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Centers for Medicare & Medicaid Services
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RE: Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans [CMS-6074-NC]

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) regarding inappropriate steering of individuals eligible for or receiving Medicare and Medicaid benefits to individual market plans. 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 serves over two million beneficiaries, caregivers, and professionals through its national helpline and educational programming annually.

Our response to this request is informed by our experience assisting individuals and their family members as they navigate the transition to Medicare, including for those aging into the program, those becoming eligible due to receipt of Social Security disability benefits (SSDI), and for those with End Stage Renal Disease (ESRD) who may apply for Medicare. Given that the RFI was accompanied by a letter to dialysis providers, our comments underscore unique enrollment considerations for the ESRD population.

Medicare enrollment decisions are complex and individually driven, and we consistently find that many current and newly eligible beneficiaries lack complete, unbiased, and accurate information about their options and about the potential consequences of their enrollment choices. Through our national helpline and educational programming, Medicare Rights regularly counsels beneficiaries and family caregivers who are overwhelmed and confused by an array of complex enrollment decisions.

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Our comments seek to define the challenges facing individuals in specific Medicare enrollment circumstances, identify questions that can be clarified through CMS action, and recommend areas of focus for investigation and oversight to reduce the risk of behaviors that inappropriately limit individuals' free, informed choice of the coverage that best suits their needs. We strongly agree with CMS that “[e]nrollment decisions should be made, without influence, by the individual based on their specific circumstances, and health and financial needs.”¹

As such, we encourage CMS to identify strategies to distinguish “steering” behaviors from appropriate education and counseling and encourage monitoring and oversight by the agency focused on egregious behaviors. Additionally, we recommend that CMS provide clear guidance on third-party payment premium programs and suggest criteria for the non-profit programs that we believe health plans should appropriately accept payment from to promote access and affordability among low-income and vulnerable populations, such as people with ESRD.

If you have questions about our comments or require additional information, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961 or Casey Schwarz, Senior Counsel for Education & Federal Policy, at cschwarz@medicarerights.org or 212-204-6271.

Medicare Enrollment Decision Factors Differ by Population/Eligibility: 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/or Part B. Critically, these considerations differ for those who are eligible based on age (those ages 65 years or older) and based on the receipt of Social Security disability benefits (SSDI) than for those who may be eligible because they have End Stage Renal Disease (ESRD). Medicare enrollment, secondary payer, and supplemental insurance rights and rules dramatically differ for these two groups: (1) age-based/SSDI-based Medicare and (2) ESRD Medicare.

As such, the consequences of various enrollment decisions also differ. The RFI identifies several potential consequences for newly eligible Medicare beneficiaries who choose to delay or decline Medicare enrollment, some of which have different impacts depending on the reason for Medicare eligibility. To ensure clear communication to newly eligible beneficiaries facing these decisions, and also to identify the risks to individuals of potential steering activities, we outline and discuss these considerations below.

Receipt of Advance Premium Tax Credits (APTC): The RFI states that, “If an individual receives the benefit of APTC for a month he or she is eligible for minimum essential coverage, the individual (or the person who claims the individual as a tax dependent) may be required to repay some or all of the APTC at the time such person files his or her federal income tax return.”² It is important to note that the Internal Revenue Service (IRS) defines what it means to be eligible for minimum essential coverage where that coverage is government-provided insurance, like Medicare.³ To be considered

¹ Centers For Medicare & Medicaid Services (CMS), Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans, 81 Fed. Reg. 57554, 57555, August 23, 2016.

² 81 Fed. Reg. 57555.

³ 26 CFR 5000A(f)

eligible for minimum essential coverage under Medicare, a person must be enrolled in Part A, or be deemed to have enrolled because “only administrative” requirements for enrollment have not been met.⁴

Notably, in the examples and illuminating guidance, two groups are not considered to be eligible for minimum essential coverage unless and until they apply for and enroll in Medicare, including (1) those who do not have the requisite working quarters to be considered “fully insured” and who must pay a premium for Part A and (2) those whose application for benefits depends on a the government’s determination of their health status—people who may be eligible for Medicare due to ESRD.⁵

For these two groups, people who have ESRD and may be eligible and people who are eligible for Medicare but must pay a premium for Part A, the IRS guidance directs that they may keep APTCs until they actually enroll in Medicare Part A or the agency makes a favorable determination of eligibility.⁶ Therefore, individuals who fit into these categories are an important exception to the general rule that people who are “eligible,” in a colloquial sense, for minimum essential coverage may not receive APTCs.

