Policy Recommendations for the Biden Administration

The Medicare Rights Center (Medicare Rights) looks forward to working with the Biden administration to advance policies that protect and strengthen Medicare as well as the health and economic well-being of those who rely on its coverage. To facilitate this dialogue, we respectfully submit a set of recommended actions for your consideration. While the majority are administrative, some require external collaboration. We encourage you to work with Members of Congress, state policymakers, and stakeholders to advance these and other solutions.

Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to nearly three million people with Medicare, family caregivers, and health care professionals each year, including through our National Consumer Helpline.[1] Every day, we help geographically and socioeconomically diverse populations tackle an array of complex Medicare-related issues, and hear directly from beneficiaries how policy decisions affect them.

These experiences are reflected in the policy changes we seek and support and inform our recommendations below to **(1) Immediately Respond to COVID-19** in ways that prioritize older adults and people with disabilities; **(2) Simplify Medicare Enrollment** to ensure active, informed, and meaningful beneficiary choice; **(3) Reduce Barriers to Care** by making coverage more available, accessible, and affordable; and **(4) Address Disparities and Inequities** to improve health care and coverage for all.

1. IMMEDIATELY RESPOND TO COVID-19

The Medicare Rights Center encourages the Biden administration to immediately respond to COVID-19 in ways that prioritize older adults and people with disabilities.

The COVID-19 pandemic and its attendant economic fallout will have a lasting impact on people with Medicare and on the program itself. While additional interventions may be necessary as the situation evolves, the administration must first focus on reforms that are urgently needed to help people with Medicare maintain their health, safety, and independence.

Ease Access to Medicare. The administration can take immediate action to help people with disabilities and older adults obtain their Medicare coverage as soon as possible during this crisis.

- **Reinstate Lapsed Medicare Enrollment Flexibilities**. Medicare-eligible individuals who have experienced mismanaged Medicare transitions may find themselves without affordable

[1] Medicare Rights Center, "2018-2019 Medicare Trends and Recommendations" (October 9, 2020) https://www.medicarerights.org/policy-documents/2018-2019-medicare-trends-and-recommendations.

coverage during this crisis. To help people connect with their Medicare at a time when they need it most, we again[2] strongly urge CMS to utilize its existing authority to reinstate two critical enrollment flexibilities: (1) Equitable Relief for Premium Part A and Part B;[3] and (2) a Special Enrollment Period for Part C and Part D.[4] These policies should remain in effect through December 31 of the year the public health emergency ends, at a minimum.

- **Remove Barriers to Enrollment**. To further facilitate access to care, we recommend waiving or postponing financial late enrollment penalties for those who use a coronavirus-specific enrollment pathway and eliminating administrative burdens that may delay coverage. This includes a permanent change to allow people to enroll in Part B without first submitting proof of coverage paperwork (Form CMS L564) in instances when they have limited or no access to their employers, Social Security field offices, or the required documentation.[5]

Promote Health, Safety, and Financial Security. Many Medicare beneficiaries lived on fixed or limited incomes even before the COVID-19 pandemic and recession. They and others need immediate, meaningful financial relief and uninterrupted access to comprehensive, affordable care.[6]

- **Improve Vaccine and Treatment Access**. The Biden administration must make sure that cost-sharing concerns and other barriers do not prevent people from obtaining COVID-19 treatment and vaccinations. We support launching a national strategy to streamline and accelerate the vaccine manufacturing, distribution, and allocation processes, and encourage collaboration with states and Congress to put any necessary waivers, legislation, and guidance in place. Everyone, including people with Medicare, must be able to receive timely, affordable care.

- **Provide Needed Economic Relief**. Medicare Rights supports redoubling efforts to help those most in need, especially people with low or limited incomes and those hardest hit by the pandemic and recession. This includes continuing expanded unemployment benefits and paid leave, and issuing additional automatic, direct stimulus payments that reach Supplemental Security Income (SSI) and Veterans Affairs (VA) benefits recipients, people who use Individual Taxpayer Identification Numbers (ITIN), and dependents of all ages.

- **Promote Nursing Home Safety and Resident Rights**. The administration and Congress must improve nursing home resident and health care worker safety. Immediate action is needed to ensure adequate protective equipment and testing is available and correctly used, as is funding to aid state efforts to assist with clinical care, infection control and prevention, and staffing. We also recommend strengthening public reporting and oversight; developing standardized

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[2] Medicare Rights Center, *et al.*, "Letter to CMS on Extending Enrollment Flexibilities" (June 2020), https://www.medicarerights.org/pdf/061720-cms-mr-letter.pdf.

[3] Centers for Medicare & Medicaid Services, "Medicare Part A and Part B Enrollment Equitable Relief for the COVID-19 Pandemic-Related National Emergency" (last accessed January 13, 2021), https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/index.

[4] Centers for Medicare & Medicaid Services, "Enrollment Issues for COVID-19 Pandemic-Related National Emergency Questions and Answers for Medicare Beneficiaries" (last accessed January 13, 2021), https://www.cms.gov/files/document/enrollment-issues-covid-ab-faqs.pdf; Medicare Rights Center, "CMS Announces Limited Enrollment Flexibilities for People Affected by the Public Health Crisis" (May 7, 2020), https://www.medicarerights.org/medicare-watch/2020/05/07/cms-announces-limited-enrollment-flexibilities-for-people-affected-by-the-public-health-crisis.

[5] Centers for Medicare & Medicaid Services, "Request for Employment Information" (last accessed January 13, 2021), https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009718.

[6] Wyatt Koma, *et al.*, "Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic" (April 24, 2020), https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-financial-security-before-the-coronavirus-pandemic/.

guidance, training materials, and protocols for staff, residents, and visitors; and encouraging better communication between staff and families, as well as to prevent social isolation and loneliness.[7]

Bolster Medicaid and Other Community Supports. States, localities, and programs need additional resources to help older adults and people with disabilities in the community, ensuring they are not forced into institutional or other congregate settings during this crisis—in violation of their rights and at risk to their health.

- **Support Aid to States and a Medicaid Federal Medical Assistance Percentage (FMAP) Increase**. Recognizing that the funds of states, territories, and localities have been stretched to the limit, and that Medicaid rolls are surging,[8] we ask the Biden administration to back a COVID-19 relief package that provides a 10% increase in the federal Medicaid match for Home and Community Based Services, as well as a general 14% Medicaid increase. CMS's deeply flawed interpretation[9] of the Families First Coronavirus Response Act's Medicaid Maintenance of Effort provisions[10] should be rescinded and the original interpretation reinstated.[11] We also support direct fiscal aid to states, cities, and towns, so they can continue to fund services that help Medicare beneficiaries live safely at home.

- **Prioritize Community Living Programs**. During the coronavirus outbreak and beyond, initiatives that help people with Medicare maintain their health and independence for as long as possible must be a funding priority. We recommend that any forthcoming package include adequate resources and flexibilities for programs that promote community living. In addition to Medicaid and Medicare, this includes those authorized by the Older Americans Act, such as home delivered meals, elder abuse prevention, and caregiver supports; LIHEAP energy relief; housing supports and homelessness prevention; and SNAP and other food assistance.

2. SIMPLIFY MEDICARE ENROLLMENT

Medicare Rights asks the Biden administration to simplify Medicare enrollment in order to ensure active, informed, and meaningful beneficiary choice.

A rapidly aging population, complex Medicare rules and timelines, and an ever-evolving health care landscape means a growing number of individuals will face increasingly difficult Medicare coverage decisions in the coming months and years. The Biden administration must act without delay to better empower current and future beneficiaries to make optimal choices, both initially and annually.

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[7] *See,* e.g., S. 3644 https://www.congress.gov/116/bills/s3644/BILLS-116s3644is.pdf and H.R. 6800, Secs. 30202; 30209; 30210; and 30211 https://www.congress.gov/116/bills/hr6800/BILLS-116hr6800pcs.pdf.

[8] Joe Weissfeld & Anthony Galace, "Medicaid Enrollment In The Age Of COVID-19: A Nine-Month Analysis Of Trends Across The Nation" (December 2020), https://familiesusa.org/wp-content/uploads/2020/12/MCD2020-466_Medicaid_Enrollment_Covid_Analysis-2.pdf.

[9] 85 Fed. Reg. 71142 (November 11, 2020), https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency.

[10] *See* e.g., H.R. 6800, Secs. 30101, 30103 https://www.congress.gov/116/bills/hr6800/BILLS-116hr6800pcs.pdf.

[11] Medicare Rights Center, "Comments on Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (January 4, 2020), https://www.medicarerights.org/pdf/010421-comments-covid-ifr.pdf.

Modernize Part B Enrollment

Implement the Beneficiary Enrollment Notification and Simplification (BENES) Act. Recently signed into law, key provisions of the bipartisan BENES Act are set to take effect on January 1, 2023.[12] The enacted policies will update Medicare enrollment rules for the first time in over 50 years to end lengthy waits for coverage, expand critical administrative flexibilities, and inform future policymaking on enrollment period alignment.

- **Make Timely Updates**. We encourage the agencies to begin implementation now, so that all necessary changes are in place and well known prior to 2023. In particular, we urge updates to enrollment systems and the Programs and Operational Manual System (POMS), as well as employee training and education, well in advance of the effective date.

- **Engage Stakeholders**. Throughout the implementation process, we encourage thoughtful public dialogue that engages an array of stakeholders, including people with Medicare, beneficiary advocates, and State Health Insurance Assistance Program (SHIP) counselors.

- **Utilize Expanded Special Enrollment Period (SEP) Authority**. We also urge the administration to explore how the "exceptional circumstances" Special Enrollment Periods can advance universal coverage and equity goals. This includes, for example, making it available to ease transitions and increase timely enrollment for (1) formerly incarcerated individuals, (2) people who live in states that do not participate in a Part A buy-in agreement, (3) those whose enrollment period was impacted by the COVID-19 Public Health Emergency, and (4) Medicare-eligible people who mistakenly remain in Marketplace plans.

- **Update Enrollment Timelines**. Shifting Medicare's General Enrollment Period (GEP) to the fall would align it with sign-up periods for other types of coverage, greatly reducing the likelihood of consumer confusion and enrollment mistakes. One of the recently-enacted BENES Act provisions directs the Secretary to submit a report to Congress on ways to achieve this alignment. We urge compliance with this requirement, and a parallel effort to effectuate the underlying enrollment period shift using existing authorities. We also support extending Medicare's Fall Open Enrollment Period from December 7 to December 15, for consistency with Marketplace open enrollment.

Effectively Engage and Educate Consumers. In our experience, many people who are approaching Medicare eligibility do not understand the program or its enrollment rules and experience mismanaged transitions as a result. The agencies that oversee Medicare—the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA)—could address these knowledge gaps by updating outreach strategies, decision-making tools, and educational materials in ways that empower consumers.

- **Notify People Nearing Medicare Eligibility**. Currently, far too many people make honest mistakes when trying to understand and navigate Medicare's confusing enrollment system. The consequences of such missteps can be significant—including lifelong late enrollment penalties,

[12] "Consolidated Appropriations Act, 2021," P. L. 116-260 (December 27, 2020), https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

higher out-of-pocket health care costs, and gaps in coverage.[13] As noted by the Medicare Payment Advisory Commission (MedPAC), notice from the federal government to individuals approaching Medicare eligibility about basic enrollment rules could help prevent these errors.[14] But today, no such notice exists. We encourage the administration to correct this without delay, in fulfillment of its obligation to facilitate Part B enrollments.

- **Seek Public Input to Improve the "Welcome to Medicare" Packet**. Focus group testing could help identify needed updates to the Welcome to Medicare packet. Regular reviews are necessary to ensure these materials provide actionable information that newly Medicare eligible individuals can use to make informed decisions about their Medicare and supplemental insurance enrollments.

