long-neglected ailments, who are gaining health insurance for the first time. Additionally, fully covering preventive services makes health insurance more attractive to young and healthy people and makes it easy for them to understand what services are and are not covered. Covering preventive services as a covered benefit before the deductible is applied provides an appropriate incentive to enrollees to use the preventive care and chronic disease management, as well as early diagnosis and treatment of acute conditions offered by family physicians and other primary care providers. Furthermore, this essential health benefit is consistent with the AAFP's [policy](#) on "Health Care for All," which advocates that primary care is provided through the patient-centered medical home and that patients should have no financial barriers, such as co-payments, that might impede access to their family physician.

Network Adequacy. The AAFP believes universal access to basic health care services can be attained with a pluralistic approach to the financing, organization, and delivery of health care. A pluralistic health care delivery approach naturally involves the continuously evolving health care delivery system options available to physicians and their patients. In addition, as described in the AAFP's [policy](#) on, "Health Care Delivery Systems," the AAFP supports the physician and patient option to choose any ethical health care delivery system, which would include integrated health care delivery systems. CMS proposes to bolster its network adequacy calculations by incorporating the identification of integrated health care delivery systems. Integrated health care delivery systems deliver a majority of covered professional services through their employees or through a single contracted medical group. With the growth of value-based care, CMS should incorporate integrated health care delivery systems into its network adequacy indicators, and, in particular, identify for enrollees whether a particular policy is offered as part of an integrated delivery system. Integrated health care delivery systems, which may have narrower networks, typically offer better access to care than other narrow network plans if they foster optimal health outcomes by providing cost-effective, patient-centered, quality care with a service emphasis. In addition, integrated health care delivery systems provide health care using new and innovative methods, along with using varying types of health care providers and facilities, which may improve care management and coordination. The AAFP believes CMS could use integrated health care delivery systems for its network adequacy calculations so long as the care delivered is high-quality and accessible and the delivery system supports physicians' responsibilities to treat, comfort, and educate patients.

We appreciate the opportunity to comment on this proposed rule. For any questions you might have, please contact Milack Talia, Senior Policy Analyst, at (913) 906-6000 ext. 4175 or [mtalia@aafp.org](mailto:mtalia@aafp.org).

Sincerely,

A handwritten signature in black ink that reads "Wanda D. Filer, MD". The signature is fluid and cursive, with the first name "Wanda" being the most prominent part.

Wanda D. Filer, MD, MBA, FAAFP  
Board Chair