JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

June 27, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4199-P, P.O. Box 8013
Baltimore, MD 21244-4199

Submitted via email to regulations.gov

Re: CMS-4199-P—Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules

Justice in Aging appreciates the opportunity to submit comments in response to the above-referenced Notice of Proposed Rulemaking (NPRM).

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 healthcare, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Our comments focus on the impact of the proposal on low income older adults, including especially those who have been most impacted by discrimination and marginalization.

I. Special Enrollment Periods for Exceptional Conditions

We strongly support the proposed special enrollment periods (SEPs) and appreciate that they apply to both Part A and Part B and will eliminate late enrollment penalties (LEP). Many of our recommendations below are aimed at maximizing the benefit of these new SEPs with the goal of protecting continuity of health coverage.

Despite it being an entitlement and general public awareness of the program, Medicare enrollment is far from straightforward and is not intuitive or easy for many people. Most people need help navigating the process, and individuals with limited financial resources often also have fewer avenues to turn to for assistance. They may be less knowledgeable about the Medicare enrollment process generally and more likely to experience factors that complicate their Medicare eligibility (e.g., ineligible for premium-free Part A, not having employer coverage, aging out of Medicaid expansion coverage).

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In light of the program's complexity, we very much welcome the introduction of the new SEPs proposed in this rulemaking. The new SEPs will make it possible for many more individuals to get timely access to their Medicare benefits and prevent gaps in coverage that many currently experience.

We note that in discussing its reasoning in evaluating SEPs, CMS expresses concern that an SEP should "not create an incentive for individuals to not educate themselves about the importance of enrolling in Medicare timely and make informed decisions during other available enrollment periods." As advocates, it is our experience that willful failure to educate themselves is rarely the reason that individuals experience missed or late enrollment. People trying to "game the system" are even rarer. We ask that CMS take care to ensure that addressing these outliers does not become the basis for making enrollment more difficult for the majority of people who would use these SEPs to rectify or avoid harm. Overwhelmingly, eligible individuals want to access their benefits but are frequently stymied by the sheer complexity of the program, misinformation, and limited access to assistance that causes many costly enrollment delays. Limited English proficiency, disability and other factors compound the complexity, particularly for low income individuals. As CMS moves forward with these SEPs and potentially additional ones, we ask that the agency always make simplification a major consideration and seek to eliminate policies that result in gaps in coverage.

a. SEP for Individuals Impacted by an Emergency or Disaster

We strongly support creation of this SEP for individuals who reside in or were forced to leave an area covered by a newly declared disaster or other emergency, inclusive of declarations at federal, state and local levels. As the NPRM notes, emergencies often result in disruptions to government services, including SSA office closings and mail delays, that may inhibit Medicare enrollment. In addition, emergency situations are very stressful for individuals experiencing them and maintaining health coverage is essential. Older adults may be displaced from their homes, dealing with urgent repairs or health issues, lose internet or phone access, be separated from family and their support network, or face other circumstances that make timely Medicare enrollment difficult. We agree that this SEP is especially important for people with limited income and wealth who already face housing, food and other insecurities that emergency situations exacerbate.

The NPRM asks for comment on whether the timeframe for the SEP should be limited based on type of emergency and whether it should only be available if the type of emergency explicitly restricts the ability to enroll in Medicare. We do not support either of these limitations. Any type of emergency is stressful and impacts individuals and communities differently. Advocates have seen, for example, the impact of wildfires on communities. They destroy some homes and neighborhoods and leave others unscathed. Floods, tornadoes and other natural disasters often cause more extensive destruction in neighborhoods where residents are predominantly people of color and lower-income because of the pre-existing structural inequities that make those areas less desirable and housing less equipped to withstand violent weather. Even if downtowns, including SSA offices, are spared, the impact on the entire community is immeasurable and the priorities of everyone there shift dramatically.

