

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 25, 2018

Submitted electronically to CompetitionRFI@hhs.gov

Office of the Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
Baltimore, MD 21244

Re: Request for Information—Promoting Healthcare Choice and Competition Across the United States

Justice in Aging appreciates the opportunity to provide a response to the above-referenced Request for Information (RFI).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

1. Preliminary Matters

Before discussing our substantive comments, we raise two concerns about the RFI itself.

First, we recognize the importance of reviewing how federal rules and policies empower consumers, promote consumer choice, and enhance affordability. We have serious concerns, however, about the combined approach to address these issues in Medicare, Medicaid, and the individual market in the current RFI. While we recognize that RFIs are, by their nature, broader in scope than some other comment opportunities, the breadth of this RFI dilutes much of its value and does not effectively serve our shared goals of strengthening and improving both Medicare and Medicaid, as well as the individual insurance Marketplace.

The impetus and context for this RFI, as evidenced by the discussion preceding the list of five questions posed to commenters, is a review of regulations and policies that affect the commercial market in health insurance, looking particularly at policies implementing the Patient Protection and Affordable Care Act. In the questions, however, HHS asks for responses that include the Medicare and Medicaid program.

We note that the agency's mandate for Medicare and Medicaid and the designs and operations of these programs are vastly different from the commercial market. The Medicare and Medicaid programs each have complex statutory requirements and long histories, including an extensive body of statutory interpretations by the courts. Most importantly, in both programs, HHS has a direct responsibility to beneficiaries (in the case of Medicaid, along with the states) for the delivery of care and its quality, a role that is significantly greater than its oversight of marketplace plans. Proposals for changes in each of these complex programs need to be discussed in this context and we would welcome more focused opportunities to do so.

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Second, we raise a procedural concern. Labeling the RFI as “informal” and choosing not to publish it in the Federal Register could limit public awareness of the RFI, skew the responses, and suppress important feedback from critical stakeholders. It is our experience that Federal Register publication is the best way to ensure a broad response and maximize transparency.¹ We urge its use for issues such as this one where a wide range of stakeholders are affected.

Our comments below focus primarily on regulations and policies for the Medicare and Medicaid programs, and also address Marketplace issues as they affect low-income older adults. We urge HHS to maintain strong federal standards that protect and empower older adults as consumers, regardless of which state they live in, as the key to promoting robustly competitive markets that ensure meaningful access to coverage and care.

2. Substantive Issues

Question 1. What State or Federal laws, regulations, or policies (including Medicare, Medicaid, and other sources of payment) reduce or restrict competition and choice in healthcare markets?

Competition only works effectively when consumers, including Medicare and Medicaid beneficiaries, have the information they need to make informed choices among competing offerings. Current policies in Medicare and the Marketplace are inadequate to ensure access by beneficiaries to information critical to active and accurate decision-making. Beneficiaries need to be able to understand the differences among products offered to them and what those differences will mean for their own particular situations. They also need information on quality and comparative performance by plans. To ensure beneficiary choice, we urge that HHS adopt the following policies:

Improve the Medicare Plan Finder by:

- Allowing for apples-to-apples comparison of all possible plan combinations on one page, including Medicare supplemental policies. The Plan Finder does not put Medigap plans and other supplemental coverage together with Medicare Advantage, preventing side-by-side comparison of all possible plan options and combinations on one page. Beneficiaries may access information about these various options on other pages, but it is difficult to compare them with the Medicare options included on Plan Finder.
- Providing in-depth and more personalized estimated out-of-pocket costs for beneficiaries. For example, the summary results show the range of cost sharing the plan employs, but do not include information about what the cost sharing will be for the beneficiary’s prescription drug list until clicking to see more details. Particularly where coinsurances (rather than copayments) are used, seeing dollar amounts for the range of expected costs on the plan comparison page would be useful.

¹ The Federal Register, for example, offers numerous subscription options so stakeholders can stay abreast of comment opportunities in areas of interest. See www.federalregister.gov/reader-aids/using-federalregister-gov/subscription-options-and-managing-your-subscriptions. In addition to email notification, updates are available by RSS feeds, and through Twitter and Facebook application. Its website also has a robust search function. In addition, the usual practice is that all comments are made available on the website, generally within days of submission.

- Including searchable, up-to-date provider networks and integrated comparative information on supplemental insurance benefits. Currently, the tool provides information about pharmacy networks, but only limited information about provider networks. The Plan Finder directs users to the plan’s website for additional network information; however, plan websites frequently require starting a search from scratch, choosing the correct network that matches the plan, and navigating through multiple webpages instead of linking directly to the provider directory.
- Streamlining the site’s layout and overall design to help beneficiaries easily understand and navigate.

