American College of Physicians
Leading Internal Medicine, Improving Lives

March 7, 2017

Patrick Conway
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Attn: CMS-9929-P

Re: CMS-9929-P; Proposed Rule: Patient Protection and Affordable Care Act; Market Stabilization.

Dear Dr. Conway,

The American College of Physicians (ACP) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS') *Proposed Rule: Patient Protection and Affordable Care Act; Market Stabilization*. The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 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.

We respectfully submit the following comments:

147.104: Guaranteed Availability of Coverage

ACP strongly supports the Affordable Care Act's (ACA's) guaranteed availability requirements and we are concerned that this proposal undermines the spirit of the law. We recommend that the Agency not allow issuers to deny coverage enrollees with bad debt; instead, the issuer should be required to enroll the individual and allow the enrollee to pay the outstanding debt over a period of time. We also request clarification as to whether past due premiums paid back to the issuer will be used to reimburse pended claims that may have been made during the second and third months of the enrollee's 90-day grace period for the previous plan year. We

strongly encourage the Agency to ensure physicians are promptly reimbursed for any services provided during the grace period.

155.410(e): Open Enrollment Periods

As you know, plan year 2017 plan selections in states that use the HealthCare.gov eligibility and enrollment platform decreased compared to 2016. Any move to shorten the open enrollment period may temper enrollment and discourage healthy individuals from enrolling. This likely outcome is discussed in the Impact Estimates and Accounting section of the proposed rule which states, "However the shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period." A shorter open enrollment period could create confusion and a less stable risk pool. Therefore, ACP strongly recommends that the open enrollment period for plan year 2018 begin on November 1, 2017 and end on January 31, 2018. States operating a state-based, state-based/federal platform, and partnership marketplaces should be permitted to establish longer open enrollment periods.

155.420: Special Enrollment Periods

We agree that verifying special enrollment period (SEP) eligibility with documentation could be an important way to reduce potential fraud and protect the integrity of the marketplace. However, if verification requirements and paperwork burdens are too onerous it could have the unintended effect of discouraging enrollment, particularly among healthy individuals who may be less motivated to shop for coverage. Further, the Agency intends to alter its policy on SEPs before the start of the June 2017 pilot program on pre-enrollment verification for SEPs. We believe that the Agency should maintain the existing SEP confirmation process, which may have helped to reduce 2016 SEP plan selections by 15% compared to the same period in 2015.[i] By waiting for the results of the Agency's pilot project, CMS and other stakeholders will have a better understanding of the effects of verification requirements on enrollees, the marketplace, and issuers alike.

156.140: Actuarial Value

ACP does not have specific policy on actuarial values and de minimis ranges for metal tiers but the proposed policy does raise concerns that the generosity of marketplace plans could erode if the de minimis amount is changed to -4/+2. Although the proposal may result in slightly lower premiums it could also lead to higher cost sharing for patients, which has been shown to reduce use of necessary health services.[ii] We urge caution in adopting this proposal.

156.230: Network Adequacy

The College opposes the proposed changes made to 156.230. ACP remains very concerned about the proliferation of narrow provider networks. Tight provider networks coupled with inaccurate provider directories create a frustrating, confusing and expensive experience for patients seeking care from their preferred physicians. Further, narrow networks are often developed as a way to cut costs rather than to direct patients to high-quality physicians. The evidence shows that provider network scope is shrinking:

- A report by the Robert Wood Johnson Foundation found that 41% of 2014 silver qualified health plan (QHP) networks were small (they include 10-25% of office-based participating providers in the area) or extra small (less than 10% included in network).
- By specialty, 36% of primary care networks and 23% of internal medicine specialty networks were small or extra small.[iii]
- A McKinsey & Co. report found that in 2016, 48% of individual market hospital networks across all metal tiers were tiered, narrow or ultra-narrow. Network breadth is declining in some areas and the percentage of consumers who only have access to narrow network plans has increased three-fold since 2015.[iv]
- In a review of federally-facilitated marketplace silver-level plans serving the rating area with the state's most-populous county, 15% lacked any in-network physicians for at least 1 specialty.[v]

To address this ACP has long encouraged stringent quantitative network adequacy criteria; ongoing monitoring and oversight of provider networks; transparent provider network development criteria; accurate, easily accessible and up-to-date provider directories; and requirements that QHPs should be prohibited from excluding health care clinicians whose practices contain substantial numbers of patients with expensive medical conditions. ACP supported the Agency's proposal outlined in the Notice of Benefit and Payment Parameters for 2017, which would have determined that a State's network adequacy assessment methodology is acceptable if it includes quantitative measures. While this proposal was ultimately not adopted, the College continues to believe that CMS can play an important role in ensuring that provider networks serve the needs of patients and limit the need to seek care from out-of-network physicians. States play a crucial role in enforcing insurance regulations, but not all states use quantitative standards to determine network adequacy. To address these gaps, we support the Agency's continued use of quantitative criteria to assess network adequacy and urge continued federal oversight of provider networks rather relying on the accreditation model proposed in the rule.

<u>156.235: Essential Community Providers</u>

The College continues to support requirements for the inclusion of essential community providers (ECP) such as Federally Qualified Health Centers, Ryan White HIV/AIDS Providers and safety-net hospitals, and maintains that the 30% ECP threshold should be a floor. QHPs should

be encouraged to incorporate additional ECPs to meet the needs of patients in the service area. Cutting the ECP requirement to 20% would further degrade access to crucial community providers, potentially discouraging people from enrolling because of inadequate access to local providers. CMS should closely scrutinize QHP requests for exceptions to this rule and closely monitor plans that are granted exceptions, requiring changes as needed. Contingency plans must prioritize continuity of care with the patient's preferred health care clinician.

Thank you for considering our comments. If you have questions regarding these recommendations, please contact Ryan Crowley at (202) 261-4521 or rcrowley@acponline.org

Sincerely,

Nitin Damle, MD, MS, MACP
President
American College of Physicians

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[i] Centers for Medicare and Medicaid Services. Frequently Asked Questions Regarding Verification of Special Enrollment Periods. September 6, 2016. Accessed at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf

[ii] Brook RH, Keeler EB, Lohr KN, Newhouse JP, Ware JE, Rogers WH et al. The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. Santa Monica, CA: RAND Corporation; 2006. Accessed at http://www.rand.org/pubs/research_briefs/RB9174.html

[iii] Polsky D and Weiner J. The Skinny on Narrow Networks in Health Insurance Marketplace Plans. Philadelphia; Penn LDI and Robert Wood Johnson Foundation; 2015. Accessed at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027

[iv] Coe E, Bello J, Lamb J. Hospital networks: Perspective from three years of exchanges. McKinsey Center for U.S. Health Systems Reform. March 5, 2016. Accessed at http://healthcare.mckinsey.com/hospital-networks-perspective-three-years-exchanges

[v] Dorner SC, Jacobs DB, Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA.* 2015;314(16):1749-1750. Accessed at http://jamanetwork.com/journals/jama/fullarticle/2466113