

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

February 19, 2019

Submitted electronically via regulations.gov

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9926-P  
P.O. Box 8016  
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## **Re: RIN 0938-AT37 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020**

Justice in Aging appreciates the opportunity to comment on the proposed Notice of Benefit and Payment Parameters for 2020. 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 agree with the Department of Health and Human Services (HHS) that this proposed rule should improve the Affordable Care Act's (ACA) Marketplaces for all stakeholders, but empowering consumers and improving affordability must be paramount goals. While states do play an important role in these programs, strong federal standards are necessary to protect and empower consumers in every state. In developing and modifying rules to govern the Marketplaces in 2020 and beyond, we urge HHS to ensure that older adults and people living with chronic illnesses and disabilities have meaningful, affordable access to the care and the treatment they need. Thank you for considering our recommendations and comments below which focus on maintaining and enhancing critical consumer and patient protections and enrollment assistance for these populations.

### **Requests for Comment in the Preamble**

#### ***Automatic Re-enrollment***

In the preamble, HHS seeks comment on automatic re-enrollment policies, indicating that it is considering changing the automatic re-enrollment process despite recognizing that it significantly reduces administrative burden and benefits consumers. We strongly urge HHS not to eliminate or undermine the consumer protections offered by auto re-enrollment. HHS says that it is concerned that some consumers are "shielded from changes to their coverage" and

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that “automatic re-enrollment eliminates an opportunity for consumers to update their coverage and premium tax credit eligibility as their personal circumstances change.”<sup>1</sup> While we recognize that some consumers who are auto re-enrolled could miss options to select a plan better suited to them or increase their real-time financial assistance, the alternative for these consumers who are not “active” during re-enrollment is that they are much more likely to end up without any coverage if they were not automatically re-enrolled.

Furthermore, given that consumers are required to reconcile advanced premium tax credits at the end of each tax year, we disagree that government misspending is a serious concern. This concern is further mitigated by HHS’s recent addition of data matching inconsistencies for consumers who are at or near the federal poverty level.

### ***Enrollee Cost-Sharing Transparency***

The preamble also asks for comment on ways to improve enrollee cost-sharing transparency, including what types of data would be most useful to improving consumers’ abilities to make informed health care decisions and ways to improve consumers’ access to information about health care costs.<sup>2</sup> We are grateful that HHS is seeking to improve cost-sharing transparency and is particularly looking at addressing the inherent opaqueness of co-insurance. We would support requiring issuers to disclose a consumer’s anticipated costs for particular services in a timely manner upon the consumer’s request. Often a consumer needs this information immediately in order to be able to make a decision. Therefore, we would expect the timeframe for the issuer to respond to be 24 hours or less. This would be particularly important for cost-sharing information on prescription drugs. A consumer should be able to contact an issuer with their provider during the prescribing conversation and get an immediate anticipated cost-sharing for a particular drug.

While disclosing a list of anticipated costs for common coverage scenarios would also be helpful, we are concerned that it would not have the same utility for consumers who need precise information to choose among treatments or prepare financially as it does for consumers who are trying to compare one plan to another. It seems there are too many variables for each consumer that would inhibit providing an accurate estimate of actual out-of-pocket costs. However, it may be a useful tool for commonly prescribed drugs that are on a tier with co-insurance so long as plans were required to update these anticipated costs every time the plans’ formularies or prices change.

### ***High Deductible Health Plans***

We strongly caution against HHS taking steps to promote the offering and take up of high deductible health plans (HDHPs) paired with health savings accounts (HSAs).<sup>3</sup> While it is true

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<sup>1</sup> 84 Fed. Reg. 229.

<sup>2</sup> 84 Fed. Reg. 229.

<sup>3</sup> 84 Fed. Reg. 230.

that a few consumers do reap significant tax benefits from these arrangements, they do not work for most older adults who have more limited incomes compared with all adults. For example, Justice in Aging’s analysis found that most older adults ages 55-64 would end up spending more on premiums, deductibles and cost-sharing (up to 30% of their income) under HDHPs than lower deductible health plans and would receive little to no tax benefit.<sup>4</sup> We fear that further promoting HDHPs on HealthCare.gov could lead consumers to enroll in them against their best interests. HDHPs are difficult to understand and there are no guardrails preventing someone for whom they provide no benefit from enrolling.