- **Update Standard COBRA Notices to Include Medicare Enrollment Information**. Medicare Rights recommends working with the Department to Labor (DOL) to update the standard COBRA notices to better reflect the program's interaction with Medicare.[15] This information should be presented in a consumer-friendly way, and consistently across agency websites and materials. Such notices must pay particular attention to the coordination of benefits and consequences for delaying Medicare Part B in favor of COBRA.[16]

- **Improve Employer and Employee Education**. For many individuals who must actively enroll in Medicare Part B, employers are a primary source of information about how and when to do so. But the enrollment rules are so complicated that many benefits departments are unable to provide complete advice, causing employers to issue well-intended but incorrect guidance. Current and former employees who act in reliance on this misinformation can experience irreversible health and economic adversity. To help prevent this, we urge CMS to work with DOL to make sure employers have accurate, understandable, consumer-tested Medicare enrollment information to give their employees. Such notices should be tailored to the type and size of employer, so the information is specific and actionable.

- **Notify All Marketplace Enrollees About When and How to Enroll in Medicare**. Through timely Periodic Data Matching (PDM) and notification, people who are eligible for and/or enrolled in Medicare but who remain in a federal Marketplace plan can correct their enrollment, minimizing or avoiding harmful financial penalties and periods of non-coverage. We ask the Biden administration to continue this outreach and build upon its successes. In particular, we suggest speeding up the notifications, so they are received during the first three months of an individual's Initial Enrollment Period (IEP) and expanding current matching efforts to include people who are approaching Medicare eligibility due to the receipt of Social Security Disability Insurance (SSDI) payments. Further, since current data matching is limited to states with a federally-facilitated Marketplace, the administration should encourage state-run marketplaces to engage in a similar cross-walk and notification process.

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[13] Congressional Research Service, "Medicare: Part B Premiums" (May 6, 2020), https://crsreports.congress.gov/product/pdf/R/R40082, ("In 2019, an estimated 764,000 people with Medicare were paying a Part B Late Enrollment Penalty (LEP), with the average LEP amounting to nearly a 28% increase in their monthly premium.")

[14] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019), http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

[15] U.S. Department of Labor, "Model General Notice" (last accessed January 13, 2021), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/cobra/model-general-notice.docx.

- **Revisit Marketplace Terminations**. At the same time, the administration should re-examine policies permitting automatic or unexpected Marketplace disenrollments, as such transitions can lead to unexpected gaps in coverage and care. For example, plans should not be allowed to manipulate their offerings to sidestep guaranteed renewability requirements, and people should be notified before being disenrolled based on preferences noted in initial Marketplace applications, which in some instances may have been completed years ago.

Invest in Unbiased Counseling and Assistance. Few federal programs are dedicated to helping people with Medicare select the best coverage for their circumstances and better afford needed care. We urge Biden administration to champion those that are, by supporting sufficient, sustainable funding.

- **Request Adequate Funding for State Health Insurance Assistance Programs (SHIPs)**. With locations in every state, over 3,000 offices nationwide, and 16,000 trained staff and volunteers, SHIPs are a primary and trusted source of unbiased, one-on-one counseling for people with Medicare who need help with their coverage and options. Current funding levels are unable to keep pace with growing demands, which are in part being driven by swells in the Medicare beneficiary population and an increasingly complex program. To better help SHIPs provided needed counseling and other services, we recommend requesting adequate funding for the program in the President's budget requests to Congress.

- **Support Permanent Funding for Low-Income Outreach and Enrollment Activities**. Since 2009, the Medicare Improvements for Patients and Providers Act (MIPPA) has helped nearly three million low-income Medicare beneficiaries apply for and obtain assistance that makes their health care and prescription drugs more affordable.[17] Today, MIPPA provides targeted funding to community-based organizations in every state to conduct these outreach and enrollment activities.[18] But the program must be reauthorized on a regular basis, creating uncertainty that can impede daily operations and long-term planning. We encourage the administration to support permanent funding for these critical activities. Doing so would allow MIPPA grantees to best serve the growing number of older adults and people with disabilities who need help accessing affordable health care.

Expand Part B Data Collection and Public Reporting

Fill Gaps in Knowledge. Current data collection efforts fail to capture the constellation of impacts that Part B enrollment challenges and missteps can have on people with Medicare. Regular reporting on key underexamined elements—the equitable relief process and the Part B penalty—could increase public understanding and inform future policymaking.

- **Identify Equitable Relief Patterns and Barriers**. We urge HHS to collect and publicly report data on equitable relief patterns and barriers, including the number of beneficiaries requesting equitable relief and any trends over time; the entities most commonly cited as providing misinformation; the frequency with which the Social Security Administration (SSA) grants or denies equitable relief; the average amount of time it takes to process a request; and data on

[17] Medicare Rights Center, "Testimony of Fred Riccardi at a hearing of the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health titled Investing in America's Health Care" (June 2019), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Riccardi-Investing%20in%20America%27s%20Health%20Care_060419.pdf.
[18] *Id.*

how SSA and CMS use this information to improve education and outreach to beneficiaries, employers, and others.

- **Examine Part B Late Enrollment Penalty (LEP) Rates and Efficacy**. Similarly, enhanced data collection on beneficiary experiences with the Part B LEP could improve both agency documentation and policy**.** We encourage HHS to regularly and publicly release national and state-specific data on the number of Medicare beneficiaries paying lifetime late enrollment penalties, information on the beneficiaries themselves (i.e., race, ethnicity, education completed, gender, pre-Medicare coverage source), the average penalty amount, and the length of any attendant coverage gaps. We also urge studying the efficacy of the LEP structure more broadly, as recommended by MedPAC in its June 2019 report.[19]

Improve Medicare Advantage Plan Offerings and Oversight

Strengthen Guardrails. One way to improve the onerous plan selection process is to improve the plan offerings and prohibit inappropriate marketing tactics, thereby reducing the risk a beneficiary will make a bad choice. The Biden administration must make plan selection easier—and less risky—by ensuring that plans are high-quality, limited in number, and easy to compare.

- **Reinstate Medicare Advantage Meaningful Difference and Uniformity Requirements**. People enrolled in Medicare Advantage face a daunting task each year as they attempt to assess their coverage options. Such decisions have become more challenging recently, spurred by regulatory changes that have allowed insurers to offer plans that are nearly indistinguishable from one another and target small subsections of the population.[20] These plan flexibilities have created an illusion of choice, cluttering the marketplace in ways that can hinder decision-making. We urge the Biden administration to roll back these policies.[21]

- **Restore Medicare Advantage Network Adequacy Requirements**. Medicare Advantage network adequacy rules exist to help guarantee that enrollees can access needed care. CMS guidance outlining these requirements specifies that providers must meet certain "time and distance" standards to be considered "available" to enrollees in a given area.[22] Troublingly, the 2021 Part C & D rule dilutes this protection in non-urban counties, and in all areas with respect to certain telehealth services.[23] CMS is also loosening standards concerning access to dialysis providers—just as Medicare Advantage plans will be required to accept people with End Stage Renal Disease (ESRD) in 2021. These policy changes threaten beneficiary access to care, and we urge their immediate withdrawal.[24] If a Medicare Advantage plan cannot contract with an adequate

[19] *See* MedPAC, "Medicare and the Health Care Delivery System" (June 2019), http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0 ("…the Secretary could examine whether the late-enrollment penalties are having the desired effects...Currently it is not known whether, and to what extent, the penalties are causing beneficiaries to further delay enrollment. Further study of these issues would be useful").
[20] 83 Fed. Reg. 16440, 16480.
[21] Medicare Rights Center, "Comments on [CMS-4182-P] Medicare Advantage, Medicare Fee-for-Service, and the Medicare Prescription Drug Benefit programs" (January 16, 2018), https://www.medicarerights.org/pdf/Medicare-Rights-Center-C-D-Comments-CMS-4182-P.PDF.
[22] Centers for Medicare & Medicaid Services, "Medicare Advantage Network Adequacy Criteria Guidance" (January 2017), https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.
[23] Medicare Rights Center, "Comments on Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" (April 6, 2020), https://medicarerights.org/pdf/medicare-rights-2021-c-d-rule-comments.pdf.
[24] *See* 85 Fed. Reg. 33796, 33797.

number of providers to meet minimum "time and distance" standards, it should not be allowed to offer a plan in the area. Permitting plans to operate with too few providers that are too far away from enrollees does not serve people with Medicare well. Nor does using access to telehealth—services that should supplement and not supplant in-person care—as an excuse to reduce plan compliance.

- **Reinstate Medicare Communications and Marketing Guidelines (MCMG) that Protect Beneficiaries**. The MCMG is a set of rules that governs the selling and promotion of Medicare Advantage and Medicare Part D prescription drug plans. In 2019, CMS weakened the guidelines' distinction between marketing and educational events and removed the requirement that plan materials note the availability of non-English translations.[25] Both shifts leave beneficiaries more exposed to deceptive or confusing marketing strategies, and less able to access important information in a usable format. We support immediately restoring theses protections.

Enhance Consumer Tools and Protections. To further promote meaningful beneficiary choice, we encourage the administration to provide needed guidance and protections, minimize default and sub-optimal enrollments, and prevent discriminatory practices.

- **Provide Marketing Guidance and Oversight for Supplemental Benefits**. The MCMG does not sufficiently address how Medicare Advantage plans and brokers may market supplemental benefits to current or potential enrollees. Clarity is urgently needed, given that plans and brokers may have financial incentives to use these benefits to steer enrollees into coverage that may not be right for them.[26] In drafting this guidance, we ask CMS to reinforce that supplemental benefits should not be merely or primarily a sales tool, or used to persuade beneficiaries to enroll in a plan. We also ask the agency to be vigilant in its enforcement, including by watching for unusual spikes in enrollment and other patterns that might indicate inappropriate behavior. When identified, such practices must be corrected through plan and broker penalties and enrollee Special Enrollment Periods.[27]

- **Modernize Medicare Plan Finder**. Beneficiaries are often confused about the differences between plans or how to compare them and lack sufficient tools and supports for confident decision-making.[28] The Biden administration can begin to address these unmet needs through improvements to Medicare Plan Finder. Priority upgrades should include integrated plan network information and accurate provider directories, clearer definitions and details about supplemental benefits, and the ability for unbiased assistors like SHIP counselors to easily save and send search results.[29]

- **Individually Tailor the Annual Notice of Change**. CMS should require Medicare Advantage and Part D plans to provide a tailored Annual Notice of Change (ANOC) to all enrollees. The

[25] Medicare Rights Center, *et al*., "Joint Letter to CMS" (September 27, 2019), https://www.medicarerights.org/pdf/082719-mpf-mcmg-2020-letter-cms.pdf.
[26] *Id*.
[27] Medicare Rights Center, "Comments on 2019 Final Medicare Communications and Marketing Guidelines" (August 10, 2018), http://medicarerights.org/pdf/2019-final-mcmg-comments.pdf; Medicare Rights Center, "Comments on 2020 Final Medicare Communications and Marketing Guidelines" (April 4, 2019), https://www.medicarerights.org/pdf/040419-mcmg-2020-comments.pdf.
[28] National Council on Aging, "The Modernizing Medicare Plan Finder Report" (April 2018), https://www.ncoa.org/public-policy-action/health-care/better-coverage-choices/medicare-plan-finder-report/.
[29] Medicare Rights Center, "2019 Medicare Plan Finder Review" (September 18, 2019), https://www.medicarerights.org/policy-documents/comments-2019-medicare-plan-finder-review.

individualized notice should be based on claims data and clearly describe how the enrollee's plan and costs will change, if at all, in the coming year. This includes listing any of the individual's providers or pharmacists who will no longer be in network, any of their prescription drugs that will no longer be on the plan's formulary, and any instances in which utilization management tools will be newly applied.

- **Make Medicare Advantage Provider Directories Accurate**. The Biden administration must address the long-standing problem of inaccurate Medicare Advantage provider directories.[30] This lack of accuracy can thwart beneficiary decision-making, rendering informed choices impossible. It also prevents CMS from conducting proper oversight, as the insufficient data may hide non-compliance with network adequacy and other requirements. CMS should improve the directories without delay, to guarantee accuracy before they are incorporated into Medicare Plan Finder, and to hold beneficiaries harmless with respect to any enrollment decisions they may make in reliance on provider directory-contained misinformation.

