



December 26, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-9980-P, Proposed Rule, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Acting Administrator Tavenner:

The American College of Physicians (ACP), the largest medical specialty organization and the second-largest physician group in the United States, appreciates the opportunity to provide comments regarding the proposed rule on essential health benefits, actuarial value, and accreditation issued by the Department of Health and Human Services (HHS) on November 20, 2012. ACP members include 133,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

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

Benefit Design Flexibility

The proposed rule establishes that health insurance issuers will have flexibility to determine benefit packages providing they are “substantially equal” to the base-benchmark plan chosen by the State.

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.. HHS should 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 should be required to perform rigorous audits on 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, especially if it creates restrictive formularies primarily geared towards cost control rather than high-value, cost-conscious care. 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.ⁱⁱ This is particularly important if insurers are permitted to substitute services within benefit categories as proposed by the rule. Evaluation of health plan benefit packages must be ongoing to determine its impact on access to physicians and other health care professionals, the promotion of preventive health and high value care, and the effect on racial and ethnic health disparities, among other factors.

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 focus on primary care should be continued in development of the essential health benefit package. ACP appreciates that the proposed rule affirms that preventive services without cost-sharing are to be included in EHB benchmark plans and that annual deductibles do not apply to preventive services.

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 (EHB) 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.”ⁱⁱⁱ

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.ⁱⁱ 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.

Among the recommendations made by the IOM, is 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 and that a public deliberative process should be used to inform choices about what to include in or exclude from the updated package.”ⁱⁱⁱ 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 incorporate such policy. While the calculation of actuarial value is outside of the scope of ACP policy, HHS should evaluate viability and effect of including value-based insurance design in the actuarial value calculator.

The College also supports the IOM’s recommendation 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.^{iv} Such information should be made publically available so that States and other stakeholders can review.

Cost-sharing requirements

Although the cost-sharing limitations proposed in the rule generally reflect ACP policy, the College is concerned that small group health plans may be relieved of the annual deductible limit requirement if they can prove they “may not reasonably reach the actuarial value of a given level of coverage...without exceeding the annual deductible limit.” The College acknowledges that providing cost-sharing flexibility to health plans may encourage market participation and lead to a wider choice of health plans for consumers. Deductibles can also be a useful tool in limiting overuse of services and encouraging use of evidence-based, high value procedures. However, the College cautions that relieving health plans of their obligation to limit cost-sharing may permit plans to impose high deductibles that are unaffordable to low-income individuals and cause patients to forego treatment because of cost. The College recommends that if small group health plans are permitted to increase annual deductibles, that this exception be implemented sparingly and that such flexibility be temporary and phased out over time.

ACP is also concerned that the proposed rule may undermine access to and affordability of physicians not included in a plan’s provider network. Under the proposed rule, out-of-pocket costs for care provided by an out-of-network physician would not count toward the annual cost-sharing limit or the annual limit on deductibles. To ensure that patients do not face an undue financial burden for receiving vital care, the

College requests that at a minimum, cost-sharing restrictions apply to out-of-network care received when appropriate physicians (i.e. subspecialists) or services are not offered in the plan's existing network.

Conclusion

The proposed rule 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 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,

A handwritten signature in black ink that reads "David Bronson". The signature is written in a cursive, flowing style.

David Bronson, MD FACP

President

ⁱ American College of Physicians .Controlling Health Care Costs While Promoting The Best Possible Outcomes. Philadelphia: American College of Physicians; 2009: Policy Monograph.

ⁱⁱ 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.

ⁱⁱⁱ 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.

^{iv} 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.