March 7, 2017

Patrick Conway, Acting Administrator
Centers for Medicare & Medicaid Services

Norris Cochran, Acting Secretary
Department of Health and Human Services

Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue SW.
Washington, DC 20201

Dear Acting Administrator Conway and Acting Secretary Norris Cochran:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the *Patient Protection and Affordable Care Ac*t; Market Stabilization proposed rule as published by the Centers for Medicare & Medicaid Services (CMS) in the February 17, 2017 *Federal Register*. Among other provisions, this regulation proposes changes to the individual and small group markets, amends standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year. In general, we are struck by the anti-patient bent of the regulation, shortening enrollment periods, placing more financial risk on patients and physicians, inattention to challenges narrow networks create, and a chaotic approach to narrow network designation. Far from "stabilizing the market," these changes seem designed to unfairly shift financial risk to patients and physicians from insurers. We would respectfully urge CMS to closely monitor the implementation of these insurer-friendly changes to confirm that they do not undermine the patient/physician relationship and further undermine family insurance. The AAFP appreciates the opportunity to comment, and offers the following suggestions to strengthen efforts to improve the individual and small group markets for patients and physicians.

Open Enrollment and Special Enrollment Periods

Summary

The proposed rule changes the open enrollment period from a three-month period (November 1 to January 31) to a six-week open enrollment period that more closely aligns with the large and small group markets (November 1-December 15 with coverage to begin January 1). The rule would implement pre-enrollment verification of Special Enrollment Periods (SEPs). Enrollment would be delayed or "pended" until verification of eligibility is completed. The rule indicates that this is necessary to guard against adverse selection and gaming of enrollment.

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AAFP response
The AAFP is concerned with the proposed changes to the open enrollment since continuously open enrollment and longer open enrollment timeframes would allow more time for patients to enroll in appropriate plans. Adding the pre-enrollment verification of SEPs will be a positive move to improve continuous coverage and stabilize risk pools.

Based on family physician concerns, the AAFP urges insurance cards to be issued when enrollment is verified and coverage begins. Physicians and their practice staff need accurate eligibility information at the time of care. Ideally, practice staff would be able to access this information in real time in an efficient manner through a website or portal. This ability would help mitigate billing frustrations while patients change their health plans.

Grace Periods
Summary
The rule indicates that the qualified health plan (QHP) insurer must "suspend" coverage during the second and third months of the grace period, unless the individual pays all premiums owed. Enrollees may still receive care, but are financially responsible for the cost of those services unless all premiums owed are paid and coverage is reinstated. Providers are not obligated to provide covered services to an enrollee while coverage is suspended.

To address concerns about potential gaming, CMS proposes to modify the guaranteed availability rules with respect to non-payment of premiums. Under this proposal, an issuer would not be violating the guaranteed availability requirements if the issuer attributes a premium payment for similar coverage to the outstanding debt for coverage from the same issuer enrolled in within the prior 12 months.. In the absence of state law, this would permit an issuer to require a policyholder whose coverage is terminated for non-payment to pay all past due premium owed to that issuer after the applicable due date for coverage enrolled in the prior 12 months in order to resume coverage from that issuer.

AAFP response
The AAFP wrote a letter to CMS on March 5, 2014 voicing concerns regarding the 90-day grace period in the exchange market and unfortunately these concerns still persist. Physicians are negatively impacted by this policy since the grace period shifts a large financial burden onto the medical practice. Patients that are unable to pay their premiums are more difficult to collect from because of their inability financially to pay. From a practices perspective, this policy does not eliminate or reduce the financial burden of the grace period.

Even with the change, the financial burden of services in months 2-3 remain with the practice. If a majority of patients would have coverage beginning January 1, then claims from January 1-31 would be paid according to new grace period provisions. Member practices would need to closely monitor services in months 2-3 (Feb-March) since the insurer can reject claims in these months of the grace period similar to current rules.

The AAFP requests that CMS require insurers to add a date of enrollment to insurance cards as that would be extremely helpful to billing and practice management staff since a number of patients will still qualify for coverage under SEPs. This will allow staff to understand if there may be a chance of "pending" status in months 2-3.

The AAFP also urges CMS to require that insurers immediately notify practices of patient eligibility so that they could determine whether the medical practice would be financially penalized for providing non-urgent care. Whether a patient is enrolled or not in a plan is essential information that CMS and insurers must immediately communicate to physician practices so patients can receive timely clinical care and so the medical practice can accurately file claims with the appropriate insurer.

Network Adequacy

Summary

If states do not review network adequacy, CMS proposes to rely on an issuer's accreditation from an HHS-recognized accrediting entity. HHS has previously recognized three accrediting entities for the accreditation of QHPs: the National Committee for Quality Assurance, URAC, and the Accreditation Association for Ambulatory Health Care."

AAFP response

On January 12, 2015, AAFP submitted a statement concerning network adequacy. A large number of our member practices in the northeast U.S. were narrowed out of the UnitedHealthcare Exchange Network without explanation or an appeal process in place. In a January 11, 2016 letter to CMS, AAFP cautioned CMS that its proposals should not promote the practice of dropping physicians from networks without cause or appeal. We urge CMS to monitor and prevent the further narrowing of networks.

Essential Community Provider

Summary

Changes in the proposed rule include:

1- A revision in the Essential Community Provider (ECP) enforcement standards whereby regulators will consider the insurer to have satisfied the regulatory standard if the issuer contracts with at least 20 percent of available ECPs in each plan's service area.
2- A regulatory revision so that issuers will be permitted to include as ECPs (including section 340B providers, non-profit or state-owned providers) that are not included the CMS-developed list.

AAFP Response

The AAFP is concerned that the 20 percent ECP criteria is not adequate to effectively provide primary care services to the nation's population and instead we urge CMS to require insurers' contract with at least 30 percent of ECPs.

According to the 2017 QHP Application Instructions, the CMS-established ECP standard required QHP applicants to include at least 30 percent of available ECPs in each plan's service area in the provider network. QHP applicants must also offer contracts in good faith to all Indian Health Service providers as well as at least one ECP from each of the six federally-established ECP categories in each county in the service area, where available. The 30 percent standard is more appropriate to ensure adequate access to the most vulnerable covered lives in the Exchange market. The AAFP has a policy on Essential Community Providers (ECPs) and supports ECPs as a means of protecting access to essential services delivered by qualified providers, and achieving favorable health outcomes for otherwise marginalized populations. It is appropriate for federal and state governments to ensure the availability and accessibility of medically necessary health care services to predominantly low-income, medically underserved populations by requiring payers to contract with a sufficient number and an appropriate geographic distribution of qualified local providers.

We appreciate the opportunity to comment and make ourselves available for your questions. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Wanda D. Filer, MD, MBA, FAAFP
Board Chair