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March 7, 2017

Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-9929-P — Patient Protection and Affordable Care Act; Market Stabilization

Dear Acting Administrator Conway:

The American Society for Gastrointestinal Endoscopy (ASGE) appreciates the opportunity to respond to proposals to stabilize the individual and small group markets as published on Feb. 17, 2017 in the *Federal Register*. Specifically, we wish to comment on the Centers for Medicare and Medicaid Service's (CMS) proposals to amend standards relating to guaranteed availability, the annual open enrollment period, special enrollment periods, and network adequacy.

Since its founding in 1941, the ASGE has been dedicated to advancing patient care and digestive health by promoting excellence in gastrointestinal endoscopy. ASGE, with more than 14,000 members worldwide, promotes the highest standards for endoscopic training and practice, fosters endoscopic research, recognizes distinguished contributions to endoscopy, and is the foremost resource for endoscopic education.

ASGE Guiding Elements of Health Care Reform

ASGE believes every American should have timely access to quality, affordable health care. This should include medically necessary primary care, specialty care and preventive services, such as colonoscopy screening for colorectal cancer. Payment for medical services should encourage delivery of high quality, cost-effective care.

Based on the core principle of patient-centered care, ASGE is evaluating policy and regulatory changes and will support proposals that:

- Improve the current health care insurance system in a manner such that access to affordable coverage is maximized and barriers to obtaining needed health care services, including for those with pre-existing conditions, are not created.

- Are pursued without creating uncertainty in the insurance marketplace and with as little disruption as possible to health care providers and consumers, including protection against loss of insurance coverage.

- Preserve patient-physician decision making and eliminate all barriers to providing evidence-based preventive services such as colon cancer screening.

- Are developed in a transparent manner with adequate stakeholder input and proven successful in demonstration projects prior to implementation.

- Promote care coordination, use of appropriate guidelines, and recognition of the potential value of physician-owned facilities in supporting cost-effective, efficient alternative payment models.

- Contain medical liability reforms that protect providers who base clinical decisions on guidelines and evidence-based medicine.

- Minimize regulatory burdens to enable providers to spend more time providing patient-centered care.

- Identify cost-saving measures to serve as alternatives to budget neutrality. The concept of creating artificial zero-sum financial parameters by which one group of providers must be penalized so that another group benefits works against fostering a culture of collaboration and care coordination among providers.

PROVISIONS OF THE PROPOSED RULE

Guaranteed Availability —

Under existing rules, consumers get a 90-day grace period to pay their outstanding premiums before issuers are permitted to drop their coverage. Issuers are required to reimburse providers during the first 30 days of the 90-day grace period. If a consumer still fails to make a payment after 90 days and his or her coverage is dropped, depending on most state laws, issuers will not be required to pay for claims incurred during the last 60 days of the grace period. If coverage is dropped for nonpayment, providers must work directly with patients to collect payments for the balance incurred during days 31-90 of the grace period.

As proposed, an issuer would not be considered as violating the guaranteed availability requirements if it requires a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past due premiums owed to that issuer for coverage during the prior 12 months to resume coverage from that issuer. We believe that maintaining the grace period is important, as is requiring issuers to apply their premium payment policies uniformly to all employers or individuals regardless of health status and consistent with applicable non-discrimination requirements. However, in the event an issuer recoups premium non-payment, the issuer should be required to pay claims submitted by the provider for that patient during the entire grace period. **We ask CMS to modify its proposal to guarantee that providers would be paid by issuers for services rendered during the grace period when past-due premiums are paid.**

Open Enrollment Periods —

Through previous rulemaking, it was established that the window for applying for coverage through a Qualified Health Plan (QHP) or changing coverage would gradually become more narrow and not extend into the new plan year. We acknowledge that shortening the enrollment window has the potential to simplify operational processes for issuers and the Exchanges. With the intent to reduce opportunities for adverse selection by consumers who learn they will need services in late December or January, CMS is proposing to move up the timeline for instituting a shortened enrollment period. As proposed, the open enrollment period for plan year 2018 would begin Nov. 1, 2017 and end on

Dec. 15, 2017. Under previous rulemaking, the open enrollment period for the benefit year beginning Jan. 1, 2018 would be Nov. 1, 2017 through Jan. 31, 2018.