Improve Beneficiary Notices by:

- Individualizing the Medicare Advantage and Part D Annual Notice of Change (ANOC) by including which specific providers are leaving a plan network, which specific prescription drugs are no longer on the plan formulary, and where utilization management tools will be newly applied. Ideally, these customizations should reflect an individual’s actual providers, services, and prescription drugs.
- Finalizing the proposed rule to permit plans to mail the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) separately. This move will reduce confusion and stem information overload for beneficiaries trying to understand whether their current plan is the best choice for a new plan year.
- Sending Chooser Notices to all Low-Income Subsidy (LIS) enrollees who have premium liability. Currently, the Part D LIS Chooser’s Notice is only sent to choosers with new or increased premium liability relative to the previous year. We are concerned about the approximately 300,000 enrollees who have reduced or identical premium liability compared to the previous year and thus do not receive the notice – regardless of the cost. Last year, the group averaged about \$22 a month in premiums, just a little less than the overall average of \$24. For LIS enrollees, \$264 per year can be a significant burden. This small improvement would ensure that the LIS program works more efficiently, and it would give LIS enrollees the tools they need to choose the lowest cost plans, thus increasing their participation in the market and decreasing their financial burden.
- Improving the quality and readability of notices through consistent use of plain language, simplifying content and consumer testing prior to adoption. Continuing its secret shopper surveys and other measures to ensure that plan provider directories are up-to-date and reflect current availabilities of providers.
- Building on the steps taken by the Centers for Medicare and Medicaid Services (CMS) to ensure that Marketplace plan enrollees who are newly eligible for Medicare understand their options. There has been significant confusion among Marketplace enrollees who, after enrollment, become eligible for Medicare. Many have misunderstood their Marketplace subsidy eligibility and made costly enrollment mistakes leading to gaps in coverage, having to repay premium tax credits, and Medicare enrollment penalties. We appreciate that CMS has begun outreach to

these individuals to explain their options and, more recently, extended a special enrollment period for Medicare Part B and relief from Medicare late enrollment penalties. We ask that CMS continue and expand these efforts. Clear and consistent outreach, before an individual becomes eligible for Medicare, would significantly help to avoid these costly mistakes.

Strengthen the SHIP Program and Marketplace Consumer Assistance. Older adults and people with disabilities are particularly in need of one-on-one assistance so that they can make informed active choices for their health coverage. Improved on-line tools are one step but, as statistics recently cited by CMS show, half of older adults do not have internet access.² Internet access and use are even less available to consumers with low incomes or those living in rural areas.³ SHIP counselors, who offer free unbiased assistance in sorting through Medicare choices, help fill that gap.

In many states, SHIPs have also developed relationships with Marketplace Navigators and Certified Application Counselors (CACs) to ensure that older adults have a person they can meet with face-to-face and receive unbiased information and answers to their health coverage questions. Therefore, we strongly urge HHS to restore funding for the Health Insurance Navigator and CAC programs so that older adults have access to free in-person assistance to help them choose coverage that best meets their needs prior to becoming eligible for Medicare.

In addition, we urge HHS to provide more direct training and education to agents and brokers operating in the individual market, particularly with respect to premium tax credits, Medicaid, and Medicare. We believe it is essential that older adults with lower incomes be informed of all of their coverage options regardless of whom they reach out to for assistance.

Increase access to Information on Medicare Advantage and Part D plan performance. To make reasoned choices, beneficiaries need full information on plan performance, including comparative performance.

We support the recent proposal of CMS to change the methodology for assigning star ratings to consolidating plans. We urge the agency to exercise continuing vigilance so that plans cannot game the system through strategically designed mergers and consolidations.

We urge greater transparency with respect to audit results. We appreciate that CMS conducts robust audits of plan performance and has taken significant actions against serious deficiencies that merited intermediate sanction or civil monetary penalties. We also appreciate that those actions are available on the CMS website⁴ and that, in response to advocate concerns, CMS required plans subject to

² Pew Research Center, Tech Adoption Climbs Among older adults (May 17, 2017), available at www.pewinternet.org/2017/05/17/tech-adoption-climbs-among-older-adults/, cited in the recent NPRM on Part C and D regulations, 82 Fed. Reg. 56336, 56433 (Nov. 28, 2017).

³ Pew Research Center, Technology Use Among Seniors (May 17, 2017)(only 27 percent of seniors with incomes less than \$30,000 have broadband access at home and only 46 percent use the internet at all), available at www.pewinternet.org/2017/05/17/technology-use-among-seniors/. Pew Research Center, Home Broadband 2015 (Dec. 21, 2015) (only 55 percent of rural residents had broadband at home in 2015), available at www.pewinternet.org/2015/12/21/home-broadband-2015/.

