February 19, 2019

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: [CMS-9926-P] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020

Dear Administrator Verma:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) **Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020**. 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. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

The many federal programs that provide access to health care coverage are interrelated, and a change to one program affects others. While Medicare is not directly a topic of this proposed rule, the impact of its changes on people who are approaching Medicare eligibility are significant, both for their well-being and that of the Medicare program.

Automatic Reenrollment

CMS notes that automatic reenrollment eliminates an opportunity for consumers to update their coverage and premium tax credit eligibility and asks for comments on the practice. While we support ensuring that people have the opportunity to make proactive coverage choices and we recognize that some consumers who are automatically reenrolled might not be enrolled in the best plan for their circumstances, automatic reenrollment keeps many consumers from ending up without coverage altogether. Automatic reenrollment does not prevent consumers

from choosing their best plan. Because automatic reenrollment only occurs after the enrollment period is closed, it prevents consumers who did not choose from falling through the cracks.

Navigator Program Standards

Much as the State Health Insurance Assistance Programs (SHIPs) provide vital, unbiased assistance to people with Medicare, Navigators educate consumers about the marketplace and Medicaid and assist consumers with enrollment. We oppose actions that reduce the ability of Navigators to effectively assist consumers, including past funding cuts and regulatory changes. Current proposals continue to undermine the consumer assistance requirements of the Affordable Care Act. In particular, we oppose changes to reduce requirements for Navigators to provide post-enrollment assistance, as well as the elimination of training requirements related to serving individuals with limited English proficiency and individuals with disabilities.

According to Kaiser tracking polls, most people, and particularly those who are uninsured, have limited awareness about marketplace open enrollment.[1] Further, consumers seeking help had limited understanding of health insurance as well as the eligibility and enrollment process, and lacked confidence to apply for coverage on their own.[2] Such consumers need the unbiased, thorough support only Navigators can provide. They should not be forced to rely on insurance agents and brokers who may have financial incentives to not act in the best interest of the consumer.

Rather than continuing to curtail the funding and responsibilities of Navigators, the U.S. Department of Health and Human Services should instead increase funding and strengthen the existing requirements.

Special Enrollment Periods

CMS proposes adding a Special Enrollment Period (SEP) for consumers who have off-exchange coverage and become newly eligible for tax credits. An SEP already exists for consumers in this situation with employer-sponsored coverage so the new SEP provides equity for those who do not have such coverage. We support the addition of this SEP.

Prescription Drug Coverage

Prescription drug coverage is a key factor in plan selection for many consumers who are approaching Medicare eligibility, especially those with significant health needs and chronic conditions. Troublingly, the proposed changes to formulary stability would interfere with

[1] Karen Pollitz, Jennifer Tolbert and Maria Diaz, *Data Note: Further Reductions in Navigator Funding for Federal Exchange States*, Kaiser Family Foundation, Sep. 24, 2018, https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-exchange-states/.
[2] *Id.*

consumers' ability to shop and compare plans. Plan formularies must be easily accessible to consumers prior to plan selection, and must be reliable bases for estimating out-of-pocket costs for medications.

If finalized, the proposals would not only allow plans to drop prescription drugs from formularies mid-year but actually encourage them to do so. This would harm consumers, particularly those with significant health needs for whom prescription drug coverage is paramount. Moreover, the proposal to eliminate coverage of brand drugs when a generic becomes available would arbitrarily cap an essential health benefit.

When a generic equivalent version of a brand name drug becomes available, plans should be permitted to add that drug to their formularies to expand consumer options and access to generics, which can be equally effective and less expensive than brand drugs. We strongly disagree, however, with the proposal to allow issuers to remove medications from formularies, which would harm consumers who rely on those drugs and on the assurance of a stable formulary.

In addition, the exceptions process must be bolstered in order to ensure effective access for standard and expedited reviews. Many health care consumers need access to potentially life-saving, non-formulary drugs. These processes will be even more important if mid-year formulary changes are permitted, as proposed. Such changes would put an increased burden both on consumers who rely on brand-name medications and on the exceptions process. Before expanding the role of the exceptions process, we urge a thorough and independent analysis of compliance, utilization, and outcomes, with publicly available data and results. This would ensure the current exceptions process is fully functional and able to meet the needs of health care consumers, particularly those who are approaching Medicare eligibility or who have disabilities, chronic conditions, or other significant health needs.

Conclusion

Thank you for the opportunity to provide comments on the proposed rule. As always, we look forward to working together to advance policies that promote high-value and high-quality care. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Joe Baker
President
Medicare Rights Center