Timely Medicare enrollment is unlikely to be top of mind as people respond to their own welfare needs and those of their neighbors. Further, it does not seem feasible to develop equitable criteria for determining which emergencies qualify for the SEP and for how long. It would also create more

administrative burden to apply those criteria. Simple inclusive rules are much easier to communicate, something that is particularly important in the chaos created by emergency situations with individuals often needing to deal with multiple government agencies as they cope with the aftermath of events.

We strongly support extending the SEP after the end of the emergency period, and urge CMS to extend the SEP for at least three months after the declaration ends. For individuals who evacuate or experience other major disruptions, the proposed two months may be insufficient to be settled and deal with more urgent issues before they are able to turn to Medicare enrollment.

b. SEP for Health Plan or Employer Misrepresentation or Providing Incorrect Information

We support creating an SEP for individuals who do not timely enroll in Medicare due to material misrepresentation or reliance on incorrect information provided by the individual's employer or group health plan (GHP). However, we urge CMS to broaden the criteria for this SEP and minimize the evidentiary burden on Medicare enrollees.

First, we urge CMS to expand the sources of misinformation that trigger the SEP beyond employer-based insurance. Individuals who are not auto-enrolled into Medicare may receive misinformation about Medicare enrollment from insurance agents and individual policy sellers, as well as non-federal government entities, including Medicaid, the Marketplace, and State Departments of Insurance. For example, someone may in good faith reach out to an insurance broker or the Marketplace call center about their options and receive misinformation about the Medicare enrollment process or timing. In addition, we do not believe limiting the sources of misinformation or incorrect information to employer or GHP sources serves any necessary purpose.

Second, we encourage CMS to expand the types of evidence that an individual can produce to show they qualify for the SEP. Advocates report that the misinformation individuals receive almost always is verbal, frequently through a call or meeting with a human resources department employee (or an outsourced HR advisor) or a representative of an insurer, though as noted above many other players—Medicaid representatives, independent insurance brokers or agents, Marketplace navigators and others—may give what sounds like authoritative advice. The types of letters or other documentary evidence CMS describes with explicit misinformation are rare. It is also very unlikely that a misinforming agent would readily produce a letter admitting error, particularly if they feared that doing so would expose them to some sort of liability. Further, the individual who provided the misinformation may no longer be working for the employer or insurer or other entity. Therefore, we recommend that enrollees who do not have such documentation be able to access the SEP by showing situation-specific evidence that a misrepresentation caused their delayed enrollment. For example, they could submit their own records or notes of conversations, proof of payment of premiums for alternative coverage, or provide an attestation that demonstrates they acted in good faith and were misled.

Third, we urge CMS to reconsider the proposal to exclude an omission by the employer or GHP as evidence for purposes of this SEP. While employers do not have an affirmative obligation to educate their employees about Medicare, we disagree that this precludes CMS from providing relief for individuals harmed by such omission. Allowing individuals to cite omission of Medicare information from

their employer or GHP as evidence that they were misinformed would not harm the employer or GHP or create a responsibility that does not currently exist.

CMS asks whether additional evidence should be required, for example, evidence of when and how the discovery was made. We do not support requiring any additional evidence as the burden is already significant, both for the individual seeking the SEP and for those reviewing the evidence. As explained previously, we urge CMS to broaden the scope of evidence that *can* be considered. How individuals discovered they had received misinformation may provide helpful context, but this should not be required.

Finally, we are concerned that the current duration of the SEP, only two months after the individual notifies SSA of the misinformation, is unrealistically short. We urge that it be extended to at least three months after notification, with a provision that SSA can provide extensions if reasonably needed to develop the record. This additional time may be necessary if SSA requires more information or documentation, or an attachment is inadvertently not included with the application.

c. SEP for Formerly Incarcerated Individuals

Justice in Aging strongly supports the creation of a new SEP for formerly incarcerated individuals. As discussed in the NPRM, the new SEP would benefit both individuals who turned 65 while incarcerated and did not enroll in their IEP timely, and also individuals who had been enrolled in Medicare prior to incarceration and were disenrolled because they did not—and almost always could not—pay premiums because all their Social Security benefits were suspended.