⁴ Found at www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html.

intermediate sanctions to provide that information prominently on plan websites. To further improve transparency to beneficiaries, we urge the following additional improvements:

- Post civil monetary penalty actions when they are issued. Current practice is to post all of them together in February, after the Open Enrollment Period has closed. Beneficiaries should have timely access to enforcement actions when they occur so that they can use that information as part of their decision-making. Delaying release of this information does not serve fairness in plan competition; rather, it tilts the marketplace by denying beneficiaries timely access to information that could help them distinguish among plan offerings.
- Routinely issue press releases whenever CMS imposes intermediate sanctions or civil monetary penalties. Press releases help ensure that important information actually becomes available to beneficiaries and that plans are held accountable for their performance.⁵

Expand language access for limited English proficient (LEP) beneficiaries. Current CMS regulations governing translation requirements for Medicare Part C and D plans and the agency's policies with respect to its own translation obligations severely limit the ability of LEP Medicare beneficiaries to make informed market choices both among plans and with respect to the fee-for-service Medicare benefit. To address these impediments to a transparent competitive marketplace for all beneficiaries, we ask CMS to work with stakeholders to undertake a comprehensive review of its language access policies, looking particularly at document translation. Priority issues for review and consideration that are particularly relevant to promoting a transparent market include:

- Translating the Medicare & You handbook into languages beyond English and Spanish. Medicare & You is a key resource for individuals to understand their benefits, their choices and their rights. It gives them tools to navigate their choices, but those tools are not available to the nearly two million Medicare beneficiaries who speak languages other than English or Spanish.⁶ While we appreciate that CMS has made efforts to translate some smaller consumer-facing factsheets and brochures into additional languages, the agency also needs to translate vital documents such as the Medicare & You handbook into multiple languages, both to facilitate a transparent and competitive market and to fulfill the agency's statutory obligations.⁷
- Modifying the current translation thresholds that apply to Medicare Advantage and Part D plans, which are set at five percent of the population in the service area, by adding a numerical threshold. The current regulation creates an imbalance in which Medicare Advantage plans serving relatively small populations can have significantly greater translation obligations than

⁵ We note that, in contrast, the HHS Office of Civil Rights routinely issues press releases about its actions regarding HIPAA violations. See HHS OCR Newsroom at www.hhs.gov/hipaa/newsroom/index.html. In September, OCR also issued a press release about a settlement with a nursing home concerning HIV discriminatory practices, www.hhs.gov/about/news/2017/09/08/hhs-office-for-civil-rights-enters-into-agreement-with-oklahoma-nursing-home.html

⁶ See CMS Office of Minority Health, Understanding Communication and Language Needs of Medicare Beneficiaries (April 2017), p. 9, available at www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf

⁷ See 42 U.S.C. §18116 and 45 C.F.R. §92.202.

PDPs with much larger LEP membership. The result is anti-competitive both from the plan point of view and, more importantly, because it leaves so many LEP beneficiaries without needed information in a language they can understand. Including numerical as well as percentage thresholds would lead to more rational results, particularly for PDPs that serve large populous states.

Similarly, we urge HHS to ensure language and disability access to information about Marketplace plan benefits and choices. For individuals to be empowered to make smart choices, they need information they can access and understand. In conformance with civil right laws and regulations, including Section 1557 of the Affordable Care Act, Title VI of the Civil Right Act of 1964 and the American with Disabilities Act, and to address health disparities, HHS should ensure that translations and interpretation services be provided and that individuals with disabilities have full access to plan materials as well to services. We also ask that HHS work with states to set standards for consumer information that require plain language documents. Plain language English-language documents are essential for consumers to understand program choices; further, for effective translations into non-English languages, it is important that the underlying English-language document be simple and understandable.

Ensure that beneficiaries have full access to information on “Original” Medicare. The competitive marketplace in Medicare includes both Original Medicare and Medicare Advantage plans. By statute, Original Medicare is the default option in Medicare⁸ and, though Medicare Advantage plan enrollment has grown, two-thirds of Medicare beneficiaries have chosen to remain in the Original Medicare program. We have observed that some CMS publications provide insufficient information, or no information at all, about the availability of Original Medicare. This interferes with Original Medicare and the Medicare supplemental “Medigap” plans’ ability to compete fairly. The option to choose Original Medicare, with or without a supplemental Medigap plan, must be preserved and promoted equally with Medicare Advantage.