- **Hold Beneficiaries Harmless from Mid-Year Network Changes**. Medicare Advantage enrollees must be able to count on stability in their plan networks and the knowledge that their doctors will be there when they need them. We urge the Biden administration to work with plans to minimize the practice of dropping doctors without cause in the middle of the plan year. When such changes are necessary, affected enrollees must receive adequate notice and relief, including access to a Special Enrollment Period.

- **Minimize Default Enrollment and Enhance Related Protections**. We support curtailing the use of default, passive, or auto-enrollment into Medicare Advantage and Part D plans. Such enrollments deny beneficiaries active choice and can create confusion and distrust by forcing them into coverage they did not choose or want, and which requires them to take deliberate action to undo. In addition, due to plan network and formulary restrictions, these enrollments can cause beneficiaries to lose access to their medications or providers, interrupting care continuity and delaying needed treatment. To the extent that any default enrollments are necessary, they must be accompanied by increased oversight and data collection to assess disruptions and patterns, and to ascertain whether and why beneficiaries subsequently disenroll from the default coverage.[31]

- **Increase Plan Oversight to Prevent Discriminatory Practices**. Recent analysis shows that Medicare Advantage enrollees are less expensive than the general Medicare population, even before they join a plan.[32] This discrepancy suggests that plans may be targeting lower cost beneficiaries, perhaps through discriminatory benefit designs that do not appeal to those with high needs—and high costs. It also suggests plans are abusing patient categorization rules to

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[30] *See, e.g.*, Centers for Medicare & Medicaid Services, "Online Provider Directory Review Report" (March 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf; Centers for Medicare & Medicaid Services, "Online Provider Directory Review Report (January 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

[31] Medicare Rights Center, "Proposal for New York State FIDA Replacement-Future of Integrated Care" (May 2018), https://www.healthinnovation.org/news/newsletter/health-innovation-highlights-june-27-2018/body/FINAL-MRC-Future-of-Integrated-Care-Proposal-May-2018.pdf.

[32] Gretchen Jacobson, *et al.*, "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?" (May 7, 2019), https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/.

increase payment rates.[33] We are especially concerned about plan efforts to enroll beneficiaries with well managed chronic conditions, allowing the plan to benefit from higher risk adjustment rates, even though their actual costs are lower, and about marketing and outreach practices that might exacerbate or rely on racial and economic health disparities. Robust data collection, aggressive oversight, and steep penalties should be employed to root out and discourage such practices.

- **Enforce Anti-Discriminatory Benefit Design Protections for End Stage Renal Disease (ESRD) Enrollees**. In 2021, individuals with ESRD will be permitted to join Medicare Advantage plans. With this change comes the need for heightened oversight. CMS must ensure plans do not discriminate against these beneficiaries, including by curtailing dialysis networks and increasing cost sharing in an effort to make their offerings less attractive. We also urge the administration to work with Congress to expand equitable access to Medigap policies for people with ESRD Medicare, and to impose a program-wide cap on out-of-pocket costs, so that all beneficiaries have access to this critical financial protection.

- **Improve Integration in Duals-Special Needs Plans (D-SNPs)**. Medicare Advantage Duals-Special Needs Plans (D-SNPs) can spur greater integration of benefits between Medicare and Medicaid, as well as improve care coordination and administrative simplicity. However, this is often not the case. Dually eligible individuals may be lured into Medicare Advantage plans by claims of enhanced benefits that they are already eligible for through Medicaid or that are so limited as to be nearly worthless. For example, D-SNP plans may claim to offer transportation or over-the-counter benefit cards that are no greater than Medicaid's assistance. And once enrolled, they may struggle to navigate complex Medicare Advantage plan networks and rules that are different from those for their Medicaid benefits. We ask the Biden administration to monitor D-SNPs to ensure their practices match their promises and that they are truly meeting beneficiary needs. This includes requiring that, at a minimum, integrated plans have unified grievance and appeals processes; assigned care managers for coordinating care; seamless access to data; coordinated access to all services, including Durable Medical Equipment and prescriptions; and robust oversight at both the federal and state levels.[34] We also recommend empowering CMS to build upon the successes of prior demonstrations to support truly integrated care with beneficiary protections, state-federal partnerships, and high quality outcomes.

- **Restore Continuous Special Enrollment Period (SEP) Rights**. We urge CMS to reinstate continuous SEP rights for dual eligible and Low-Income Subsidy (LIS) beneficiaries.[35] This important protection was unnecessarily eliminated in recent rulemaking.[36] Especially where dually eligible individuals may be navigating separate Medicare and Medicaid plans, this enrollment flexibility is essential to preserving access to care and services.

- **Address Prior Authorization in Medicare Advantage**. On December 10, 2020, CMS announced a proposed rule to "streamline processes related to prior authorization" in Medicaid, CHIP, and

[33] *See* p. 14, "Reduce Medicare Advantage Overpayments"
[34] Medicare Rights Center, "RE: Request for Stakeholder Input: Implementing the Dual Eligible Special Needs Plans (D-SNPs) Provisions of the Bipartisan Budget Act of 2018" (April 12, 2018), https://www.medicarerights.org/pdf/041218-dsnp-comments-section-50311.pdf.
[35] Medicare Rights Center, "Comments on the Medicare Advantage, Medicare Fee-for-Service, and the Medicare Prescription Drug Benefit programs" (January 16, 2018), https://www.medicarerights.org/pdf/Medicare-Rights-Center-C-D-Comments-CMS-4182-P.PDF.
[36] Centers for Medicare & Medicaid Services, "CMS Finalizes Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-F)" (April 2, 2019), https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-policy-changes-and-updates-medicare-advantage-and-prescription-drug-benefit-program.

Marketplace plans—but not Medicare Advantage.[37] Finalized on January 15, just days after the comment period closed, the rule limits the amount of time payers have to make a decision and requires them to specify a reason when denying a request.[38] In the final rule, CMS notes that "Medicare Advantage plans are not prohibited from adopting any of these policies" and "anticipate[s] that some of them may do so."[39] But in our experience, hoping for outcomes that center the needs of Medicare beneficiaries is not an effective strategy. We recommend that Medicare Advantage plans be part of future efforts to prevent harmful prior authorization practices, including any re-issuances of this this hastily advanced rule.

- **Improve Communications about Prior Authorization**. We are also concerned about the frequency with which prior authorization has been described as a plan benefit in draft CMS materials comparing Medicare Advantage and Original Medicare.[40] While prior authorization may help providers manage their financial exposure, beneficiaries experience it almost universally as a restriction on access to needed services or medicines. CMS should address this as part of its review of educational materials.

Reduce Inappropriate Medicare Advantage Denials. Year after year, among the most frequent calls to Medicare Rights' Helpline are those concerning Medicare Advantage coverage and service denials.[41] Far too many of these plan decisions are erroneous, which can lead to harmful delays in treatment and worse outcomes.[42] Better oversight and enforcement is needed to deter and prevent these harmful plan behaviors.

- **Enhance Oversight of Medicare Advantage Coverage and Care Denials**. A recent report from the U.S. Department of Health and Human Services (HH) Office of Inspector General (OIG) found that from 2014 to 2016, only 1% of Medicare Advantage service and coverage denials were appealed. Of those that were, a stunningly high amount—75%—were eventually overturned by the plan, with independent reviewers issuing additional reversals.[43] While this not necessarily mean that plans acted inappropriately, these findings strongly suggest a pattern that warrants attention and correction. We urge CMS to investigate further, and to increase its oversight of and penalties for Medicare Advantage plans that inappropriately deny care.[44] This includes conducting program audits more frequently and incorporating those findings into Medicare Advantage Plan Star Ratings in more concrete and transparent ways. CMS must also notify beneficiaries about plan violations and offer enrollment relief where needed.

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[37] Centers for Medicare & Medicaid Services, "Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information CMS-9123-P: Fact Sheet" (December 10, 2020), https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients.

[38] Centers for Medicare & Medicaid Services, "Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications" (January 15, 2020) https://www.cms.gov/files/document/11521-provider-burden-promoting-patients-electronic-access-health-information-e-prior.pdf.

[39] *Id.*

[40] Medicare Rights Center, "Letter to Seema Verma Re: Medicare & You Inaccuracies" (May 15, 2018), https://www.medicarerights.org/pdf/JIA-CMA-MRC-Letter-re-2019-Medicare-You.pdf.

[41] Medicare Rights Center, "An Analysis of 2018-2019 Call Data from the Medicare Rights Center's National Helpline" (October 9, 2020), https://www.medicarerights.org/policy-documents/2018-2019-medicare-trends-and-recommendations.

[42] HHS Office of the Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials" (September 25, 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[43] *Id*.

[44] We also urge CMS to increase oversight over Medicare Advantage plans for other issues that affect beneficiaries, including plan designs that drive those in poorer health to disenroll from Medicare Advantage and inaccurate online provider directories. *See*, *Id*.

- **Increase Audit Capacity**. In rulemaking for CY 2015, CMS acknowledged that limited resources mean the agency can audit only 10% of Medicare Advantage and Part D plan sponsors each year. To build up this capacity, CMS issued, but did not finalize, a proposal to require plans to hire independent auditors. We ask CMS to revisit this idea, with caution. As we said at the time, we agree that more regular auditing is needed and we support CMS efforts to effectuate that oversight.[45] However, we do not recommend wholly replacing those directed by CMS. The delegation of audits requires assurance that independent auditors will provide meaningful, truly independent, analysis. Accordingly, we ask CMS to enhance its own audits, and to strictly oversee any that are plan-directed.

- **Strengthen Data Collection and Reporting**. We also urge CMS to monitor Medicare Advantage coverage and care decisions for high denial and overturn rates as well as for low appeal rates, and for any patterns therein, like inappropriate denials for specific services. Any trends that emerge should trigger a more comprehensive review to determine the underlying cause of the error and to obligate the plan to resolve it. Plans that regularly engage in such practices should lose the ability to enroll new members or, if the violations are severe, to contract with CMS, until corrections are made and publicly documented. Offending plans should remain subject to higher levels of review going forward and all captured data should be made publicly available.

Update the Medicare Advantage Appeals Process. The Medicare Advantage appeals process is unnecessarily complicated, often trapping beneficiaries in a burdensome struggle to access care. CMS must simplify this system, working with Congress in any areas where the agency lacks the authority to make necessary changes.

- **Improve Plan Communications with Enrollees**. Under current rules, when plans issue a denial, they are required to notify the affected enrollee in a timely manner. This notification should contain everything the enrollee needs to determine next steps, which may involve pursuing an appeal. Without this notice, beneficiaries may not understand their rights, how to appeal, or even that they have been denied coverage. Despite the importance of this obligation, many plans fail to comply.[46] CMS must do more to make sure plan notices are correct, promptly delivered, available in languages other than English, and accessible to people with varying levels of health literacy. We also support invalidating and immediately escalating coverage denials that were not accompanied by proper notice.

- **Require Independent Redeterminations**. To make the appeals process more manageable and accessible, the first level of appeal should be handled by an independent entity, rather than the plan itself. This would simplify the system, help ensure that beneficiaries have more timely access to care, and further encourage plans to make accurate initial coverage determinations.[47]

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[45] Medicare Rights Center, "Comments on Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" (March 7, 2014), available upon request.

[46] In 2015, 45% of Medicare Advantage plans sent denial letters with incomplete or incorrect information. *See* HHSS Office of Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials" (September 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.

47 American Cancer Society Cancer Action Network, "The Medicare Appeals Process: Reforms Needed to Ensure Beneficiary Access" (November 17, 2020), https://www.fightcancer.org/sites/default/files/Medicare%20Appeals%20Paper%20FINAL.pdf.

3. REDUCE BARRIERS TO CARE

The Biden administration must reduce barriers to care by making coverage more available, accessible, and affordable.

On our Helpline, we frequently hear from older adults and people with disabilities who live on modest or limited incomes and are struggling to access and afford their care.[48] These financial challenges—which have in many cases been worsened by the coronavirus pandemic—along with rising health care and prescription drug costs, antiquated coverage rules, and burdensome program requirements can make it difficult for older adults and people with disabilities to obtain the care they need.[49] The following reforms would help reduce these barriers to care by making Medicare stronger, easier to navigate, and more affordable.