### **Standards for Navigators and Certain Non-Navigator Assistance Personnel (§§ 155.210, 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-person assistance navigators and other enrollment assisters provide is especially important for lower-income older adults who often have more health care needs and face complex decisions about their coverage options as they near retirement. Older adults may also have less access to or comfort with using technology to navigate the process on their own. In addition, research has found that people of color rely more on in-person assistance with enrollment than whites,<sup>5</sup> indicating that the navigator program is especially important in reducing health disparities that people of color face. Therefore, as explained below, we oppose the proposals to reduce the required scope of navigators’ duties and training and instead urge HHS to invest in this important program by fully funding it, promoting outreach to hard-to-reach populations, and ensuring navigators are well-equipped to assist consumers with the full range of questions that may arise during application and enrollment, and throughout the coverage year.

#### ***We strongly oppose HHS’s proposal to make post-enrollment assistance optional for Navigator programs.***

In our experience, older adults and other consumers need significant help with post-enrollment, including help with the very activities HHS is proposing to make optional, such as questions about how to use their health insurance, when and how to file appeals, whether they qualify for exemptions, and how to reconcile APTCs. Therefore, we strongly disagree that making this type of assistance optional would allow navigator programs to “better meet consumers’ needs,” as HHS claims. Robust and comprehensive enrollment assistance simply does not stop at enrollment. Just as SHIP counselors do, navigators need to be able to help consumers both gain and maintain effective health coverage. Navigators are uniquely

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<sup>4</sup> Justice in Aging, “Health Savings Accounts Won’t Help Most Older Adults,” (Aug. 2017), *available at* [www.justiceinaging.org/wp-content/uploads/2017/09/Health-Savings-Accounts-Wont-Help-Older-Adults.pdf](http://www.justiceinaging.org/wp-content/uploads/2017/09/Health-Savings-Accounts-Wont-Help-Older-Adults.pdf).

<sup>5</sup> Kaiser Family Foundation, “Data Note: Further Reductions in Navigator Funding for Federal Exchange States,” (Sep. 24, 2018), *available at* [www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/](http://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/).

positioned to provide post-enrollment assistance because they are often the first point of contact for consumers who have questions about their coverage given the trusted messenger relationship they build during the plan selection and enrollment process. Consumers will not stop coming to navigators to ask how to access care, find a provider or file an appeal simply because navigators are no longer required to provide such assistance.

Additionally, once the open enrollment period has ended, navigator organizations have significantly more time to dedicate to providing post-enrollment assistance. Providing post-enrollment assistance and keeping records of it is an important part of their job, not a “regulatory burden.” These organizations are already able to “prioritize work according to consumer demand, community need and organizational resources,” which ebb and flow throughout the year.

While we recognize reduced navigator funding has led some organizations to focus their assistance on enrollment, many consumers continue to need help post-enrollment. Rather than reduce responsibilities of navigators, we believe HHS should increase funding to maintain these essential services. Arguably, as more consumers have experience enrolling in Marketplace coverage, their need for one-on-one assistance with enrollment may even decrease while their post-enrollment needs grow. Every year new consumers enter the Marketplace due to changes in circumstances and every year new issues arise post-enrollment that they may not have had previously. This is especially the case as HHS continues to change the regulations regarding when consumers may be subject to an income inconsistency and eligibility for special enrollment periods.

***We likewise oppose HHS’s proposal to eliminate mandatory training on a variety of topics.***

HHS also proposes to eliminate training requirements on the post-enrollment assistance that it also proposing to make optional. While we oppose rescinding these requirements, even if HHS moves forward with making post-enrollment assistance optional, consumers will continue to ask navigators questions about these issues and we expect many if not most navigator programs will continue to provide these services. Therefore, we urge HHS to continue to require all navigators to be trained on these issues so that they are familiar with and equipped to handle the full continuum of Marketplace consumer assistance.

