December 21, 2015

VIA ELECTRONIC SUBMISSION

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 [CMS–9937–P]

The Medicare Rights Center (Medicare Rights) is pleased to submit comments on the proposed Notice of Benefit and Payment Parameters for 2017.[1] 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 working with Medicare beneficiaries and their families, particularly those approaching Medicare eligibility as well as individuals who erred while managing the transition to Medicare. Ensuring that older adults and people with disabilities receive appropriate notice and support to navigate the Medicare enrollment process continues to be a top priority for the Medicare Rights Center. For additional information, please contact Casey Schwarz, Senior Counsel for Education and Federal Policy, at CSchwarz@medicarerights.org or 212-204-6271 and Stacy Sanders, Federal Policy Director at SSanders@medicarerights.org or 202-637-0961.

It is essential that people with Marketplace plans nearing Medicare eligibility receive clear information at the appropriate time in order to make an informed decision about nearing Medicare enrollment. For Marketplace enrollees, honest enrollment mistakes can lead to lifetime premium penalties, gaps in coverage, disruptions in access to needed care, and/or tax penalties. As such, we urge CMS to develop a comprehensive system to screen, notify, and educate people with Marketplace coverage approaching Medicare eligibility about Medicare enrollment rules and obligations.

While our comments focus primarily on individuals with Qualified Health Plans (QHPs), people with Small Business Health Options Program (SHOP) plans who are approaching Medicare eligibility face a similarly complex Medicare enrollment process, yet have different considerations than those in the individual market. In addition, policies concerning access to premium tax credits and Medicare enrollment differ for people who can apply for Medicare due to End Stage Renal Disease (ESRD) and for those who are ineligible for premium-free Part A.

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 [CMS–9937–P] 45 CFR Parts 144, 146, 147, 153, 154, 155, 156, and 158 (pg. 156)

As such, it is critical that CMS design a notification and education strategy that ensures tailored messages reach targeted populations. Below we outline key messages critical for specific populations.

According to a March 2015 study by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), nearly 75,000 individuals ages 65+ were enrolled in individual market Marketplace plans from November 2014 through February 2015.[2] Further analysis is needed to assess the risks to these individuals, including how many receive premium tax credits, how many are also Medicare enrolled, how many continue to remain eligible for premium tax credits due to ineligibility for premium free Part A, and how many unknowingly missed their initial Medicare enrollment window. The same study found that one quarter of Marketplace enrollees (3 million people) are ages 55-64. It is imperative that CMS develop a strategy to ensure this sizable population is prepared to transition to Medicare, while also exploring policy options to assist those in the Marketplace who may have already erred by delaying Medicare enrollment.

Medicare Enrollment Rules and Long-Standing Notification Gaps: Making an informed decision about whether and when to enroll in Medicare remains a complicated task for many individuals because it requires them to identify and understand a complex set of rules, along with the implications of these rules for their personal situations. Of the 15,000 questions fielded annually on the Medicare Rights national helpline, year after year, the second most common issue presented concerns Medicare enrollment.[3] Many of these callers are retirees and people with disabilities facing higher health care costs, gaps in coverage, and barriers to care continuity resulting from honest enrollment mistakes.

No federal agency is responsible for notifying people new to Medicare who are not already collecting Social Security benefits about enrollment rules and obligations. These individuals receive no specific prompt about the need to actively enroll in Medicare and what factors to consider as part of that decision-making. This void represents a stark information gap for consumers who naturally look to the government for instructions and information about their Social Security and Medicare benefits.

As approximately 10,000 people become Medicare eligible on a daily basis, facilitating seamless transitions to Medicare is vital to protecting the health and economic security of older adults and people with disabilities. Enhanced beneficiary notification and education is essential, including notifications and education transmitted through the Marketplace.

Unique Considerations for Individuals Transitioning from QHPs to Medicare: People enrolled in QHPs must manage additional complexities as they near Medicare eligibility. To successfully navigate the switch from a QHP to Medicare, a person turning 65 who has not yet taken Social Security retirement benefits must:

- Actively enroll in Medicare Part A and Part B;
- Cancel their QHP—giving the plan "reasonable notice;"[4]
- Notify the Marketplace about their Medicare eligibility to ensure termination of premium tax credits; and
- Choose among Medicare coverage options, including a Part D prescription drug plan

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[2] Department of Health and Human Services (HHS) Office of the Assistant Secretary of Planning and Evaluation (ASPE), "Health Insurance Marketplaces 2015 Open Enrollment Period," (March 2015), available at: https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf

[3] Sutton, C., Bennett, R., Sanders, S., and F. Riccardi, "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline," (2013), available at: http://www.medicarerights.org/pdf/2012-helpline-trends-report.pdf; Morales, S., Bennett, R., and S. Sanders "Medicare Trends and Recommendations: An Analysis of 2013 Call Data from the Medicare Rights Center's National Helpline," (2014), available at: http://www.medicarerights.org/pdf/2013-helpline-trends-report.pdf

[4] "Reasonable notice" is understood to be two weeks. 45 CFR 155.430 (d).