Sale of Individual Market Coverage to People with Medicare: The RFI states that, “...it is unlawful to enroll an individual in individual market coverage if they are known to be entitled to benefits under Medicare Part A, enrolled in Medicare Part B, or receiving Medicaid.”⁷

While the statuses of “enrolled in Medicare Part B or receiving Medicaid” have their plain meaning in the section of the law the RFI seems to be referring to here—42 U.S.C. 1395ss(d)(3)(A)(i)—the phrase “entitled to benefits under Medicare Part A” has a particular definition in the statute that is distinct from the commonly used definition of entitled. 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.⁸

As such, a person who has not enrolled in Medicare Part A or Part B is not limited by this provision. This understanding is longstanding and is consistent with several CMS publications and “Frequently Asked Questions (FAQ) Regarding Medicare and the Marketplace.”⁹ People who do not have Medicare, even if they might be able to enroll, may be sold insurance in the private market.

Medicare Part B Late Enrollment Penalties: The RFI notes that, “Importantly, those eligible for Medicare may be subject to late enrollment penalties if they do not enroll in Medicare when first eligible

⁴ In general, an individual is treated as eligible for minimum essential coverage under a government-sponsored program if the individual meets the eligibility criteria for coverage under the program. However, the Commissioner may define eligibility for minimum essential coverage under specific government-sponsored programs in additional published guidance. *Id.* at 1.36B-2(c)(2)(i). Notice 2013-41, 2013-29 I.R.B. 60,

⁵ Notice 2013-41, 2013-29 I.R.B. 60,

⁶ *Id.*

⁷ 81 Fed. Reg 57556.

⁸ 42 USC. 426; 42 USC. 426-1

⁹ Centers for Medicare and Medicare Services “Frequently Asked Questions Regarding Medicare and the Marketplace” https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf, *see* A14, B2, B3.

to do so.”¹⁰ This statement, while accurate with regard to age-based Medicare or SSDI-based Medicare, is incomplete with regard to people who may be eligible for ESRD Medicare.

As outlined in the Programs and Operations Manual System (POMS) guidance to Social Security employees processing Medicare enrollments, individuals eligible for ESRD Medicare are only subject to the Part B Late Enrollment Penalty (LEP) if they enroll in Part A when first eligible for Medicare but delay enrollment in Part B; if, on the other hand, the same individual delays applying for both Medicare Part A and Part B, no penalty attaches.¹¹

This is particularly important for beneficiaries who may be eligible for ESRD Medicare to understand as there is no Special Enrollment Period (SEP) available to individuals who have ESRD Medicare. If such an individual wishes to delay Medicare while their employer-based or other insurance is the primary payer during the 30-month coordination period (as discussed below), they can only do so and avoid a penalty by declining both Part A and B as outlined in the POMS.¹² It is important to note that the POMS also outlines how a person with ESRD Medicare can, having made the mistake of enrolling in only Part A, withdraw their application and re-enroll in both Part A and Part B when they wish their coverage to start.¹³

The rules described above for people with ESRD are dramatically different for people eligible for age-based Medicare or SSDI-based Medicare, most of whom cannot decline Part B without substantial consequences, including but not limited to the Part B LEP, but who can enroll in Part A and delay Part B if they have access to a SEP as the result of being covered by insurance related to their or their spouse’s current employment.¹⁴

As described above, the considerations related to the Part B LEP differ significantly for those eligible for age-based or SSDI-based Medicare compared to those eligible for ESRD Medicare. This distinction must be considered when communicating to newly eligible Medicare beneficiaries about what to consider pertaining to Medicare enrollment.

Repayment of Social Security Cash Benefits to Forgo Medicare Part A: As the RFI notes, “Individuals who become eligible for Medicare based on receipt of Social Security benefits based on age or Social Security Disability Insurance must forgo and if received, repay their Social Security cash benefits if they wish to decline Medicare Part A benefits.”¹⁵

It is important to note, however, that those who are eligible for age-based Medicare but who are ineligible for premium-free Part A and those who are eligible for ESRD Medicare are not entitled to any cash benefits and may therefore delay or decline Part A without having to repay such benefits. People who are

¹⁰ 81 CFR 57556.