The SEP will ease transitions into the community for affected individuals and help prevent gaps in vital health care coverage. The SEP will be particularly valuable for reentering individuals in group payer states who do not qualify for premium-free Part A and who would be eligible for the Qualified Medicare Beneficiary (QMB) program, but only after conditionally enrolling in Part A. The SEP would give these individuals the opportunity to not only receive their Medicare benefits more timely but also to promptly enroll in the QMB program so that they can afford their Medicare coverage.

We ask that CMS also consider additional actions to maximize the positive impact of the proposed SEP. We recognize that some of these actions are beyond the scope of the NPRM but are amenable to administrative action without the need for new legislation.

Acceptance and processing of applications prior to release date: As we understand the proposed SEP, it would only allow applications to be accepted and processed after release from custody. Coverage would begin the month following application. Though a huge improvement to the current system, this procedure means that pre-release programs helping individuals to get their benefits lined up prior to reentry cannot ensure that Medicare applications are filed prior to the release date.

In contrast, in the Medicaid program, states can enroll incarcerated individuals at any time, although coverage will not begin until the individual leaves the institution. For Social Security benefits, the Social Security Administration has entered into a national prerelease agreement with the Federal Bureau of Prisons and local prerelease agreements with many state prisons to facilitate filing of SSI and SSDI

applications prior to release date. See POMS SI 00520.910. Further, SSI benefits can start on the date of release even if mid-month. In the Medicare program itself, both the Initial Enrollment Period regulation and the Employment SEP regulation allow submission and processing of enrollments prior to eligibility for coverage.

We ask that CMS and SSA explore the best routes to make Medicare coverage as seamless as possible under this SEP without gaps in coverage, be it through extension of the SEP to allow enrollment prior to coverage availability, extension of prerelease agreements to include Medicare enrollment, or other mechanisms. We recognize that release dates in prisons and jails can frequently not match those that were planned and that this variability can created logistical challenges.

Extend the SEP to 12 months. Older adults reentering the community often have been incarcerated for decades.[1] Advocates report that many older adults leaving custody after long terms of incarceration are at sea for at least the first year. They have not handled their own affairs and have not been allowed to. Learning to use computers and cell phones, much less to make appointments and complete government forms online, is a significant challenge. Many have lost contact with family members who could assist them and struggle to find stable housing and integrate into the community. Further, the reentry population includes disproportionate numbers of individuals with disabilities and serious or debilitating chronic conditions, including dementia.[2] Those conditions not only signal an urgent need for Medicare coverage, they also interfere with the ability to timely enroll in the program.

Though there are pre-release and post-reentry programs at an increasing number of institutions, the current reality is that availability of comprehensive assistance to reentrants with enrolling in benefit programs is spotty at best and many individuals returning to the community are left to fend for themselves. Extending the SEP to 12 months would help address the challenges they face by providing a longer opportunity to connect to a critical health benefit.

*Eliminate the financial burdens of the Medicare grace period for incarcerated individuals. C*urrently, incarcerated individuals who had previously been enrolled in Medicare with premium payments automatically deducted from a monthly SSA benefit are switched to direct payment when their SSA benefits are suspended. If direct payments are not received, enrollment (but without coverage because of incarceration) continues during a grace period and then, if non-payment continues, the individual is disenrolled. If the individual later re-enrolls in Part B after suspended SSA benefits are restored, SSA deducts premium payments for the grace period from the first SSA benefit payment.[3] This deduction causes significant hardship upon reentry, a time when individuals are most in need of all available resources to establish themselves in the community.

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[1] Over 40% of incarcerated individuals in state prisons over 50 years old were serving sentences of more than 20 years or life sentences. Human Rights Watch, "Old Behind Bars, the Aging Prison Population in the United States," (Jan. 27, 2012), available at https://www.hrw.org/report/2012/01/27/old-behind-bars/aging-prisonpopulation-united-states.

[2] Bureau of Justice Statistics, "Disabilities Among Prison and Jail Inmates," 2011-12 (Dec. 14, 2015), available at https://bjs.ojp.gov/ press-release/disabilities-among-prison-and-jail-inmates-2011-12.

