JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

July 12, 2017

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

Submitted via the Federal eRulemaking Portal

Re: CMS-9929-P, RIN 0938-ZB39 -- Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients

Dear Administrator Verma:

Justice in Aging is a national non-profit legal advocacy organization that fights senior poverty through law. Since our founding in 1972, we have worked for access to affordable health care and economic security for older adults with limited resources, focusing especially on populations that have traditionally lacked legal protection.

We appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Request for Information (RFI) on "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients." We share CMS' stated goals of empowering patients and promoting consumer choice, stabilizing the individual and small group health insurance markets, enhancing affordability, and affirming traditional regulatory authority of states with respect to health insurance. We believe that central to these goals are strong federal standards that protect and empower patients as consumers, regardless of which state they live in. We urge CMS to consider our recommendations and comments below to provide meaningful access to care for older adults and promote robust enrollment and competition in the individual health insurance market.

1. **Empowering patients and promoting consumer choice.** What activities would best inform consumers and help them choose a plan that best meets their needs? Which regulations currently reduce consumer choices of how to finance their health care and health insurance needs? Choice includes the freedom to choose how to finance one's healthcare, which insurer to use, and which provider to use.

Over 70 percent of adults ages 50 to 64 have at least one chronic condition[1] and rely on affordable access to care and treatment to keep them healthy. It is critical that the more than three million adults

[1] AARP, Chronic Conditions Among Older Americans, p.11 *available at* assets.aarp.org/rgcenter/health/beyond_50_hcr_conditions.pdf

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ages 55 to 64 who enrolled in Marketplace plans[2] maintain access to plans with quality, comprehensive coverage and that they are empowered with the protections and resources necessary to choose a plan that meets their needs. In particular, we believe that strong consumer protections and quality coverage with the full range of benefits older adults need establishes the foundation to help them live in the community as long as possible and avoid more costly, less person-centered care. To achieve this, we recommend CMS:

- **Support consumer-friendly standardized benefit options to reduce consumer confusion and facilitate access to plans that meet care, treatment, and affordability needs.** We support the standardized options outlined in the 2018 Notice of Benefit and Payment Parameters Final Rule. As we have seen in the Medicare context, consumers struggle when benefit structures are not standardized and they are unable to make apples-to-apples comparisons of provider networks, cost-sharing, and drug formularies.[3] Therefore, in the individual market context, we believe CMS should continue to improve upon the current standardized benefit options and ensure that consumers can compare plans across issuers by requiring issuers to offer standardized plans if they participate in the marketplace.

- **Monitor and enforce transparency requirements and enhance tools that help consumers make informed plan choices**. Transparency of plan information – including ensuring plans provide up-to-date and accurate formularies and provider networks to both prospective and current enrollees – is critical to ensuring consumers have the information they need to choose the best plan. Older adults who often have established relationships with providers and current prescription drug regimens cannot make an informed choice without easy access to this critical information. We are concerned that formularies and provider network information posted online for individual market plans are often outdated or incomplete, both on Healthcare.gov and issuers' own websites. We encourage CMS to enforce current requirements for issuers to ensure their individual market plan information is accurate and up-to-date and to work with issuers to improve on their processes and develop additional tools to make this information more accessible to consumers. Of particular importance is the ability to compare total costs, not just premiums. Thus we urge CMS to continue to improve the Healthcare.gov cost-estimator tool so that consumers can more easily understand how the plans they are choosing among would meet their needs and what their out-of-pocket costs will be throughout the year. The formulary and plan compare tools Medicare has developed demonstrate both the feasibility and value of such tools.

- **Protect consumers from "surprise bills."** We strongly support the rule that will take effect in 2018 that requires plans to provide advance notice to consumers when they receive prior authorization for a service that may be provided all or in-part by out-of-network providers. Such notice helps consumers avoid "surprise bills" by empowering them to choose an in-network

[2] ASPE Issue Brief: HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT, p.25 (March 2016), *available at* aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf

[3] See, e.g., Kaiser Family Foundation How are Seniors Choosing and Changing Health Insurance Plans (May 2014), available at kaiserfamilyfoundation.files.wordpress.com/2014/05/8589-how-are-seniors-choosing-and-changing-health-insurance-plans.pdf.

option when possible. We encourage CMS to work with states to further enhance such protections, especially in emergencies and other instances when a consumer has no in-network options.

