



January 8, 2019

VIA ELECTRONIC SUBMISSION

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9922-P
P.O. Box 8016
Baltimore, MD 21244-8010

Re: CMS-9922-P

Dear Administrator Verma:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the proposed rule regarding Patient Protection and Affordable Care Act; Exchange Program Integrity [CMS-9922-P]. Medicare Rights is a national, nonprofit organization that works to ensure access to health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

The following comments are informed by our experience assisting beneficiaries, their family members, and health care professionals as they navigate selecting and accessing care through Medicare and the Marketplaces, including the Marketplace-to-Medicare transition.

We appreciate that the Centers for Medicare & Medicaid Services (CMS) is proposing this rule in an effort to strengthen Marketplace integrity, and as such is focused on coverage systems and mechanics. However, we are concerned that the agency's close adherence to this perspective does not appear to allow for adequate consideration of how its proposal to terminate Marketplace coverage for certain enrollees would impact people with Medicare and those approaching eligibility.

While we agree with CMS's stated goal of ensuring that people are in the "most appropriate type of coverage," we disagree with the agency's proposal to automate this process.¹ Allowing the Marketplaces to terminate coverage for those who are eligible for or enrolled in Medicare Part A would create harmful coverage gaps, as the affected individuals may not have Medicare Part B or the ability to immediately

¹ Centers for Medicare & Medicaid Services, "CMS releases proposed rule to improve the integrity of the Exchange," (November 7, 2018), <https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-rule-improve-integrity-exchange>

enroll. Losing their Marketplace plan, therefore, would cause these consumers to lose their comprehensive health coverage—putting their health and economic security at risk. Instead of abruptly eliminating dual enrollees’ access to critical medical care, we strongly urge CMS to assist these individuals in making timely, optimal coverage decisions.

Currently, there are people over 65 with Marketplace coverage who are not yet fully enrolled in Medicare. Some of these people may not have Part B because they mistakenly delayed or declined enrollment when first eligible, in favor of Marketplace coverage. Others may have been automatically enrolled in Part A—but not Part B—when they began taking Social Security. Still others may be deferring these benefits, along with Medicare coverage—a group whose numbers are likely only to grow as the population ages and people work later in life. At the same time, others with Marketplace plans are approaching Medicare eligibility and these complicated coverage intersections. If these dually enrolled individuals were to abruptly lose their qualified health plan (QHP), they would be left without comprehensive coverage. For those without access to a Special Enrollment Period or equitable relief, this could mean lifelong financial penalties and going without coverage for up to a year, until the next General Enrollment Period (GEP).

Instead of terminating QHP coverage and creating these hardships, CMS must better prepare people in the Marketplaces to transition to Medicare. Based on our experience assisting people with Medicare and their families, dual Medicare-Marketplace enrollment is generally a symptom of a larger problem—the need for better outreach to Marketplace enrollees who are or will soon be eligible for Medicare. Though we applaud CMS’s recent efforts to improve its materials and process, we continue to hear from individuals who are confused or misinformed about how Medicare and the Marketplaces interact and who face significant coverage and financial challenges as a result. For example, Ms. R, a former Medicare Rights client, was enrolled in a Marketplace plan when she became eligible for Medicare due to age in 2015. She was not collecting Social Security retirement benefits at the time, so received no notice about her Medicare eligibility. Unaware that she needed to enroll in Parts A and B, she did not do so. She was also unaware that this put her at risk of a late enrollment penalty and a gap in coverage. Upon realizing her mistake in 2016 she tried to immediately enroll in Medicare. But under the law’s enrollment rules, she had to wait until the 2017 GEP to access coverage. Fortunately, Ms. R was able to maintain her QHP during this transition. If instead the Marketplace had terminated her plan, she would have been left uninsured and highly vulnerable to adverse health circumstances and the associated out-of-pocket costs.

While our work with Ms. R and other clients generally supports CMS’s assertion that for many consumers, concurrent enrollment in Medicare and a Marketplace plan “does not represent an informed decision” we do not agree that the solution is to remove beneficiaries from this decision-making process.² Rather, CMS must address the underlying issue of inadequate beneficiary education by supporting Marketplace enrollees in choosing the best coverage for their unique needs. If CMS is unable or unwilling to help these consumers understand their Medicare eligibility, as the agency suggests, it must not put them in a position to need this assistance.³ Empowering beneficiaries must be the first step, not further complicating their Medicare enrollment by stripping them of their agency and their QHP.

