

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 27, 2017

Submitted electronically via regulations.gov

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9930-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

## **Re: RIN 0938-AT12 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019**

Justice in Aging appreciates the opportunity to comment on the proposed Notice of Benefit and Payment Parameters for 2019. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources.

We believe that strong federal standards are necessary to protect and empower patients as consumers in the Affordable Care Act's (ACA) Marketplaces in every state. In developing rules to govern the Marketplaces in 2019 and beyond, we urge the Centers for Medicare and Medicaid Services (CMS) to ensure that older adults and people living with chronic illnesses and disabilities have meaningful access to the care and treatment they need. Thank you for considering our recommendations and comments below which focus on maintaining and enhancing basic consumer and patient protections for these vulnerable populations.

### **Rate Increases Subject to Review (§ 154.200)**

We oppose changing the threshold for review of unreasonable premium increases from 10 to 15 percent. First, we believe this proposal would normalize high rate increases and work against controlling the premium cost growth. Insurers have cited uncertainty related to reimbursement of cost-sharing reduction subsidies and the individual mandate as primary drivers of rate increases for the 2018 plan year.<sup>1</sup> Therefore, we believe the recent significant premium increases are outliers, rather than the norm, and urge CMS to continue to work to stabilize the Marketplaces so that the increases we saw in 2018 will not be necessary in future years. Older adults and others with greater health care needs who may need to purchase more robust coverage with higher premiums simply cannot afford such increases year over year.

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<sup>1</sup> S. Corlette, *Proposed Premium Rates for 2018: What do Early Insurance Company Filings Tell Us?*, (May 17, 2017) <http://chirblog.org/proposed-premium-rates-for-2018-what-do-early-filings-tell-us/>.

#### **WASHINGTON**

1444 Eye Street, NW, Suite 1100  
Washington, DC 20005  
202-289-6976

#### **LOS ANGELES**

3660 Wilshire Boulevard, Suite 718  
Los Angeles, CA 90010  
213-639-0930

#### **OAKLAND**

1330 Broadway, Suite 525  
Oakland, CA 94612  
510-663-1055

Furthermore, while the proposed rule states that this proposed change would promote state flexibility, as CMS notes, some states currently impose stricter standards than the federal 10 percent threshold indicating that states already have and exercise flexibility. We are concerned that the benefits of further state flexibility do not outweigh the dangers of signaling to insurers that higher rate increase are acceptable. Therefore, we urge CMS to not finalize this proposal and instead maintain the current 10 percent threshold.

### **Standardized Options (§ 155.20)**

We strongly oppose eliminating the standardized plan options for the 2019 plan year and beyond. Standardized plans have simplified the plan selection and enrollment process, allowing consumers to make easier and more informed choices. Having the ability to make apples-to-apples comparisons of plans is especially important to older adults, who we know from the Medicare context struggle to choose the best option for them when benefit designs are not standardized.<sup>2</sup> Furthermore, standardizing benefit structure encourages consumers to compare and select plans based on the provider networks, cost-sharing for services they use, and drug formularies, rather than on premium price alone. Informed shopping helps consumers select the plan that best meets their needs and budget, leading to greater utilization and consumer satisfaction, and in turn, better health outcomes.

Standardized plan options also limit insurers' ability to manipulate actuarial value to produce discriminatory benefit designs that discourage enrollment by individuals with higher-cost chronic health conditions.<sup>3</sup> By restricting the flexibility to set differential cost-sharing amount for certain items and services, standardized options encourage plans to compete based on the generosity of other plan design elements, such as by providing more robust provider networks and formularies. Encouraging competition along these metrics will improve access to specialists and medications for those with pressing health needs, such as older adults.

We are also concerned that eliminating standardized plan options would erode the strides made in streamlining the plan assessment and enrollment process and eliminate an important tool to incentivize insurers to improve and compete on the quality of their offerings. Therefore, we urge CMS to maintain and strengthen the standardized plan options.

### **Standards for Navigators and Certain Non-Navigator Assistance Personnel (§§ 155.210 and 155.215)**

The Navigator program has ensured that older adults have access to the assistance and information they need to be able to understand their options and select the plan that is best suited for their particular health needs. As we know from the experience of Medicare beneficiaries working with the State Health Insurance Assistance Programs (SHIPs), the free, in-

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<sup>2</sup> See, e.g., How are Seniors Choosing and Changing Health Insurance Plans, Kaiser Family Foundation, (May 2014), available at [kaiserfamilyfoundation.files.wordpress.com/2014/05/8589-how-are-seniors-choosing-and-changinghealth-insurance-plans.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2014/05/8589-how-are-seniors-choosing-and-changinghealth-insurance-plans.pdf).

