



September 22, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

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

Families USA 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. Families USA is a national, nonprofit organization that works to ensure access to affordable, high-quality health care for all. We have provided numerous previous comments to the agency related to the issue of third party payment of marketplace premiums and welcome the opportunity to offer further input on this important topic.

We strongly agree with CMS that “enrollment decisions should be made, without influence, by the individual based on their specific circumstances, and health and financial needs.” Third party financial assistance programs should not be leveraged by providers to steer patients towards coverage options with higher reimbursement and they should not dissuade individuals eligible for Medicare or Medicaid from enrolling in such coverage.

While we agree that appropriate safeguards must be in place to prevent such abusive steering, we think it is equally critical that CMS establish safeguards to ensure that insurers accept payments from responsible, independent, nonprofit financial assistance programs. These programs provide critical help to low- and moderate-income patients and, so long as they adhere to certain safeguards, do not operate with abusive practices. We have growing concern that existing CMS guidance on the topic of third party premium and cost-sharing assistance has proved ineffective at both curtailing abusive activities, and protecting responsible nonprofit financial assistance programs.

Of particular concern, a growing number of issuers are rejecting third-party premium payments from responsible nonprofit financial assistance programs that adhere to safeguards already endorsed by CMS. Many of these issuers are targeting nonprofits that serve individuals with high-cost conditions. Such action is discriminatory and simply a backdoor way to undercut the consumer protections in the Affordable Care Act that guarantee coverage to people with pre-existing conditions.

While this RFI does not directly address the issue of nonprofit premium and cost-sharing assistance programs, much of the public discourse in response to this RFI has conflated the abusive practices raised by CMS within this RFI with these legitimate nonprofit financial assistance programs that should not be deemed abusive. Unless CMS issues future regulations that mandate that insurers accept premium payments from nonprofit entities that adhere to certain safeguards, we are concerned that this RFI and any future guidance related to it will only embolden more issuers to reject premium payments provided by these entities. This would have devastating consequences for many low-income patients who rely on such



assistance programs to afford necessary coverage and care, and would undermine the core consumer protections of the Affordable Care Act.

Furthermore, public and CMS discourse on this RFI connects issues of provider steerage of patients receiving third party payments into marketplace plans with broader issues of marketplace risk pool and premium stability issues. While we certainly concur that providers inappropriately steering a significant number of consumers out of public programs and into marketplaces could destabilize the marketplaces, we are concerned that these assertions have been made without the data to substantiate them. We are concerned with policy approaches that prematurely move to restrict consumers' access to legitimate third party payment programs under a presumption, based primarily on anecdotes, that they are undermining marketplace stability. We would instead recommend pursuing broad-based strategies to address marketplace stability, looking holistically at the issue and using a data-based approach to determine policy solutions.

In addition, we have concerns that this RFI overlooks key factors related to the End Stage Renal Disease (ESRD) population and the Medicare benefits available to them that matter greatly to any discussion about the factors these patients must weigh when making decisions about whether Medicare or private coverage is the best option for their individual needs. Based on CMS issuance of a concurrent letter to dialysis providers on inappropriate steerage of patients away from Medicare, it appears that there is heightened concern of this population being unduly steered away from Medicare. While we strongly concur with CMS that decisions about what coverage option is best should be the sole decision of patients, there are unique considerations that CMS must weigh in developing any policies to mitigate against provider steerage targeted at this population.

As such, our comments focus on the need for future regulations that set clear guidelines regarding the scope of abusive activities that warrant investigation and that also ensure that consumers have the right to access assistance from responsible, independent nonprofits. We also provide comments on coverage issues specific to the ESRD Medicare population that we believe must be considered when developing policies to best address inappropriate steerage for this population, as well respond to some questions CMS poses within this RFI.

Thank you for your ongoing attention to this issue. If you have any questions regarding the recommendations in these comments, please do not hesitate to contact Lydia Mitts at lmitts@familiesusa.org or (202) 628-3030.