Improve Coverage and Access to Care

Expand Medicare Health Coverage. The word "Medicare" is often used as shorthand for the sort of comprehensive, equitable insurance that we want for all Americans. However, there are critical gaps in the benefit, such as Medicare's total or near-total lack of coverage for dental, vision, and oral health care services. To make the shorthand accurate—and the program stronger—the Biden administration must address these and other challenges.

- **Approve Coverage of Medically Necessary Dental Care**. Medicare Rights joins an array of advocates and stakeholders in calling on the administration to use its discretion and existing authority to clarify that Medicare can cover medically necessary oral health and dental services.[50] This revision to current CMS policy would better fulfill Congress' goal of ensuring access to and coverage of medically necessary treatment for major health problems while upholding the general statutory exclusion of basic, routine dental care.

- **Identify Opportunities to Expand Access to Oral Health, Vision, and Hearing Services**. Medicare Rights also urges the administration to pursue care expansions more broadly. This includes working with Congress to extend Medicare coverage to dental, hearing, and vision services, as contemplated by recent legislation, and using existing demonstration authority to test these services for fee-for-service enrollees.[51]

- **Improve Medicare Coverage of Post-Hospital Skilled Nursing Facility (SNF) Care**. Medicare beneficiaries who need post-hospital care in a SNF may be forced to pay out-of-pocket for this care when the hospital chooses to assign them to "observation status" instead of admitting them as an inpatient. The administration should work with Congress to re-evaluate whether maintaining the requirement for a 3-day inpatient stay is appropriate. In the interim, CMS

[48] Medicare Rights Center, "An Analysis of 2018-2019 Call Data from the Medicare Rights Center's National Helpline" (October 9, 2020), https://www.medicarerights.org/policy-documents/2018-2019-medicare-trends-and-recommendations.
[49] NPR, *et al*., "The Impact of the Coronavirus on Households in Major U.S. Cities" (September 2020), https://media.npr.org/assets/img/2020/09/08/cities-report-090920-final.pdf.
[50] "Community Statement on Medicare Coverage for Medically Necessary Oral and Dental Health Therapies" (September 2019), https://familiesusa.org/wp-content/uploads/2019/09/Community-Statement-on-Oral-Health-083019-update-1.pdf.
[51] H.R. 3—Elijah E. Cummings Lower Drug Costs Now Act (2019), https://www.congress.gov/bill/116th-congress/house-bill/3; H. R. 1393/S. 1423—Medicare Dental, Vision, and Hearing Benefit Act of 2019 (2019), https://www.congress.gov/bill/116th-congress/house-bill/1393 and https://www.congress.gov/bill/116th-congress/senate-bill/1423.

should use its existing authority to redefine inpatient status to count all time in the hospital towards the requirement.

- **Expand Medicare Coverage of Telehealth Cautiously, Following the Data**. We recognize the recent expansion of Medicare-covered telehealth services has helped beneficiaries and their families safely and responsibly obtain needed care during the pandemic, likely leading to improved outcomes and reduced transmission of the COVID-19 virus. We applaud these successes and understand the impulse to keep many of the underlying policies in place. However, doing so without further study risks locking in an unexamined expansion of services that was developed for and during a crisis. We ask the Biden administration to move forward deliberately, using outcomes, experiential, and financial data to ensure people are receiving the care they want and need in a way that is affordable for beneficiaries and sustainable for the program.[52]

- **Enforce Mental Health Parity in Medicare**. We encourage the administration to require equivalent Medicare coverage for mental and physical health conditions across the program, including by strengthening mental health and substance use disorder coverage and payment, ensuring the full range of appropriate behavioral health services providers are eligible for Medicare reimbursement, and revoking the lifetime limit on inpatient services in a mental health specific facility.[53]

Level the Medicare Playing Field. To best support people with Medicare and the program, the Biden administration must equalize payment and coverage between Medicare Advantage and Original Medicare.

- **Reduce Medicare Advantage Overpayments**. Overpayments to Medicare Advantage plans can increase program, beneficiary, and taxpayer costs.[54] These additional expenses are significant, and well documented. According to a 2017 *Health Affairs* study, one of the key drivers of the unacceptably high payments—plan abuses of patient categorization rules, known as "upcoding"—could raise Medicare expenditures by $200 billion over the next decade.[55] Another report found that Medicare overpaid Medicare Advantage plans a $70 billion from 2008 through 2013,[56] and the Government Accountability Office estimates that in 2013 alone, Medicare Advantage plans received an extra $14.1 billion.[57] We urge CMS to be more aggressive in its attempts to control these costs, such as by increasing the coding intensity adjustment beyond the statutory minimum, better monitoring and auditing risk-adjusted payments, and more

[52] Center for Medicare Advocacy & Medicare Rights Center, "Joint Principles: Telehealth" (July 23, 2020), https://www.medicarerights.org/pdf/072320-cma-joint-principles-telehealth.pdf.
[53] Medicare Interactive, "Inpatient Mental Health Care" (last accessed January 10, 2021), https://www.medicareinteractive.org/get-answers/medicare-covered-services/mental-health-services/inpatient-mental-health-care.
[54] *See* MedPAC, "The Medicare Advantage Program: Status Report" (March 2019), http://medpac.gov/docs/default-source/reports/mar19_medpac_ch13_sec.pdf ("Excess payments to MA plans allow them to offer additional benefits to enrollees, thus benefiting the MA program but costing taxpayers more than if MA beneficiaries had remained in FFS Medicare. Further, additional payments to MA plans increase the Part B premium for all Medicare beneficiaries. The size of the Part B premium is based on total Part B spending, which for MA is calculated as a proportion of all MA spending").
[55] Richard Kronick, "Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By $200 Billion Over Ten Years" (February 2017), http://content.healthaffairs.org/content/36/2/320.abstract.
[56] The Center for Public Integrity, "Why Medicare Advantage Costs Taxpayers More Than It Should" (January 2015), https://publicintegrity.org/health/why-medicare-advantage-costs-taxpayers-billions-more-than-it-should/.
[57] U.S. Government Accountability Office, "Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments" (April 2016), https://www.gao.gov/assets/680/676441.pdf

strictly deterring upcoding. We also encourage CMS to more closely oversee plans' use of at-home risk assessments, to ensure they result in services that effectively treat beneficiaries' clinical needs.[58] As we have long noted, there is a continued risk that such assessments serve as a vehicle for plans to collect diagnoses and increase payments without providing meaningful care.[59]

- **Examine Changes to the Medicare Advantage Payment System and Investigate Potential Steering**. Recent analysis from the Kaiser Family Foundation indicates that people who choose Medicare Advantage plans have lower spending and use fewer services relative to their peers with Original Medicare—even before they enroll. While additional data collection and study is needed, these initial findings suggest the current basis for Medicare Advantage payments, which assumes Medicare Advantage enrollees have the same overall health costs as people with Original Medicare, may be flawed, and contributing to the problem of plan overpayments.[60] They also raise questions about plan benefit designs, billing practices, and marketing strategies; and the extent to which plans are actually lowering spending or managing care. CMS must not leave these questions unanswered. As the authors note, given the increases and projected growth in Medicare Advantage enrollment and expenditures, "the stakes are high for making payments to plans as accurate as possible."[61] We urge the administration to heed this call. CMS must step up its enforcement of existing safeguards and identify ways to improve the current payment system to promote sustainability and equity.

- **Equalize Access to Supplemental Benefits**. While some Medicare Advantage enrollees have access to the recently expanded supplemental benefits that focus on non-medical concerns and risk factors, most Medicare beneficiaries—those with Original Medicare—do not.[62] As a result, these services may function more as an inducement to enroll in Medicare Advantage than as a true aid to beneficiaries or as an effective mechanism to address deeply rooted inequities. Amid growing evidence[63] that social factors can shape health across a wide range of indicators, settings, and populations, and that tackling these issues can help reduce health disparities and promote health equity, all people with Medicare should have equal access to these new benefits.[64] The Biden administration must advance this goal by testing ways to deliver these and other expanded benefit packages—including dental, vision, and hearing services—to people with Original Medicare, engaging in transparent data collection, and reporting on the availability, utilization, and outcomes associated with these benefits as currently offered in Medicare Advantage.[65]

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[58] HHS Office of Inspector General, "Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns" (December 2019), https://oig.hhs.gov/oei/reports/oei-03-17-00470.asp.
[59] Medicare Rights Center, "Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter" (March 2018), https://www.medicarerights.org/pdf/030518-2019-call-letter-comments.pdf.
[60] Gretchen Jacobsen, *et al.*, "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?" (May 2019), https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/.
[61] *Id.*
[62] Tyler Comer & Elexa Rallos, "Newly Expanded Non-Medical Supplemental Benefits in Medicare Advantage: A Primer" (last accessed January 13, 2021), https://atiadvisory.com/newly-expanded-non-medical-supplemental-benefits-in-medicare-advantage-a-primer/.
[63] Paula Braverman & Laura Gottlieb, "The Social Determinants of Health: It's Time to Consider the Causes of the Causes" (January 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/.
[64] Hilary Daniel, *et al.*, "Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper" (April 17, 2018), https://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve-patient-care-promote-health-equity-american.
[65] *See* p. 14 "Expand Medicare Health Coverage"

- **Promote Meaningful Choice**. Due to outdated restrictions, not everyone is eligible to buy a Medigap plan, and most are only guaranteed the right to do so during very limited time frames. As a result, while Medicare Advantage enrollees can typically change plans on an annual basis, Medigap enrollees—people with Original Medicare—cannot. To address this inequity, we ask the Biden administration to support state and federal efforts to expand access to affordable, high-quality Medigap policies to all beneficiaries, along with the opportunity to re-evaluate their coverage choices on a regular basis and as their needs change. This includes extending the same federal Medigap protections to beneficiaries under 65 as those given to beneficiaries over 65 and providing for open enrollment, guaranteed issue, and community rating of Medigap for all people with Medicare. We also recommend making the plan selection process easier by embedding robust and accurate comparison data into consumer-facing tools.

- **Guarantee Objectivity**. In recent years, as Medicare Rights and others have highlighted, Medicare enrollment materials and outreach strategies have sometimes failed to provide objective, neutral information about coverage options, appearing to promote Medicare Advantage over Original Medicare.[66] The Biden administration must ensure that future Medicare communications are neutral and accurate.

Streamline Part D Appeals. The Medicare Part D appeals process is an essential safety valve that allows older adults and people with disabilities to obtain needed medications. However, the current process is overly onerous and deeply flawed.[67] Its inefficiencies can lead to delays in beneficiary access, abandonment of therapies, reduced adherence to treatment protocols, worse health outcomes, and higher costs.

- **Modernize Pharmacy Counter Communications**. We often hear from beneficiaries who were told at the pharmacy counter that their plan would not cover their medication—but not the reason why. Pharmacists do not tend to have details about the coverage decision, and can only provide the required standard notice, which directs enrollees to contact drug plan for an explanation.[68] As a result, affected enrollees often have no choice but to leave the pharmacy without their medication or a clear understanding of why it was denied. Confused about what to do next, some may bypass the appeals process—knowingly or not—returning later to pay what they can or deciding to forgo the medication altogether. Those who do take action must embark on a tedious fact-finding mission, winding their way through a multi-layered, burdensome system, often with little help. To best address these challenges, we recommend allowing a refusal at the pharmacy counter to function as the plan's initial coverage determination. This would allow the enrollee to obtain an individually tailored denial notice in real-time and initiate the appeals process for those who need it. We endorse legislation that would effectuate these changes, the bipartisan Streamlining Part D Appeals Process Act (S. 1861/H.R. 3924).[69] We urge

[66] Medicare Rights Center, *et al.*, "Joint letter to CMS re: inaccuracies in the draft Medicare & You Handbook for 2019" (May 15, 2018), https://www.medicarerights.org/policy-documents/letter-to-cms-re-inaccuracies-in-the-draft-medicare-you-handbook-for-2019; Medicare Rights Center, *et al.*, "Joint letter to CMS re: education and outreach materials for the current Medicare Annual Coordinated Election Period" (November 16, 2018), https://www.medicarerights.org/pdf/11.16.18-joint-ltr-cms.pdf.

