



January 25, 2018

Submitted electronically via email to CompetitionRFI@hhs.gov

Re: Promoting Healthcare Choice and Competition Across the United States

To Whom It May Concern:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the Request for Information Promoting Healthcare Choice and Competition Across the United States (the RFI). 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 following comments are informed by our experience assisting people as they navigate the Medicare program. In particular, our recommendations draw from multiple years of analysis on the most common challenges facing callers to our national helpline.

For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

General Comments

We would like to begin by expressing our disappointment at the way this Request for Information (RFI) has been published and promoted. The Department of Health and Human Services (HHS) labeled the RFI “informal” and chose not to publish it in the Federal Register. This decision could limit awareness of the RFI, skew the responses, and cause HHS to miss out on important feedback from critical stakeholders. We urge all agencies to be as transparent and open about commenting opportunities as possible in order to gather the most relevant information.

The RFI presents an open-ended question on how to promote health care choice and competition. The RFI states the goal of its mandate is, in part, to “encourage the development of a free and open market in interstate commerce for the offering of healthcare services and health insurance, with the goal of achieving and preserving maximum options for patients and consumers.”

Medicare Rights is always interested in promoting the ability of people with Medicare to make free, open, informed choices about the care they receive, and to have their choices prioritized and respected. We note that a vital component of a free market is information. Indeed, this RFI points to HHS’s mandate to “improve access to and the quality of information that Americans need to make informed healthcare

decisions, including data about healthcare prices and outcomes.” We agree that people with Medicare must be given all the information, tools, assistance, guidance, and protection from bad actors they need in order to make the best choices for their particular, unique, circumstances. We are skeptical about the need for additional choice in the already crowded Medicare and general healthcare marketplace. We are also certain that without significant additional informational, counseling, assistance, and ombudsman resources being invested in and made available to the Medicare population, additional clutter in the healthcare marketplace will not empower people with Medicare to make appropriate health and financial decisions.

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?

Health care is complicated, and health insurance is no exception. Like all forms of insurance, Medicare can be confusing or even overwhelming, especially when a person has chronic illness, limited resources, or a lack of help. Our firsthand experiences on our national helpline suggest that the abundance of offerings in the Medicare Advantage (MA) and Medicare Part D plan space can render decision-making almost paralyzingly complex given the current lack of robust choice aid tools.¹ A series of focus groups conducted by the Kaiser Family Foundation validates this experience, finding “Seniors say they found it frustrating and difficult to compare plans due to the volume of information they receive...and their inability to organize the information to determine which plan is best for them.”² People with Medicare are drowning in information, but it is not always the information they need.

Another analysis determined that “In 2014, only 11% of MA enrollees voluntarily switched from one plan to another between 2013 and 2014...”³ And a similar study showed that only 13% of Part D enrollees switched plans each year.⁴ Inertia is widespread even though changing plans may lead to lower premiums and cost-sharing for MA and Part D enrollees. These programs, and taxpayers, rely on beneficiaries to make informed, savvy choices—in other words, to “vote with their feet”—so that competition can reward plan innovations that work, identify bad actors and problematic behaviors, and reduce both beneficiary and program costs.

As Medicare and health care choices proliferate, the dire lack of quality, useful information becomes more and more punitive. We cannot support proposals that will shift costs to people with Medicare, penalize them for failing to make optimum choices, or otherwise transfer burden onto their shoulders. This becomes especially egregious when people are kept in the dark about what their choices are or what

¹ For helpline trends for 2012-2015, see: “Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center’s National Helpline” (2014), <https://www.medicarerights.org/pdf/2012-helpline-trends-report.pdf>; “Medicare Trends and Recommendations: An Analysis of 2013 Call Data from the Medicare Rights Center’s National Helpline” (2015), <https://www.medicarerights.org/pdf/2013-helpline-trends-report.pdf>; “Medicare Trends and Recommendations: An Analysis of 2014 Call Data from the Medicare Rights Center’s National Helpline” (2016), <https://www.medicarerights.org/pdf/2014-helpline-trends-report.pdf>; “Medicare Trends and Recommendations: An Analysis of 2015 Call Data from the Medicare Rights Center’s National Helpline” (2017), <https://www.medicarerights.org/pdf/2015-helpline-trends-report.pdf>.

² Gretchen Jacobson, Christina Swoope, Michael Perry & Mary C. Slosar, “How are Seniors Choosing and Changing Health Insurance Plans?” Kaiser Family Foundation (May 13, 2014), <http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/>.

³ Kaiser Family Foundation, “Few People Switch Medicare Advantage Plans Each Year, Raising Questions About Whether Seniors Have the Tools and Information They Need To Compare Plans” (September 20, 2016), <http://kff.org/medicare/press-release/few-people-switch-medicare-advantage-plans-each-year-raising-questions-about-whether-seniors-have-the-tools-and-information-they-need-to-compare-plans/>.