Question 2: What State or Federal laws, regulations, or policies (including Medicare, Medicaid, and other sources of payment) may promote or encourage anticompetitive behavior in healthcare markets?

In responding to this question, we focus first on our deep concern about establishing an appropriate analytical framework for reviewing regulations and the effect on competitive behavior. We urge that HHS, when determining whether laws, regulations or policies encourage anticompetitive behavior, always assess how a particular policy affects beneficiary protections.

Prioritize consumer protection. Protecting consumers from harm and ensuring continued access to quality care must be the highest priority when evaluating any proposed regulatory change. Changes geared to affect the competitive environment must first and foremost serve those bedrock concerns.

In considering any change in regulations and policies, HHS should first closely analyze the potential impact, direct and indirect, on beneficiaries. The regulations currently in place did not emerge in a vacuum. Many, such as the Medicare and Medicaid regulations that accompanied the Nursing Home

⁸ Section 1851(a) of the Social Security Act, 42 U.S.C. §1395w-21(a).

Reform Act, signed into law by President Reagan, responded to serious issues in quality of care, access and, often, instances of very serious beneficiary harm.

HHS should carefully examine the reason that any regulation originally was put in place, and all relevant data and analysis available (Inspector General Reports, Government Accountability Reports, inspection histories, audit findings, CAHPS surveys, etc.) to identify the concerns that prompted the regulation and the extent to which the regulation or policy has been effective. Part of that analysis must be a determination of what alternate mechanisms are in place or could be initiated to ensure that beneficiary protections will be maintained in the face of any change or elimination of a regulation or policy.

Move with caution. To protect beneficiaries, we also ask that HHS move deliberately with care and caution. The Medicare and Medicaid programs have many moving parts and even a small change can have repercussions that are not immediately apparent or expected. Too many moves too fast can endanger beneficiaries. We have seen repeated situations where beneficiaries have suddenly lost access to benefits and services when changes were introduced into the labyrinth of computer systems operated by SSA, CMS and CMS contractors, states and state contractors and regulated entities involved in the Medicare and Medicaid programs. Identifying problems and quickly correcting them can better be achieved when any changes are introduced piece by piece. Multiple simultaneous changes raise the stakes for potentially harmful beneficiary impacts.

Avoid negative financial incentives for beneficiaries. While we strongly support empowering consumers to make the best decisions they can about their own health and care, we are concerned about any changes that would increase costs for beneficiaries. For example, “Consumer Directed Care” models that focus on increasing “skin in the game” for consumers, rather than providing them with information and tools to navigate their care options, do not further the purpose of the Medicare and Medicaid programs. In particular, we urge HHS not to implement models that impose additional cost-sharing on or provide potentially negative financial incentives to beneficiaries as these can encourage people to choose a treatment option that may not be optimal for their health or even forgo treatment altogether. Market-based models should not penalize low-income enrollees based on their employment status, premium payment histories, or inability to keep up with cost-sharing requirements.

Reject the premium-support model. We also are very concerned that, in HHS’s pursuit of choice and competition, the agency is seeking to transform Medicare into a defined contribution, premium-support program. Undoing the current defined benefit system would have a costly and harmful impact on the beneficiary population. Original Medicare offers a guaranteed benefit package which generally ties payments to the specific services beneficiaries use. This ensures all beneficiaries have access to and can choose any doctor accepting Medicare. It also keeps coverage affordable by defraying costs over a large national risk-pool. Under premium support, rather than a guaranteed benefit package, the government would provide a fixed dollar amount – often referred to as a voucher – to all beneficiaries who could then choose among competing private health insurance plans or Original Medicare.

The value of the voucher is typically tied to a general economic index and not to actual health costs, which generally rise faster than other costs. As a result, the price of plans would increase faster than the value of the voucher, which would lead to older adults being priced out of the plan they chose. Right now, people with Medicare can count on obtaining Medicare's package of benefits when paying the premium determined by law. Premiums are the same nationwide, and they typically increase by a percentage each year to reflect growth in Medicare spending (for Part B services) per person.

Moreover, Medicare already allows for beneficiary choice and market-based competition through Medicare Part C. Currently under Medicare, all beneficiaries are generally entitled to the same set of benefits whether they are in traditional Medicare or private Medicare Advantage plans. Medicare Advantage plans have some flexibility to offer different cost-sharing, but are required to at least cover the same benefits as Original Medicare. Premium support proposals generally only require private insurers to cover the same actuarial value of Medicare coverage, not the same benefits.