<sup>3</sup> D. Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, Health Affairs Blog (January 6, 2016) <http://www.healthaffairs.org/doi/10.1377/hblog20160106.052546/full/>.

person assistance Navigators and other enrollment assisters provide is especially important for lower-income older adults who often have more health care needs and may have less access to or comfort with using technology to navigate the process on their own. Therefore, we strongly urge CMS to continue investing in this important program by fully funding it and promoting outreach to vulnerable populations.

We strongly oppose CMS's proposal to remove the requirement that each Marketplace must have at least two Navigator entities, one of which is a community and consumer-focused nonprofit. Similarly, we urge CMS to maintain the requirement that Navigator entities maintain a physical presence in the Marketplace service area. Both of these requirements are vital to ensuring outreach to vulnerable populations and the remaining uninsured who are likely unaware that coverage is available to them. Locally present organizations that have ties to the community are critical to ensuring that populations with the greatest need for Navigator support are identified and reached.

Furthermore, there is no substitute for in-person assistance delivered by a known and trusted community-based organization. This is particularly true for those living with significant health needs for whom web- or phone-based assistance can prove inadequate and frustrating. The ability to discuss particularized and sometimes sensitive health needs requires direct, face-to-face communication in a confidential space that web or phone-based assistance cannot provide. Additionally, web-based brokers and assistance platforms are not accessible to everyone, such as older or lower-income individuals who may have limited access to the internet or familiarity with technology.

#### **Eligibility Determinations for Exchange Participation and Insurance Affordability Programs (§ 155.305)**

We strongly oppose the proposal to remove the requirement that exchanges send direct notification to the tax filer informing them that eligibility will be discontinued due to failure to file a tax return and reconcile advance premium tax credits (APTC) received before discontinuing eligibility. Removing this requirement increases the potential for treatment interruptions due to coverage lapses, a particularly significant concern for those living with chronic health conditions. As CMS notes, only 60 percent of households that were notified their APTCs would be discontinued for one of three reasons took the appropriate action; meaning 40 percent of households did not.<sup>4</sup> Therefore, we believe that direct and specific notice to the tax filer is necessary to ensure that those wishing to continue their eligibility have the information necessary to do so.

#### **Income Inconsistencies (§ 155.320)**

We oppose HHS' proposal to generate income inconsistencies for consumers whose attested projected annual income is over 100 percent FPL while the federal data source indicates their income is under 100 percent FPL. We think this provision would unfairly penalize consumers

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<sup>4</sup> See 82 Fed. Reg. 51086.

who over-estimate their income, and, contrary to the reason CMS cites for this proposed rule,<sup>5</sup> would not help limit tax filers' potential liability for excess APTC. This is because consumers who attest to income above 100 percent FPL but end the year with an actual income below 100 percent FPL are exempt from repaying excess APTCs. Therefore, no consumer in this situation will have any tax liability if they receive APTCs during the year.

Furthermore, as we have seen over the course of five open enrollment periods, low-income consumers often face difficulty estimating their annual incomes because their incomes often fluctuate due to shift work, seasonal work, time off needed for child/elder care, or a host of other reasons. We should not penalize consumers for not having a steady, predictable source of income by creating a data inconsistency which will require them to provide additional information and may result in harmful interruptions in their coverage or care.

### **Special Enrollment Periods (§ 155.420)**

We support several of the proposed changes to Special Enrollment Periods (SEPs):

- We support aligning the flexibilities available to enrollees and dependents when a dependent is newly enrolling in Exchange coverage through an SEP.
- We agree that if information about a plan or benefit has a material error, a consumer who selected that plan should be allowed to select a new plan from any metal level rather than be limited to the metal level in which they originally enrolled. Therefore, we support excluding paragraph (d)(12) from paragraph (a)(4)(iii).
- We support the proposal to amend paragraph (a)(5) to exempt qualified individuals from the prior coverage requirement if, for at least 1 of the 60 days prior to the date of their qualifying event, they lived in a service area where there were no QHPs offered through an Exchange.
- We support CMS's proposal to standardize the coverage effective date options for consumers who have qualified for SEPs due to gaining or becoming a dependent whether through birth, adoption, placement for adoption, placement in foster care, or through a child support or other court order.
- We support extending the SEP for loss of coverage to consumers who lose CHIP pregnancy-related coverage.