[3] See SSA POMS HI 01001.045

We ask that CMS and SSA explore ways to eliminate or waive the premium recoupment. We note that elsewhere in the NPRM, CMS sought comments on the burden of collecting premiums for the lag period between loss of eligibility for Medicare buy-in and commencement of deductions from SSA benefits.[4] The same impact on ability to meet basic needs such as food and housing identified in the NPRM exists with the current post-incarceration practice. Moreover, because Medicare benefits are suspended during incarceration, the Medicare program has no coverage costs to recoup.

Revise 42 C.F.R. § 411.4(b): Though beyond the scope of this rulemaking, we ask CMS to review its regulatory definition of an individual in custody. In defining incarceration for purposes of the SEP for Formerly Incarcerated Individuals, CMS refers to 42 C.F.R 411.4(b), which broadly defines individuals in custody of penal authorities as "individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule." The regulation assumes that penal authorities have responsibility to cover, and will cover, medical expenses during all these circumstances, an assumption that is inconsistent with actual coverage by corrections authorities.

In contrast, the Medicaid program uses a different –and significantly narrower--definition that allows Medicaid coverage for individuals "on parole, probation, or released to the community pending trial; living in a halfway house where individuals can exercise personal freedom; voluntarily living in a public institution; or on home confinement."[5]

The Medicare restrictions are both broad and imprecise, particularly in their failure to fully define "under supervised release." These restrictions affect both eligibility for the proposed SEP and access to services for Medicare enrollees.

They prevent many older individuals returning to the community from being able to enroll in Medicare or, even if already enrolled, from using Medicare providers because of conditions connected with their release. This creates severe gaps in coverage, particularly for those who do not qualify for Medicaid upon reentry. Advocates have reported, for example, cases where individuals subject to home confinement have been unable to access needed surgery because neither Medicare nor the penal authority accepted responsibility for payment.[6]

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[4] 87 Fed. Reg. 25090, 25122 (April 27, 2022).

[5] Vikki Wachino, State Health Official Letter Re: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities (CMS, SHO #16-007, April 28, 2016), available at www.medicaid.gov/sites/default/fles/Federal-Policy-Guidance/ Downloads/sho16007.pdf.

[6] Under the regulation, the only situations in which an individual can rebut the presumption that the penal authority has responsibility for payment are if "(1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody; or (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts." If there was no state payment in the first place and thus no repayment obligation, the individual is without recourse. 42 C.F.R. § 411.4(b).

Advocates have also reported situations where, because of the ambiguity of the Medicare criteria, dual eligible individuals who, under the broader Medicaid criteria, should be eligible for Medicaid coverage, cannot access that coverage because state Medicaid programs require Medicare denial first. One example reported by an advocate was a dual eligible individual who was under home confinement, which triggered suspension of his Medicare coverage. He had Medicaid coverage because home confinement is not a bar under Medicaid rules. When he needed chemotherapy, however, his state Medicaid program was unwilling to provide authorization for a Medicaid claim unless there was first a Medicare denial, but Medicare does not process claims until after a service has been provided. With his provider unwilling to take the payment risk without some assurance of payment by some payor, this individual did not receive the chemotherapy he needed. The penal authority asserted it had no duty to provide care in a home confinement situation, Medicare suspended coverage because of its assertion that the penal authority had that responsibility, and the Medicaid program, though recognizing that the penal authority had no responsibility, was itself unwilling to pay because there was no Medicare denial. Thus even with three potential payors, this individual could not access urgent cancer treatment.