Moreover, we are very concerned about the proposed elimination of the full list of training topics in §§ 155.210(b)(2) and 155.215(b)(2). In particular, all navigator entities, as recipients of federal funds, must comply with Section 1557 of the ACA, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. The current required training offers these entities basic knowledge essential to meeting these requirements and working with individuals with disabilities or limited English proficiency. Although the requirement for navigators to comply with these laws remains, HHS’s proposal would take away the tools that can provide navigator entities with essential information to meet these requirements.

Moreover, a key component of navigators' responsibilities is to serve underserved populations, including residents of rural areas, immigrants, LGBTQ individuals, individuals with disabilities, and individuals with limited English proficiency. Agents and brokers are less likely to seek out and serve these hard-to-reach populations. Thus, all navigator entities should have training on these topics to help them understand the particular issues these groups may face and how to help them.

### **Ability of States to Permit Agents and Brokers to Assist with QHP Enrollment (§ 155.220)**

HHS is proposing to allow web-brokers and health insurance issuers to display complete information about only some of the QHPs on their direct enrollment websites along with a disclaimer saying that information about other plans is available on the exchange website with a link. Although web-brokers would be required to display information about short-term and other non-QHP products on a different webpage, we are concerned that this information will be very confusing to consumers, especially when these brokers are allowed to steer consumers to these other products or to recommend certain QHPs. We strongly urge HHS not to move forward with this proposal and to carefully consider how consumers are going to navigate a world where they can enroll in QHPs on multiple websites and not get misled into enrolling in non-comprehensive coverage to which premium tax credits do not apply.

We do not support the apparent shifting of enrollment responsibilities to agents and brokers, as HHS cuts funding and support for navigators. This increased reliance on agents and brokers is especially worrying for hard-to-reach populations because brokers are significantly less likely than navigators to help individuals who are uninsured, have low enough income to qualify for Medicaid, have limited English proficiency, or lack internet at home.<sup>6</sup> In addition, brokers are far less likely to help complete Medicaid applications for low-income consumers who discover they are not eligible for premium tax credits but may be eligible for Medicaid or other public coverage.

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.

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<sup>6</sup> Kaiser Family Foundation, "Data Note: Further Reductions in Navigator Funding for Federal Exchange States," (Sep. 24, 2018), available at [www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/](http://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/).

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

We support the proposed change to add a Special Enrollment Period (SEP) for individuals enrolled in off-exchange coverage who experience a decrease in household income and become newly eligible for APTCs. This SEP would provide these individuals an equal opportunity to enroll as those who are enrolled in employer coverage and experience a change in income.

We also agree with the proposal to modify the types of coverage that may satisfy the prior coverage requirement to include all of the coverage types described in paragraphs (d)(1)(iii) and (iv).

### **Essential Health Benefits (§§ 156.111, 156.115)**

We continue to strongly oppose the new EHB benchmark options that HHS finalized in the 2019 Notice of Benefit and Payment Parameters final rule. These options open the door to less comprehensive coverage for consumers, which will disproportionately impact individuals with disabilities and people with pre-existing medical conditions who could face reduced access to needed services and medical debt as a result of higher out-of-pocket costs. A robust EHB standard is essential to individuals receiving effective care. HHS recognized that offering less coverage might result in “spillover” effects, including increased use of emergency services and other services provided by safety net and government-funded providers.<sup>7</sup> This not only affects the individual patient but also affects our productivity as a nation, and ultimately increases the cost of health care.

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 prescription drug covered discussed below.

