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December 13, 2016

President-Elect Donald Trump
1717 Pennsylvania Avenue NW
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Dear President-Elect Trump:

Though Medicare was not a dominant theme in the 2016 election, the future of the program is an important issue for the incoming Administration. The U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have many tools at their disposal to protect and strengthen Medicare and to ensure that the people who rely on it can maximize their earned benefits.

Therefore, I am writing on behalf of the Medicare Rights Center (Medicare Rights) to identify administrative policy recommendations intended to help people with Medicare more successfully navigate the program. Our organization submitted these same recommendations to Congressional leadership, and we encourage you to work with members of Congress to advance these goals. 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.

We serve over two million beneficiaries, family caregivers, and professionals through our national helpline and educational programming each year. Our organization's purpose is to safeguard Medicare and its beneficiaries, and our direct experience with people with Medicare reinforce the need to make the program simpler and easier to navigate through better information and streamlining of program rules and coverage. We believe this goal is consistent with concerns heard throughout the election season about the responsiveness of government to people's needs and would make an important contribution that most Americans would value.

As an organization that represents all people with Medicare, we believe it is critically important that the incoming Administration seek to preserve and improve both Original Medicare as well as private Medicare Advantage (MA) options. While enrollment in MA continues to grow (31%), the majority of the 57 million people enrolled in Medicare receive their benefits through Original Medicare.[1] As the new Administration

[1] Kaiser Family Foundation, "Fact Sheet: Medicare Advantage," (May 2016), available at: http://kff.org/medicare/fact-sheet/medicare-advantage/

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develops policy, we urge a balanced approach that advances innovations in both MA and Original Medicare. We agree wholeheartedly with your repeated sentiment that, "[Medicare] is actually a program that works great,"[2] and we believe the program's fundamental guarantee and structure should be preserved.

We also strongly believe that the economic status of our nation's older adults and people with disabilities provides important context for all Medicare policymaking. Most people with Medicare live on low and fixed incomes. Half of all people with Medicare live on annual incomes of $24,150 or less, and one in four live on $14,350 or less. Additionally, most people with Medicare lack sufficient savings. Half of all people with Medicare have $63,350 or less in savings, 25% have $11,900 or less, and 8% have no savings whatsoever.[3]

Year after year, a common trend heard on the Medicare Rights national helpline involves callers who simply cannot afford their out-of-pocket health care costs. As a result, far too many go without needed care. For this reason, Medicare Rights does not support policy proposals that shift additional costs to people with Medicare. We will continue to evaluate proposed policies for this effect and any others that we believe, given our experience and knowledge of Medicare and its beneficiaries, will not facilitate increased access to affordable, high-quality care for our nation's older adults, people with disabilities, and their families.

Taking this context into consideration, along with other trends heard among people served by Medicare Rights, we offer the following recommendations to the new Administration and encourage swift action in 2017:

Simplify Medicare Part B Enrollment

A persistent challenge heard on Medicare Rights' national helpline concerns Medicare Part B enrollment for those newly eligible. While many individuals are automatically enrolled in Medicare because they are receiving Social Security benefits, an increasing share of those newly eligible must actively enroll in the benefit. Knowing whether and when to enroll in Medicare Part B requires that a person understand when to sign up during time-limited windows, how their current insurance will work with Medicare, and what penalties may result if enrollment is inappropriately delayed. The consequences of missteps can be significant and often lead to a lifetime of higher Part B premiums.

In 2014, 750,000 people with Medicare were paying a Part B Late Enrollment Penalty (LEP) and the average LEP amounted to nearly a 30% increase in a beneficiary's monthly premium.[4] In addition to this considerable penalty, many retirees and people with disabilities face significant out-of-pocket health care costs, gaps in coverage, and barriers to care continuity resulting solely from honest enrollment mistakes.[5]

All people approaching Medicare eligibility deserve timely, clear, and complete information about how and when to sign up. Through the 2015 White House Conference on Aging, CMS and the Social Security Administration (SSA) took tangible steps to improve basic education about Medicare enrollment, including

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[2] C-SPAN clip (December 2015), available at: https://www.c-span.org/video/?c4564634/donald-trump-social-security