We ask that CMS through rulemaking address these gaps and barriers to care by harmonizing the Medicare and Medicaid definitions and ensuring that there is clarity by both penal authorities, CMS, and Medicaid programs as to the scope of coverage by each entity.

d. SEP to Coordinate with Termination of Medicaid coverage

We strongly support creating an SEP to help individuals who lose Medicaid coverage to timely enroll in Medicare without penalty. We agree that this SEP promotes health equity, given that people of color make up a disproportionate share both the Medicaid population and the population of Medicare enrollees with low-incomes. As the NPRM notes, continuity of health coverage is extremely important for low-income individuals, who are more likely to have disabilities and chronic health conditions and be in poorer health than higher income individuals. Further, as noted in the NPRM, individuals in some states missed their IEP because their state did not enroll them through state buy-in agreements, even though such automatic enrollment was required. We appreciate that CMS has prioritized protecting individuals from the fallout of the many things that did not go as they should have or were unintended consequences during the extraordinary period of the COVID emergency. We also appreciate that CMS recognizes the complexity and confusion that may result when Medicaid coverage is terminated and that the transition to Medicare is often not seamless.

We support the proposal to allow enrollees whose Medicaid is terminated before January 1, 2023 the option to start their Medicare the month following Medicaid termination. We also agree that LEPs should be reimbursed to people who enrolled in Medicare during the PHE but before this SEP is available. Otherwise these individuals would be penalized for having taken rational steps during a period when CMS post-PHE enrollment policies were uncertain.

With respect to the SEP's trigger and duration, we are concerned about what happens if the notice that triggers the SEP is never received. We know a major concern with Medicaid redeterminations at the end of the PHE is reaching people whose address has changed. Potentially millions of individuals could lose coverage because the state Medicaid agency is unable to contact them. We recommend ensuring that individuals can access the SEP even if they do not receive notice that their Medicaid coverage is

terminated until after the six months has passed. For example, if an individual goes to a provider seven months after termination and that visit is the first time that they have any notice that their Medicaid coverage is no longer active, the actual notice would be the start of their 6-month SEP.

We also ask for clarification about the application of this SEP to certain individuals who could potentially qualify for QMB coverage. The SEP covers individuals whose Medicaid coverage has terminated. Our concern is specifically about individuals who had expansion Medicaid and do not qualify for premium-free Part A coverage, who live in a group payer state, and who would qualify on the basis of income and assets for QMB coverage. We believe they would be in the group of individuals whose Medicaid eligibility would be terminated because, without an SEP, they would not have the opportunity to apply for conditional Part A enrollment, a necessary predicate step to QMB enrollment. Thus the SEP should apply to them. We ask for CMS to confirm our understanding and explicitly clarify this in the final rule. We also see this particular scenario as highly confusing to SSA offices, Medicaid programs and beneficiaries and ask that CMS work with states and SSA to make the transition for this especially vulnerable group and their timely access to QMB benefits as seamless as possible.

e. SEP for Other Exceptional Conditions

We support the general SEP for Exceptional Conditions. It provides an opportunity to address circumstances that are unanticipated but merit enrollment relief. We appreciate that CMS proposes to use the information and experience gained from this flexibility to establish new SEPs through rulemaking, and encourage the agency to do so in a transparent, data-driven, and public way. We also suggest that CMS and, to the extent relevant, the Social Security Administration (SSA) track and report any trends or patterns in the use (and limitations) of the other new SEPs to determine if there is any need to modify their requirements so that they can fully meet their purposes.

f. Recommendations for Additional SEPs

We encourage CMS to consider creating an SEP for immigrants who are unaware of their Medicare eligibility prior to citizenship. Eligibility rules for public benefits, including Medicare and Social Security, are more complicated for immigrants and involve complex calculations that vary based on immigration status, residency, work history, and waiting periods. Further obscuring the situation is the fact that immigrants do not receive any notice when they become eligible for Medicare. We have heard from advocates that many older immigrant adults miss their IEP because they, and sometimes those assisting them, do not realize that Medicare eligibility can start prior to citizenship. Some low-income individuals may understand that they are eligible to enroll, but the premium(s) are cost-prohibitive and they are unaware that the Medicare Savings Programs exist or are concerned about implications of enrolling in Medicaid on their path to citizenship, especially in light of the chilling effect and confusion surrounding the prior administration's public charge rulemaking.