We urge CMS to reconsider its imposition of continuous coverage requirements for SEP eligibility. Life circumstances will inevitably result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll through an SEP when they meet all other criteria. We understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

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<sup>5</sup> 81 Fed. Reg. 51086.

We also urge CMS to allow current enrollees to change metal levels using an SEP. This is particularly important for some qualifying life events that result in increased or modified health needs as well as those that change APTC eligibility. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

### **Effective Dates for Terminations (§ 155.430)**

We support the proposal to simplify the process for enrollee termination of coverage by allowing termination to be effective on the day an enrollee requests, or on another prospective date selected by the enrollee. This issue has been particularly vexing for individuals enrolled in marketplace coverage who are transitioning to Medicare. Sometimes Call Center Representatives let these individuals cancel prospectively, other times they tell individuals to cancel on the day before Medicare becomes effective. Consumers should be able to prospectively cancel their coverage without having to call back multiple times or worry about penalties for having dual coverage if they forget to call back. If they originally called in a timely manner, consumers should be permitted to complete all necessary transactions within that one call and should get automatic guidance from Call Center representatives on how to do so. Navigating transitions to Medicare has proved particularly difficult for consumers, a fact that CMS has recognized by providing a Special Enrollment Period for individuals who were confused and failed to enroll in Part B within their Initial Enrollment Period.<sup>6</sup> We welcome that SEP and also see the proposal to simplify termination of coverage as another important step in easing the transition and preventing inadvertent errors.

### **Essential Health Benefits**

The ACA's Essential Health Benefits (EHB) provisions ensure that older adults, especially those living with chronic health conditions and disabilities, have access to the medically necessary care and treatment they require. These individuals need a minimum benefits package that includes the range of services and treatments needed to manage their conditions, including prescription drug benefits, substance use and mental health treatments, and preventive services. Additionally, because the ACA's protections related to out-of-pocket maximums and annual and lifetime limits only apply to EHBs, a comprehensive EHB package helps protect older adults and other consumers with higher health care needs from unaffordable medical expenses.

Therefore, we urge CMS to ensure that the EHB package remains robust and not to adopt the proposed changes to the EHB-Benchmark Plan selection or allow substitution between EHB categories. Justice in Aging incorporates herein by reference the thorough comments on these proposed changes submitted by the National Health Law Program and FamiliesUSA that we co-signed.

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<sup>6</sup> A description of the SEP is available at [www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/SHIP-and-Navigators-Fact-Sheet-Limited-Equitable-Relief.pdf](http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/SHIP-and-Navigators-Fact-Sheet-Limited-Equitable-Relief.pdf).

### **Federal Prescription Drug Benefit Standard**

We recognize that prescription drug access and affordability continues to be a significant challenge for older adults and others with chronic and serious conditions, and we urge CMS to extensively evaluate the potential impact on people living with chronic illnesses and disabilities before making any changes to the prescription drug standard. We also urge CMS to rigorously enforce existing coverage and non-discrimination protections in order to improve access to prescription drugs, especially for people with chronic and serious conditions.

### **Application to Stand-Alone Dental Plans Inside the Exchange (§ 156.150)**

We are concerned by CMS's proposal to eliminate actuarial value (AV) standards for Stand-Alone Dental Plans (SADPs). Older adults' oral health is too often neglected, resulting in preventable tooth loss, increased emergency room use, and a decline in overall health and quality of life. One quarter of individuals age 60 and over no longer have their natural teeth, and twenty-three percent of older adults have severe gum disease, which increases their risk for aspiration pneumonia and other infections.<sup>7</sup>

CMS proposes this change so that "consumers [may] select from a greater variety of plans and find one that is more likely to meet their specific needs."<sup>8</sup> But without these protections, SADP issuers may offer *less* coverage to consumers. If no AV standard exists, a dental insurer could offer a product that covers very minimal benefits, leading older adults who have significant oral health needs to purchase insurance that is of little use.