⁴ Jack Hoadley, Elizabeth Hargrave, Laura Summer, Juliette Cubanski, & Tricia Neuman, “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?” Kaiser Family Foundation (October 10, 2013), <http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/>.

they will mean. The existing resources are insufficient and must be improved before new complexities and illusory choices are added.

For this reason, it is imperative that we approach added flexibility with care and never assume that the addition of another plan increases actual choice. When additional flexibilities are granted to MA or Part D plans—namely the ability to alter or target benefits—they add complexity to what is already an exceedingly complex program. As it stands, people with Medicare must evaluate MA and Part D plans based on monthly premiums, cost-sharing requirements and benefit tiering, covered services and prescription drugs, provider and pharmacy networks, and utilization controls and restrictions. And, as noted above, research consistently demonstrates that beneficiaries struggle to navigate and maximize their current MA and Part D benefits—due in no small part to this complexity.

Further, as plan offerings become more complex, the Centers for Medicare & Medicaid Services's (CMS) responsibility to provide oversight of plans appears to be less emphasized. But such oversight is an obligation that the agency owes to its beneficiaries and is only increased by increasing complexity.⁵ In addition, strong monitoring and oversight of the MA program guards against discriminatory benefit designs, fraud, waste, and abuse.

People with Medicare, their families, and caregivers require adequate, actionable information about each decision point they face—from enrollment to care planning and appeals to switching to new coverage. A combination of print, online, and individualized, in-person assistance is required to achieve this end.

We support several actions HHS could take to improve the level of assistance and information available to beneficiaries that would help support their informed choices:

- **Support the State Health Insurance Assistance Program (SHIP).** As the only source of free, personalized, unbiased counseling on Medicare coverage options, SHIPs play a key role in empowering people with Medicare. In 2016, over seven million people with Medicare received help from SHIPs.⁶ SHIP counseling encompasses a broad range of areas, including coverage options, fraud and abuse issues, billing problems, appeal rights, and enrollment in low-income assistance programs. As such, SHIPs offer increasingly critical services that cannot be supplied by 1-800-MEDICARE or through web-based and written materials.
- **Require MA and Part D Plan Sponsors to Create a Point of Contact/Liaison for SHIP Counselors.** Within traditional Medicare, SHIP counselors now can contact a particular number at 1-800-MEDICARE to resolve certain issues. Avoiding long hold times and speaking immediately with a knowledgeable, high-level problem solver is instrumental to fixing problems for beneficiaries quickly and at a low cost. We recommend that this same access be provided by MA and Part D plan sponsors.
- **Elevate the Office of the Medicare Ombudsman.** Through casework, the Ombudsman works to resolve beneficiary problems not addressed through 1-800-MEDICARE or other means. The Ombudsman reports to CMS, Congress, and the public about back on systemic challenges facing people with Medicare.⁷ As 10,000 Baby Boomers age into Medicare each day, this office must be adequately resourced and staffed to meet growing needs.

⁵ For more information, *see*, Medicare Rights, “Comments on Medicare Advantage, Medicare Fee-for-Service, and the Medicare Prescription Drug Benefit programs (CMS-4182-P)” (January 16, 2018), <https://www.medicarerights.org/pdf/Medicare-Rights-Center-C-D-Comments-CMS-4182-P.PDF>.

⁶ Susan Jaffe, “Federal Program That Helps Patients Navigate Medicare May Be Cut,” NPR (June 17, 2016), <https://www.npr.org/sections/health-shots/2016/06/17/482392987/federal-program-that-helps-patients-navigate-medicare-may-be-cut>.

⁷ *See, e.g.*, Centers for Medicare & Medicaid Services Office of the Medicare Ombudsman, “FY 2013 Report to Congress” (2014), <https://www.cms.gov/Center/Special-Topic/Ombudsman/2013-Ombudsman-Report-to-Congress-.pdf>.

- **Revitalize the Plan Finder.** While this tool has significantly improved, it still lacks a searchable provider directory that includes both individual practitioners and hospitals. To date, provider network information is not fully integrated in Plan Finder, significantly diminishing its utility for those seeking to compare MA plan options. Clearer information on cost-sharing and coverage for MA supplemental benefits, like dental and vision care, is also needed. Further, we believe CMS should add information on Medigap options to Plan Finder to allow beneficiaries to fully assess the coverage choices available to them. This content should include information on states that allow a guaranteed issue right to Medigap beyond a beneficiary’s initial eligibility.
- **Improve Notices.** Written notices regarding enrollment, plan changes, coverage decisions, appeals, and costs are the most frequent method of communication between Medicare, MA plans, Part D plans, and beneficiaries. Notices should be in plain language, developed with stakeholder participation, tested on consumers, and available in languages other than English.

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?