Sincerely,

Lydia Mitts
Senior Policy Analyst
Families USA

Addressing Inappropriate Steering While Protecting Access to Nonprofit Financial Assistance

Families USA appreciates CMS's concern that commercial entities, like hospitals and providers, could use premium and cost-sharing assistance in abusive manners to increase their reimbursements. We agree that any activity on the part of providers to steer consumers towards particular coverage in order to enhance their reimbursement rates is unacceptable. These practices have the potential to drive up everyone's health care costs and are not in the best interest of consumers or the broader health care system. We strongly agree with CMS that decisions regarding coverage should be the exclusive decision of individuals based on what is best given their personal circumstance.

While we are skeptical that these types of nefarious activities are highly prevalent to date or currently have a marked impact on market stability, we support measured and targeted actions to curtail such inappropriate steering. **It is critical that when addressing such inappropriate steering, CMS takes parallel regulatory action that mandates that all marketplace insurers accept payments from independent, nonprofit premium and cost-sharing assistance programs that adhere to certain safeguards (outlined below).**

Broadly, Families USA has concerns that existing guidance outlining CMS's expectations regarding third party financial assistance programs has proved inadequate in effectively curtailing abuse while also preserving access to responsible financial assistance programs operated by nonprofit foundations.

In a federal FAQ issued on February 7, 2014, CMS made clear that, while it is concerned with financial assistance provided by commercial entities, these concerns *do not* apply to: 1) Ryan White HIV/AIDS programs; and 2) private, nonprofit foundations that provide assistance for the full plan year, and that provide assistance based on financial status and do not consider individual health status. In this guidance, it encourages issuers to accept such payments from both entities. CMS took subsequent regulatory action to mandate that health plans accept payments from Ryan White HIV/AIDS programs, tribal organizations, and other federal and state run assistance programs. To date, it has not mandated that issuers accept payments from non-profit foundations.

This has emboldened issuers to reject payments from independent, nonprofit premium and cost-sharing assistance programs that adhere to the above mentioned safeguards that CMS has endorsed. Most concerning, it appears that issuers are targeting nonprofits that serve high-cost disease populations. In a growing number of states, there are reports of issuers denying premium payments from non-profits that specifically help people with kidney disease, hemophilia, and other high cost conditions.

While these programs serve specific disease populations, they offer financial assistance to all individuals with such conditions based purely on financial need and without consideration to the severity of an individual's health status. In that sense, they operate in a very similar fashion to Ryan White HIV/AIDS premium assistance programs. These programs pose no risk for abuse so long as they do not restrict patients' choice of plan, provider or treatment, they provide assistance for the full duration of the plan year, and they have strict firewalls between individuals who determine eligibility and manage assistance and any commercial funders or providers. Programs that adhere to such safeguards should be treated no differently than Ryan White HIV/AIDS premium assistance programs.

Issuers' rejection of payments from these entities is a discriminatory attempt to undercut critical consumer protections within the Affordable Care Act and avoid covering people with pre-existing conditions. These actions closely mirror previous attempts by issuers to reject premium payments from Ryan White HIV/AIDS programs prior to CMS issuing regulations prohibiting such activity. Based on the discriminatory actions taken by issuers, it is evident that a regulatory mandate is needed in order to ensure that all issuers accept payment from these nonprofit programs.

While this RFI does not directly address the issue of nonprofit premium and cost-sharing assistance programs, we are deeply concerned that public discourse in response to this RFI has conflated the abusive practices raised by CMS within this RFI with these legitimate financial assistance programs that should not be deemed abusive. In addition, we are concerned that if CMS continues to put out guidance on the issue of third party payments without addressing these discriminatory actions on the part of issuers, more issuers will feel embolden to reject premium payments provided by responsible nonprofit entities.