As the underlying issue here is a misunderstanding of eligibility for Medicare for immigrants and a lack of notice, we believe an SEP, rather than individual equitable relief, is appropriate to provide clarity to this population. Besides providing an enrollment opportunity to people who missed their IEP due to a misunderstanding of their eligibility, an SEP would more generally better inform immigrants and their advocates about eligibility rules and thus make it less likely for immigrants to miss their IEP in the first

place. In addition, an SEP would provide much needed financial relief from late enrollment penalties for immigrants who do not qualify for Medicare Savings Programs.

II. Immunosuppressive Drugs: Ensuring Coverage Under the Medicare Savings Program

We recognize and appreciate that implementing the Part B-ID benefit, which is so important to kidney transplant recipients, is extremely complex and that implementation of this partial benefit presents unique challenges. We appreciate the careful work of CMS on the details of implementation and, in particular, the detailed discussion in the NPRM of the various scenarios related to MSP coverage of individuals with Part B-ID coverage.

In light of those complexities, we ask that CMS provide substantial technical assistance to states, pharmacies, nephrologists and other physicians, SHIPs, and navigators about the new benefit and its intersection with Medicaid benefits. We suggest extensive FAQs with multiple examples to provide guidance. Education of pharmacists and support for them during the rollout is particularly crucial. We urge that CMS, for example, consider having a dedicated pharmacy hotline during the first few months so that questions and concerns by pharmacists can be resolved in real time. We also ask that consumer materials about the benefit be tested with focus groups and be made available in multiple languages.

We also have serious concerns that, even with preparation, there are likely to be many instances at the start of the program of inaccuracies in state and federal data exchange about the coverage status of individuals for immunosuppressive drugs. We know that data exchange issues, particularly with respect to QMB status, already are common challenges for state and federal systems and fear that, with the layering of a new element – particularly during a timeframe that is likely to overlap with the unwinding of the Public Health Emergency—additional challenges are inevitable.

Our primary concern is what happens at the pharmacy counter when data errors occur. Given the life and death need for timely and uninterrupted access immunosuppressive drugs for kidney transplant recipients, we ask CMS to take steps to ensure that there is a safety net so that affected individuals do not have to walk away from the pharmacy without needed medications. The LI-NET system addressed similar issues in Part D. We ask that CMS put in place a system that similarly ensures access to medications while back-end determinations of payment responsibility are sorted out.

III. Proposal on Simplifying Regulations Related to Medicare Enrollment Forms

We strongly support this effort toward simplification and reduction in the number of forms. Reduction in the number of forms also makes it easier to translate forms into more non-English languages to ensure equitable availability of information to enrollees. We strongly recommend that CMS and SSA take this opportunity to create new forms that are easy to understand and to routinely make the forms available in multiple non-English languages and accessible formats.

IV. Modernizing State Payment of Medicare Premiums

We appreciate the many improvements in this section. Updating these regulations reduces confusion that arises when sub-regulatory guidance and longstanding practices may appear to be in conflict with

regulations. Also putting important requirements into regulation makes it easier to ensure compliance from the states and uniformity in application. Though many of the items in this section are technical, they have significant impact on beneficiary access to benefits.

a. State Plan Amendment as Agreement Between State and CMS

Transforming buy-in agreements into SPAs is particularly helpful. Not only is the SPA approach more familiar to states, as noted in the NPRM, but it has the added benefit of being more transparent since SPAs are available and searchable on the Medicaid.gov website.

b. Limiting State Liability for Retroactive Changes and Related Updates

We appreciate that the proposed regulation limiting state liability for retroactive Part B premium coverage connected to retroactive SSDI determinations includes an exception for cases where there could be beneficiary harm. While we agree that in most cases a state Medicaid program would have paid for medical services so retroactive coverage would not be necessary or useful, we do envision circumstances where an individual used a specialist or other provider who was not enrolled in Medicaid and incurred significant medical debt. For example, people with disabilities or rare conditions sometimes rely on a narrow community of highly specialized providers, some of whom are unwilling to enroll in Medicaid but do accept Medicare. They may rely on these providers, even though doing so involves substantial financial hardship. These situations would be relatively few since individuals would have been highly motivated to find providers who are in the Medicaid system, but for the people affected, would be incredibly important. There also would be limited opportunities to identify affected individuals but, in those cases, retroactive Part B coverage beyond the proposed 36-month cut-off could have a significant impact on economic well-being, particularly for those carrying significant debt.

