American Society for Gastrointestinal Endoscopy

Gastroenterologists care for patients with some of the most common, costly and consequential diseases facing the American public and the world today. Roughly 60 to 70 million people in the United States are affected by all gastrointestinal (GI) diseases, which are responsible for more than $111 billion in annual direct health care costs, and contribute to more than 43 million ambulatory care visits, 14.5 million emergency room visits, 2.9 million hospital admissions, and 281,413 deaths annually.[i]

Endoscopy procedures, performed by ASGE members, play a significant role in the prevention, diagnosis and management of digestive diseases, including many gastrointestinal cancers.

ASGE members provide endoscopic procedures predominantly in ambulatory surgery centers (ASCs). ASGE members also deliver hospital inpatient and outpatient procedure-based care, and provide office-based care and services, such as infusions for the treatment of intestinal inflammatory disease.

Issues confronting ASGE members and their patients are wide-ranging, many of which are not specific to gastroenterology. ASGE, however, is the foremost society in endoscopic care and is eager to work with Congress to advance policies and initiatives that address critical issues of health inequity and cancer prevention and early diagnosis, and to offer unique perspectives on payment and coverage policies, regulatory requirements and patient access to gastrointestinal care.

ASGE's Requests to Congress on Priority Issues

Medicare Physician Payment

- Force CMS to revisit its new indirect practice expense policy for CY 2027 rulemaking and to consider a more discerning methodology—such as the use of a payment modifier or other mechanism—to distinguish between different practice arrangements.
- Support the *Efficiency Adjustment Delay Act* (H.R. 7520), which would pause the new Medicare -2.5% efficiency adjustment and require CMS to issue a report with data justifying its application and only if certain conditions are met.
- Address critical issues with the Medicare physician payment system through legislative reform, which includes critical inflationary updates, budget neutrality reforms, and replacement of the Merit-based Incentive Payment System.

Prior Authorization & Step Therapy

- Pass the *Improving Seniors' Timely Access to Care Act* (S. 1816 / H.R. 3514) to codify CMS prior authorization regulations for Medicare Advantage plans and require greater transparency of prior authorization processes which will help patients and health care providers understand whether particular services are likely to be approved.
- Support the *Safe Step Act* (S. 2903 / H.R. 5509) to create guardrails around insurer drug therapy fail-first protocols.

Access to GI and Endoscopy Care

- Support policies, including patient cost-sharing policies, that improve access to and age-appropriate coverage of preventive colorectal cancer screening colonoscopy, especially in historically under-screened populations.

- Improve the current health care insurance system in a manner such that access to affordable coverage is maximized. Coverage and payment policies should support GI patient access to timely care, including expanded access to telehealth services.

Medicare Site Neutral Payment Policy

- Exempt ASCs from site neutral payment policies since current Medicare policy requires that procedures performed in physicians' offices at least 50% percent of the time be paid at the lower of the standard ASC rate or the practice expense portion of the physician fee schedule rate when the service is provided in the physician's office.

- Address payment inadequacy as a root cause of practice acquisition and consolidation, and, therefore, ensure any savings from site-neutral policy changes are reinvested in rural and underserved hospitals, as well as to offset the cost of improving physician and ASC payment adequacy.

National Institutes of Health (NIH) Funding

- Reject proposals that arbitrarily cap the indirect cost (Facilities and Administrative Costs) rate for NIH grant funding.

- Increase funding for medical research through the NIH for FY2027 to $51.3 billion — a 8.7% increase over FY 2026. Of this amount, $2.75 billion should be allocated to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

- Maintain the NIDDK as a stand-alone institute to ensure digestive disease research remains a top national priority.

Health Care Price Transparency

- Support improved health care price transparency by promoting compliance by health plans and issuers with current price transparency requirements. This would ensure health plan enrollees get the most accurate price and cost information specific to their insurance plan, including cost-sharing obligations. Further, the *No Surprises Act* requires that uninsured and self-pay patients receive a good faith estimate when required from their provider.

- Oppose the *Patients Deserve Price Tags Act* (S. 2355 / H.R. 5582). ASCs control just one of the costs of health care services or procedures provided in their facility — the facility fee— which does not reflect the total cost of care. The *Patients Deserve Price Tags Act* will lead to consumer misinformation and confusion regarding what a service will actually cost and imposes huge administrative burden on physician-owned ASCs.

Prevention and Public Health

- Uphold the value of preventive health care services and improve equality in health care access, quality and outcomes, including through cultural competency training and by addressing racism and social determinants of health.

[i] Peery AF, Murphy CC, Anderson C, Jensen ET, Deutsch-Link S, Egberg MD, Lund JL, Subramaniam D, Dellon ES, Sperber AD, Palsson OS, Pate V, Baron TH, Moon AM, Shaheen NJ, Sandler RS. Burden and Cost of Gastrointestinal, Liver, and Pancreatic Diseases in the United States: Update 2024. Gastroenterology. 2025 May;168(5):1000-1024. doi: 10.1053/j.gastro.2024.12.029. Epub 2025 Feb 4. PMID: 39920892; PMCID: PMC12018144.