[67] Medicare Rights Center, "Medicare Prescription Drug Appeals Packet" (2021) https://www.medicarerights.org/fliers/Rights-and-Appeals/Part-D-Appeals-Packet.pdf?nrd=1.

[68] Medicare Interactive, "The Medicare Prescription Drug Coverage and Your Rights Notice" (last accessed January 13, 2021), https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/part-d-appeals/the-medicare-prescription-drug-coverage-and-your-rights-notice.

[69] S. 1861 (2019) https://www.congress.gov/bill/116th-congress/senate-bill/1861, and H.R. 3924 (2019) https://www.congress.gov/bill/116th-congress/house-bill/3924?s=1&r=3; Medicare Rights Center, "Congress Must Streamline the Medicare Part D Prescription Drug Appeals

the Biden administration to prioritize this commonsense solution and to use existing authorities to advance its goals and policies. This includes immediately requiring plans to issue pharmacy counter refusal notices that explain why the beneficiary is being turned away (i.e., prior authorization, step therapy, quantity limits, off-formulary, non-covered, etc.).

- **Address Incomplete Data on Point-of-Sale Refusals**. Current CMS reporting rules, and therefore the agency's data systems, do not capture all instances in which plans fail to properly interpret their own or Medicare's rules when making coverage decisions. While plans are required to report information and outcomes related to coverage determinations, including the number requested, appealed, and overturned, they are not required to report all point-of-sale rejections. And the data that is required on these interactions is often incomplete.[70] Requiring plans to treat the beneficiary's presentation of the prescription at the pharmacy as a coverage determination request, as outlined above, would capture refusals at the pharmacy counter and any resulting appeals and reversals through existing reporting mechanisms. This would ensure that CMS has more robust data on situations in which people are turned away at the pharmacy and may pay out-of-pocket or go without needed drugs.[71] We urge the Biden administration to support this legislative fix and encourage CMS to update its reporting requirements in the interim.

- **Improve the Specialty Tier and Allow Tiering Exceptions**. The current exceptions process allows people with Part D to request that their plan allow them to pay less for high-cost medications when a similar, lower-cost medicine is available on the plan's formulary. But this right is not available to beneficiaries whose prescription drugs are placed on the plan's specialty tier, where cost-sharing can be exorbitant.[72] In addition, the cost threshold for drugs to be included on the specialty tier is too low, leading to an expansion in the number of drugs that are eligible for this tier.[73] CMS must give Medicare beneficiaries the right to an exception for specialty tier medications and raise the cost threshold.

- **Deter Inappropriate Plan Denials**. Some challenges with Part D appeals are the result of plan behaviors that can exacerbate an already complicated process. Among the most egregious are instances in which plans deny coverage for insufficient and incorrect reasons, forcing beneficiaries to appeal bad decisions and go without needed medications in the interim. CMS should step up oversight and audits of plan denials, and more harshly sanction plans for patterns of inappropriate denials

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Process" (2019), https://www.medicarerights.org/pdf/s.1861-hr.3924-fact-sheet.pdf, and Medicare Rights Center, "Streamlining Part D Appeals Process Act" (2019) https://www.medicarerights.org/pdf/s.1861-hr.3924-case-study.pdf.

[70] *See,* MedPAC "The Medicare Prescription Drug Program: Status Report" (March 2018) http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf, ("Sponsors are not required to report all rejections, but must report rejections associated with nonformulary claims, prior authorizations, step therapy, quantity limits, and certain high-cost edits. The plan-reported and IRE data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that are reported do not pass data validation requirements.").

[71] S. 1861 (2019) https://www.congress.gov/bill/116th-congress/senate-bill/1861, and H.R. 3924 (2019) https://www.congress.gov/bill/116th-congress/house-bill/3924?s=1&r=3; Medicare Rights Center, "Congress Must Streamline the Medicare Part D Prescription Drug Appeals Process" (2019), https://www.medicarerights.org/pdf/s.1861-hr.3924-fact-sheet.pdf, and Medicare Rights Center, "Streamlining Part D Appeals Process Act" (2019) https://www.medicarerights.org/pdf/s.1861-hr.3924-case-study.pdf.

[72] Juliette Cubanski, et al., "The Out-of-Pocket Cost Burden for Specialty Drugs in Medicare Part D in 2019" (February 1, 2019), https://www.kff.org/medicare/issue-brief/the-out-of-pocket-cost-burden-for-specialty-drugs-in-medicare-part-d-in-2019/.

[73] Centers for Medicare & Medicaid Services, "Memo re: Updated Contract Year (CY) 2021 Final Part D Bidding Instructions" (May 22, 2020), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2021%20mtm%20and%20specialty%20thresholds%20final%20part%20d%20bidding%2005.22.2020_8.pdf.

- **Require Independent Redeterminations**. If a plan denies a beneficiary's exception request, they may then request a redetermination by filing a written appeal with the plan.[74] Our experience reveals that instead of engaging in a good faith effort to determine coverage eligibility, many redeterminations simply reiterate the plan's previous decision. This wastes valuable time (7 days for a standard appeal, 72 hours in an expedited process) and creates unnecessary medication delays and administrative burdens. To correct this, and to better incentivize plans to make accurate initial decisions, CMS should require that a plan's initial coverage decision be reviewed by an independent entity, rather than the plan itself. Overturned decisions should trigger a review of the file and necessary employee training.

- **Strengthen Processes and Timeliness**. As CMS notes, Part D appeals are inherently time-sensitive because "the majority of Part D coverage requests involve prescription drugs an enrollee has not yet received, which increases the risk of adverse clinical outcomes if access to the drug is delayed."[75] Yet, both the process can be onerous and time-consuming. In part, this is due to the significant backlog at the Administrative Law Judge (ALJ) and Medicare Appeals Council levels and plan failure to comply with response rules and timelines.[76] Although the regulations are clear, some plans do not issue coverage decisions or respond to grievances in a timely manner. Nor do they send the claim to the Independent Review Entity (IRE) when the required time frames are not met. The Biden administration should better encourage plans to submit timely determinations and communicate with enrollees effectively. We also recommend that CMS respond directly to enrollee complaints about plan non-compliance, require remedial actions by the plan when necessary, and clear the backlog at the ALJ and Appeals Council levels.

- **Address Prescriber Documentation and Plan Outreach**. From seeking coverage determinations and exceptions on behalf of beneficiaries to providing plans with needed clinical documentation, prescribers are vital to the Part D appeals process.[77] Yet, many are non-responsive and plans often make no effort to follow up appropriately. This is detrimental to beneficiaries, who may end up going without needed medication and lose the ability to appeal entirely as deadlines pass.[78] Because plans have existing relationships with prescribers, they are well-positioned to establish in-plan requirements for timely prescriber engagement. In 2017 plan guidance, CMS acknowledged as much, and stated that the agency "expects that plans will be able to obtain requested documentation from contracted providers in a reliable and timely manner."[79] But this expectation has not been met. CMS must do more to require coordination between plans and prescribers, and to establish policies that hold beneficiaries harmless.

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[74] *See e.g.,* Medicare Interactive, "Introduction to Part D Appeals" (last accessed January 13, 2021), https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/part-d-appeals/introduction-to-part-d-appeals; Medicare Rights Center "Medicare Part D Drug Appeals" (2019), https://www.medicareinteractive.org/pdf/PartD_DrugAppeals_Chart.pdf.

[75] MedPAC, "Status report on the Medicare prescription drug program" (March 2017), http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch14.pdf?sfvrsn=0.

[76] HHS, "Medicare Appeals Backlog Primer" (last accessed January 13, 2021), https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf.

[77] Centers for Medicare & Medicaid Services, "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance" (effective as of January 1, 2020), https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.

[78] MedPAC, "Status report on the Medicare prescription drug program" (March 2017), http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch14.pdf?sfvrsn=0.

[79] Centers for Medicare & Medicaid Services "Updated Guidance on Outreach for Information to Support Coverage" (February 2017), https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/HPMS-Guidance-on-Outreach-for-Information-to-Support-Coverage-Decisions-2017Feb22.pdf.

- **Strengthen Beneficiary Notices**. Plan communications to beneficiaries about coverage decisions, such as denial letters and redetermination notices, are often uninformative, unactionable, and confusing.[80] As a result, beneficiaries may not understand the reason for the plan's decision or what to do next. We encourage CMS to direct plans to provide readable and clear notices and enforce such standards. This includes requiring plans to make all beneficiary communications available in non-English language formats and increasing penalties for plans that do not send timely and adequate notices.

- **Require Plan Recognition of Beneficiary Representation**. An enrollee may appoint a representative to act on their behalf during the appeals process by submitting a written statement to the drug plan sponsor.[81] In our experience, plans are not always responsive to these statements, even after multiple requests. Some fail to list the beneficiary's appointed representative in their system or to send the representative copies of the plan's correspondence with the beneficiary. This can leave enrollees without the help they need. CMS must increase oversight of beneficiary representative requests.

- **Curb Misclassifications of Appeals and Grievances**. In addition to the Part D appeals process that allows beneficiaries to challenge plan decisions about drug coverage, they have access to a grievance system through which they can dispute other, generally service-related, plan activities or decisions. It is up to the plan to correctly determine whether a beneficiary's filing should be handled through the appeals process or as a grievance. Unfortunately, plans do not always accurately classify these submissions, which can create significant problems for beneficiaries.[82] Again, increased oversight and transparency, as well as improved plan-to-beneficiary communications, would allow beneficiaries and advocates to track issues and recognize improper classifications more quickly.

- **Bolster Transparency and Data Collection**. The Part D appeals process is hampered by limited data and transparency.[83] Beneficiaries and advocates alike can struggle to track not only an individual's specific claim, but also improper denial patterns that may be tied to hundreds of thousands of beneficiaries. Better data could lead to better solutions, as a more transparent system would lend itself to targeted recommendations and self-correction. We ask CMS to conduct a comprehensive, in-depth analysis of the Part D appeals process and to release that information publicly. The analysis should include data collection on specialty tier medications and extend to all levels of appeals, from plans through the Medicare Appeals Council and federal court.

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[80] For example, Medicare Rights finds these materials are often not in plain language; do not include the criteria the plan used to make the coverage decision; name incorrect reasons for denial; and rarely cite the Medicare rule at issue, instead using vague terms like "medical necessity" without explanation. Redacted sample letters may be available upon request.

[81] Congressional Research Service, "Medicare Part D Prescription Drug Benefit" (December 18, 2020), https://crsreports.congress.gov/product/details?prodcode=R40611, ("An enrollee may request a representative by using a government form (Form CMS-1696) or by submitting an equivalent written notice that includes information about enrollee and is signed and dated by both the enrollee and the representative. There are exceptions in the case of institutionalized or incapacitated enrollees.")

[82] AISHealth, "2016 Audit Notices Highlight Growing Misclassification Issue" (March 2017), https://aishealth.com/medicare-and-medicaid/2016-audit-notices-highlight-growing-misclassification-issue/.

[83] In 2014, MedPAC and the Senate Select Committee on Aging both pointed to this lack of data as an urgent problem. *See, e.g.*, Medicare Rights Center, "Letter to MedPAC" (October 10, 2014), https://www.medicarerights.org/pdf/101014-medpac-part-d-appeals.pdf; Senator Bill Nelson, *et al.*, "Letter to Marilyn Tavenner" (March 10, 2014), https://www.aging.senate.gov/imo/media/doc/03.10.14_CMS%20Part%20D%20Appeals%20Letter2.pdf.

Improve Access to Long Term Services and Supports (LTSS). The lack of a national LTSS framework forces many older adults and people with disabilities to rely on a patchwork of programs and caregivers, often depleting their assets and increasing program costs in the process.[84] The Biden administration must update existing systems and test new ways to deliver sustainably financed LTSS.