This can result in insurers crafting plans to appeal to certain customers – whether through particular geographic provider networks or cost-sharing design – and to favor healthy consumers over the chronically ill. If a person wanted a more generous plan (such as seeing any doctor of their choice), they pay the premium difference out of their own pocket. Conversely, plans could potentially offer very low premiums that are attractive to poorer beneficiaries, but which force plan enrollees to pay very high deductibles and copays if they ever get sick. Inevitably, the premium support system would raise premiums and co-pays for people who stay in Original Medicare, because over time more healthier and wealthier beneficiaries would purchase private plans, leaving behind poorer and less-healthy beneficiaries and weakening the Medicare risk-pool. Gradually, a premium support program will make care less affordable for older adults, and threaten the guaranteed benefits upon which they rely. We strongly oppose any attempt by HHS to pursue a defined contribution program in Medicare as it would risk harming beneficiaries without ensuring affordable, high-quality care for all.

Maintain beneficiary cost protections in Medicaid. Policies that restrict Medicaid eligibility, impose additional cost burden on struggling Medicaid beneficiaries through higher premiums or copayments or shrink their access to needed services through restricted provider networks do not advance the purposes of the Medicaid statute. There is little evidence that these methods accomplish their aims and ample evidence that they harm consumers' access to care. Studies have shown that even small out-of-pocket costs reduce access to care, especially for those with low incomes or chronic illnesses.⁹ Going down this route would increase existing health disparities by their disproportionate effect on low-income beneficiaries.

Maintain caps on provider charges. We have related concerns about models that would remove beneficiary cost protections in Medicare that prohibit providers from charging patients more than

⁹ For example, a Wisconsin study found that adding a \$10 premium for Medicaid beneficiaries made them more likely to exit the program. This study also found that it was the premium itself and not the amount of the premium that caused people to leave the program, showing that even small out-of-pocket costs can significantly reduce access to care. Laura Dague, The effect of Medicaid premiums on enrollment: A regression discontinuity approach, *Journal of Health Economics*, (2014), available at <https://ccf.georgetown.edu/wpcontent/uploads/2012/03/Dague-Premiums.pdf>.

the Medicare rate. Such demonstrations would not advance the goals of the Medicare statute and would erode the universality of Medicare coverage by segmenting beneficiaries into those who can afford to pay additional amounts to providers and those who cannot. Many Medicare beneficiaries already spend large portions of their disposable income on out-of-pocket health expenses.¹⁰ They would not be able to afford increased costs for health services, and would have limited negotiating power. A private contract system would largely benefit those with more expendable resources who would be in a position to negotiate, thereby creating a 2-tiered system where those who can afford greater costs have access to more providers, and eroding support for the Medicare program overall. In addition, if providers can privately contract, those beneficiaries who need less common specialty services, but can't afford to pay more, may not have a choice of a Medicare participating providers and may take on unaffordable financial risk. At a time when health disparities are recognized as among the most significant challenges facing our health care system, a move in this direction is only likely to widen existing gaps and hinder efforts to achieve health equity.

Protect Essential Health Benefits requirements that will meet the needs of enrollees. With respect to the individual health insurance market, we recognize and support the traditional authority of states in regulating insurance. However, we believe there should be a strong federal and state regulatory partnership to ensure that Marketplace consumers are protected. We believe that the Essential Health Benefits requirements that mandate coverage for critical services will help attract a sustainable mix of healthy and sick enrollees. Because health status is not static, it is important to require plans to cover the range of services that individuals may need over the course of their lives. In particular, older adults need a benefits package that includes the range of services and treatments necessary to manage their conditions, including prescription drug benefits, substance use and mental health treatments, rehabilitative and habilitative services, and preventive services. Without such a minimum standard of benefits, older adults could find themselves with insurance that does very little to provide meaningful access to care and treatment. Moreover, if insurers can offer more narrow benefit packages, this will segment the market into healthier, younger people in skimpier plans and older adults and others with more significant health care needs in more comprehensive plans, and, in turn, lead to less robust competition. This will drive up health care costs for everyone, but particularly for older adults who need it most.

Work with states to ensure adequate monitoring and enforcement of federal network adequacy requirements and nondiscrimination rules. We urge HHS to work with states to ensure that there is adequate monitoring and oversight to enforce essential non-discrimination and access protections. Given the increased reliance on state network adequacy review (including reliance on accreditation standards), we urge HHS and CMS to work with state Medicaid programs and state departments of insurance to ensure that sufficient capacity exists to conduct these reviews and that review processes are robust enough to ensure plan compliance with important network adequacy requirements. We also

¹⁰ See The Commonwealth Fund, Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status (May 12, 2017), available at www.commonwealthfund.org/publications/issuebriefs/2017/may/medicare-out-of-pocket-cost-burdens.

urge HHS and CMS to work closely with state regulators on best practices for reviewing plans' formularies and other benefits and to monitor compliance with federal nondiscrimination rules.