Despite these responsibilities, Marketplace enrollees not already collecting Social Security benefits receive no notice about nearing Medicare eligibility. In addition, they receive no notice that that their premium tax credit eligibility will end when they become eligible for Medicare. Yet, failure to follow through on these obligations—or mis-timing them—can result in significant gaps in coverage or gaps in effective coverage, high out-of-pocket premium costs, delayed Medicare effective dates, lifetime Medicare premium penalties, and tax penalties.

Individuals with QHPs who are auto-enrolled in Medicare Part A and Part B (including people with disabilities who reach the end of their two-year waiting period and individuals turning age 65 who are collecting Social Security retirement benefits) face similar challenges. They too must cancel their Marketplace plan and notify the Marketplace about their Medicare eligibility for the purposes of cancelling premium tax credits. Yet, while these individuals receive notice about Medicare enrollment, they are not informed about the loss of premium tax credits.

As such, because Part B is a voluntary benefit, we witness many cases where an individual inadvertently declines Part B—assuming that they will retain affordable access to their Marketplace plan. We regularly observe that the lack of information about the loss of premium tax credits can directly result in delayed access to adequate coverage and lifetime Medicare enrollment penalties for individuals who mistakenly turn down Part B.

Given this, while we continue to believe that all individuals approaching Medicare eligibility must receive notice and information about their enrollment rights and responsibilities, we also support more narrow efforts that reflect the particular needs of QHP enrollees and the opportunity for targeted communication through the Federal and State Marketplaces.

Essential Messaging for Marketplace Enrollees Nearing Medicare Eligibility: We encourage CMS to develop a comprehensive system to notify individuals in the Marketplace about nearing Medicare eligibility. Ideally, this system would include multiple types of notification and educational content that is appropriately timed ahead of an individual's Initial Enrollment Period (IEP) for Medicare. Below we outline potential notices and educational messaging critical to facilitating seamless transitions for individuals approaching Medicare eligibility.

As referenced in the proposed rule, "pop-ups" on Healthcare.gov: We suggest that this content "pop up" for both those seeking a Marketplace plan who will turn 65 during the plan year and for those who will reach their 25th month of disability coverage in the upcoming year. These "pop-ups" should:

- Inform people that they need to learn more about Medicare;
- Refer to appropriate sources, including SSA.gov and State Health Insurance Assistance Programs (SHIPs); and
- Provide information about how Medicare eligibility affects eligibility for premium tax credits

While we agree that online "pop-ups" are a useful tool, we do not believe "pop-ups" will be sufficient to provide advance notice to individuals about nearing Medicare eligibility given the complexity of the Medicare enrollment process, particularly for those transitioning from the Marketplace to Medicare.

Notice(s) for QHP enrollees becoming Medicare eligible due to age or disability that includes:

- Clear and directive language that asserts it is generally not advisable to keep a QHP and delay Medicare enrollment or decline Medicare Part B;
- Clear information about the termination of premium tax credits (with noted exceptions);
- A full explanation of the possible consequences of delayed Medicare enrollment;
- A full explanation on how to disenroll from the QHP upon becoming Medicare eligible;
- Information on Medigap insurance, emphasizing guaranteed issue rights and open enrollment periods;

- Information on Medicare Advantage and Part D enrollment periods; and
- Information on Medicare Savings Programs and the Low Income Subsidy (Extra Help)

Notice(s) for SHOP plan enrollees becoming Medicare eligible due to age or disability that includes:
- Clear and detailed language about coordination of benefits rules, with an emphasis on employer size;
- Information on the availability of a Part B Special Enrollment Period (SEP);
- Information on how to assess whether the SHOP plan's drug coverage is creditable under Part D;
- A full explanation of the possible consequences of delayed Medicare enrollment;
- A full explanation on how to disenroll from the plan upon becoming Medicare eligible or during a SEP;
- Information on Medigap insurance, emphasizing guaranteed issue rights and open enrollment periods;
- Information on Medicare Advantage and Part D enrollment periods; and
- Information on Medicare Savings Programs and the Low Income Subsidy (Extra Help)