c. Technical Changes to Regulations on State Payment of Medicare Premiums

We appreciate these updates and clarifications, particularly the revisions to Sections 406.21 and 406.26. We have seen confusion at the state level about some of the details in these regulations and appreciate the clarity of the proposed revisions.

d. Alternative Proposals Considered on Modernizing State Payment of Medicare Premiums

1. Months of Premiums for Which SSA May Bill Beneficiaries When Buy-In Ends

We strongly encourage CMS to revisit the current premium recoupment rule which causes tremendous hardship to beneficiaries. Advocates report having no real options to assist the many individuals they see who are suddenly surprised by a massive reduction in their monthly Social Security benefit and find themselves without the ability to pay rent or meet other expenses. Many fear homelessness and some indeed lose their housing.

These are individuals whose budgets allow no room for error. In 2021, the average Social Security benefit for retired workers was $1544/mo. Three months of Part B premiums are more that $510, a third of that amount. The impact on most individuals losing Medicaid eligibility is likely even more dramatic since their income would in most cases be well below average.

We urge at a minimum that those facing recoupment of back premiums be automatically placed on a payment plan of $10/mo. for the two-month overpayment, which is the same payment schedule that Low Income Subsidy beneficiaries can request with respect to Social Security overpayments. See POMS GN 02210.030(C).

A reduced payment plan should be automatic, rather than requiring the individual to request it. Experience in the Medicare and Medicaid programs has shown that low income beneficiaries have difficulty understanding correspondence about their benefits and frequently do not understand changes until a negative event takes place. Limited English proficiency, disabilities and cognitive impairments also may add barriers to initiating requests.

More broadly, we ask CMS to consider eliminating or reducing repayment liability. Two months of premium liability for this subset of the Medicare population is a relatively small amount in the context of the Medicare program but it can and does destabilize individuals in this economically fragile population, leading to negative housing and health outcomes that are much more expensive to fix.

It is not the fault of these beneficiaries that SSA procedures require two months to process premium payment changes. They should not bear the potentially catastrophic burden of those procedures on their ability to maintain financial stability.

2. State Payment of Medicare Premiums When Medicare Benefits Are Not Available

We are pleased to see that CMS is considering removing Medicare premium payment responsibility from state Medicaid programs for enrollees whose Medicare coverage is in suspension.

The arguments for taking this step for incarcerated individuals are particularly compelling. CMS both permits and encourages states to suspend Medicaid coverage for periods from one month to the entire length of incarceration. Suspending benefits rather than disenrolling incarcerated individuals facilitates timely start-up of Medicaid benefits upon release and eases both administrative burden and burden on those reentering the community. The current financial burden of paying for Part B premiums for dual eligible beneficiaries in state custody, however, disincentivizes states from adopting a policy of extended Medicaid suspension and thus interferes with the broader aims of putting policies in place to make reintegration into the community as seamless as possible.

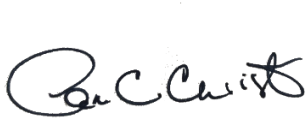
The policy that CMS is considering would remove this barrier and be consistent with a broader interagency commitment to address reentry barriers and the agency's other initiatives—including the proposed SEP for incarcerated individuals—to ensure that individuals returning to the community do not experience gaps in health care coverage.

Conclusion

Justice in Aging appreciates the important steps that CMS is taking in this rulemaking to improve eligibility for and access to Medicare benefits. We look forward to working with the agency to publicize, explain and implement these important changes that will have a significant impact on millions of individuals.

Thank you for considering our comments. If any questions arise concerning this submission, please contact Georgia Burke at gburke@justiceinaging.org.

Sincerely,



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