We appreciate that HHS is actively encouraging states to explore whether modifications to their EHB benchmark plan would be helpful in addressing the opioid epidemic. However, we emphasize the importance of modifying EHBs in a way that provides individuals with or at risk of opioid use disorders with access to comprehensive care options. For example, we strongly support state policies that require health plans to cover the complete array of substance use disorder (SUD) treatment options, including all medications used for medication-assisted treatment. In addition, benchmark plans that provide comprehensive coverage of non-opioid

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<sup>7</sup> Preamble of the NBPP for 2019 proposed rule, 82 Fed. Reg. 51131.

alternatives for pain treatment should be encouraged. However, we caution against measures that seek to curb the opioid epidemic by imposing strict limits on the doses of opioids for treating pain. While we support efforts to improve opioid prescribing practices, this should not happen at the expense of individuals who need access to these medications to treat their conditions. Our experience has been that such policies disproportionately affect low-income people who have difficulty accessing medically necessary care.

### **Prescription Drug Benefits (§ 156.122)**

We strongly disagree with HHS' proposal to allow issuers to remove medications from formularies, which would harm consumers who rely on those medications. Under current rules, issuers may only modify plan benefits, including formularies for outpatient prescription drugs, during open enrollment.<sup>8</sup> However, despite this federal requirement, consumers continue to be surprised and put in a difficult position when issuers reduce coverage or benefits during the plan year, whether it be increasing cost sharing, imposing prior authorization, step therapy, or other requirements, and dropping certain drugs from plan formularies.<sup>9</sup> Such changes can be particularly harmful for people with certain medical conditions where there is no one-size-fits-all treatment regimen and medication needs are highly individualized.<sup>10</sup>

Prescription drug coverage is a key factor in plan selection for many consumers, especially older adults and those with significant health needs and chronic conditions. However, the proposed NBPP would radically depart from HHS' ongoing efforts to increase transparency and strengthen consumer protections. If finalized, the rule would not only allow plans to drop prescription drugs from formularies mid-year but actually encourage plans to do so. This proposal would harm consumers, particularly older adults and those with significant health needs for whom prescription drug coverage is paramount.

We also oppose HHS's proposal to allow issuers to remove the brand drug from its formulary when a generic becomes available because it would arbitrarily cap an essential health benefit, contrary to congressional intent to authorize HHS to establish minimum coverage standards. We appreciate that HHS acknowledges that complex contracting arrangements and state generic substitution laws may affect whether a generic is less costly than the brand or can be substituted. In light of this, at the very least, plans should not be permitted to remove the brand name drug if the generic is not in fact "more affordable" (i.e., lower cost-sharing in terms

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<sup>8</sup> 45 C.F.R. § 147.106(e).

<sup>9</sup> See e.g., NAIC, "Promoting Access to Affordable Prescription Drugs: Policy Analysis and Consumer Recommendations for State Policymakers, Consumer Advocates, and Health Care Stakeholders," (Aug. 2016), available at [https://advocacy.consumerreports.org/wp-content/uploads/2016/08/Promoting-Access-to-Affordable-Prescription-Drugs\\_Aug-2016.pdf](https://advocacy.consumerreports.org/wp-content/uploads/2016/08/Promoting-Access-to-Affordable-Prescription-Drugs_Aug-2016.pdf). HHS has previously stated that states, as the traditional regulators of insurers, are primarily responsible for EHB and other protections. Ctrs. Medicare & Medicaid Servs, Final 2016 Letter to Issuers in the Federally-Facilitated Exchange 37-38 (Feb. 20, 2015).

<sup>10</sup> See, e.g., Alexia Elejalde-Ruiz, "Her daughter's epilepsy was under control, but then their insurer stopped covering the drug: 'It's devastating,'" CHICAGO TRIBUNE (Mar. 14, 2018), available at [www.chicagotribune.com/business/ct-biz-illinois-nonmedical-switching-bill-0315-story.html](http://www.chicagotribune.com/business/ct-biz-illinois-nonmedical-switching-bill-0315-story.html).

of actual dollars) for consumers. We agree that when a generic, equivalent version of brand drug becomes available, plans should be permitted to add that drug to its formulary. Expanding formularies increases consumer choice and provides greater access to generics, which can be equally effective and less expensive than brand drugs. We also agree that plans should have the opportunity to encourage providers to prescribe a less expensive equivalent version of a brand drug, which may entail moving the brand drug to a higher cost sharing tier, or imposing prior authorization, step therapy, or other utilization controls. However, plans must be required to adequately and timely notify consumers who rely on those drugs and provide an effective exceptions process to continue access to the brand drug when clinically appropriate. We would support 90 or 120 days notice with a follow up reminder at 60 and 30 days. We urge HHS to not implement these changes until stakeholders have had an opportunity to review and provide feedback on the planned notices, and the notices are field tested.<sup>11</sup>