[3] Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries—2014 – 2030," (Kaiser Family Foundation: September 2015), available at: http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030/

[4] P. Davis, "Medicare: Part B Premiums," (Congressional Research Service: August 2016), available at: https://www.fas.org/sgp/crs/misc/R40082.pdf

[5] See, S. Jaffe, "Don't Skip Medicare Coverage For Doctor Visits, Even If You Have Other Insurance," NPR, December 2016, available at: http://www.npr.org/sections/health-shots/2016/12/10/504953764/dont-skip-medicare-coverage-for-doctor-visits-even-if-you-have-other-insurance

through a revised Social Security statement and the creation of an employer webpage with content for human resources professionals.[6] **We urge the incoming Administration to expand on this progress as follows:**

- Provide advance notice to those not auto-enrolled about when and how to enroll in Medicare Part B;
- Adequately fund outreach and education on existing CMS resources for employers;
- Seek public input on how to improve the "Welcome to Medicare" packet for those auto-enrolled in Medicare, as reflected in Section 17003 of the 21st Century Cures Act of 2016;[7]
- Update standard COBRA notices to include Medicare enrollment information[8]; and
- Continue efforts to notify Marketplace enrollees about when and how to enroll in Medicare.[9]

We also urge the incoming Administration to work with Congress to pass the bipartisan Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (H.R. 5772 and S. 3236). The BENES Act is supported by more than 70 national and state organizations representing older adults, people with disabilities, insurers, and health care providers and by eight former Administrators of the Health Care Finance Administration (HCFA) and CMS from both Republican and Democratic administrations.[10] The BENES Act simplifies the Part B enrollment system—unchanged since Medicare was created more than 50 years ago—by addressing shortcomings in notification, enrollment windows, coverage start dates, and beneficiary safeguards.[11]

Ensure Active and Informed Beneficiary Choice

From both a counseling and policy perspective, Medicare Rights remains firmly committed to empowering older adults and people with disabilities to make an active and informed choice about the Medicare option that is best for them, selecting among Original Medicare, MA plans, supplemental Medigap policies, and stand-alone Part D prescription drug plans. Policies designed to ensure that each of these coverage options is affordable and able to fully meet beneficiary needs, such as payment rates, monitoring tools, and consumer protections, are critical.

Guaranteeing active, informed, and meaningful beneficiary choice should be a priority for the incoming Administration, particularly given evidence that demonstrates how infrequently people with Medicare compare their coverage options. While year-to-year changes in MA and Part D plan premiums, coverage rules, networks, and cost sharing are commonplace, most people with Medicare do not review their options, even when a switch

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[6] White House Conference on Aging (WHCOA), "What You Need to Know First about Enrolling in Medicare," (July 2015), available at: https://archive.whitehouseconferenceonaging.gov/blog/post/white-house-conference-on-aging-what-you-need-to-know-first-about-enrolling-in-medicare.aspx; Cavanaugh, S. "Helping You Help Your Employees with Medicare," (CMS: September 2015), available at: https://blog.cms.gov/2015/09/25/helping-you-help-your-employees-with-medicare-enrollment/

[7] See, Section 17003, 21st Century Cures Act of 2016 at: http://docs.house.gov/billsthisweek/20161128/CPRT-114-HPRT-RU00-SAHR34.pdf

[8] See, U.S. Department of Labor, Employee Benefits Security Administration for the COBRA Model Notice and the COBRA Model Election Notice at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra

[9] See, CMS, "Press Release: Strengthening the Marketplace – Actions to Improve the Risk Pool," (June 2016), available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html and CMS, "Medicare Periodic Data Matching," (August 2016), available at: https://marketplace.cms.gov/technical-assistance-resources/medicare-periodic-data-matching.pdf

[10] See, BENES Act endorsement letters at: http://www.medicarerights.org/pdf/CMS-Admin-Support-Ltr-BENES-Act-S3236-HR5772-082216.pdf and http://www.medicarerights.org/pdf/Support-Ltr-BENES-Act-HR5772-082216.pdf

[11] See, H.R. 5772 and S. 3236 at: https://www.congress.gov/bill/114th-congress/house-bill/5772?q=%7B%22search%22%3A%5B%22HR+5772%22%5D%7D&r=1

in coverage might prove beneficial.[12] **To ensure active and informed beneficiary choice, we urge the new Administration to advance the following recommendations:**

- **Personalize the Annual Notice of Change (ANOC) for MA and Part D plans:** Our experience shows that people with Medicare sometimes lack a basic understanding of insurance concepts and are often confused by the many choices available to them when selecting among MA and Part D plans. Informed, enabled beneficiaries are essential to well-functioning health insurance markets. To fully evaluate plan choices, people with Medicare need access to more robust support tools.

