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Patrick Conway, MD, MS
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-9929-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Conway:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit comments on the Proposed Rule, *Patient Protection and Affordable Care Act; Market Stabilization* (CMS-9929-P) (the "Proposed Rule").

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our vision for the future is that every older American will receive high quality person-centered care. In order to achieve this vision, we strive to help guide the development of public policies that support improved health and health care for seniors.

We strongly believe that all Americans should have access to high-quality, affordable healthcare coverage. The Patient Protection and Affordable Care Act (ACA) improved access to such coverage for over 20 million Americans. It is essential that we maintain the gains in the number of Americans who are covered by health insurance achieved under the ACA, with the proportion of Americans lacking health insurance now at a historic low of 8.6%.

Our comments on the Proposed Rule cover the following topics:

- Open Enrollment Period
- Pre-Enrollment Verification
- Guaranteed Availability
- *De Minimus* Variation
- Network Adequacy

Open Enrollment Period

The AGS supports CMS' proposal to change the Open Enrollment Period for Exchanges to November 1 through December 15 of the year prior to the coverage year. Aligning the Open Enrollment Period for Medicare Advantage and Medicare Part D with that of the individual and small group plans sold on Exchanges will simplify communications to potential enrollees, reduce confusion about different requirements, and allow plans to simplify their operational processes. We agree that CMS will need to conduct significant outreach during the first Open Enrollment Period for which this change is effectuated to ensure that eligible individuals do not lose coverage due to missing the new, earlier deadline.

Pre-Enrollment Verification

The AGS supports additional pre-enrollment verification for open enrollment periods that will limit gaming and adverse selection. However, we recommend that CMS (1) rely to the greatest extent feasible on electronic data that is already shared by Exchanges, (2) give consumers 60 days to provide their documentation (rather than 30 days) and (3) maintain self-attestation for certain individuals, rather than requiring verification of eligibility for 100% of enrollees. In particular, for individuals aged 0-19 whose eligibility for a special enrollment period is based on their birth (that is, the new enrollee is a newborn), adoption, or changes in foster care or child support arrangements, self-attestation should be sufficient. Children do not pose a significant risk of fraudulent behavior, and don't cost as much as an adult to insure, so the risk of adverse selection from unverified eligibility for a special enrollment period should be minimal in this case.

We do not believe CMS should impose <u>any</u> requirements (such as a look-back period or requirement for 63 days of continuous coverage as in HIPAA) that would permit plans in the individual market to deny enrollees coverage on the basis of pre-existing conditions. The AGS also opposes the creation of a waiting period or late enrollment penalty that discriminates against individuals with pre-existing conditions.

Guaranteed Availability

The AGS supports CMS' efforts to limit gaming of the system through non-payment of premiums and believes CMS should finalize the proposed changes to the guaranteed availability requirement. Plans should be able to apply premium payments to outstanding debt from the prior 12-month period when individuals re-enroll in the same or a different insurance product, without violating the guaranteed availability rule. The AGS agrees with CMS that it is important that this policy be applied uniformly to all enrollees regardless of health status, and consistent with non-discrimination requirements. In the Final Rule, CMS should provide more information on how it will monitor plans' compliance with these important consumer protections. The AGS recommends that CMS require plans to provide notice to individuals regarding their premium payment policies as they apply to this rule.

Network Adequacy

Adequacy of provider networks is a critical issue for AGS members, their patients, and patients' families. CMS proposes to rely on states' reviews of network adequacy in states with federally-facilitated Exchanges and, in 2018, to defer to state reviews in states that have an authority at least equal to the "reasonable access standard" at 45 C.F.R. § 156.230.

Some states lack the authority or means to conduct network adequacy reviews, but such reviews by state or federal regulators are critical to ensure that patients have access to in-network providers who will provide services to them at in-network cost-sharing amounts. In such states, relying upon insurer-led, voluntary accreditation programs to assure network adequacy is insufficient to ensure such access. Reverting to a 2014 stopgap process to solve a 2018 access problem is progress in the wrong direction.

A recent Kaiser Family Foundation survey[1] found that nearly 70% of insured, non-elderly adults facing unaffordable out-of-network medical bills did not know the health care provider was not in their plan's network at the time they received care. Patients do not have the information or the ability to avoid these surprise costs.

The study cites other troubling statistics that highlight nationwide, systemic issues such as emergency out-of-network charges, a lack of in-network emergency physicians at in-network hospitals, and out-of-network services provided by specialty physicians in in-network hospitals.

A study of hospital networks for Medicare Advantage HMOs found that there was no relationship between network size and premiums or quality ratings,[2] and that 40% of plans excluded NCI-designated cancer centers located in their service areas.

The AGS recommends that CMS make no changes to the network adequacy standards that would restrict enrollees' choice of providers or ability to avoid surprise bills.

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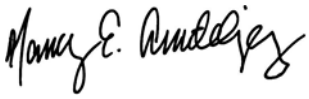
Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Anna Mikhailovich, amikhailovich@americangeriatrics.org.

Sincerely,

Ellen Flaherty, PhD, APRN, AGSF
President



Nancy E. Lundebjerg, MPA
Chief Executive Officer

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[1] Pollitz K, "Surprise Medical Bills." Kaiser Family Foundation Issue Brief, Mar. 17, 2016. Available at: http://kff.org/private-insurance/issue-brief/surprise-medical-bills/

[2] Jacobson, G, Trilling A, Neuman T, Damico A, and Gold M. "Medicare Advantage Hospital Networks: How Much Do They Vary?" Kaiser Family Foundation, June 2016. Available at: http://kff.org/medicare/report/medicare-advantage-hospital-networks-how-much-do-they-vary/