- **Invest in consumer outreach and education activities.** Enrollment advertising and assistance is critical to ensure that consumers understand that coverage is available and empowering them to enroll in a plan that best meets their needs. We strongly support continued investment in the Health Insurance Navigator and Certified Application Counselor (CAC) programs, including adequate grant funds to support direct consumer engagement efforts and continued training to build an effective and efficient assister workforce. We have observed the value of the State Health Insurance Assistance Programs (SHIPs) providing in-person assistance for older adults navigating Medicare. In many states, SHIPs have developed relationships with Navigators and CACs to ensure that all consumers, especially 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 CMS to continue to fully support all of these programs.

  In addition, we urge CMS to 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 who they reach out to for assistance.

- **Build on the steps taken by CMS to ensure that members of marketplace plans 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, instituted 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.

- **Ensure language and disability access to information about 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, CMS 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 CMS 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.

2. **Stabilizing the individual, small group, and non-traditional health insurance markets.** What changes would bring stability to the risk pool, promote continuous coverage, increase the number of younger and healthier consumers purchasing plans, reduce uncertainty and volatility, and encourage uninsured individuals to buy coverage?

We recommend the following to stabilize risk pools, promote continuous coverage, and attract younger, healthy consumers to sign up for coverage:

- **Ensure continued commitment to provide cost-sharing reduction (CSR) payments to issuers.** Uncertainty about the Administration's commitment to this important affordability program makes it very difficult for issuers to set rates for the upcoming plan year and is impacting decisions by some issuers not to continue selling products in the marketplace. A strong commitment from CMS to continue CSR payments is critical to bringing stability to the individual market for the 2018 plan year and beyond.

  This program has proven effective to lower deductibles and increase access to care, goals that this Administration shares. CSRs help consumers avoid medical bills that they cannot afford, thereby helping them retain the financial ability to maintain their coverage. Additionally, all consumers, but especially low-income older adults, avoid higher costs such as hospitalizations in the future if they are able to afford routine care and treatment. Avoiding more costly care is a win for both consumers and the health insurance market. The Medicare Part D low-income subsidy program provides a good example; Part D simply would not have worked without the relief it provided to lower income Medicare consumers.

- **Protect Essential Health Benefits requirements that will meet the needs of enrollees.** 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 skimpier benefit packages, this will segment the market—resulting in healthy, younger people and older adults and others with more significant health care needs selecting separate plans and therefore being in separate risk pools. This will drive up the costs of health care for everyone, but particularly for older adults who need it most.

- **Limit the availability of limited benefit and short-term coverage plans.** We do not support changes that would increase the availability of plans that offer limited coverage (either with or without federal subsidies). Prior to the ACA, these types of plans were ubiquitous, providing consumers with little protection when they tried to actually use their benefits. Moreover, we believe allowing these plans would remove young, relatively healthy consumers from the marketplaces, negatively impacting the risk pools for participating issuers.

- **Invest in consumer education, outreach, and enrollment rather than creating barriers or disincentives that keep consumers out of the marketplace.** We recommend CMS focus on attracting as many consumers as possible, including young, relatively healthy individuals, to sign up for coverage through robust outreach and education. This proactive approach to fostering a sustainable risk pool is far preferable to creating barriers to access, such as continuous coverage requirements, waiting periods before effectuating enrollment, pre-existing condition exclusions, and penalties for people who experience a gap in insurance coverage. Such barriers would greatly harm consumers, particularly older adults and those who may be living with disabilities or with serious chronic conditions who are more likely to experience changes in employment and life circumstances throughout the year. Additionally, individuals who need care but are denied coverage due to such rules are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on thus contributing to higher overall costs. Often, particularly for older adults in the marketplace, those costs will fall on the Medicare program when the consequences of those failure in care appear in later years.

