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ACA CHIROPRACTORS  Hands down better™

November 22, 2017

Administrator Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9930-P
P.O. Box 8013
Baltimore, MD 21244-8016

Re: CMS-9930-P, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma,

The American Chiropractic Association (ACA) appreciates the opportunity to provide comments on the Notice of Proposed Rulemaking (NPRM) regarding the proposed 2019 Notice of Benefit and Payment Parameters published in the *Federal Register* on Nov. 2, 2017. ACA is the largest organization in the United States representing doctors of chiropractic. ACA is leading our profession in the most constructive and far-reaching ways – by working hand in hand with other health care professionals, by supporting meaningful research, and by using that research to inform chiropractic practice. ACA members pledge to adhere to the highest standards of ethics and patient care, contributing to the health and well-being of the estimated 33 million individuals across the United States who seek chiropractic care each year.

Essential Health Benefits and Benchmark Plans

ACA recognizes that it is the Department of Health and Human Services' (HHS) approach to provide states the flexibility and freedom to design and adopt an essential health benefits package. We understand that to ensure that the goal of balancing comprehensiveness and affordability of coverage is met, state input should be respected and recognized, as the states can identify and recognize the health care needs of their constituents. However, we believe strongly that since the proposed rule contemplates giving states even more latitude in determining the appropriate benchmarks to establish what benefits must be included in individual and small group plans, **HHS must maintain oversight of what may otherwise become a patchwork of standards across the country and there must be continued federal interaction on this vital component of the Affordable Care Act, anything less may result in the unintended consequence of patients losing important benefits.**

We would urge HHS to maintain strong federal oversight as states vet and select benchmarks. Under plans instituted through the Affordable Care Act, consumers have come to rely on important benefits and protections. **We strongly recommend that HHS require actuarial data from the states to justify adoption of benchmarks that vary significantly from their current benchmarks in any category. In addition, we would also recommend that HHS encourage states to work with the Center for Medicaid and Medicare Innovation (CMMI) to develop payment models that would improve care, improve the patient experience in the health care landscape, improve population health, and reduce per-capita expenditures on health care.**

While affording state flexibility is often laudable, we do have concerns that some of the proposed approaches--such as selecting another state's benchmark plan in its entirety--could potentially violate state patient protection laws. ACA believes that it is important for HHS and the states to remain mindful of these rules, such as insurance equality laws and other patient protections as decisions are made regarding benchmark plans. Insurance equality laws, for example, do not constitute mandated benefits. Insurance equality laws only apply after an employer has included a specific benefit or service in their employee benefit package. At that point, the insurance equality laws stating that no *discrimination can*

be directed at any provider licensed to provide the service at issue are applied. Currently, chiropractors fall under the insurance equality laws in more than 40 states. The insurance equality laws increase competition among providers, ensure freedom of choice and improve access for patients, and are critical to improving patient-centered health care and reducing health care costs.

Insurance equality laws are congruent with Section 2706 of the Public Health Service Act (nondiscrimination in health care). It is estimated that 12.2 million Americans purchased health insurance on the exchanges in 2017, and that number will remain on track for 2018. **It is imperative that as the states make decisions regarding benchmarks, both HHS and states remain aware of, and adhere to, provisions in the Affordable Care Act and insurance equality laws that protect the patient's right to choose a specific provider.** It is critical to deter insurance issuers, especially those who have plans available in the exchanges, from limiting the patient's provider choice by discriminating against certain provider types in benefit policy language. Section 2706 of the Public Health Service Act (as enacted under Section 1201 of the Affordable Care Act) addresses this inequity by specifically preventing insurance issuers from arbitrarily excluding the participation of providers in their health care plans. Section 2706 applies to insured plans available on the exchanges, and **we urge HHS to take all steps necessary to ensure that this provision is not diminished in any way.** As cost-sharing increases and patients become consumers concerned about value and quality, it is critical to take all steps necessary to protect patients' choice—especially as insurers withdraw from the exchanges, diminishing patients' choices for health insurance coverage.

Considering HHS' effort to ensure comprehensiveness of coverage included in essential health benefits as well as affordability of coverage, **it is essential for HHS and the states to ensure that the benchmark plan selected includes coverage for cost-effective, low-risk interventions offered by doctors of chiropractic and other conservative health care providers.** Patients are often directed to higher risk and higher cost interventions such as prescription drugs or surgery to address common conditions such as low back pain—which in many cases can be treated in a more cost-effective and conservative manner. According to a 2011 report from the Institute of Medicine (IOM), an estimated 100 million Americans suffer from chronic pain, with an estimated annual cost to American society of at least \$560-\$635 billion.¹

In a recent letter to America's Health Insurance Plans (AHIP) CEO Marilyn Tavenner², attorneys general from 37 states detailed the impact that the opioid crisis has had on the country, in fiscal terms as well as regarding the toll on American life. The attorneys general went on to recommend that AHIP encourage doctors "to explore and prescribe effective non-opioid alternatives, ranging from non-opioid medications (such as NSAIDs) to physical therapy, acupuncture, massage, and chiropractic care." Their recommendation is in line with leading health care organizations such as the American College of Physicians³ and the Joint Commission,⁴ which recommend chiropractic care, physical therapy, and acupuncture as non-pharmacological approaches to pain management to address the opioid crisis. It is critical, therefore, to ensure that coverage for the conservative, primary care, portal-of-entry interventions that doctors of chiropractic provide (including spinal adjustment/manipulation, physical medicine procedures, counseling on risk avoidance, health promotion, prevention, wellness and other physician services) is protected, as they would help to keep health care costs down and increase access to necessary services.

The ACA strongly encourages HHS to ensure that states avoid placing arbitrary limits on coverage of essential benefits to limit the cost of the package. Benefits, such as the services doctors of chiropractic provide, can reduce expenditures.

¹ Institute of Medicine Report from the Committee on Advancing Pain Research, Care, and Education: Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research. The National Academies Press, 2011.

http://books.nap.edu/openbook.php?record_id=13172&page=1

² Rutledge, Leslie, et al. "Final NAAG Opioid Letter to AHIP." Received by Marilyn Tavenner, 18 Sept. 2017.

³ Qaseem A, Wilt TJ, McLean RM, Forcica MA, for the Clinical Guidelines Committee of the American College of Physicians. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. *Ann Intern Med.* 2017;166:514–530. doi: 10.7326/M16-2367

⁴ *R 3 Report: Requirement, Rationale, Reference.* 29 Aug. 2017,

www.jointcommission.org/assets/1/18/R3_Report_Issue_11_Pain_Assessment_8_25_17_FINAL.pdf. Accessed 13 Nov. 2017.

Essential health benefits should be covered regardless of the provider performing the services. Furthermore, the inclusion of specific health services as essential benefits (e.g. manipulation and physical medicine and rehabilitation services) should be based on evidence of effectiveness, safety, clinical outcomes, patient satisfaction, and patient preference. This will ensure true health care reform, increasing patients' choice of health provider, treatment options and appropriate access to care.

ACA sincerely appreciates the opportunity to provide comments on the proposed rule. We believe that looking at benefits from the standpoint of both effectiveness and cost-effectiveness (factoring relative risk into each) will enable states to ensure that patients receive high-quality care that is responsive to their needs and preferences, at a cost both they and the government can afford. If you should have any questions, please feel free to contact Julie Lenhardt, Senior Director, Payment Policy at (703) 812-0222.

Respectfully,

A handwritten signature in black ink that reads "David A. Herd, D.C." in a cursive style.

David A. Herd, D.C.
President