- **Modernize Medicare LTSS Coverage**. Medicare does not cover many long-term services and supports, and pays for help with activities of daily living, like eating and bathing, in very limited circumstances. Reflecting broad national trends, many of our Helpline callers seek help paying for this care. The administration can take steps to modernize the Medicare program to meet this growing need by filling existing coverage gaps, such as eliminating the requirement that Medicare beneficiaries be homebound to qualify for home health coverage, and by changing payment incentives so that people can access care for as long as they need.

- **Strengthen Oversight of Nursing Facilities**. A recent Government Accountability Office report found that most nursing homes had at least one infection prevention and control deficiency between 2013 and 2017, with many facilities cited year after year and few actions taken to enforce standards.[85] To date, over one hundred thousand nursing home residents and staff have died during the COVID-19 public health emergency, and poor infection control fueled by negligent regulation, inspection, and deterrence is at the heart of the problem.[86] We urge strong oversight of all nursing facility deficiencies, including close monitoring and auditing of state agency activities and the imposition of appropriate and meaningful sanctions for noncompliance.

- **Improve Non-Medicare Home and Community-based Services**. Absent comprehensive Medicare coverage for home and community-based services (HCBS), many beneficiaries typically rely on a constellation of other programs to fully participate in their communities, such as Medicaid and the Older American's Act (OAA). The Biden administration should ensure these programs are up to the task. This includes best positioning Medicaid to serve beneficiaries in the least restrictive, most appropriate setting; ensuring states are facilitating access to HCBS, in part by fully implementing the spousal impoverishment protections for HCBS and expanding or starting the Money Follows the Person program; and requesting adequate funding for OAA and other programs that help older adults, people with disabilities, and their caregivers maintain their health and independence.

- **Test LTSS Delivery and Financing Reforms**. Currently, more than 24 million adults have LTSS needs,[87] and demand is likely only to grow due to demographic and other trends.[88] At the same time, the cost of these services is also expected to rise considerably in the coming years, putting

[84] Melissa Favreault, *et al*., "Financing Long-Term Services And Supports: Options Reflect Trade-Offs For Older Americans And Federal Spending" (December 2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1226.
[85] U.S. Government Accountability Office, "Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic" (May 20, 2020), https://www.gao.gov/assets/710/707069.pdf.
[86] AARP, "AARP Nursing Home COVID-19 Dashboard" (last updated January 14, 2020), https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html?cmp=RDRCT-350d888f-20201013.
[87] Edem Hado & Harriet Komisar, "Long-Term Services and Supports" (August 2019), https://www.aarp.org/content/dam/aarp/ppi/2019/08/long-term-services-and-supports.doi.10.26419-2Fppi.00079.001.pdf.
[88] Nga Thach & Joshua Weiner, "An Overview of Long-Term Services and Supports and Medicaid: Final Report (August 8, 2018), https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report.

an increasingly heavy burden on individuals, families, and government programs.[89] While positioning existing programs to better serve older adults and people with disabilities is an important first step, these changes alone will not build the type comprehensive, cohesive system that will be necessary to meet future LTSS needs. We strongly encourage the administration to test broad systemic LTSS changes. Using CMMI demonstration authority, HHS could work to develop a robust, effective program that is equitable and universal; promotes consumer choice, quality of life, and quality of care; is affordable and financially sound; and adequately compensates direct care and professional staff.

Bolster Family Caregivers and the Health Care Workforce. The existing community-based health and social services infrastructure, which relies on family and paid caregivers, is essential to allowing millions of older adults and people with disabilities live in their homes and communities. The administration should pursue funding, policies, and programs that recognize the contributions of and challenges facing direct care professionals, health care workers, and family caregivers.

- **Support Caregivers**. The nation's fragmented LTSS system means that unpaid family caregivers and undervalued home care workers play a critical role in helping people with Medicare age in the community. The administration can support these families and paid workers by championing paid leave that recognizes caring for relatives of all ages; requesting robust funding for annually appropriated HCBS and caregiver support programs; and developing promising practices to recruit and retain a robust workforce.

- **Promote Safety and Equity**. All of those who work in care fields must have greater access to training and certification, higher pay with opportunities for advancement, sick and overtime pay, personal protective equipment, and supportive systems. Ensuring better conditions and supports for these invaluable workers helps older adults and people with disabilities remain safely in their homes; combats racial and gender inequity; and more effectively aids women of color, who provide a disproportionate percentage of care both for their own families and for the families of others.[90]

Enhance Health Care and Prescription Drug Affordability

Increase Access to Medicare Assistance Programs. Medicare's low-income assistance programs, the Medicare Savings Programs and Part D's Extra Help/Low-Income Subsidy, were established to help qualifying Medicare beneficiaries afford needed care. But burdensome processes and outdated requirements unnecessarily limit participation. We urge the Biden administration to modernize these programs to help more people obtain the financial assistance they need to pay for their coverage and care.

- **Encourage Outreach and Enrollment in Medicare Savings Programs (MSPs)**. Administered by states through a combination of federal and state funding, MSPs—including the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) programs—help people with very low incomes and assets pay for Part B. In doing

[89] I*d*., and "Genworth 17th Annual Cost of Care Survey" (December 2, 2020), https://newsroom.genworth.com/2020-12-02-Genworth-17th-Annual-Cost-of-Care-Survey-COVID-19-Exacerbates-Already-Rising-Long-Term-Care-Costs-Care-Providers-Foresee-Additional-Rate-Hikes-in-2021#assets_20295_124101-118.
[90] *See, e.g.*, National Partnership for Women and Families, "The Female Face of Family Caregiving" (November 2018), https://www.nationalpartnership.org/our-work/resources/economic-justice/female-face-family-caregiving.pdf.

so, MSPs allow beneficiaries to stretch their limited budgets and better afford groceries, utilities, and other basic needs. Troublingly, less than half of those eligible for this assistance are enrolled, in part to due to ineffective outreach and complex rules.[91] Since CMS plays an important role in convening states and disseminating best practices on the administration of MSPs, the agency has a unique opportunity to improve enrollment. We recommend encouraging states to identify and implement strategies to enhance MSP participation rates, including easing eligibility criteria, expanding outreach, simplifying enrollment, participating in a Medicare Part A buy-in, and improving provider payment.

- **Continue to Minimize Inappropriate Billing of Qualified Medicare Beneficiaries (QMB)**. By law, people with QMB, among the lowest-income Medicare beneficiaries, are shielded from Medicare Part A and Part B cost-sharing.[92] However, they are often billed illegally by their providers, to the detriment of their financial stability.[93] Medicare Rights appreciates CMS's ongoing work to curb these practices. We encourage the Biden administration to expand on existing strategies, which include increased assistance for health care providers; the involvement of Medicare Advantage plans in related efforts with network providers; and the development of beneficiary supports through 1-800-MEDICARE, the Medicare & You handbook, and more.[94]

- **Ease Access to and Administration of the Extra Help/Low-Income Subsidy (LIS) Program**. Extra Help/LIS helps beneficiaries afford their Part D premiums and reduces their out-of-pocket prescription drug costs,[95] saving beneficiaries an average of $4,900 a year.[96] Improving enrollment in this important program—by increasing eligibility thresholds and eliminating the asset test —and making it more effective—by eliminating cost-sharing on generics, sending the LIS "Choosers Notice" to all enrollees with premium liability, and allowing intelligent assignment—would further reduce costs and improve health outcomes for low-income Medicare beneficiaries, and likely generate Medicare savings.[97] We ask the Biden administration to support these reforms, and to provide states with models for expanding access to the Medicare Savings Programs, enrollment in which automatically qualifies one for Extra Help.

Address High and Rising Costs. Many people with Medicare live on fixed or limited incomes and cannot keep paying ever-rising health and prescription drug costs. Even before the pandemic, half of all Medicare beneficiaries—nearly 30 million older adults and people with disabilities—were living on $29,650 or less per year, while one quarter had incomes below $17,000 and less than $8,500 in

[91] MedPAC, "Medicare Savings Program Enrollees and Eligible Non-Enrollees" (June 2017), https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.
[92] Centers for Medicare & Medicaid Services, "Medicare Savings Programs" (last accessed January 13, 2021), https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs.
[93] Centers for Medicare & Medicaid Services, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)" (July 2015), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-CoordinationOffice/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.
[94] Centers for Medicare & Medicaid Services, "Reducing Inappropriate Billing of Qualified Medicare Beneficiaries" (December 2016), http://nhelp.org/conf2016/uploads/presenters/28_MMCO%20Inappropriate%20QMB%20Billing.pdf.
[95] Medicare Interactive, "Extra Help Basics" (last accessed January 13, 2021), https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/the-extra-helplow-income-subsidy-lis-program/extra-help-basics.
[96] Social Security Administration, "Extra Help with Medicare Prescription Drug Plan Costs" (last accessed January 13, 2021), https://www.ssa.gov/benefits/medicare/prescriptionhelp/.
[97] Congressional Budget Office, "Effects of Drug Price Negotiation Stemming From Title 1 of H.R. 3, the Lower Drug Costs Now Act of 2019, on Spending and Revenues Related to Part D of Medicare" (October 2019), https://www.cbo.gov/publication/55722.

savings.[98] At the same time, health care costs are taking up a larger and more disproportionate share of beneficiaries' limited budgets. In 2016, nearly 30% of Medicare households spent 20% or more of their income on health care, while only 6% of non-Medicare households did so.[99] Out-of-pocket costs for prescription drugs represent a significant share of this spending, accounting for nearly one out of every five beneficiary health care dollars.[100] The Biden administration must work administratively and with Congress to rein in health care and prescription drug prices, lowering costs for consumers and for Medicare.

- **Improve Prescription Drug Affordability**. Prescription drug affordability consistently presents as a top trend on Medicare Rights' Helpline.[101] Given that many people with Medicare live on limited incomes that cannot keep pace with high and rising drug prices, the perennial nature of these calls is alarming, but not surprising.[102] Changes are urgently needed to meaningfully reduce drug prices and lower costs both for people with Medicare and for the program as a whole. Important strategies to do so include restructuring the Part D benefit in ways that firmly cap beneficiary out-of-pocket spending, expanding low-income assistance programs, allowing Medicare to negotiate drug prices, and increasing pricing transparency and accountability throughout the supply chain. Reforms to the current system must not undermine beneficiary protections or access to care, and savings achieved through drug pricing reform should be reinvested in improvements to the program, as outlined in the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3).[103] We urge the administration to prioritize these reforms, and the needs of beneficiaries, in any regulatory or administrative changes it may seek.[104]

- **Limit Beneficiary Exposure to Out-of-Pocket Costs, Program-wide**. Much of the Part A and Part B benefit structure has not been updated in over 50 years. As a result, Original Medicare can lack consumer protections that have become prevalent in private insurance, like an out-of-pocket spending cap. While Medicare Advantage plans are required to include an out-of-pocket maximum in their benefit packages, the threshold is too high—$7,550 for in-network care in 2021—and does nothing for the two-thirds of beneficiaries with Original Medicare.[105]As discussed above, Part D also lacks a hard cap on beneficiary spending. We request the administration to work with Congress and limit beneficiary financial exposure across the program in a way that preserves the Part A Trust Fund. Such arrangements have long been a

[98] Wyatt Koma, *et al.*, "Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic" (April 24, 2020), https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-financial-security-before-the-coronavirus-pandemic/.
[99] Juliette Cubanski, *et al.*, "The Financial Burden on Health Care Spending: Larger for Medicare Households than for Non-Medicare Households" (March 1, 2018), https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care- spending-larger-for-medicare-households-than-for-non-medicare-households/.
[100] Kaiser Family Foundation, "10 Essential Facts about Medicare and Prescription Drug Spending" (January 29, 2019), https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/.
[101] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2017 Call Data from the Medicare Rights Center's National Helpline" (April 2019), https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf.
[102] Leigh Purvis, *et al.*, "Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update" (September 2019), https://www.aarp.org/content/dam/aarp/ppi/2019/09/trends-in-retail-prices-of-prescription-drugs-widely-used-by-older-americans.doi.10.26419-2Fppi.00073.003.pdf.
[103] H.R. 3—Elijah E. Cummings Lower Drug Costs Now Act (2019), https://www.congress.gov/bill/116th-congress/house-bill/3.
[104] For more information on Medicare Rights' recommendations for drug pricing reform, *see* Medicare Rights feedback on draft Medicare Part D legislation (June 6, 2019) http://medicarerights.org/pdf/060619-partd-legislation-medicare-rights-response.pdf; Joint letter to Senate leaders about Part D reforms (June 27, 2019) http://medicarerights.org/pdf/062719-joint-letter-part-d.pdf; Joint letter about Part D reforms and drug pricing (September 10, 2019) https://www.medicarerights.org/pdf/091019-partd-reforms-joint-letter.pdf; Medicare Rights letters of support for H.R. 3 (October 16, 2019) https://www.medicarerights.org/pdf/101619-letter-support-hr3.pdf and (December 11, 2019) https://www.medicarerights.org/pdf/121119_hr3_letter.pdf.
[105] Meredith Freed, *et al.*, "A Dozen Facts About Medicare Advantage in 2020" (January 13, 2021), https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.

feature of private health plans, including employer-sponsored insurance, and are now more broadly required under the Affordable Care Act.[106] People with Medicare, who already incur relatively high out-of-pocket costs, must not be left behind.[107]

Make Organizational Changes

Update Structures and Practices. We recommend that CMS and SSA examine internal policies for ways to promote beneficiary protections and strengthen relationships with stakeholders.

