AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

Executive Office
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

March 7, 2017

Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted electronically: www.regulations.gov

RE: Patient Protection and Affordable Care Act; Market Stabilization (CMS-9929-P)

Dear Acting Administrator Conway:

The American Society of Plastic Surgeons (ASPS) is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer. ASPS promotes the highest quality patient care, professional and ethical standards, and supports the education, research, and public service activities of plastic surgeons. We appreciate the opportunity to provide comments on the Market Stabilization proposed rule.

Network adequacy (§156.230)

CMS proposes to rely on State reviews for network adequacy in States in which a Federally-Facilitated Exchange (FFE) is operating, provided the State has a sufficient network adequacy review process, rather than performing a time and distance evaluation. In States without the authority or means to conduct sufficient network adequacy reviews, CMS would rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity (i.e., the National Committee for Quality Assurance (NCQA), URAC (formerly the Utilization Review Accreditation Commission), and Accreditation Association for Ambulatory Health Care (AAAHC)). Unaccredited issuers would be required to submit an access plan as part of the Qualified Health Plan (QHP) Application that demonstrates that the issuer has standards and procedures in place to maintain an adequate network consistent with the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act.

Our read of CMS' proposals implies that the agency intends to relinquish all responsibility for establishing and enforcing network adequacy standards at the federal level and defer this activity to private organizations and the States. Following a review of the NCQA Health Plan Accreditation (HPA) program, the Accreditation Association for Ambulatory Health Care (AAAHC) QHP Accreditation program, and the URAC Accreditation for Marketplace Plans, we are concerned that specialty and subspecialty physicians are not accurately nor adequately captured in network adequacy standards. In fact, CMS' QHP Application/Network Adequacy Template (v7.2)[1] does not include most medical specialty and subspecialty types so that plans can demonstrate including them in their networks.

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/EcpNetworkAdequacyTemplate.xlsm

CMS' departure from the policy process is even more troubling given the recent wave of State legislative activity to limit out-of-network medical bills aimed at addressing "surprise medical bills." Frankly, these State legislative "fixes" simply remove the consumer from the equation, leaving the physician to battle it out with the insurer. If the insurer is not required to have an adequate network, there is no incentive to negotiate with the physician, and the physician is left "holding the bag." CMS must use its authority to hold insurers accountable for having a sufficient network of physicians, including specialists and subspecialists.

Again, this is a time when we need CMS to engage more heavily in establishing and enforcing network adequacy standards – not less. **We urge CMS to reconsider its proposals and require all physician specialties and subspecialties to be included in network adequacy calculations for QHPs.**

Guaranteed Availability (§147.104)

CMS proposes to modify its interpretation of the guaranteed availability rules with respect to non-payment of premiums. Specifically, an issuer would not be considered to violate the guaranteed availability requirements if the issuer attributes a premium payment for coverage under the same or a different product to the *outstanding debt* associated with non-payment of premiums for coverage from the *same issuer* enrolled in within the prior 12 months and refuses to effectuate new coverage for failure to pay premiums. Assuming State law does not prohibit such action, this would permit an issuer to require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market 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.

If CMS finalizes this policy, **ASPS requests that CMS clarify in the final rule that, once a policyholder (whose coverage was terminated for non-payment of premium in the individual or group market) has paid all past due premiums 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, medical claims for covered services rendered to the policyholder/others covered under the policy during the time the policy was deemed terminated for non-payment of premiums, must be paid by the insurer as if there were no break in coverage and the policy had not been terminated.**

We appreciate the opportunity to comment on the Market Stabilization proposed rule. If you have any questions about our comments, please contact Catherine French, ASPS Health Policy Manager at cfrench@plasticsurgery.org or via phone number 847-981-5401.

Sincerely,

Debra Johnson, MD
President, American Society of Plastic Surgeons