  The ANOC is the most important document for improving beneficiaries' ability to make wise choices. The incoming Administration should take steps to personalize the ANOC for individual recipients, so that it explains changes through the beneficiary's frame of reference.[13] We understand that individual plans, such as United American and Aetna, are taking steps towards personalization regarding medication and pharmacy network changes. We encourage the new Administration to test, encourage, and require these steps.

- **Revitalize the Plan Finder tool, taking into account input from beneficiaries and their advocates:** The Medicare Plan Finder is the premier online tool available to help people with Medicare, caregivers, and professionals evaluate and compare the MA and Part D plan options available in a given region. While this tool has significantly improved since the inception of the Part D benefit, more can and should be done to enhance the usability of the Plan Finder.

  With regularity, Medicare Rights provides written feedback and recommendations to CMS on how to strengthen the Plan Finder experience, drawing from our helpline expertise. These include suggestions related to basic formatting and pharmacy and cost-sharing displays as well as the addition of critical, missing information, like content on MA provider networks and Medigap supplemental options.[14] We urge the new Administration to heed these recommendations and engage in a process to update the Plan Finder.

- **Strengthen consumer protections in "seamless conversion" arrangements**: In October 2016, CMS issued a temporary moratorium and released previously unavailable information on seamless conversion, a practice that allows select insurers to auto-enroll an individual currently in one of their commercial or Medicaid products into an MA plan when that person becomes Medicare-eligible.[15] Before the moratorium is lifted, we urge CMS to add stronger consumer protections and transparency to seamless conversion policies.

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[12] See, Jacobson, G., Neuman, T. and A. Damico, "Medicare Advantage Plan Switching: Exception or the Norm?" (Kaiser Family Foundation, September 2016), available at: http://files.kff.org/attachment/Issue-Brief-Medicare-Advantage-Plan-Switching-Exception-or-Norm; Hoadley, J., Hargrave, E., Summer, L., Cubanski, J., and T. Neuman, "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?" (Kaiser Family Foundation: October 2013), available at: http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/

[13] GAO, "Medicare Part D: Opportunities exist for improving information sent to enrollees and scheduling the annual election period," (2008), available at: www.gao.gov/assets/290/284178.pf

[14] See, Medicare Rights Center, "MEMO: Plan Finder Observations (2013-2015)" (September 2016), available at: http://blog.medicarerights.org/medicare-rights-offers-recommendations-make-medicare-plan-finder-user-friendly/

[15] CMS, "MEMO: Seamless Enrollment of Individuals upon Initial Eligibility for Medicare," (October 2016), available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS_Memo_Seamless_Moratorium.pdf

We believe the use of seamless conversion should be limited to ensure that people new to Medicare can make an active and fully informed choice about the coverage option that best fits their needs. CMS' existing policy defaults a person into an MA plan with minimal outreach requirements and no conditions that the auto-assigned MA plan align with a person's needs concerning provider access, coverage rules, and out-of-pocket costs. As such, we encourage the incoming Administration to adopt additional consumer protections as part of seamless conversion practices, as outlined in our September 2016 letter. [16]

Enhance Affordability

As noted above, the affordability of needed health care presents a continued challenge for the millions of older adults and people with disabilities living on fixed incomes. The Administration has many tools at its disposal to minimize these burdens. **We urge the incoming Administration to make full use of these tools as follows:**

- **Encourage States to further outreach and enrollment in Medicare Savings Programs (MSPs):** Administered by States through a combination of federal and State funding, MSPs—including the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) programs—provide critical assistance with Medicare Part B premiums and cost-sharing to people with Medicare who have exceedingly low incomes and assets. We often find that enrollment in MSPs can free up limited funds to allow beneficiaries to afford groceries, utilities, and other basic needs.