We believe CMS should advance policies that encourage people with Medicare to make active and informed choices about the coverage option(s) that are right for them, selecting among traditional Medicare, MA plans (including integrated Medicare-Medicaid options), supplemental Medigap policies, and stand-alone Part D prescription drug plans. There must never be a thumb on the scale that would push people with Medicare away from the options that would best serve their needs.

We have identified several ways in which current policy prevents people with Medicare from obtaining quality information on the market and from both choosing and using their benefits effectively:

- **Cumbersome Appeals Processes.** Year after year, the most common trend presented on the Medicare Rights national helpline involves a caller denied a health care service or prescription drug, most frequently by an MA or Part D plan. Slow, unwieldy, unfair, or opaque appeals processes keep beneficiaries in the dark about their rights, their benefits, and inappropriate plan and provider behaviors. This can permit bad actors to flourish in disguise while higher quality options may languish. The top five deficiencies uncovered through CMS’s audits of MA and Part D plans have remained consistent since 2011 and a significant share of these involve the management of denials and appeals.⁸
- **Lack of Oversight.** HHS should enhance audit capacity and increase transparency on enforcement actions. CMS owes a responsibility to Medicare beneficiaries and taxpayers to engage in robust oversight and management of Medicare—including the MA and Part D markets—through multiple means. These include the Star Ratings program, audit and enforcement procedures, and open and ongoing dialogue with stakeholders who represent diverse interests. Each of these tools plays a critical role in ensuring not only that MA and Part D plans are optimally serving their enrollees but also that taxpayer dollars are well spent. Without such robust oversight, high-performance plans have no method to get the recognition they deserve for their excellence, and low-performance plans can exploit the asymmetry of the information sharing to thrive at the expense of people with Medicare and the country at large.
- **Star Ratings that Do Not Reflect Audits.** We continue to strongly urge CMS to ensure that the Star Rating system does not camouflage or minimize plan behaviors that put Medicare enrollees

⁸ Centers for Medicare & Medicaid Services, “2015 Part C and Part D Program Audit and Enforcement Report” (September 6, 2016), https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-andAudits/Downloads/2015_C_and_D_Program_Audit_and_Enforcement-Report.pdf.

at risk. When CMS determines that a plan's conduct poses a serious threat to the health and safety of beneficiaries, CMS should accurately signal this assessment through Star Ratings, providing beneficiaries with a clear tool that helps them fully evaluate and compare health plans. Of particular concern is the repeated finding of the same serious deficiencies in audit scores while Star Ratings continue to rise. To address this imbalance, it is critically important that Star Ratings incorporate audit measures and reflect audit results in meaningful ways, while CMS continues to impose significant sanctions and penalties when serious deficiencies are identified.

- **Proposals that Increase Complexity.** Recent CMS proposals that would add more clutter to the market will likely push even more people with Medicare away from making strong, informed choices. As we discussed above, many people struggle to select among several MA plans and multiple, complex plan variables. A 2011 *Health Affairs* study attributes some degree of beneficiary inertia with having too many plans from which to choose. The authors write, "Our study suggests that the Medicare Advantage program presents an overabundance of choices for elderly beneficiaries, posing a level of complexity far beyond that experienced by the nonelderly." The findings also show that difficulty selecting among MA plans and traditional Medicare is more pronounced among older adults with low cognitive function, such as those in the early stages of dementia.⁹ Ideally, the MA and Part D offerings would become more standardized, not less. This would allow people with Medicare to compare apples to apples fairly and easily as they can do in the supplemental Medigap market.

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?

In addition to rules that privilege MA availability over that of Medigap, recent emphasis on MA creates an uneven playing field between choices about how to access Medicare benefits. We are troubled by what appears to be deliberate downplaying of—or even complete failure to mention—the availability of traditional Medicare in some CMS publications. This interferes with traditional Medicare and Medigap's ability to compete fairly. The ability to choose traditional Medicare, with or without a supplemental Medigap plan, must be preserved and promoted equally with MA.

Moreover, the traditional Medicare program, which places the fewest restrictions or limitations on beneficiaries, must also continue to be the default for those new to Medicare who have not made a different choice for their care.

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?

Medicare should always pay a fair price for quality service. As Baby Boomers age, this burgeoning Medicare population will put new cost pressures on the program. As such, we believe it is in the best interest of both taxpayers and people with Medicare to fairly and efficiently reimburse for care provided by MA plans. Indeed, the purpose of offering MA options is to achieve better quality and lower costs through competition and innovation.

⁹ J. Michael McWilliams, Christopher C. Afendulis, Thomas G. McGuire & Bruce E. Landon, "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking," *Health Affairs* 30:9 (September 2011), <http://content.healthaffairs.org/content/30/9/1786.long>.