¹¹ Social Security, Program & Operational Manual System, HI 00801.197, HI 00801.247, <http://policy.ssa.gov/poms.nsf/lnx/0600801197>, <http://policy.ssa.gov/poms.nsf/lnx/0600801247>

¹² POMS HI 00801.191, <http://policy.ssa.gov/poms.nsf/lnx/0600801191>

¹³ POMS HI 00801.197

¹⁴ POMS HI 00805.275

¹⁵ 81 Fed. Reg. 57556.

eligible for age-based Medicare but who are ineligible for premium-free Part A may, however, face a Part A LEP for any time that they were eligible for Medicare but not enrolled in Part A.¹⁶

Part B Coverage For Immunosuppressant Medications: The RFI states that individuals who “...have a kidney transplant while enrolled in the individual market plan will not be eligible for Medicare Part B coverage of their immunosuppressant drugs if they enroll in Medicare at a later date.” While generally true, we consider this statement to be incomplete.

First, this limitation on Part B coverage is only accurate if the person is enrolled in an individual market plan alone. If the person has both Medicare and an individual market plan, then Part B will cover immunosuppressant prescription drugs during future Medicare enrollments (age-based or SSDI-based) even if the transplant takes place during the 30-month coordination period while the individual market plan is paying primary and before Medicare becomes primary.¹⁷

Second, although Medicare Part B will not cover immunosuppressant prescription drugs if the person was not enrolled in Medicare at the time of their kidney transplant, Medicare will still cover these needed medications, albeit under Medicare Part D.¹⁸ For some individuals, like those with supplemental Medigap coverage or other secondary insurance, Part B coverage may be lower cost. For others, however, Part D coverage of immunosuppressant drugs may be more affordable as a result of the Part D out-of-pocket maximum or because they are eligible for the Part D Low-Income Subsidy (LIS/Extra Help).

Medicare Secondary Payer Rules: Though not directly addressed by the RFI, an additional and significant reason that people who are eligible for age-based or SSDI-based Medicare should usually not delay enrolling in Part B concerns the order of insurance payments and their insurers’ obligations to pay as primary or secondary. Under federal coordination of benefits rules, only insurance that results from an individual’s or their spouse’s current work for a large employer (for example, defined as 20+ employees for age-based Medicare) pays primary to Part B for a person with age-based Medicare.¹⁹

Under National Association of Insurance Commissioners (NAIC) model coordination of benefits rules, adopted in more than 40 states, other forms of insurance, including group health plans provided by small employers and individual market plans, may refuse to pay altogether or may make only limited payments if the person is eligible for but not enrolled in Part B.^{20,21} Furthermore, as discussed above, people who are enrolled in Medicare are not eligible for APTCs, therefore the cost of individual insurance that will

¹⁶42 USC § 1395i-2.

¹⁷ Centers for Medicare and Medicaid Services “Outpatient Drugs: Examples of Drugs Covered under Part B”

<https://www.medicare.gov/coverage/prescription-drugs-outpatient.html>

¹⁸ Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit Manual, <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/chapter6.pdf> Appendix C.

¹⁹ The rules differ slightly for SSDI-based Medicare, where employer-coverage from current work by the beneficiary, their spouse, or their family member is primary if the employer has more than 100 employees; 42 U.S.C. 1395y(b)(1)(A) & (B)

²⁰ NAIC Model Rules, Section 5D(2). <http://www.naic.org/store/free/MDL-120.pdf>

²¹ Medicare Rights continues to press CMS to provide clarity on the treatment of individual market Qualified Health Plans (QHPs) under federal/state coordination of benefits rules. See 2017 NBPP comments. We appreciate that the agency solicited comment on this issue in the proposed 2018 NBPP.

provide only secondary coverage is a consideration for people eligible for age-based or SSDI-based Medicare who are considering keeping private insurance after they become eligible for Medicare.

The rules that govern this coordination of benefits and allow private plans to pay as secondary to Medicare in some circumstances are different for people who have ESRD Medicare.²² Rather than depending on the source of the insurance (from current work) and employer size, for ESRD Medicare coordination of benefits rules require a 30-month period during which the “other” payer is primary, after which Medicare takes over as primary payer.²³ This time-based, rather than source-based, determinant of primary payer status means that people who are eligible for ESRD Medicare have different considerations with regard to both enrolling in Medicare and with regard to retaining other insurance after their Medicare eligibility.²⁴

Medicare Coverage Options: Another issue not directly addressed in the RFI concerns differing access to coverage options for people newly eligible to Medicare. People who are eligible for age-based, SSDI-based, and ESRD Medicare have differing access to insurance options to limit their exposure to high out-of-pocket costs once they are enrolled in Medicare, dramatically affecting the affordability of Medicare coverage.