² Proposed Rule at 56019.

³ *Id.*

To that end, we agree that CMS should continue to engage in the Periodic Data Matching (PDM) process as a way to identify and notify those who are dually enrolled. These notices can be a powerful consumer engagement tool and we appreciate CMS’s proposal to expand the scope of Medicare PDM to include individuals with QHP coverage who are not receiving advanced premium tax credits (APTCs) or cost-sharing reductions (CSRs). Sharing this information with additional Marketplace enrollees could help more people make informed decisions about when to enroll in Medicare. However, we caution that these coverage choices should be managed by fully-informed beneficiaries, not by the Marketplaces. Automatically ending an enrollee’s QHP coverage because they are eligible for Medicare would be a mistake. Instead, we again encourage CMS to educate and equip individuals to successfully manage this transition.

We also note that even with these improvements, the PDM process is inadequate to provide timely notice to all Marketplace enrollees who are or will be eligible for Medicare. The process is insufficient, in part, because it cannot identify “any consumer who is eligible for premium-free Part A.”⁴ Further, the notices it is able to generate are issued too infrequently. While we appreciate that CMS recognizes the need to conduct PDM more often, the proposed requirement that Exchanges do so “at least twice a year” still falls short.⁵ Given the significant consequences associated with automatically terminating QHP coverage, CMS must provide all who are at risk with as much notice and time to respond as possible. Accordingly, we encourage CMS to work with the Social Security Administration (SSA) to identify Marketplace enrollees who are approaching Medicare eligibility, in order to send PDM notices during the first month of an individual’s Initial Enrollment Period. This more timely receipt of information would help Marketplace enrollees better plan for their Medicare effective date and avoid a gap in coverage. Such a notice must clearly explain the steps the consumer must take to enroll in Medicare, the timeline for doing so, the consequences of inaction, and where to go for help. We also recommend that CMS give consumers sufficient time to respond to the notice; 30 days is not long enough to receive, understand, and act on this complex coverage information.

Troublingly, the absence of front-end beneficiary education is not unique to Marketplace enrollees. We continue to urge CMS and SSA to work together to notify everyone who is approaching Medicare eligibility about enrollment rules and their responsibilities, including active Part B enrollment and information about Medicare Savings Programs, Part D Extra Help, and other coverage decisions.

We also request clarification regarding CMS’s proposal to add a question to the Federally-facilitated Exchange (FFE) application “that would allow an individual to authorize the FFE to receive Medicare eligibility and enrollment information about the enrollee.”⁶ CMS appears to be portraying this question and the authorization as voluntary for consumers, stating that “[i]f an applicant provides this authorization and elects to have the Exchange automatically terminate QHP coverage...then the FFE will end enrollees’ QHP coverage on their behalf.”⁷ However, it is our understanding that the question on which the proposal is modeled—which CMS recently added to the FFE application “to provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if he or she becomes eligible for other [minimum essential coverage], or to terminate QHP coverage if the enrollee does not choose to remain enrolled in the QHP”—is mandatory, and that consumers can select between having their Marketplace plan or their financial assistance terminated if they are found to be

⁴ *Id.*

⁵ Proposed Rule at 56017.

⁶ *Id.*

⁷ *Id.*

eligible for other qualifying coverage, such as Medicare.⁸ We ask that CMS clarify whether applicants will be required to answer these questions. If applicants may leave the questions blank, we also ask the agency to clarify the consequences of doing so. Further, if the application is to include these questions, we ask that CMS engage in rigorous beneficiary testing to ensure the questions are highly visible and easily understood.

Thank you again for the opportunity to comment. Though well-intentioned, this proposed rule could have significant, adverse consequences for people with Medicare. Currently, dual Medicare-Marketplace enrollees can voluntarily choose to terminate their QHP coverage and enroll in Medicare. Rather than circumventing this process, we encourage CMS to improve it by giving enrollees more control over their health coverage and costs—not less. Accordingly, instead of finalizing the rule as written, we urge CMS to pursue an approach that includes safeguards necessary to maximize beneficiary choice and minimize gaps in coverage. For more information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Baker". The signature is fluid and cursive, with the first name "Joe" and last name "Baker" clearly distinguishable.

Joe Baker
President
Medicare Rights Center

⁸ Proposed Rule at 56018.