- **Immediately Pause New "Geo" Demonstration Model**. The incoming administration must immediately halt implementation of the Direct Contracting "Geo" model aimed at coordinating care and clinical management for beneficiaries with Original Medicare.[108] We are concerned by the Trump administration's last-minute rush to implement this model, especially amid a lack of complete information about how it will work. There is no valid policy or program reason to proceed in a hurried manner, or without ample study and stakeholder feedback. We urge a pause and at least a one-year delay, to allow for additional investigation.

- **Rescind the SUNSET Rule**. A proposed rule issued on November 4, 2020 would impose an expiration provision on most HHS regulations and establish an onerous review process for the agency to use to determine which, if any, regulations should be retained or revised. This proposal, the Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) rule,[109] would lead to chaos for Medicare beneficiaries, providers, and payers and would force federal agencies to engage in hundreds of hours of pointless busywork each year, reducing their capacity to manage other, more critical issues like ensuring access to coverage and care in a pandemic. As we noted at the time, we oppose this ill-conceived and destructive proposal and ask the administration to withdraw it in its entirety.[110]

- **Institute a Competitive Bidding Program for Durable Medical Equipment with Strong Beneficiary Protections**. The Durable Medical Equipment Prosthetics, Orthotics and Supplies (DME-POS) Competitive Bidding Program (CBP) established important price controls and beneficiary protections, including the CBP Ombudsman and the requirement that contract suppliers serve all beneficiaries within their geographic area. When the Trump administration allowed the program to lapse without a replacement, beneficiaries again faced limitless cost sharing on their DME and no centralized place to turn for assistance. We urge the Biden administration to create equitable processes for suppliers to participate in the competitive bidding program with fair prices and reasonable cost sharing; re-authorize and empower the

[106] AHIP, "Patient Cost Sharing under the Affordable Care Act" (November 2015), https://www.ahip.org/wp-content/uploads/2015/11/CostSharing_IssueBrief_11.19.15.pdf.
[107] Juliette Cubanski, *et al.*, "Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future" (January 26, 2018), https://www.kff.org/medicare/report/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future/.
[108] Centers for Medicare & Medicaid Services, "CMS Announces New Model to Advance Regional Value-Based Care in Medicare" (December 3, 2020) https://www.cms.gov/newsroom/press-releases/cms-announces-new-model-advance-regional-value-based-care-medicare and "Geographic Direct Contracting Model" (December 3, 2020) https://www.cms.gov/newsroom/fact-sheets/geographic-direct-contracting-model-geo.
[109] *See* RIN 0991–AC24; Docket No. HHS–OS– 2020–0012.
[110] Medicare Rights Center, "Comments on Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) proposed rule" (January 4, 2021), https://www.medicarerights.org/pdf/010421-comments-sunset-rule.pdf.

CBP Ombudsman to resolve both supplier and beneficiary issues; and ensure equitable access to needed equipment and supplies.

- **Elevate the Office of the Medicare Ombudsman**. The Ombudsman works to resolve beneficiary problems not addressed through 1-800-MEDICARE and other means, and presents systemic challenges facing people with Medicare to CMS, Congress, and the public. Given the importance of this office, the administration must make sure it is adequately resourced.

- **Create the Alternative Payment Models Beneficiary Ombudsman**. In December 2016,[111] and again in 2017,[112] CMS announced plans to create an Alternative Payment Models Beneficiary Ombudsman to help support Medicare beneficiaries in these models. We ask the Biden administration to act upon this promise as soon as possible.

- **Engage Stakeholders**. It is critical that the agencies administering Medicare are aware of and responsive to challenges facing beneficiaries. To further and ongoingly incorporate the beneficiary perspective and lived experience into agency policies and structures, we recommend convening regular meetings with advocates for older adults and people with disabilities.

- **Fill Vacancies at the Medicare Board of Trustees**. The two public representatives on the Medicare Board of Trustees provide important and independent perspectives on the state of the program. These positions have been vacant since 2015, violating the intent of federal law and depriving Congress and the public of key objective insights into the health of the Trust Funds. We encourage the Biden administration to swiftly appoint well-suited individuals to these positions.[113]

4. ADDRESS DISPARITIES AND INEQUITIES

Medicare Rights urges the administration to address disparities and inequities in order to improve health care and coverage for all.

Medicare has long been a powerful tool to reduce injustice and inequality. The program played a pivotal role in "forc[ing] the desegregation of every hospital in America virtually overnight" and continues to offer coverage to all who qualify.[114] But inequities remain. Every day, we see the destructive and persistent effects of institutionalized racism, individual bias, and systemic oppression. Medicare Rights welcomes the Biden administration's commitment to addressing these problems directly, in ways that advance equity, justice, and access to care—including by strengthening Medicare, Medicaid, and the Affordable Care Act.

[111] Centers for Medicare & Medicaid Services, "Advancing Care Coordination through Episode Payment Models (Cardiac and Orthopedic Bundled Payment Models) Final Rule (CMS-5519-F) and Medicare ACO Track 1+ Model" (December 20, 2016), https://www.cms.gov/newsroom/fact-sheets/advancing-care-coordination-through-episode-payment-models-cardiac-and-orthopedic-bundled-payment.
[112] 82 Fed. Reg. 180, 430; 82 Fed. Reg. 22895, 22897.
[113] Centers for Medicare & Medicaid Services, "About the Board of Trustees" (last accessed January 13, 2020), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/AboutTheBoard.
[114] Steve Sternberg, "Desegregation: The Hidden Legacy of Medicare" (July 29, 2015), https://www.usnews.com/news/articles/2015/07/30/desegregation-the-hidden-legacy-of-medicare.

Prohibit Discrimination in Health Care

Reverse Harmful Rules and Orders. The interdependent nature of the nation's health care system means that improving coverage and care will not only help individual people and programs, but the system as a whole. The Biden administration must roll back discriminatory policies that perpetuate or widen health disparities and inequities in all programs.

- **Reverse Rules that Permit or Promote Discrimination**. The Trump administration weakened important health care nondiscrimination protections for people with limited English proficiency (LEP) and LGBTQ+ people,[115] and has attempted to roll back rules prohibiting discrimination based on sex, gender identity, sexual orientation, and religion within HHS-funded entities.[116] These harmful changes detrimentally limit care for older adults and people with disabilities of all ages. We ask the Biden administration to rescind these rules as quickly as possible, and to promote access to high-quality care that respects the worth and dignity of all people. Additionally, we ask HHS to engage in new rulemaking that builds on and strengthens the prior interpretation of Section 1557 of the Affordable Care Act[117] and request that the Office of Civil Rights (OCR) clearly vacate its religious conscience rules to ensure that non-discrimination mandates may be enforced.[118]

- **Withdraw Proposed Changes to Social Security Disability Reviews**. The Social Security Administration (SSA) should withdraw its pending rules that would adopt stricter standards for SSI Continuing Disability Reviews (CDRs).[119] There is no acceptable policy rationale for these changes; they would simply make it harder for people with disabilities to obtain and maintain benefits and could limit Medicaid eligibility.[120]

- **Rescind Public Charge Rules**. A new public charge rule greatly expands the government's ability to refuse green cards or visas for legal immigrants who are deemed likely to use public programs including Medicaid, food assistance, and public housing.[121] These changes make it much more difficult for immigrants—especially older adults and people with disabilities—to pursue citizenship, reunite with their families, and access the supports they need to thrive. On our Helpline, we have heard from people that the rule has had a chilling effect, frightening individuals and families away from needed health care and public services even if they are not subject to it. This is dangerous at any time, and even more so during a pandemic. HHS should

[115] CMS Final Rule, "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority" (June 2020), https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.
[116] HHS Proposed Rule, "Office of the Assistant Secretary for Financial Resources; Health and Human Services Grants Regulation" (November 2019), https://www.federalregister.gov/documents/2019/11/19/2019-24385/office-of-the-assistant-secretary-for-financial-resources-health-and-human-services-grants.
[117] Medicare Rights Center, "Comments on Nondiscrimination in Health and Health Education Programs or Activities" (August 13, 2019), http://medicarerights.org/pdf/081319-health-care-rights-law-comments.pdf.
[118] Medicare Rights Center, "Comments on Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (March 27, 2018), https://www.medicarerights.org/pdf/032718-conscience-rights-comments.pdf.
[119] Medicare Rights Center, "Comments on Rules Regarding the Frequency and Notice of Continuing Disability Reviews" (January 31, 2020), https://www.medicarerights.org/pdf/013120-SSDI-SSI-CDR-comments.pdf.
[120] MaryBeth Musumeci, *et al.*, "Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey," Kaiser Family Foundation (June 14, 2019), https://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey/.
[121] 84 Fed. Reg. 41282 (August 14, 2019)

collaborate with the Department of Homeland Security (DHS) to immediately rescind the public charge rule and other discriminatory policies.[122]

Enforce Prohibitions on Discrimination. In many cases, reversing damaging policies is not enough. Additional, new guidance is needed to best clarify and enforce anti-discrimination responsibilities and practices across health programs.

- **Prohibit Discrimination, Including Rationing of Medical Care, Based on Age, Disability, or Other Cultural Characteristics**. In new guidance, we urge the Biden administration to clearly prohibit entities that contract with Medicare and Medicaid from denying medical care or services based on discriminatory grounds. The guidance should specify what constitutes unlawful discrimination on the basis of age, disability, or health condition; race, color, or ethnicity; national origin or English proficiency; sex or gender identity; sexual orientation; and religion in HHS-funded programs.

- **Clarify Nondiscrimination Authorities and Enforcements**. Additionally, we recommend that OCR remind contracting entities of their obligation to prohibit discrimination in the allocation of health care resources in accordance with the Americans with Disabilities Act of 1990,[123] Section 504 of the Rehabilitation Act of 1973,[124] the Age Discrimination Act of 1975,[125] and Section 1557 of the ACA.[126]

- **Reinforce Americans with Disabilities Act (ADA) Protections**. Some insurers may be relying on discriminatory methodologies to make benefit and reimbursement decisions, causing people with disabilities to be denied medical care.[127] Such discrimination is contrary to Title II of the ADA, which prohibits not only discrimination by any public entity, but also exclusion from the benefits of services, programs, or activities of any public entity. These provisions are applicable across the private and public sectors, including for insurance coverage and for programs administered by state and local governments. We ask that OCR issue guidance clarifying that the use of discriminatory assessments is not lawful under the ADA for state-run programs or the private market.

- **Collect Comprehensive Data**. The administration should collect robust data in a non-invasive way, across all health programs, in order to ensure the provision of appropriate, non-discriminatory care and coverage.