We also strongly encourage CMS to explore developing specific notices and/or educational content for populations with unique Medicare enrollment considerations. Specifically, CMS should provide targeted information to QHP enrollees who are becoming eligible for Medicare but who are ineligible for premium-free Part A. These individuals need information on their ability to retain premium tax credits and on the possible consequences of delayed Medicare enrollment. They also need assistance identifying potential avenues to secure access to premium-free Part A, such as through state Part A buy-in programs or the Qualified Medicare Beneficiary (QMB) program.

In addition, QHP enrollees with End Stage Renal Disease (ESRD) need notice and educational content that explains that a person with ESRD newly eligible for Medicare must *forgo* Medicare in order to enroll in a QHP. These individuals also need information on their ability to retain premium tax credits (so long as an individual does not apply for Medicare). There are many reasons an individual with ESRD might opt to retain or enroll in a Marketplace plan rather than apply for Medicare, including access to trusted healthcare providers, more favorable coverage rules, and more affordable cost sharing. As such, individuals with ESRD need adequate notice and information to determine whether or not applying for Medicare is the right healthcare decision for them.

Finally, we encourage CMS to thoughtfully consider the kind of notice and educational content that needs to be made available to individuals in Marketplace plans who are *currently* Medicare eligible, as opposed to those *approaching* Medicare eligibility. As suggested by the findings of the March 2015 ASPE report, there may be individuals currently enrolled in QHPs who missed critical Medicare enrollment deadlines.[5]

For example, we encourage CMS to explore the feasibility of using a Periodic Data Matching (PDM) program for Medicare eligibility, like that recently conducted for Medicaid and the Children's Health Insurance Program (CHIP). We believe the notification process used in the Medicaid/CHIP PDM program could be helpful for Marketplace enrollees who are Medicare eligible and should no longer be receiving premium tax credits.[6] These individuals should receive information as soon as possible on the potential loss of premium tax credits, on the Medicare General Enrollment Period (GEP), and on potential avenues for relief, including screening for Medicare low-income assistance programs and the equitable relief process. In particular, we strongly recommend that these individuals be referred to their state SHIP for personalized assistance.

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[5] Department of Health and Human Services (HHS) Office of the Assistant Secretary of Planning and Evaluation (ASPE), "Health Insurance Marketplaces 2015 Open Enrollment Period," (March 2015), available at: https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf

[6] Centers for Medicare and Medicaid Services, "Periodic Data Matching in the Federally-facilitated Marketplaces (Marketplaces) FAQ," (2015), available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Periodic-Data-Matching-FAQ-92815.pdf

Additionally, SHOP enrollees who are Medicare eligible need information on the Part B SEP, on how to assess whether their SHOP coverage is creditable to Part D prescription drug benefits, and on federal coordination of benefits rules specifically concerning whether their SHOP coverage is primary or secondary to Medicare based on the size of their employer. It is vital to ensure that individuals currently in the Marketplace who are Medicare-eligible receive Medicare enrollment information as soon as possible.

Provide Clarification on Coordination of Benefit Rules: Adequate messaging development for the groups described above requires that CMS clarify how QHPs interact with Medicare. We appreciate the clarifications provided by CMS in the August 2014/June 2015 "Frequently Asked Questions Regarding Medicare and the Marketplaces."[7] Yet, we continue to press the agency to release guidance on what QHPs are required to pay—or permitted not to pay—when an individual has a QHP and is eligible for or enrolled in some or all parts of Medicare.

Unlike for employer-sponsored health coverage, there is no federal law regarding the order of insurance payments for individual health coverage and applicable state law varies. Specifically, consumers need to know what their QHP will or will not pay if they delay or decline enrollment in Part B. Clear information on this issue is particularly important given that many States have adopted model coordination of benefits rules that allow individual market health plans to pay secondary to Part B for eligible individuals, even if that person is not enrolled in the benefit.[8] It is increasingly important for CMS to weigh in on these policies, as we are recently hearing that some QHPs are in fact refusing to pay primary benefits in these situations.

Clarification on how QHPs coordinate with Medicare—specifically concerning what plans are obligated to pay—is critical to ensuring that consumers are adequately informed about how to manage the transition to Medicare. Clear information concerning how QHPs will coordinate payment with Medicare, both for those eligible and for those enrolled, should be incorporated in notices and educational content developed by CMS to promote smooth transitions from the Marketplace to Medicare.