  Unfortunately, fewer than one-third of those eligible for this assistance are enrolled.[17] CMS plays an important role in convening States and disseminating best practices on the administration of MSPs.[18] As such, we encourage the new Administration to further these efforts and to engage States on identifying and implementing strategies to enhance MSP enrollment among vulnerable seniors and people with disabilities.

- **Continue to minimize inappropriate billing of Qualified Medicare Beneficiaries (QMB):** We appreciate ongoing efforts by CMS to lessen illegal billing of QMB participants, among the lowest-income Medicare beneficiaries, by their health care providers. By law, people with QMB are appropriately shielded from Medicare Part A and Part B cost-sharing. Inappropriate billing risks the financial stability of these individuals, even causing some to be pursued by debt collectors.[19]

  We urge the new Administration to continue and expand on existing efforts, which include increased assistance for health care providers; the involvement of MA plans in related efforts with network providers; and the development of beneficiary supports through 1-800-MEDICARE, the Medicare & You handbook, and more.[20]

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[16] See, Letter to Andy Slavitt, CMS Acting Administrator from Medicare Rights Center and partner organizations (September 2016), available at: http://medicarerights.org/pdf/cms-letter-seamless-conversion-093016.pdf

[17] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," (June 2016, pg. 239), available at: http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0

[18] See, CMS, "BULLETIN: Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees," (September 2015), available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-23-2015.pdf

[19] CMS, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)," (July 2015), available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf

[20] See, CMS "Reducing Inappropriate Billing of Qualified Medicare Beneficiaries," (December 2016), available at: http://nhelp.org/conf2016/uploads/presenters/28_MMCO%20Inappropriate%20QMB%20Billing.pdf

- **Test value-based pricing initiatives to address rising prescription drug costs:** Sky-high and ultimately unaffordable prescription drugs are among the most persistent and intractable problems we hear on the Medicare Rights national helpline, whether covered under Medicare Part B or Part D. 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 the incoming Administration to consider testing these concepts in Medicare, 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. Below we detail options available to the new Administration to advance truly person-centered payment and delivery system innovations.

Advance Person-Centered Innovation

In 2015, Congress passed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA), thereby undoing an ill-advised payment mechanism for Medicare's health care providers and advancing a reimbursement system centered on value-based care—as opposed to volume-based care. The voices of people with Medicare are critical to ensuring these payment reforms are meaningfully implemented.

As such, we urge the incoming Administration to create mechanisms to ensure that people with Medicare and their advocates are fully involved in the development of new care models created to achieve the ends outlined in MACRA. Towards this end, we strongly encourage the new Administration to:

- Establish new ombudsman and other monitoring programs;
- Convene regular meetings of a consumer and patient advisory council;
- Create multi-stakeholder advisory panels on specific delivery and payment models;
- Involve beneficiaries and their advocates in Technical Expert Panels (TEPs);
- Solicit public comment on proposed model designs;
- Regularly engage beneficiaries and their advocates as new models are implemented;
- Publicly release all data, metrics, outcomes, and evaluation findings for each model;
- Enhance supports via 1-800-MEDICARE and State Health Insurance Assistance Programs (SHIPs); and
- Carry out beneficiary testing and readability reviews of patient-facing content for each model.

We also believe that the new Administration should **prioritize demonstration concepts identified by beneficiaries and their advocates.** For example, we urge CMS to assess the potential for cost savings and enhanced care quality via the provision of medically-necessary dental care, including dental care that is required to allow an acute procedure to proceed, such as a kidney transplant. In partnership with allied organizations, Medicare Rights has previously recommended that CMS incorporate medically-necessary dental services in existing demonstration programs on kidney, cardiac, and cancer care as well as joint replacements.