People who are eligible for Medicare due to age have the most options, including Medigap standardized supplemental coverage to cover the cost sharing associated with most Part B covered services and prescription drugs and Medicare Advantage (MA), whereby private insurers can offer reduced out-of-pocket costs in conjunction with managed care networks and sometimes additional services. MA plans also have an out-of-pocket maximum limit—a cap on a person’s annual cost sharing expenses.

People with SSDI-based Medicare can enroll in an MA plan, but have no federal right to purchase a Medigap plan that would allow them to access the open network of the Original Medicare program without significant out-of-pocket risk. Only 30 states provide people with SSDI-based Medicare rights to purchase a Medigap supplemental plan at all.²⁵

The options for people with ESRD Medicare are even further limited. These individuals have no federal right to purchase a Medigap plan, and some states that extend such rights to SSDI-based Medicare beneficiaries explicitly exclude people with ESRD.²⁶ Generally, people with ESRD Medicare are also excluded from enrollment in MA plans. These restrictions mean that a person with ESRD who enrolls in Medicare—even a person who was receiving financial assistance in the Marketplace—faces unrestricted out-of-pocket costs in Medicare and virtually no pathway to insure against these high costs.

That people with ESRD altogether lack affordable Medicare coverage options provides important context

²² 42 U.S.C. 1395y(b)(1)(C)

²³ *Id.*

²⁴ See POMS HI 00801.247 <http://policy.ssa.gov/poms.nsf/lnx/0600801247>

²⁵ Kaiser Family Foundation, “Medigap: Spotlight on Enrollment, Premiums, and Recent Trends,” April 2013.

<https://kaiserfamilyfoundation.files.wordpress.com/2013/04/8412-2.pdf>

²⁶ *Id.*

for the questions and policy options considered in the RFI. While we recognize that CMS is not positioned to directly address these long-standing inequities, it is critically important that the agency acknowledge the unique considerations facing the ESRD population as it develops policies to protect patient choice, facilitate informed consumer decision-making, identify and minimize inappropriate steering, and clarify policies related to third-party premium payments.

Identifying and Minimizing Inappropriate Steering: As described above, the nuanced considerations that individuals new to Medicare must grapple with highlight and reinforce the importance of CMS' focus on preserving individual decision-making. We strongly agree that people should not be inappropriately steered in or out of coverage in ways not well suited to their health and financial needs.

We continue to maintain that most people eligible for Medicare—namely age-based or SSDI-based—who are currently enrolled in individual market Marketplace plans should enroll in both Medicare Part A and Part B. As described above and as referenced in the RFI, most individuals eligible for Medicare face significant risks when they maintain individual market coverage. Yet, there are important exceptions to this rule—including people eligible for ESRD Medicare and those ineligible for premium-free Part A—for whom enrollment rules and affordability considerations significantly differ.

As such, we encourage CMS to examine, monitor for, and oversee the actual behaviors that may constitute “steering” by health care providers, issuers, and other entities. Importantly, we encourage CMS to name behaviors that constitute “steering” and to clearly differentiate those behaviors from appropriate counseling and education about Medicare coverage options. For example, anecdotally, Medicare Rights has heard about behaviors that are clearly inappropriate, including enrolling people into individual market plans without their knowledge or consent to increase provider payment rates and implying that a private health plan will be terminated if a person with ESRD does not apply for Medicare.

In addition, we encourage CMS to develop clear guidance and review enrollment materials provided to individual market plan enrollees by health plans, providers, and third-party payment entities to ensure that complete, unbiased information is made available from trusted sources like 1-800-MEDICARE, the State Health Insurance Assistance Program (SHIP) networks, Navigators, and so forth. Further, the agency should establish clear mechanisms for issuers, health care providers, beneficiaries, and consumer advocates to report inappropriate messaging and tactics, such as through reporting to CMS Regional Offices, the Medicare Ombudsman, and other such existing resources. Creating a mechanism for reporting and tracking problematic behaviors will also help CMS to quantify the scope and source of this problem, rather than relying on anecdote and accusations between parties with conflicting financial interests.

Finally, the agency's concerns about potential “steering” of people eligible for Medicare reinforces Medicare Rights continued insistence that the federal government do more to provide enhanced notice and support to individuals who are approaching Medicare eligibility.²⁷ The surest way to ensure that people are not inappropriately steered by incomplete or biased information is to provide them with complete, accurate, and neutral materials to assist their independent choice.