Deliver Notices via the Federal Marketplace and State Marketplaces: We strongly prefer that any notice related to nearing Medicare eligibility for Marketplace enrollees come from the Federal or State Marketplace. People look to the Marketplaces for information about their health coverage options, and it is vital that information about Medicare obligations come from a trusted, unbiased source. Where necessary, we encourage the CMS to partner with other federal agencies, like the Social Security Administration (SSA), on the development and delivery of advance Medicare enrollment notices for Marketplace enrollees.

For example, we were encouraged by recent action by SSA to send a notice to people with disabilities in their two-year waiting period for Medicare alerting them to the availability of Marketplace coverage.[9] While this notice directs people to the Marketplaces and gives them important information about tax benefits, it does not include any information about an individual's obligations when they become eligible for Medicare. We encourage CMS to work with SSA to build on this notice and to create other such notices to inform people approaching Medicare eligibility about Medicare enrollment rules and the risks of declining Part B.

Should resource limitations limit the ability of the Federal and State Marketplaces to deliver the needed notification, we may support policies that leverage QHPs to notify Marketplace enrollees about nearing Medicare

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[7] Centers for Medicare and Medicaid Services (CMS), "Frequently Asked Questions Regarding Medicare and the Marketplace," (August 2014; June 2015), available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html

[8] NAIC, "Coordination of Benefits Model Regulation" (October 2013), available at: http://www.naic.org/store/free/MDL-120.pdf

[9] Notice unavailable online, reads: "Social Security Administration, Important Information… Good news! We are writing to tell you about programs that help you get health insurance and help you work and earn more money…" (2015)

eligibility. We caution, however, that any such policy must be carefully designed, including both flexible staging and timing to ensure notices are sent when they are likely to be acted upon.

Further, careful review by CMS is needed to ensure that notices do not improperly steer enrollees to an issuer's Medicare Advantage products. In addition to information on Medicare enrollment rules, it is essential that individuals nearing Medicare eligibility receive clear and unbiased information about all of their Medicare coverage options, including Medicare Advantage and Medigap plans, as well as information on how to access low-income assistance programs, including the Medicare Savings Programs and Extra Help.

In order to develop a thoughtful strategy for effective information dissemination, we urge CMS to collect and promote best practices among both health plans and State Marketplaces already doing this education. Importantly, we encourage CMS to actively engage multiple stakeholders—including consumer advocates, health insurers, and States—as the agency develops policies to notify Marketplace enrollees about nearing Medicare eligibility.

Finally, we recommend that any consumer-directed content be appropriately vetted, through input by key partners as well as through robust focus group testing. We strongly encourage CMS to take into account diverse format and language needs as it considers avenues to provide appropriate notice to this population.

Screen for Medicare Eligibility and Other Key Programs: In addition to notification, we believe screening can serve a critical role in alleviating transition challenges, by identifying individuals at risk of mismanaging their Medicare transition or who have already potentially mismanaged this transition. We believe the Federal and State Marketplaces should screen for Medicare eligibility (as they do for Medicaid and CHIP) to appropriately direct individuals who are already eligible for Medicare to SSA for enrollment. While we know the Marketplace screens for Medicare eligibility for the purposes of calculating premium tax credits, that screening does not translate into notification about Medicare enrollment rules or referral to the appropriate entity, and may not stop enrollment, even when the anti-duplication provisions are applicable.

We also urge CMS to ensure that States are completing comprehensive screening and referral programs for all individuals who lose eligibility for expansion Medicaid as a result of Medicare eligibility but who may be eligible for other Medicaid programs, including Medicare Savings Programs. We also recommend that CMS encourage State Marketplaces to explore opportunities to extend the "no wrong door" enrollment concept advanced through the Affordable Care Act to newly eligible low-income Medicare beneficiaries. For example, State Marketplaces could facilitate screening and referral for Medicare Savings Programs and traditional Medicaid eligibility categories. Over time, State Marketplaces could also fold enrollment and application processes for these programs into their existing systems.[10]

[10] See Goggin-Callahan, D., "Lessons from New York: Building a Better Medicaid Eligibility and Enrollment System for Duals," (New York State Health Foundation: September 2012), available at: http://nyshealthfoundation.org/uploads/resources/lessons-from-new-york-building-a-better-medicaid-eligibility-and-enrollment-system-for-duals.pdf