JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

January 8, 2019

By electronic delivery to www.regulations.gov

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

Re: CMS-9922-P, Patient Protection and Affordable Care Act; Exchange Program Integrity

Justice in Aging appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the above-referenced Notice of Proposed Rulemaking (NPRM).

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 extensive experience with Medicare, Medicaid, and the Affordable Care Act (ACA), with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Our comments focus on the proposals to change the current periodic data matching processes and add an option to allow consumers to authorize the federally-facilitated health insurance exchange (FFE) to automatically terminate exchange coverage if they are found to be enrolled in Medicare.

Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

The American Health Benefit Exchanges established under the ACA are a vital source of coverage for millions of low- and moderate-income older adults who are not eligible for Medicare or Medicaid. However, many of these consumers have difficulty understanding and knowing when to transition from Qualified Health Plan (QHP) coverage through the Exchanges to Medicare. Too often, older adults who become eligible for Medicare when they turn 65 do not understand their coverage options or that they need to take action and therefore inadvertently decline or delay their Medicare enrollment and stay enrolled in QHPs. We agree with CMS that many consumers who are enrolled in both Medicare Part A and a QHP do not actively choose this or if they did, they were not well-informed about the consequences. Thus, we appreciate CMS's attention to improving periodic data matching (PDM) between the Exchanges and public insurance programs, including Medicare and Medicaid, to include all enrollees, regardless of whether they are receiving advanced premium tax credits (APTCs) or

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cost-sharing reductions (CSRs). Obtaining and sharing this information about concurrent enrollment with consumers could eliminate a lot of confusion about when consumers should disenroll from QHP coverage upon becoming Medicare eligible and help them make informed decisions about their health coverage.

However, we strongly oppose the proposal to allow consumers to authorize the FFE to automatically terminate their QHP coverage if they are found to be concurrently enrolled in Medicare Part A or Part C. We are concerned that this will cause coverage gaps because consumers who are only enrolled in Medicare Part A will not realize that they need to enroll in Part B in order to have comprehensive insurance coverage (or may not be able to enroll immediately in Part B depending on the timing). Individuals without access to a Part B special enrollment period or equitable relief could be without coverage for months or even a year before the next General Enrollment Period and face lifelong late enrollment penalties. Moreover, a more than 63-day gap in coverage could lead to lifelong penalties for Part D premiums as well.

Rather than automatically terminating coverage, we recommend CMS provide direct outreach and assistance to QHP consumers identified by PDM as being concurrently enrolled in Medicare. In addition to providing written notice, some state-based exchanges are connecting these consumers with duplicative enrollment to in-person assisters. We urge CMS to do the same for FFE consumers by having local exchange navigators or State Health Insurance Assistance Program (SHIP) counselors contact them to help them make informed decisions about their coverage.

As CMS recognizes, the current PDM process cannot identify consumers who are eligible for but not enrolled in premium-free Part A. Thus, CMS cannot reach all Marketplace enrollees who are or will be eligible for Medicare. We encourage CMS to develop methods to effectively identify and notify all Exchange consumers who may need to navigate the transition to Medicare. Specifically, CMS should work with the Social Security Administration (SSA) to identify all QHP enrollees who are approaching Medicare eligibility and send PDM notices during the first month of an individual's Initial Enrollment Period for Medicare. Such a notice should clearly explain the steps the consumer must take to enroll in Medicare, the timeline for doing so, the consequences of inaction, and where to go for help. Ideally, CMS would share this information with in-person assisters who would contact these consumers during their Initial Enrollment Period as well. Providing this information and assistance in a timely manner would help QHP enrollees plan ahead of their Medicare effective date and avoid gaps in coverage.

Although we oppose the option for automatic termination of QHP coverage, should CMS choose to move forward with this proposal we recommend extending the 30-day period for the consumer to respond to the notice. This is an extremely short period of time to receive and digest the information and make an informed decision about whether and when to terminate QHP coverage. For example, a consumer will need to find out when they can enroll in Part B or Part C and whether they qualify for a SEP in order to be able to choose to keep their QHP and avoid a gap in coverage.

In addition, if CMS does move forward with this proposal, it should connect consumers identified as being concurrently enrolled in a QHP and Medicare with in-person help, as recommended above. CMS should also clarify whether consumers will be required to answer the proposed Exchange application questions/authorizations related to PDM and the consequences of not answering all or part of these questions. Finally, CMS must test the revised application with consumers prior to implementing it to ensure they understand the authorization questions.

Eligibility Redetermination during a Benefit Year (§ 155.330)

CMS is proposing to require Exchanges to conduct PDM for Medicare, Medicaid/CHIP, and Basic Health Plan enrollment at least twice a year in order to facilitate termination of APTCs and CSRs for consumers who are found to be enrolled in other minimum essential coverage (MEC). While we agree that PDM can help ensure consumers are in the coverage that best meets their needs by informing QHP enrollees who are eligible for Medicaid or Medicare of their eligibility or enrollment, we are concerned that this requirement will lead to erroneous APTC and CSR terminations absent systems to ensure data accuracy and that consumers are actually getting help with their coverage. Medicaid data in particular is not necessarily accurate and up-to-date in every state, and low-income consumers can have frequent fluctuations in income. This means that a Medicaid eligibility determination made in a previous month may not apply to the current month or reflect the consumer's yearly income, which qualifies them for APTCs. These consumers cannot afford QHP coverage without APTCs and therefore would be at risk of coverage gaps if the Exchange terminates their financial assistance based on erroneous or outdated state Medicaid data.

In addition, CMS has not shown that there is a serious problem with duplicative enrollment. Therefore, before moving forward with this proposal, we urge CMS to ensure that state Medicaid programs are capable of providing accurate and timely data and that Exchanges are able to connect consumers who are identified as having MEC to an in-person assister prior to terminating their APTC and CSRs.

Conclusion

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director