Streamline Beneficiary Appeals

The most frequent call to the Medicare Rights helpline comes from an MA or Part D plan enrollee denied coverage for a health care service or treatment prescribed by their provider. In particular, we find that people

with Medicare struggle to navigate an overly onerous Part D appeals process—resulting in delayed access to needed prescription drugs, abandonment of medications, reduced adherence to treatment protocols, and higher than appropriate out-of-pocket costs for older adults, people with disabilities, and their families.[21]

To minimize these burdens, Medicare Rights has long advocated for improvements to plan-level appeals processes, particularly in Medicare Part D. **We urge the new Administration to move ahead on the following reforms to streamline the Part D appeals process:**

- Require the presentation of a prescription to count as a coverage determination request, thereby eliminating the need for a beneficiary to formally request coverage after leaving the pharmacy empty handed;
- Provide notice at the pharmacy counter explaining the reason for a denial;
- Improve denial notices, tailoring such notices to the specific reason for the denial;
- Enhance outreach on tiering exceptions, which allow requests for lower cost-sharing for high-cost drugs;
- Allow tiering exceptions for medications on the Part D specialty tier;
- Solicit input from beneficiaries and their advocates on an HHS report on how to improve Part D appeals, as mandated by Section 705 of the Comprehensive Addiction and Recovery Act (CARA) of 2016[22]; and
- Increase transparency on how plans manage all stages of the appeals process, starting at the point of sale.

Elevate the Office of the Medicare Ombudsman

Through casework, the Ombudsman works to resolve beneficiary problems not addressed through 1-800-MEDICARE and other means and presents systemic challenges facing people with Medicare to CMS, Congress, and the public.[23] As 10,000 Baby Boomers age into Medicare each day, this office should be adequately resourced to meet growing needs. Similarly, it is critical that the agencies administering Medicare are responsive to common challenges beneficiaries present. Working in concert with organizations like Medicare Rights, the Ombudsman can and should bridge policymaking and the lived experiences of people with Medicare.

Conserve initiatives to improve access to care for people with both Medicare and Medicaid

The Medicare-Medicaid Coordination Office (MMCO) sits squarely at the intersection of Medicare and Medicaid and is tasked with identifying solutions to ensure people dually eligible can access needed health care. We believe strongly in the mission of MMCO and generally support many of its initiatives, ranging from efforts to align coverage policies for Durable Medical Equipment (DME) to enhanced education and supports to prevent fraudulent billing for Medicare cost-sharing among the lowest-income people with Medicare. MMCO should be preserved and adequately resourced to continue and expand on its work.

[21] Letter to MedPAC from 30+ consumer advocates and health care providers (October 10, 2014), available at: http://www.medicarerights.org/pdf/101014-medpac-part-d-appeals.pdf; Letter to MedPAC from the Medicare Rights Center (September 20, 2013), available at: http://www.medicarerights.org/pdf/092013-part-d-appeals-medpac.pdf

[22] See, Section 705, CARA at: https://www.congress.gov/bill/114th-congress/senate-bill/524?q=%7B%22search%22%3A%5B%22CARA%22%5D%7D&r=1

[23] For example see, CMS Office of the Medicare Ombudsman, "FY 2013 Report to Congress," (2014), available at: https://www.cms.gov/Center/Special-Topic/Ombudsman/2013-Ombudsman-Report-to-Congress-.pdf

Preserve the ability to test person-centered innovations in delivery and payment

The Center for Medicare & Medicaid Innovation (CMMI) is a laboratory for the latest advancements in paying for and delivering care to older Americans and people with disabilities. We believe CMMI should be preserved and adequately resourced to aid in the learning and evaluation of new and emerging care models, particularly as such models are fundamental to the successful implementation of MACRA. And, as described above, we urge a renewed focus on patient and consumer engagement in the design and implementation of CMMI programs.

While the above recommendations do not represent an exhaustive list of Medicare Rights' policy priorities, we believe the advancement of these administrative policies will serve to strengthen Medicare for today's beneficiaries and future generations. We stand ready to engage in a constructive dialogue throughout President-Elect Trump's term on these and other issues critical to the health and economic security of those who today and those who will someday rely on Medicare.

If you have questions or need additional information, please contact Stacy Sanders, federal policy director, at ssanders@medicarerights.org or 202-637-0961. Thank you.

Sincerely,

Joe Baker
President
Medicare Rights Center