ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

January 31, 2012

Steve Larsen
Director, Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Larsen:

The American College of Physicians (ACP), representing 132,000 internal medicine physician specialists in primary and comprehensive care of adults and adolescents, appreciates the opportunity to provide comments regarding the "Essential Health Benefits Bulletin," issued by the Department of Health and Human Services (HHS) on December 16, 2011.

ACP Policy Related to Coverage and the Essential Benefit Package

The College has long supported efforts to expand health insurance coverage to all legal residents. In the 2008 paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years,* ACP recommended that Medicaid coverage be expanded to low-income individuals regardless of categorical eligibility; that advanced, refundable tax credits be provided to eligible uninsured individuals to purchase insurance; that regulated health insurance exchanges be established to facilitate the purchase of health coverage; that small businesses be provided new insurance purchasing opportunities and assistance; that insurance be regulated to ensure access and affordability; and that an expert advisory committee be charged with developing an essential benefit package.

ACP policy routinely states that any effort to increase health insurance access must ensure that plans cover an essential benefit package that covers primary and preventive care. Of particular relevance, ACP's Core Principles on Health Insurance Coverage recommend that:

> Flexibility should be provided for states to investigate different approaches to expanding coverage, controlling costs, identifying funding sources, and reducing barriers to access and quality, provided that such state-based approaches contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to assure portability and access to the basic benefits package. State initiatives, while encouraged, are not a substitute for federal action when state initiatives are lacking or ineffective.

College policy proposes that States have latitude in choosing a benefit package, providing it meets minimum federal standards. The College recommends that licensed health plans should provide coverage in one of the following three categories:

1) *Benchmark coverage*. Such coverage should have benefits not less than, and out-of-pocket cost-sharing not greater than, one of the following:

a) The most highly subscribed FEHBP plan among federal employees during the prior year

b) Non-waivered Medicaid or SCHIP coverage in the state *or*

c) The most highly subscribed plan in the state among either state employees or commercial, non-Medicaid HMO enrollees during the prior year.

2) *Benchmark-equivalent coverage.* To qualify as benchmark-equivalent, a plan should:

a) Have an aggregate actuarial value not less than a benchmark plan *and*

b) Cover the most recent set of essential benefits recommended by an expert Commission and adopted by Congress.

3) *Alternative coverage* should offer benefits not less than, and out-of-pocket cost-sharing not greater than, an FEHBP fee-for-service or HMO plan that does not provide benchmark coverage.

While the Bulletin generally reflects College policy on essential benefit requirements, ACP respectfully offers the following recommendations on establishing a comprehensive, value-based benefit package:

<u>Benefit Design Flexibility</u>

The Bulletin establishes that health insurance issuers will have flexibility to determine benefit packages providing they are "substantially equal" to the benefit package of the benchmark plan chosen by the State. The Bulletin intends to permit insurance issuers to alter specific services covered and any quantitative limits as long as the plan covers services within the 10 mandated benefit categories. Any modified plan would be required to meet a baseline set of relevant benefits.

The College is concerned that 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. Further scrutiny must be applied to protect against risk segmentation if benefit packages are tailored in a way that attracts a disproportionate share of healthy, low-cost enrollees. ACP requests that HHS clarify the definition of "baseline set of relevant benefits" to provide States with adequate guidance in overseeing benefit substitutions. HHS should also consider only permitting substitutions if the procedure or service to be replaced is proven to be of limited clinical effectiveness or low value. Independent actuaries (that meet standards established in the "Actuarial report for benchmark-equivalent coverage" section of the Children's Health Insurance Program, 42 CFR 457.431) should be required to perform rigorous audits of insurance plans to determine whether the plans cover all services in the 10 benefit categories, include benefits that are substantially equal to the benchmark plan, and are at least actuarially equivalent to the benchmark plan.

ACP also recommends caution on permitting substitutions among prescription drug categories. The College opposes any formulary that may operate to the detriment of patient care, such as those developed primarily to control costs. Decisions about which drugs are chosen for formulary inclusion should be based upon the drug's effectiveness, safety, and ease of administration rather than solely based on cost.

In designing an essential benefit package and/or selecting a benchmark plan, stakeholders across the health care spectrum – particularly patients and physicians and other health care providers – must be consulted. ACP strongly believes that the public, patients, physicians, insurers, payers, and other stakeholders should have opportunities to provide input to health resource allocation decision-making at the policy level.[2] This is particularly important if insurers are permitted to substitute services within and across benefit categories.