Moreover, HHS' proposal to eliminate coverage of brand drugs when a generic becomes available means that if a plan covers a brand drug where a generic exists, the brand drug would no longer be considered EHB.<sup>12</sup> This proposal, which encourages plans to drop brand drugs, would have serious, far-reaching implications across the health care landscape:

- plans subject to EHB protections would no longer be required to count co-pays of drugs toward out-of-pocket maximums for drugs outside of EHB, thereby driving up costs for consumers;
- premium tax credits (PTCs) could not be applied to any portion of the premium attributable to coverage of brand name drugs not covered as EHB, requiring plans to allocate premiums among enrollees; and
- ACA protections against annual and lifetime caps on benefits would no longer apply to prescription drugs designated as non-EHB, putting consumers at risk for denials of needed care and medical-related bankruptcy.

This proposal is dangerous and would seriously undermine the EHB protections Congress established by carving out essential benefits and designating them as non-EHB. We are likewise very concerned by HHS's suggestion that this approach could be applicable to durable medical equipment (DME) provided as part of the EHB category for habilitative and rehabilitative services.<sup>13</sup> These treatments and services are truly essential for older adults and others with chronic and serious health conditions.

### **Premium Adjustment Percentage (§ 156.130)**

We strongly oppose the proposal to change the premium adjustment percentage formula because it will inevitably result in individuals losing coverage. HHS estimates the proposed change in formula will result in a decline of approximately 100,000 marketplace enrollees in

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<sup>11</sup> HHS indicates that it will seek comment on the content of notices through a PRA process. 84 Fed. Reg. 234.

<sup>12</sup> 84 Fed. Reg. 289-290.

<sup>13</sup> 84 Fed. Reg. 235.

2020 as well as premium increases of over \$180 million from 2020-23. We also strongly disagree with the justification HHS provides for using a new formula, that it will “additionally reduce federal premium tax credit expenditures.” The primary purpose of providing APTCs to marketplace enrollees is so that the federal government, rather than individuals, bears the burden of any premium increases in the individual market. Ensuring individuals have access to quality, affordable health coverage is a significantly more important goal than reducing federal spending. Therefore, we urge HHS not to make this change and instead keep the current premium adjustment percentage formula in place.

We also urge HHS not to take any steps to end the practice of “Silver loading.” Prohibiting this practice would greatly harm consumers, leading many of them to not be able to afford comprehensive coverage that meets their needs. Instead, HHS should work to further stabilize the market so that this is no longer an issue.

### **Segregation of Funds for Abortion Services (§ 156.280)**

We are also opposed to the proposed changes to § 156.280 as they go directly against the intent of the ACA, which was to provide the ability to purchase and enroll in health insurance to millions of individuals who did not previously have coverage. In an effort to provide comprehensive health care coverage, Congress permitted states as well as qualified health plans (QHPs) to offer comprehensive reproductive health services, including abortion, through the individual market exchanges. The proposed changes to § 156.280 conflict with the intent of the Affordable Care Act to allow abortion coverage in the exchanges. If adopted, this proposal would create an alarming precedent of carving out services from plan coverage critical to the health and safety of enrollees which could extend to any covered service leading to separate risk pools and increased costs. Requiring the creation of mirror plans that exclude certain services will harm consumers, insurers, and the exchanges, putting access to these health care services further out of reach. The proposed requirement creates unduly and burdensome hurdles for issuers and will increase costs for consumers. It takes a step backward towards the days before the ACA when women had to pay more than men for coverage and access to any coverage, much less comprehensive services, was not guaranteed.

Thank you for considering our comments. If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney at [nkean@justiceinaging.org](mailto:nkean@justiceinaging.org).

Sincerely,



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