Question 3. What State or Federal grants or other funding mechanisms (including Medicare, Medicaid, and other sources of payment) reduce or restrict competition and choice in healthcare markets?

Though this RFI is framed primarily around barriers to health providers and health plans resulting from current regulations and policies that reduce competition and choice, many regulatory barriers also directly affect beneficiaries. The funding mechanisms of Medicare and Medicaid include numerous enrollment restrictions and overly cumbersome enrollment procedures that effectively restrict beneficiary choice. We urge CMS to address ways to simplify processes and reduce unnecessary burdens on beneficiaries and to undertake a comprehensive review of those barriers. Proposals for consideration include:

Address Medicare Part D Enrollment Restrictions. The competitive landscape for Medicare Part D is skewed because plans are not required to maintain a drug's retail price throughout the year. Plans can adjust prices based on changed agreements with manufacturers, and they can do so as frequently as every two weeks. The result is that prices can rise mid-year, sometimes quite dramatically. Importantly, price changes are not the result of across-the-board increases by drug companies but, instead, result from particular contractual relations between a plan and drug suppliers. For example, a beneficiary can, during the Open Enrollment Period, choose a plan because its costs for the drugs that the individual needs are significant lower than those of competing plans. Yet, by the beginning of the plan year, pricing may have changed and that plan's prices are significantly higher than competing plans. A month later prices may have changed again. Because of these price gyrations, beneficiaries who made rational market-based choices during an Open Enrollment Period find themselves locked into a plan that, both from a comparative and absolute perspective, is not what they bargained for. The beneficiary is locked in but the plan is not. This is an unequal and unfair bargain that does not promote genuine competition. Yet consumers affected by a major price hike by one plan have no Special Enrollment Period in which to move to a plan that better fit their needs, no transition protections, and no other recourse. Therefore, we recommend CMS relieve beneficiaries of this unfair burden and establish a Special Enrollment Period for individuals adversely affected by a significant change in co-insurance responsibility mid-year.

Improve the Medicaid eligibility determination process. Overly cumbersome state procedures for Medicaid and Medicare Savings Program eligibility create barriers to the smooth operation of the Medicaid program. Income counting requirements, such as determining the value of in-kind assistance and asset counting requirements like requiring separate burial accounts or determining the cash value of small life insurance contracts, are too difficult for many potentially eligible beneficiaries to navigate. CMS has encouraged states to streamline the application process by eliminating overly complicated procedures and instead adopting simpler procedures, such as those used for the Part D Low Income Subsidy. States however have been slow to act. We urge CMS to put additional efforts into working with states and providing technical assistance and best practices in order to streamline and simplify eligibility determinations.

Another area of needless complication in the Medicaid application process is state handling of Medicare Savings Program applications forwarded by the Social Security Administration for LIS applicants. States

are permitted to treat as verified any information that SSA has already confirmed through the LIS review process. Thus states receiving information from SSA can prepopulate MSP applications and only require the beneficiary to provide those few pieces of information not covered by the LIS application. In fact, however, some states do nothing more than send out a blank MSP application to beneficiaries referred by SSA. As a result the beneficial impact of the referral process is not fully realized. Again, CMS and the states together could bring significant improvements.

Improve the Medicaid redetermination processes. Medicaid redeterminations, which vary greatly from state to state, are more complex than they need to be and frequently result in disenrollment of individuals who should continue to qualify for Medicaid or for Medicare Savings Programs. Disenrollment from Medicaid managed care plans and, in some cases, disenrollment from D-SNPs or from fully integrated Medicare-Medicaid plans follows this loss of eligibility. Though the vast majority of these individuals usually requalify eventually, the process disrupts their care and causes administrative and financial disruptions for plans and state Medicaid programs.

Perhaps the most dramatic recent example of these problems is what is happening in Tennessee. In 2017, TennCare, the state's Medicaid program, sent renewal packets to Medicare Savings Program beneficiaries that, including applications and informational materials, came to 98 pages and required beneficiaries to provide up to 17 pages of information. Despite the fact that TennCare had significant information about the individuals from SNAP data and other sources, nothing was prepopulated. Not surprisingly, many beneficiaries were confused and did not return fully completed renewals, leading to many disenrollments of people who continued to meet eligibility requirements but got lost in the system.¹¹

The TennCare situation is especially egregious. Most affected beneficiaries were in MSP programs rather than in Medicaid managed care plans, but it is illustrative of how disruptive a complicated or ill designed redetermination process can be. For beneficiaries enrolled in Medicaid managed care plans, even a disruption in enrollment of a month or two while problems are straightened out can result in interruption of care and sometimes disenrollment from the plan. Plans can lose members through no fault of their own or may end up carrying members while eligibility is in doubt. Smoothing and simplifying redeterminations would serve the interests of both beneficiaries and plans.