Emphasis on Primary and Preventive Care

Future guidance should clarify what services must be covered under the preventive and wellness services and chronic disease management category, as such interventions are crucial in the drive to prevent and manage chronic disease. States must be encouraged to select benchmark plans that provide a comprehensive menu of preventive and primary care services that will help stave the growth of chronic illness and foster wellness. The Affordable Care Act has been instrumental in enhancing access to preventive services approved by the United States Preventive Services Task Force by requiring coverage of such benefits without cost sharing. This primary care focus should be continued when developing essential health benefit package guidelines.

Encourage Adoption of High-Value Services

HHS charged the Institute of Medicine (IOM) with creating a framework designed to help the agency define benefits and update benefit packages to reflect the latest science, access issues, and effects on cost. While IOM did not provide any recommendation on specific services that should be included in the essential health benefits package, it did make a number of recommendations that reflect ACP policy and could potentially facilitate the evolution of the essential benefit package to one that would provide high-value, evidence-based services.

Of notable interest to ACP, the recommendations support the consideration of clinical and cost effectiveness in determining the benefit package. ACP policy supports the expansion of value-based health insurance, where use of evidence-based, high-quality services and products is encouraged. Specifically, ACP policy states that, "employers and health plans should consider adopting value-based benefit design programs that use comparative research on clinical outcomes and cost effectiveness developed by an independent entity that does not have an economic interest in the benefit determinations."[1] In addition to clinical effectiveness and cost, factors such as patient need, values, potential benefit; safety; societal priorities that include fiscal responsibility and equitable access; quality of life gained, consistent and compliant with the Americans With Disabilities Act; public health benefit; impact on families and caregivers; should be considered.[2] Consideration should also be given to achieving a balance between cost and clinical effectiveness to minimize adverse economic consequences on future generations. Further, ACP has established the High-Value Cost-Conscious Care Initiative, a campaign to teach physicians about how to deliver high-quality, medically-appropriate care to patients, and reduce waste in the health care system. The campaign was borne out of the crucial need to slow health care cost

growth while strengthening the patient-physician relationship and educating stakeholders on what interventions will most benefit the patient.

IOM recommended that beginning in 2015, HHS should "update the essential benefits package to make it more fully evidence-based, specific, and value-promoting — explicitly incorporating costs."[3] This encouraging step towards promoting clinically-effective care should be integrated into the essential benefit package as the evidence permits. States should seek benchmark plans that incorporate value-based insurance design, and the College recommends that future HHS guidance on this matter include such policy.

The College also supports the IOM's recommendation that data be gathered and that the benefit package be updated based in part on provider payment rates, contracting mechanisms, financial incentives, scope and organization of practice. Other important factors that should be considered in future changes include patient demographics, health status, disease burden, and access issues. Health plan characteristics, such as cost-sharing and integration of value-based insurance design, should also be considered.[4] Such information should be made publically available so that States and other stakeholders can review.

Conclusion

The Bulletin generally reflects ACP policy on the essential health benefit package as it seeks to strike a balance between comprehensiveness and affordability while giving States some freedom to determine a package that best serve the needs of residents. The College believes that strong oversight is needed when determining the initial benchmark plan (and whether it reflects the coverage requirements of the Affordable Care Act) and how the package will be updated, particularly if insurers are given the ability to substitute benefits within and across categories. State and the federal government must work in concert with physicians, health care providers and payers to determine and promote use of clinically effective and cost-effective services that result in improved patient health while bending the cost curve.

Sincerely,

Virginia Hood, MBBS, MPH FACP

President

[1] American College of Physicians .Controlling Health Care Costs While Promoting The Best Possible Outcomes. Philadelphia: American College of Physicians; 2009: Policy Monograph.
[2] American College of Physicians. How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently? Philadelphia: American College of Physicians; 2011: Policy Paper.
[3] Iglehart JK. Defining Essential Health Benefits-The View from the IOM Committee. *NEJM.* 2011;365:1461-1463. Accessed at http://www.nejm.org/doi/full/10.1056/NEJMp1109982 on January 24, 2012.
[4] Institute of Medicine Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans. Report on essential health benefits: balancing coverage and cost. Washington, DC: National Academies Press, October 7, 2011.