Changes to MA payment rates must be transparent, predictable, and gradual to allow health plans to find operational and other efficiencies so rate cuts do not become benefit cuts or premium hikes for their enrollees. MA plans can provide real value, but should not come at the expense of people with Medicare accessing their Medicare benefits affordably.

Bearing these principles in mind, we continue to encourage HHS and CMS to more assertively address inappropriately inflated MA payments resulting from “upcoding” practices such as by revisiting CMS’s prior proposal to exclude at-home risk assessments from the risk score; to continue with the agency’s transition to the use of encounter data to establish MA risk scores; and to ensure bidding and payment for Employer Group Waiver Plans (EGWP) is reflective of those plans’ true costs, as compared to covering similarly situated beneficiaries under fee-for-service Medicare.

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 proposals above, we believe people with Medicare would benefit from changes within the program that would increase their agency to make informed choices, get the care they want and need, and hold plans accountable for problems.

We suggest that CMS:

- **Improve Part D Appeals.** The appeals process is an essential safety valve and we continue to strongly encourage CMS to improve information at the point of sale and to streamline the appeals process. Access to information about the reason for a plan denial—provided at the pharmacy counter—will both eliminate significant beneficiary confusion and limit delays in accessing needed medications. Along these same lines, we strongly support allowing the pharmacy counter refusal to serve as the coverage determination. This would serve the dual purpose of removing a burdensome step for beneficiaries and their prescribers by explicitly stating why the drug is not covered, and by expediting the appeals process for those who need it.
- **Improve Model Development at the Innovation Center.** In order for CMS to create true choice and competition in a market as complex as health care, it must serve as an active gatekeeper and overseer, permitting only models that meet rigorous standards, are likely to improve the health and wellbeing of beneficiaries, and are meaningfully different such that consumers can make reasoned, informed choices to participate. Any reliance on consumers choosing among competing plans or benefits must be accompanied by rigorous information sharing that includes strategies to ensure information is well understood and actionable. Communication about models needs to strike a delicate balance between providing too much information and too little. To make decisions in their best interests, consumers, along with their families and caregivers, need to be able to access meaningful information about their choices, including results and data from current models. Such information should be available both at the outset, when a person is deciding whether to participate in a model, and periodically, as people decide whether to continue participation.
- **Create the Alternative Payment Model (APM) Ombudsman.** In addition, as expressed in our recent comments on the proposed cancellation of the “Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P),” we strongly support CMS’s commitment to creating an APM Ombudsman to monitor the beneficiary experience with existing and emerging Innovation Center models and to serve as a clearinghouse for patient and

consumer information and supports.¹⁰ We applaud the creation of this APM Ombudsman program and urge CMS to move forward with urgency. We expect the APM Ombudsman will play a critical role for MA enrollees in the MA Value-Based Insurance Design (V-BID) program, the Enhanced Medication Therapy Management (Enhanced MTM) demonstration, and any other health plan innovations the agency might pursue. We welcome a dialogue with CMS on how the agency plans to staff the APM Ombudsman office and other key questions about its infrastructure and ongoing engagement with outside stakeholders, like the Medicare Rights Center and other consumer and patient advocates.

- **Test Value-Based Pricing Initiatives to Address Rising Prescription Drug Costs.** Whether covered under Medicare Part B or Part D, unaffordable prescription drugs are among the most persistent and intractable problems we hear about on the Medicare Rights national helpline. We are heartened by initiatives in the private sector—such as indications-based pricing, outcomes-based risk-sharing agreements, and lowered cost-sharing for high-value medications—intended to tie reimbursement and/or cost-sharing to evidence on clinical effectiveness. Medicare Rights encourages CMS to consider testing these concepts in Part D, so long as any such testing is designed with robust consumer and patient input, incorporates adequate beneficiary protections, and ensures that all data, metrics, and outcomes are made fully transparent.

Conclusion

We welcome an opportunity to increase the choice and competition in Medicare through empowering people with Medicare with information, tools, assistance, guidance, and protection from bad actors they need to make the best choices for their particular, unique circumstances. Currently, people with Medicare are more paralyzed than empowered by their choices because of the lack of usable information, tools, and assistance.

If we move to multiply the number of plans and increase the complexity of plan design, we are only limiting further the ability of Americans to make informed health care decisions. Creating a new, infinitely customizable array of plans shifts the burden onto Medicare. We must ensure that people with Medicare are provided with the help they need now, before any added complexity makes this a more difficult lift. Only then can we genuinely say that the market promotes real competition and real choices.

At every step, our goal must be to ensure better health, better coverage, and better care. Beneficiary choice means nothing if beneficiaries do not have the tools to reasonably exercise that choice.

Thank you for the opportunity to comment.



Joe Baker

¹⁰ Medicare Rights Center, “RE: Medicare Program: Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P)” (April 19, 2017), <http://medicarerights.org/pdf/102617-cms-leter-epm-cardiac-ombuds.pdf>.

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