Question 4. What State or Federal grants or other funding mechanisms (including Medicare, Medicaid, and other sources of payment) may promote or encourage anticompetitive behavior in healthcare markets?

Over many years, there had been an uneven playing field between Medicare Advantage plans and Original Medicare. HHS payments to Medicare Advantage plans, when considered on a per beneficiary basis, generally were higher than payments made for beneficiaries in Original Medicare. In recent years,

¹¹ There have been many other problems with the TennCare renewals including a failure of the state to record address changes, a failure to send disenrollment notices, and misinformation given to beneficiaries, to name a few. See, e.g., Tennessee Comptroller of the Treasury, Review of TennCare Eligibility Determinations (Dec. 6, 2017), available at www.comptroller.tn.gov/repository/SA/TennCareMemoandReport.pdf; see also Daily News Journal, Seniors left scrambling after TennCare makes cuts to Social Security checks (July 27, 2017), available at www.dnj.com/story/news/2017/07/21/seniors-left-scrambling-after-tenncare-cuts-social-security-checks/479597001/?from=global&sessionKey=&autologin.

legislation has reduced that inequity in Medicare spending between Medicare Advantage and Original Medicare.¹² Unfortunately, these gains in leveling the competitive field have been offset in part by the effects of improper “upcoding” by some Medicare Advantage plans.¹³ When a plan upcodes a member’s diagnosis, it receives a larger payment for that beneficiary than it should. The practice both causes significant losses for the Medicare program and reintroduces distortions in payment levels between Medicare Advantage and Original Medicare. We encourage CMS to vigorously address this practice to ensure program integrity and genuine competition among delivery system options.

We also have concerns that the recent proposed changes to Part C and D regulations give too much flexibility to Medicare plans with too little oversight and offer opportunities for anticompetitive behavior by plans. We are concerned, for example, that CMS proposes to give Medicare Advantage plans significantly greater flexibility in offering supplemental benefits, despite the fact that the Value Based Insurance Design (VBID) demonstration, which would test the concept on a more limited scale, is in its early stages and has not yet been fully evaluated. Further the agency is proposing to abandon the meaningful difference standard for both Part C and Part D plans and also allow segmentation of benefits within a Part C plan service area, all without testing or detailed protections. While we support incremental changes in Medicare regulations and controlled demonstrations to test larger changes, we fear that moving so broadly so fast opens the door to anticompetitive responses that will not be caught or timely addressed. For a further discussion of our concerns, see our comments to the rulemaking, filed on January 16, 2018.¹⁴

Question 5. What suggestions do you have for policies or other solutions (including those pertaining to Medicare, Medicaid, and other sources of payment) to promote the development and operation of a more competitive healthcare system that provides high quality care at affordable prices for the American people?

In addition to the policies described in the responses above, we suggest the following:

Focus on both premiums and out-of-pocket costs when addressing Marketplace coverage affordability. We believe that it is critical to ensure that consumers have access to affordable premiums and manageable out-of-pocket costs. This is particularly important for older adults living with chronic conditions that necessitate greater utilization of the health care system. Ensuring that plans cover a certain percentage of health care costs has been a critical protection to make sure that people living with chronic illnesses and disabilities have access to insurance that has affordable cost sharing. We are concerned that a singular focus on reducing premium costs will create an uneven playing field, and only benefit young, relatively healthy individuals with low health care needs and push higher out-of-pocket costs onto older adults and those living with chronic illnesses and disabilities. We urge HHS to restore

¹² See MEDPAC, Report to the Congress: Medicare Payment Policy (March 2017), available at http://medpac.gov/docs/default-source/reports/mar17_entirereport224610adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.

¹³ See, e.g., GAO, Medicare Advantage: Fundamental Improvements Needed in CMS’s Effort to Recover Substantial Amounts of Improper Payment (May 9, 2016), available at www.gao.gov/products/GAO-16-76, and M. Geruso & T. Layton, Upcoding: Evidence from Medicare on Squishy Risk Adjustment, National Bureau of Economic Research (May 2015), available at www.nber.org/papers/w21222.pdf.

¹⁴ Available at www.justiceinaging.org/wp-content/uploads/2018/01/Part-C-and-D-comments-1-16-2018.pdf.

the actuarial value standards that have protected Marketplace consumers against prohibitively high out-of-pocket costs.