Given this, it is critical that any action that CMS takes in response to this RFI clearly distinguishes between truly abusive practices that unduly steer patients for provider financial gain, and independent nonprofit financial assistance programs that provide help to high-cost disease populations in accordance with expectations that CMS has outlined for acceptable nonprofit financial assistance programs. The former activity presents a real risk to both consumers and the stability of our broader health care system. The latter form of assistance safeguards against perverse provider incentives and provides critical help affording coverage and care for patients.

We strongly recommend that CMS issue federal regulations stipulating that issuers are required to accept third party payments from independent nonprofit entities where:

- i. Eligibility for assistance is based on uniform financial need criteria and, if applicable, uniform criteria for assessing diagnosis of a specific condition or disease, without any consideration of the severity of an individual's health status;
- ii. The program does not restrict consumers' choice of plan, issuer, provider, or treatment; *and*
- iii. The program guarantees to offer financial assistance for the full plan year, or through the duration of short term financial hardship where assistance is required, such as due to unemployment or loss of spouse.

Federal regulations should also establish clearer guidelines regarding the range of practices that could pose a risk for abuse and could warrant investigation by an issuer or CMS. In setting these guidelines we strongly recommend that CMS focus on financial assistance programs directly connected to commercial entities (meaning that commercial entities have direct influence in the design and operation of the program) and that include any of the following characteristics:

- i. The program does not guarantee to provide premium assistance for the entire policy year, and in effect, only provides assistance through the duration of a patient's treatment or admittance to an inpatient facility;
- ii. The program limits consumers' choice of plan, provider, or treatment in order to qualify for financial assistance, or uses inappropriate financial incentives to steer consumers to particular plans, providers, or treatments.

- iii. The program does not provide assistance on a first come, first serve basis to individuals and does not use uniform financial need criteria to assess eligibility for such assistance

We believe setting clearer standards will allow CMS and issuers to combat fraudulent and abusive activities that could drive up health care costs, while ensuring that well-intentioned, responsible financial assistance programs are able to help consumers across all states. It will also help proactively curtail future abusive practices on the part of commercial entities by providing greater detail to all stakeholders regarding the scope of activities that would warrant investigation.

Unique Considerations for the End Stage Renal Disease Population:

Based on the issuance of a letter to dialysis providers in concurrence with this RFI, we conclude that CMS is particularly concerned with potential steorage of ESRD-eligible Medicare beneficiaries out of Medicare and into marketplace plans. **Given the attention paid to this population, we are concerned that this RFI does not adequately consider the legitimate reasons that individuals eligible for ESRD Medicare may independently decide to enroll in marketplace coverage, completely uninfluenced by a third party.**

This population is treated differently than the aged and disabled Medicare populations in terms of their eligibility for marketplace coverage, and their responsibilities and benefits under Medicare. CMS overlooks many of these differences in the discussion within this RFI. The RFI also mischaracterizes some of the risks this population could face if they opt to elect marketplace coverage and delay enrollment in Medicare. It is important that CMS consider these differences in order to understand the full scope of factors that influence this population's coverage decisions. As such, we offer the following comments specific to this population to help better inform the discussion on this issue.

Medicare Benefits for ESRD Populations

First and foremost, individuals eligible for Medicare due to End Stage Renal Disease (ESRD) face more limited coverage options in Medicare, compared to people who are eligible for age-based or Social Security Disability Insurance-based (SSDI-based) Medicare.

Unlike age-based Medicare beneficiaries, ESRD Medicare individuals have no federal right to purchase a Medigap plan. Furthermore, some states that extend rights to purchase Medigap plans to SSDI-based Medicare beneficiaries explicitly exclude people with ESRD.¹ Generally, people with ESRD Medicare are also excluded from enrollment in Medicare Advantage plans. As a result of these restrictions, a person with ESRD who enrolls in Medicare—even a person who was receiving financial assistance in the marketplace—has no protective caps on out-of-pocket costs in Medicare and has virtually no pathway to insure against these high costs. As such, people with ESRD altogether lack affordable Medicare coverage options.

