January 11, 2017

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3337-IFC
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities--Third Party Payment [CMS-3337-IFC]

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the Centers for Medicare & Medicaid Services (CMS) interim final rule with comment establishing new requirements for Medicare-certified dialysis facilities that make payments of premiums for individual market health plans for patients with End-Stage Renal Disease (ESRD). 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. Each year, Medicare Rights provides services and resources to over two million Medicare beneficiaries, family caregivers, and professionals.

The following comments are informed by our experience assisting individuals with End-Stage Renal Disease (ESRD) and their family members as they navigate the transition to Medicare. Our comments underscore unique enrollment considerations for the ESRD population. For additional information, please contact Stacy Sanders, Federal Policy Director, at SSanders@medicarerights.org or 202-637-0961 and Julie Carter, Federal Policy Associate, at jcarter@medicarerights.org or 202-637-0962.

Medicare Rights is disappointed that CMS has issued an interim final rule without allowing comment on drafts of the rule. We recognize that CMS perceives this issue to be urgent to protect those with ESRD, but this is a complex topic that may significantly affect the coverage, financial health, and choices of these individuals. An open approach with multiple opportunities for comment as options are refined provides the best opportunity for sound policy decisions. We hope this absence of a formal comment period is an anomaly.

Education Provisions: Medicare Rights often counsels people nearing or recently eligible for Medicare who question what they must consider when making decisions about whether and when to enroll in Medicare Part A and Part B. More information and education for all people approaching Medicare eligibility is in everyone's best interests, and those with ESRD have additional considerations that other Medicare-eligible populations do not have. As such, we appreciate and support the provisions in the interim final rule around unbiased education that will

better prepare these patients to make decisions about their coverage. This education is consistent with our previous recommendations to ensure people are able to make appropriate decisions.[1]

Late Enrollment Penalties (LEPs): We are concerned that the final rule does not lay out the complexity of these choices with enough specificity, which can lead to inaccurate perceptions around what rules govern ESRD and what the implications are of these rules for people with ESRD. The rule states:

> For example, individuals who are entitled to Part A and do not enroll in Part B generally will incur a Part B late enrollment penalty when they do ultimately enroll in Medicare Part B. Accordingly, an individual who enrolls in Part A based on ESRD but does not enroll in or drops Part B will generally be subject to a late enrollment penalty should they decide to enroll in Part B later while still entitled to Part A on the basis of ESRD.

The rule's use of "entitled to Part A" may be confusing. In the Medicare statute, "entitled to Part A" is not synonymous with "eligible for," but means a person has met all the requirements to receive those benefits, including applying for them directly or applying for Social Security benefits. It is vital to note that individuals eligible for ESRD Medicare are *only* subject to the Part B LEP if they enroll in Part A when first eligible for Medicare but delay enrollment in Part B.

As outlined in our comments to the agency's Request for Information (RFI) on inappropriate steering, if a person who is eligible for ESRD Medicare delays applying for both Medicare Part A and Part B, no penalty attaches. A person who wishes to delay Medicare because of other coverage can do so and avoid a penalty by choosing not to enroll in Part A and Part B. And if a person with ESRD-based Medicare eligibility makes the mistake of enrolling in Part A only, they may be able to withdraw their application and re-enroll in both Part A and Part B when they wish their coverage to start.

Anti-Duplication: This same potential confusion around entitlement to Part A arises in the anti-duplication section of the rule which discusses the legality of enrolling people with ESRD into individual marketplace plans. The rule states "Section 1882(d)(3) of the [Affordable Care] Act makes it unlawful to sell or issue a health insurance policy (including policies issued on and off Exchanges) to an individual entitled to benefits under Medicare Part A or enrolled under Medicare Part B with the knowledge that the policy duplicates the health benefits to which the individual is entitled."

Again, the distinction between "eligible for" and "entitled to" is vital. "Entitled to benefits under Medicare Part A" means a person has met all the requirements to receive those benefits, including applying for them or for Social Security benefits. A person with ESRD who has not enrolled in Medicare Part A or Part B is not limited by this anti-duplication provision.

In addition, the rule notes that "CMS has, moreover, solicited comments in a recent proposed rulemaking about whether it is unlawful in most or all cases to knowingly renew coverage under the same circumstances." We submitted comments on that proposed rulemaking and here would like to reiterate our belief that the guaranteed renewability provision at 45 CFR § 147.106(h)(2), interpreting 42 USC § 300gg–2, and the anti-duplication provision at section 1882(d)(3) of the Act should be read together to require renewal of individual market

[1] *See* Medicare Rights Center, comments RE: Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans [CMS-6074-NC] (September 22, 2016).

coverage.[2] This reading is consistent with canons of statutory construction, longstanding CMS treatment of State guaranteed renewability requirements, and sound public policy.

Acceptance of Third-Party Payments: We remain concerned about a lack of clarity on an insurer's responsibility to accept third-party payments and would have preferred clear guidance that required insurers to accept such payments when certain guidelines are met. Please refer to our prior comments for specific information on what we believe appropriate guidelines entail.

Steering: Steering is always a concern, and one that Medicare Rights shares, but we continue to believe that decisions must be based on clear evidence of wrongdoing, not on assumptions that people with ESRD must be victims of steering if they maintain individual market coverage. Individual market coverage may be in the best interest of some ESRD patients, but CMS sees the prevalence of such coverage as concerning. The rule notes that "increased enrollment in the individual market among individuals who have ESRD is not in itself evidence of inappropriate provider or supplier behavior," but goes on to state that "these changes in enrollment patterns raise concerns that the steering behavior commenters described may be becoming increasingly common over time." As stated in our prior comments, we would prefer that the agency's policymaking on this issue was informed by clear evidence of steering that inappropriately limits patient choice.

Part B Coverage For Immunosuppressant Medications: In addressing some of the risks people with ESRD may face when delaying enrollment in Medicare, the rule notes that "individuals who receive a kidney transplant may also face higher cost-sharing for immunosuppressant drugs if they delay Medicare enrollment as immunosuppressive drugs are covered under Part B only if the transplant recipient established Part A effective with the month of the transplant."

While it is true that some individuals will have higher cost-sharing if Part B does not cover the drugs, some will find the drugs more affordable. In lieu of Part B coverage, Part D covers these needed medications, and that Part D coverage has an out-of-pocket maximum. Other people will be eligible for the Part D Low-Income Subsidy (LIS/Extra Help). This makes it difficult to know if Part B coverage is better or worse for any given individual, as explained in our prior comments.

Thank you for the opportunity to comment.

[2] *See* Medicare Rights Center, comments RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 [CMS–9934–P] (October 6, 2016).