Furthermore, the elimination of AV standards would prevent consumers from easily understanding the value of marketplace offerings and be especially harmful to those with limited incomes who are likely to choose a plan based on premium price. We strongly believe that any policy enacted by CMS should continue to protect quality, value, and ultimate utility of coverage products. Without some up-front marker of plan value, it will be more difficult for consumers to accurately compare options. It is important to maintain a standard of value for consumers purchasing a SADP through marketplaces. Because all state marketplaces have 2018 plans available at the specified AV levels, we request that CMS maintain a minimum standard of 70% AV and require insurers to advertise plan AV as part of the marketplace shopping experience.

### **Network Adequacy, Essential Community Providers, and Other QHP Certification Standards**

While we understand the traditional role states have played in regulating insurance, we believe that there should be a strong federal-state partnership to ensure robust consumer protections. At a minimum, CMS should not abandon its role in setting and enforcing federal minimum standards with respect to Qualified Health Plan certification. We urge CMS to work to ensure that states have adequate capacity to undertake the increased regulatory responsibilities

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<sup>7</sup> Centers for Disease Control and Prevention, Adult Oral Health, available at [www.cdc.gov/oralhealth/publications/factsheets/adult\\_oral\\_health/adult\\_older.htm](http://www.cdc.gov/oralhealth/publications/factsheets/adult_oral_health/adult_older.htm).

<sup>8</sup> 82 Fed. Reg. 51109.

contemplated by this rule, particularly with respect to non-discrimination and access to care protections.

### **State oversight of network adequacy and Essential Community Provider standards (§ 155.200)**

We urge CMS to continue requiring that State-based Exchanges on the Federal platform (SBE-FPs) enforce Federally-Facilitated Exchange (FFE) standards for network adequacy, including Essential Community Provider (ECP) standards. Robust networks are particularly important for older adults and people living with chronic illnesses and disabilities, for whom access to provider with expertise to treat their particular conditions is critical to ensure meaningful access to care. While state regulators can and should play important role in enforcing network adequacy protections, CMS should ensure a strong federal minimum with specific quantitative standards to ensure access to providers.

### **Essential Community Provider standard (§ 156.235)**

We urge CMS restore the minimum ECP inclusion standard to 30 percent instead of continuing the 20 percent standard set forth by the Market Stabilization rule for the 2018 plan year. ECPs are particularly important for those living with chronic conditions who have established relationships with community providers, who are in the best position to ensure continuity of care. As CMS noted in the preamble to the Marketplace Stabilization Rule, only six percent of issuers were unable to meet this standard in 2017.<sup>9</sup> Therefore, continuing with this reduced standard does not serve to reduce any significant burden on issuers, and may instead disrupt continuity of care – actually increasing costs for issuers.

### **Meaningful Difference Standard for Qualified Health Plans in the Federally-Facilitated Exchanges (§ 156.298)**

We oppose the proposal to remove the meaningful difference standard outlined in 45 C.F.R. §156.298. Assessing plans for comprehensive coverage is already a complex and overwhelming process for older adults and consumers living with complex medical needs. The meaningful difference standard ensures that QHP offerings are easily distinguishable from one another and that consumers have the ability to readily differentiate and compare plans, leading to informed choices.<sup>10</sup> While we understand the need to ensure robust issuer participation on the Marketplaces, allowing insurers to offer plans without meaningful differences will confuse consumers and obscure the process of selecting an appropriate plan. CMS has insisted on meaningful differences among Medicare Advantage plans<sup>11</sup> and its efforts to date have helped reduce consumer confusion. The CMS requirements have not inhibited competition and the Medicare Advantage market remains robust.<sup>12</sup>

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<sup>9</sup> 82 Fed. Reg. 18373

<sup>10</sup> Research suggests that consumers may prefer more limited arrays of choices. See Iyengar, S.; Lepper, M. *Journal of Personality and Social Psychology*, Vol. 79(6), Dec 2000, 995-1006.

<sup>11</sup> See, e.g., 2018 Final Call Letter, p. 115 et seq., available at [www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf](http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf).

<sup>12</sup> The average Medicare beneficiary will have 21 Medicare Advantage plans to choose from in 2018, an increase from 19 in 2017. See Kaiser Family Foundation, Medicare Advantage 2018 Data Spotlight: First Look, available at [www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-spotlight-first-look/](http://www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-spotlight-first-look/).

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at [jgoldberg@justiceinaging.org](mailto:jgoldberg@justiceinaging.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with the first name "Jennifer" written in a larger, more prominent script than the last name "Goldberg".

Jennifer Goldberg  
Directing Attorney