Support consumer-friendly standardized benefit options in the Marketplace. To further enhance consumers' ability to make informed decisions about which plans best meet their needs and to predict their costs, we recommend that insurers be required to offer standardized benefit plans and that those plans primarily use co-payment structures that set specific dollar payments for particular services. Co-insurance based on a percentage of the full charges often conceals the true out-of-pocket cost from enrollees and potential enrollees who usually do not know how much a drug or other service costs and, therefore, have difficulty calculating and comparing the expected costs. This is particularly important for older adults and other individuals living with chronic conditions and disabilities who depend on access to plans with predictable and affordable out-of-pocket costs.

Enforce non-discrimination protections that prohibit discriminatory benefit designs and ensure accessibility. Despite federal regulations and guidance prohibiting plan designs that discourage enrollment of individuals with high-cost conditions, such as individuals living with chronic illnesses and disabilities, Marketplace plans continue to use adverse tiering that prices people living with particular conditions out of the plan. Without strong enforcement of non-discrimination requirements, insurers will continue to utilize benefit designs that penalize individuals living with chronic illnesses and disabilities and prevent them from getting the care they need. We urge HHS to continue to monitor compliance with non-discrimination requirements and to work directly with plans to correct anticompetitive plan designs that discriminate against individuals living with high-cost conditions.

In addition to discriminatory benefit design, there are other ways in which plans can make benefits inaccessible to consumers, creating an inherently unfair market where some consumers do not get the services they bargained for. For example, if a plan member has a disability and the plan network does not include accessible providers or if providers do not have needed equipment, the plan's benefits are effectively unavailable to the member. The results are similar if a plan fails in its obligation to provide needed language services during provider appointments. HHS and the states should cooperate in monitoring, technical assistance and, where needed, enforcement to ensure that plans are meeting their obligations. We note that CMS and other parts of HHS have considerable expertise in both language and disability access issues and we urge the agency to leverage this expertise in providing technical assistance to help Marketplace plans meet their obligations to all their members.¹⁵

Facilitate relationships between health plans and community-based providers. We suggest that CMS and the Administration for Community Living (ACL) continue and expand their efforts to facilitating relationships between health care plans and community-based providers.

We share with CMS the goal that beneficiaries have access and choice in the health care market, including access to networks of providers of quality services. For home and community-based services upon which older adults and seniors and persons with disabilities rely, community-based programs,

¹⁵ See, e.g., Office of Minority Health, The National CLAS Standards, available at minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53; AHRQ, Patients with Limited English Proficiency, available at www.ahrq.gov/teamsteps/lep/index.html; and AHRQ, Re-Engineered Discharge Toolkit, available at www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool4.html#Prep3.

most of which are operated by not-for-profit entities, play a central role. As states have increasingly moved responsibility for long-term services and supports to Medicaid managed care plans, we have seen a number of technical issues arise as community-based providers contracting with participating health plans sought to align business systems that were differently designed and had not worked together before. In some cases, that misalignment resulted in beneficiary harm.¹⁶ Similar issues arose in the Medicare-Medicaid financial alignment initiative.

CMS and ACL played very valuable roles by providing trainings and technical assistance to the parties, both through formal training and through technical assistance.¹⁷ That work helped strengthen the competitive market by ensuring that more providers had the opportunity to participate in plan networks and, importantly, helped make it possible for more beneficiaries to continue to use the services of trusted local providers. There is much more work to be done in this area and CMS, both because it is an honest broker and because of its expertise in program requirements, is uniquely situated to address these issues. We urge that CMS continue to contribute its expertise to train and facilitate.

More generally, we urge CMS to ensure that its regulations and policies in Medicare and Medicaid do not have the direct or indirect effect of discriminating against non-for-profit or community-based providers or health plans.

Conclusion

We appreciate that HHS recognizes the importance of empowering patients, promoting consumer choice, and enhancing affordability, and we urge HHS to prioritize the potential effects on consumers when assessing the impact of changing policies and regulations. Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,



Jennifer Goldberg
Directing Attorney

¹⁶ See Kaiser Family Foundation, Early Insights From Ohio's Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries (May 2015), pp. 20-21, available at <http://files.kff.org/attachment/issue-brief-early-insights-from-ohios-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries>; RTI, "Report on Early Implementation of Demonstrations under the Financial Alignment Initiative," (October 2015), p. 5, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf.

¹⁷ See, e.g., the Business Acumen Initiative for Community-Based Organizations, described at www.acl.gov/programs/strengthening-aging-and-disability-networks/improving-business-practices.