As acknowledged in the proposed rule, we share CMS' concerns that a shorter enrollment period could negatively affect the ability of issuers to enroll younger and healthier consumers who typically enroll later in the enrollment period. Furthermore, we appreciate CMS' recognition that without adequate support for enrollment assisters, a shorter enrollment period could lead to longer wait times for potential enrollees.

To adequately evaluate the effect of this proposal on risk pools, it would be helpful to understand past patterns of adverse selection by consumers during more extended enrollment periods before finalizing this proposal. Should CMS finalize this proposal, we agree that extensive outreach by CMS would be necessary to ensure consumers are aware of this change, thereby providing adequate opportunity to enroll in coverage within the shorter time frame.

Special Enrollment Periods —

Special enrollment periods (SEP) are intended, in part, to promote continuous enrollment in health coverage during the plan year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage. Continuous coverage is important to protecting the risk pool. However, if a verification process is not well understood by consumers or if the process is not completed in a timely manner, it could deter young and healthier individuals from enrolling in coverage, and it could deter consumers from seeking necessary medical care while verification is pending.

CMS proposed to implement a pilot program for conducting pre-enrollment verification of eligibility for certain SEPs beginning in June 2017. The pilot would sample 50 percent of consumers who were attempting to newly enroll in Exchange coverage. **We ask CMS to consider implementing the pilot before finalizing a pre-enrollment verification requirements.** A pilot would allow CMS to better determine whether a verification process discourages otherwise eligible consumers from enrolling in Exchange coverage or from submitting documents required for verification.

Consistent with current practice, it is important the coverage start date be determined by the date of plan selection and not when SEP eligibility verification is complete. As proposed, consumers could start their coverage one month later than what their effective date would ordinarily have been - if the verification process results in a delay in enrollment that requires the consumer to pay two or more months of retroactive premium to effectuate coverage or avoid termination for non-payment. **We support the proposed flexibility for consumers to start coverage one month later than what the effective date would ordinarily have been. However, there must be clear guidance to providers and consumers on the process of submitting claims for services rendered during the verification period.**

Network Adequacy —

Amid growing concerns that the health insurance industry was trending toward "narrow network" health plans, which offer a limited choice of providers for members, the National Association of Insurance Commissioners (NAIC) in 2014 began a review of its network adequacy model act. After nearly a year of input from a variety of stakeholders, including representatives of the insurance industry, a revised model act was adopted in November 2015. States have the option to adopt all or

parts of the model act; however, to date, very few states have taken steps to tighten their network adequacy standards.

As proposed, for the 2018 plan year, CMS would defer to the states' reviews to ensure whether the "reasonable access standard" is met when assessing issuer network adequacy. In doing so, the federal minimum threshold would be eliminated. We acknowledge that a federal "one-size-fits-all" threshold may not work for every state. The NAIC Model Act provides flexibility for states to establish appropriate network adequacy measures that take into account the state's geography, density, and markets. Therefore, we believe that for states that do not have the authority and means to conduct sufficient network adequacy reviews, issuers should be required to submit an access plan, as part of the QHP application, that demonstrates the issuer has standards and procedures in place to maintain an adequate network consistent with the NAIC Health Benefit Plan Network Access and Adequacy Model Act (Model #74).

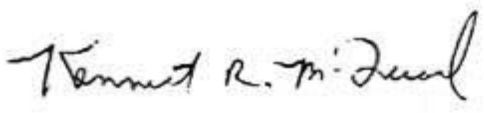
In States without the authority or means to conduct sufficient network adequacy reviews, we do not believe it is sufficient to rely on an issuer's accreditation (commercial or Medicaid) from an accrediting entity recognized by the Department of Health and Human Services. Accreditation is not a comparable substitute for governmental oversight. Accreditation agencies cannot resolve consumer grievances and cannot take action against an insurer with an inadequate network other than to downgrade accreditation.

In turning over network adequacy reviews to the states, we suggest that CMS commit to periodic checks of state network adequacy reviews, including whether provider directories are accurate. Despite provider directory requirements and standards, the accuracy of these directories remains poor overall.

CONCLUSION

Thank you for the opportunity to comment. Should you need any additional information please contact Lakitia Mayo, Senior Director of Health Policy, Quality, and Practice Operation at (630) 570-5641 or lmayo@asge.org.

Sincerely,



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