Eligibility for Advance Premium Tax Credits

This population also faces different rules regarding eligibility for Advance Premium Tax Credits (APTC),

¹*Id.*

which go unaddressed in the RFI.

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

However, 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 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 IRS examples and illuminating guidance, two groups are not considered to be eligible for minimum essential coverage unless and until they choose to apply for and enroll in Medicare: (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

These two groups have the option to keep APTCs until they actively choose to enroll in Medicare Part A or the agency makes a favorable determination of eligibility.⁶

Medicare Late Enrollment Penalties

The ESRD population also faces different rules regarding Medicare Late Enrollment Penalties, which are not accounted for in this RFI.

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 to do so.”⁷ 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, they face no penalty.⁸

² 81 Fed. Reg. 57555.

³ 26 CFR 5000A(f)

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 CFR 57556.

⁸ 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>

The POMS also outlines how a person with ESRD Medicare, having made the mistake of enrolling in only Part A before they plan to enroll in Part B, can withdraw their application and re-enroll in both Part A and Part B when they wish their coverage to start.⁹ Taking such action ensures that they do not face any penalties once they do enroll in Medicare Part A and Part B.

Medicare Coverage of Immunosuppressant Drugs

Finally, the RFI's discussion regarding coverage of immunosuppressant drugs is incomplete. 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."

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). This includes situations where a transplant takes place during the 30-month coordination period that this population is provided when transitioning from individual coverage to Medicare. During this transition time, the individual market plan would be primary payer for a transplant, and once Medicare became primary payer then Part B would cover immunosuppressant drugs.¹⁰

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.¹¹ 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).

In sum, individuals who are eligible for ESRD Medicare face very different considerations when weighing their coverage options, compared to the aged and SSDI populations. Given the unrestricted out-of-pocket costs that this population faces in Medicare, some patients may find that marketplace coverage is a more affordable option. So long as these individuals have not enrolled in Medicare, they can still be eligible for federal financial assistance for marketplace coverage through APTC, and they do not face any penalties for choosing to delay enrollment in Medicare. Restrictions on Medicare Part B coverage of immunosuppressant drug coverage is complex and could have varied impact on patients, depending on their individual circumstance. Individual patients must consider the impact of that policy based on their individual circumstances when making coverage decisions. Given these factors, there may be ESRD Medicare-eligible individuals who independently decide that Marketplace coverage is better suited to meet their health and financial needs.

These inter-related factors highlight how important it is for ESRD patients to maintain the freedom of

⁹POMS HI 00801.197

¹⁰ Centers for Medicare and Medicaid Services "Outpatient Drugs: Examples of Drugs Covered under Part B"
<https://www.medicare.gov/coverage/prescription-drugs-outpatient.html>

¹¹ Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit Manual,
<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/chapter6.pdf> Appendix C.



choice to decide which coverage option is best for them. **It is critically important that CMS acknowledge these unique considerations facing the ESRD population as it develops policies to minimize inappropriate steering and clarifies policies related to third-party premium payments. Any actions taken by CMS should protect this population’s freedom of choice in selecting coverage. This includes protecting their access to nonprofit financial assistance for marketplace coverage in the situation that they independently decide that marketplace coverage is the best option for them.**

Capping Marketplace Reimbursement of Certain Services

The RFI requests input on approaches that would allow individual market plans to limit their reimbursement for particular services and items of care to Medicare-based amounts, in order to limit provider incentive to steer patients away from programs. While we welcome future discussions about how to holistically address unwarranted variations in the unit price of care across payers, we have concerns that such piecemeal caps on reimbursement for specific services could have adverse consequences on provider participation in marketplace plans and detrimentally harm access to certain types of specialty care for marketplace enrollees. As such, we caution against CMS adopting this policy, which applies a blunt and over-simplified approach to an issue that involves complex factors such as network adequacy and unit price variation across payers, in addition to the concerns of provider steering.