- **Extend the open enrollment period and avoid barriers for eligible consumers to use special enrollment periods.** As we have observed, the first to enroll in coverage are those who have the greatest health care needs. We believe that shortening the open enrollment period will weaken the risk pool by providing less opportunity for healthier individuals who are likely less aware of the enrollment period or availability of coverage to sign up. Similarly, those who may qualify for a special enrollment period but who do not have an urgent health care need will be less likely to complete an onerous verification process.

3. **Enhancing affordability.** What steps can HHS take to enhance the affordability of coverage for individual consumers and small businesses?

Because cost is often a barrier to enrollment, we believe that commitment to out-of-pocket maximums, standardized plans with limited deductibles and co-insurance, and strong actuarial value standards are all essential in providing plans that will meet the prevention, care, and treatment needs of consumers. We believe the following policies would help to address affordability:

- **Support consumer-friendly standardized benefit options.** As noted above, we support requiring issuers to offer standardized plan options. To further enhance consumers' ability to make informed decisions about which plans best meet their needs and to predict their costs, we recommend that standardize options primarily use co-payment structures that set specific dollar payments for particular services. We urge limiting the use of co-insurance based on a percentage of the full charges, including for specialty medications. Co-insurance 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 individuals living with chronic conditions and disabilities who depend on access to plans with predictable and affordable out-of-pocket costs.

- **Focus on both premiums and out-of-pocket costs when addressing 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 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 CMS to restore the actuarial value standards that have protected consumers against prohibitively high out-of-pocket costs.

- **Enforce non-discrimination protections that prohibit discriminatory plan designs**. 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, we continue to see plans that utilize adverse tiering that serves to price 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 CMS to continue to monitor compliance with non-discrimination requirements and to work directly with plans to correct plan designs that discriminate against individuals living with high-cost conditions.

- **Ensure that program benefits are accessible to plan members.** In addition to discriminatory benefit design, there are other ways in which benefits can be unavailable to plan members. 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. CMS 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 plans meet their obligations to all their members.[4]

4. **Affirming the traditional regulatory authority of the States in regulating the business of health insurance.** Which HHS regulations or policies have impeded or unnecessarily interfered with States' primary role in regulating the health insurance markets they know best?

We understand the traditional authority of States in regulating insurance and believe there should be a strong federal and state partnership to ensure that consumers are protected. We urge CMS to work with states to ensure that there is adequate monitoring and oversight to enforce essential non-discrimination and access protections. In particular, we urge CMS to consider the following:

[4] 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 ahrq.gov/teamstepps/lep/index.html; and AHQR, "Re-Engineered Discharge Toolkit," available at ahrq.gov/professionals/systems/hospital/red/toolkit/redtool4.html#Prep3

- **For states that have plan management authority and are conducting formulary and non-discrimination reviews, CMS should require states to demonstrate that they are using the federal templates or equivalent tools to monitor compliance with federal rules.** We also urge CMS to work closely with state regulators on best practices for conducting these types of reviews and to monitor compliance, particularly for the 2018 plan year when the role of state regulators in monitoring formulary compliance is much greater.
- **Similarly, CMS should work with states to ensure adequate monitoring and enforcement of network adequacy requirements.** Given the increased reliance on state network adequacy review (including reliance on accreditation standards) for the 2018 plan year, we urge CMS to work with 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.
- **Do not allow insurers to sell health insurance across state lines.** We believe that selling insurance across states lines undermines individual states' authority to regulate the insurance products sold in their own state and states' own consumer protections. Allowing this would lead to risk segmentation and a "race to the bottom" wherein issuers will choose to be regulated in the state with the weakest standards.

Thank you for your consideration of our comments. Please feel free to contact me at JGoldberg@justiceinaging.org with any questions or if we can provide any further information.

Sincerely,

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