²⁷Medicare Rights Center, Enrollment Sign-on Letter, <http://www.medicarerights.org/pdf/121114-medicare-enrollment-signon-letter.pdf>

As such, it is essential that people new to Medicare receive unbiased, accurate information about Medicare enrollment rules and their coverage options. We continue to believe that individuals who are nearing age 65 should receive advance notice from the federal government explaining Medicare enrollment rules and the potential consequences of delayed enrollment. Further, we believe that advance notice for people eligible for SSDI-based Medicare can be significantly improved, as can educational content and tools for people with ESRD who may apply for Medicare. As reflected in the RFI and the discussion above, access to unbiased information about Medicare enrollment rules is essential to the health and well-being of people new to Medicare.

On this topic, we greatly appreciate the agency's recent efforts to notify Federally-Facilitated Marketplace enrollees approaching age 65 (through email) and to identify and notify individuals over age 65 dually enrolled in the Marketplace and Medicare (in writing) about eligibility concerns related to APTCs through a pilot program.²⁸ We strongly encourage the agency to identify mechanisms to notify those approaching age 65 with written notice and to incorporate those nearing eligibility for SSDI-based Medicare and ESRD Medicare in future phases of the pilot program where possible.

To complement and strengthen these administrative efforts, we encourage the agency to review and support the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (H.R. 5772; S. 3236). The BENES Act would permit cooperation and data sharing among the IRS, the Social Security Administration (SSA), and CMS to provide advance notification to people nearing eligibility for age-based or SSDI-based Medicare on considerations related to Medicare enrollment.²⁹ The BENES Act also modernizes and simplifies Part B enrollment periods and equitable relief processes created when Medicare was first signed into law more than fifty years ago.

Recently, H.R. 5772/S. 3236 was endorsed by more than 70 national and state organizations representing older adults, people with disabilities, health insurers, and health care providers as well as eight former Administrators of CMS and the Health Care Financing Administration (HCFA) dating from 1978 – 2011.³⁰ Medicare Rights is eager to work with the Administration to ensure the provisions of the BENES Act can be carried out in the most cost-effective manner possible and with minimal administrative burden.

Needed Guidance on Third-Party Premium Payments: We encourage CMS to provide clear guidance on third-party payment types and strategies that are appropriate and allowable. Guidance about what constitutes an appropriate third-party payment will provide certainty to individuals relying on non-profit organizations to afford their medical and other health expenses, the charities themselves, and health plans. Importantly, this guidance should establish clear rules for the administration of third-party payments for premiums and cost sharing that protect and promote free choice.

²⁸ Centers for Medicare & Medicaid Services, Periodic Data Matching, <https://marketplace.cms.gov/technical-assistance-resources/medicare-periodic-data-matching.pdf>; Centers for Medicare & Medicaid Services, Fact Sheet: Notices <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html>

²⁹ This legislation does not include individuals who have ESRD who may be eligible for Medicare, if they apply, because of the challenges related to indentifying this pre-application population.

³⁰ Medicare Rights Center, Over 70 Groups Urge Lawmakers to Support Bill to Simplify Part B Enrollment, <http://blog.medicarerights.org/70-groups-urge-lawmakers-support-bill-simplify-part-b-enrollment/>; Medicare Rights Center, Former Medicare Administrators Endorse the BENES Act, <http://blog.medicarerights.org/former-medicare-administrators-endorse-benes-act/>

Non-profit organizations that provide this assistance could be required to:

- Register and report on all activities;
- Have existing and clear application procedures and financial need-based criteria (and, if applicable, criteria for assessing a specific diagnosis or disease condition);
- Provide assistance for any coverage choice as determined by the individual receiving the assistance, including Marketplace and other commercial insurance plans, Part B, Medigap (where available), Medicare Advantage, and Part D premiums and cost sharing;
- Restrict donors from any involvement in the administration of the assistance program;
- Submit to neutral training of advisors and vetting of consumer-directed materials; and
- Provide assistance for a full coverage year.

With appropriate protections, like those noted above, we encourage CMS to require Marketplace plans to accept third-party payments from non-profit organizations that meet the stated criteria. In addition, we encourage CMS to identify clear mechanisms by which issuers, health care providers, consumer advocates, and beneficiaries themselves can refer potential improper behaviors or payment structures that do not meet the criteria set forth by CMS.