[122] Medicare Rights Center, "Comments on Proposed Rulemaking: Inadmissibility on Public Charge Grounds" (December 10, 2018), https://www.medicarerights.org/pdf/121018-2019-dhs-public-charge-rule-comments.pdf.
[123] *See* 42 U.S.C. 12101 *et seq*.
[124] *See* 29 U.S.C. 794
[125] *See* 42 U.S.C. 6101 *et seq*.
[126] *See* 42 U.S.C. 18116
[127] National Council on Disability, "Quality-Adjusted Life Years and the Devaluation of Life with Disability" (November 2019), https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf.

Restore and Improve Medicaid

Restore Medicaid Programmatic Integrity. Medicaid is a critical source of coverage for many Americans, including over 12 million people with Medicare.[128] It has long been associated with a range of positive health behaviors and outcomes, such as increased access to care; improved self-reported health status; higher rates of preventive health screenings; lower likelihood of delaying care because of costs; decreased hospital and emergency department utilization; and decreased mortality rates.[129] We urge the Biden administration to protect and strengthen the program.

- **Recall Medicaid Guidance Targeting State Funding and Reverse Waiver Approvals**. The Biden administration must rescind the January 2020 "Healthy Adult Opportunity Initiative" guidance and clarify its non-application.[130] Doing so is necessary to prevent states from using block grants, per-capita caps, and eligibility restrictions to cut Medicaid rolls and coverage. The administration must also reverse state waivers that were approved under this policy, like the "TennCare" application, which if left in place will lead to reductions in access to care for older adults and people with disabilities.[131]

- **Rescind Policies Burdening Medicaid Recipients**. CMS guidance released in January 2018, "Work and Community Engagement Requirements in Medicaid," allows states to mandate work or other community engagement activities as a condition of Medicaid eligibility.[132] These damaging requirements are administrative obstacles that prevent people from accessing needed care. As such, they have been found by several courts to be contrary to the purpose of the Medicaid program.[133] Yet, CMS has continued to approve these waivers, allowing states to put their residents at risk.[134] The Biden administration must correct this by rescinding the 2018 guidance, rejecting any pending or future waiver applications that seek to implement Medicaid work requirements, remedying or withdrawing approval of existing waivers, and supporting federal legislation that would clarify states' inability to impose such burdens.

- **Reverse Policies that Cut Benefits**. In recent years, HHS has approved 1115 waivers that sanction state efforts to increase out-of-pocket costs for Medicaid enrollees and limit their coverage. These policies—including those that eliminate retroactive eligibility, allow states to charge premiums coupled with lockouts, and require more frequent eligibility

[128] Centers for Medicare & Medicaid Services, "People Dually Eligible for Medicare and Medicaid" (March 2020), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.
[129] Robert Wood Johnson Foundation, "Medicaid's Impact on Health Care Access, Outcomes and State Economies" (February 1, 2019), https://www.rwjf.org/en/library/research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html#:~:text=Of%20all%20types%20of%20health,and%20taxes%20paid%20as%20adults.
[130] Centers for Medicare & Medicaid Services, "State Medicaid Director Letter, RE: Healthy Adult Opportunity" (January 30, 2020), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf.
[131] Medicare Rights Center, "Comments on TennCare Demonstration" (December 27, 2019), https://www.medicarerights.org/policy-documents/comments-tenncare-demonstration-amendment-42.
[132] Centers for Medicare & Medicaid Services, "State Medicaid Director Letter, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries" (January 11, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.
[133] Gresham v. Azar (February 14, 2020), https://www.cadc.uscourts.gov/internet/opinions.nsf/DDBA611EB31A1A218525850E00580F2D/$file/19-5094%20-%201828589.pdf.
[134] Centers for Medicare & Medicaid Services, "Nebraska 1115 Waiver Approval Letter" (October 20, 2020), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ne-hha-ca.pdf.

redeterminations—must not be permitted to continue.[135] Such provisions create barriers to care, undercutting Medicare's core protections and primary purpose.

- **Revoke Changes to Medicaid Maintenance of Effort (MOE) Requirements**. The Families First Coronavirus Response Act (FFCRA) authorized a temporary 6.2% federal medical assistance percentage (FMAP) increase for states that meet certain MOE conditions.[136] CMS originally interpretated those obligations as precluding states from maneuvering people within Medicaid tiers. But the agency recently, and starkly, reversed itself in the fourth COVID-19 Interim Final Rule (IFC).[137] Under the new policy, states may move people from one Medicaid eligibility category to another and remain in compliance with the FFCRA MOE, even if those changes restrict the enrollee's benefits or increase their costs. We oppose this deeply flawed reinterpretation and urge the administration to reverse course.[138]

- **Promote Continuous Medicaid Eligibility**. Many states have made enrolling in or maintaining Medicaid coverage unnecessarily difficult, leading to churn as individuals and families get coverage, miss an arbitrary deadline or filing, lose coverage, and then, often, regain it.[139] This cycle burdens and costs both individuals and providers, and appears designed solely to make it difficult for people to access needed coverage. We ask the Biden administration to work with states to promote a reduction of churn through fewer and more streamlined determination and redetermination processes and annual continuous eligibility.

Ensure Universal Access to Coverage

Protect the Affordable Care Act (ACA). As the COVID-19 public health emergency continues to reveal, the need for health care can arise at any moment and may be the difference between life and death. People without comprehensive health coverage may delay or forgo care, worsening their own and public health outcomes. Those who do seek treatment may face extreme financial hardships, impacting patient, program, and taxpayer costs. The ACA has a critical role in improving access to affordable coverage and care. The Biden administration must fortify the health law against all threats.

- **Safeguard the Affordable Care Act**. The administration must staunchly defend the Affordable Care Act in court and work with Congress to render *California v. Texas* moot.

- **Reverse Policies Promoting non-ACA Compliant Health Plans**. Recent rules have expanded the availability of insurance plans that are not required to comply with the ACA's consumer protections and coverage requirements. These plans can deny coverage for pre-existing conditions, place limits on care, offer benefit packages that exclude critical services. Such schemes threaten to weaken public health, damage insurance markets, and undermine

[135] Paul Shafer, *et al.*, "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible For Coronavirus Treatment Costs" (May 8, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200506.111318/full/.
[136] Families First Coronavirus Response Act, 134 STAT. 208, Pub. Law 116-127 Sec. 6008, (March 18, 2020)
[137] Centers for Medicare & Medicaid Services, "[CMS-9912-IFC] Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (November 11, 2020), https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency.
[138] Medicare Rights Center, "Comments on Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (January 4, 2020), https://www.medicarerights.org/pdf/010421-comments-covid-ifr.pdf.
[139] Emmett Ruff and Eliot Fishman, "The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018" (April 16, 2019), https://familiesusa.org/resources/the-return-of-churn-state-paperwork-barriers-caused-more-than-1-5-million-low-income-people-to-lose-their-medicaid-coverage-in-2018/.

individual health and economic security.[140] We ask the Biden administration to immediately reverse all changes that have made short-term[141] and association health plans[142] more widely available. Future rulemaking should focus on bolstering coverage and consumer protections within these policies.

- **Restore Weakened Affordable Care Act Standards**. In 2018, the Trump administration released guidance reinterpreting the ACA's Section 1332 waivers, encouraging states to pursue changes that could undermine access to comprehensive coverage and care.[143] The Notice of Benefit and Payment Parameters (NBPP) for 2022[144] seeks to codify that guidance.[145] We urge the Biden administration to reject this approach, by rescinding the regulatory language and the underlying State Relief and Empowerment Waivers guidance.

Strengthen the Marketplace and Medicaid. From expanding affordable care to preventing discrimination based on health status, the ACA made significant improvements to the nation's health care infrastructure. We ask the administration to build on the law's successes to further enhance enrollment, access, and affordability.

- **Promote Medicaid Expansion**. Medicaid expansion improves individual and public health—addressing social determinants, diminishing disparities, and improving coverage and access to care—while helping to stabilize state budgets.[146] The Biden administration must do all it can to encourage states that have not yet expanded Medicaid to do so.

- **Increase and Expand Marketplace Subsidies**. We strongly urge working with Congress to make ACA plans more affordable, including by increasing Marketplace tax credits, fixing the "subsidy cliff," and easing access to coverage for families whose employer-based insurance is unaffordable.

- **Ensure Access to Healthcare.gov**. States must maintain strong ACA standards to ensure residents have access to coverage. The Notice of Benefit and Payment Parameters (NBPP) for 2022[147] and Georgia's approved "Georgia Access Model"[148] would do precisely the opposite. The

[140] "Short-Term, Limited-Duration Insurance," 83 Fed. Reg. 38212; "Certain Medical Care Arrangements," 85 Fed. Reg. 35398.
[141] Medicare Rights Center, "Comments on Short-Term, Limited-Duration Insurance" (April 23, 2018), https://www.medicarerights.org/pdf/042318-comments-cms-9924-p.pdf.
[142] Medicare Rights Center, "Comments on Definition of 'Employer' under Section 3(5) of ERISA—Association Health Plans" (March 6, 2018), https://www.medicarerights.org/pdf/Medicare-Rights-DOL-AHP-NPRM-comments.pdf.
[143] Centers for Medicare & Medicaid Services, "[CMS–9936–NC] State Relief and Empowerment Waivers" (October 24, 2018), https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf.
[144] Centers for Medicare & Medicaid Services, "[CMS-9914-P] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations" (November 24, 2020), https://www.cms.gov/files/document/cms-9914-p.pdf.
[145] Medicare Rights Center, "Comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations" (December 29, 2020), https://www.medicarerights.org/pdf/122920-comments-notice-benefit-payment-parameters-2022.pdf.
[146] Hailey Mensik, "Medicaid expansion key indicator for rural hospitals' financial viability" (June 2, 2020), https://www.healthcaredive.com/news/medicaid-expansion-rural-hospitals-health-affairs/579005/ and Jonathan Gruber, *et al*., "Paying for Medicaid—State Budgets and the Case for Expansion in the Time of Coronavirus" (June 11, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2007124.
[147] Centers for Medicare & Medicaid Services, "[CMS-9914-P] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations" (November 24, 2020), https://www.cms.gov/files/document/cms-9914-p.pdf.
[148] Medicare Rights Center, "Comments on Georgia's modified State Relief and Empowerment Waiver proposal under Section 1332 of the Affordable Care Act (ACA)" (September 16, 2020), https://www.medicarerights.org/pdf/091620-comments-georgia-proposed-1332-waiver.pdf.

waiver, and subsequent rule, permit states to deny their residents access to HealthCare.gov as a one-stop shop for unbiased health insurance information and enrollment and force them to rely on private plan and broker sites instead. The NBPP also further reduces Healthcare.gov user fees, which help finance the Marketplace and its consumer safeguards. We support swift action to terminate these harmful policies, as well as a reversal of the Trump administration's 2018 user fee cuts.

- **Restore Navigator Funding and Standards**. We urge increasing funding for navigator services for Healthcare.gov states to 2016 levels, at a minimum, in order to reverse recent cuts. Similarly, we support restoring the minimum number of navigator programs in each federal Marketplace state to two, along with the requirement that navigators maintain a physical presence in their service area.

- **Align Enrollment Periods**. We encourage the Biden administration to ease Marketplace enrollment by aligning the annual open enrollment period start date with that of Medicare's Annual Coordinated Election Period (October 15) and allowing both to run through December 15, and by shifting Medicare's General Enrollment Period to this fall timeline.

- **Strengthen Guardrails for Online Brokers**. In 2017, the Trump administration reduced standards for web brokers that sell Marketplace and non-ACA compliant plans.[149] Recent investigations found that some of these broker sites did not correctly screen for Medicaid eligibility or display plan information in non-biased ways.[150] We recommend tightening both standards and oversight, to ensure that web-broker sites adhere to the same consumer protections and information requirements as Healthcare.gov.

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[149] Centers for Medicare & Medicaid Services, "The Centers for Medicare and Medicaid Services (CMS) announces streamlined direct enrollment process for consumers seeking Exchange coverage" (May 17, 2017), https://www.cms.gov/newsroom/press-releases/centers-medicare-and-medicaid-services-cms-announces-streamlined-direct-enrollment-process-consumers.
[150] Tara Straw, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm" (March 15, 2019), https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes.