Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Legislation to Improve American's Health Care Coverage and Outcomes"
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The Honorable Gus M. Bilirakis (R-FL)

1. **What is credible coverage and does Medicare recognize all forms of health insurance coverage as credible coverage?**

"Creditable coverage" is a specific term with applicability to Medicare Part D. It refers to prescription drug coverage that is expected to pay, on average, as much as the standard Medicare prescription drug coverage.[1]

Creditable coverage can be from job-based insurance or from other sources such as federal programs or retiree plans. Every year, health plans must notify enrollees whether their drug coverage is creditable.

This classification is important because those who maintain enrollment in creditable drug coverage can avoid a late enrollment penalty (LEP) for delaying Part D. They can also access a two-month Special Enrollment Period (SEP) to enroll in a Part D plan.

Similarly, though there is no "creditable coverage" under Part B, certain Medicare-eligible individuals can access a Part B SEP that allows them to sign up outside of the normal enrollment timelines without being subject to the LEP that would normally accrue.

The Part B SEP is only available to people with coverage from current employment (from their job, their spouse's job, or sometimes a family member's job) who have been continuously insured since becoming eligible for Medicare. The Part B SEP begins when the individual is in their first month of Part B eligibility and ends eight months after they lose coverage from current work.[2]

[1] Medicare Rights Center, Medicare Interactive. "Creditable drug coverage," https://www.medicareinteractive.org/get-answers/coordinating-medicare-with-other-types-of-insurance/coordination-of-benefits-basics/creditable-drug-coverage.
[2] Medicare Rights Center, Medicare Interactive. "Enrolling in Medicare with job-based insurance," https://www.medicareinteractive.org/get-answers/coordinating-medicare-with-other-types-of-insurance/job-based-insurance-and-medicare/enrolling-in-medicare-with-job-based-insurance.

However, just because someone has access to this enrollment pathway doesn't mean they should delay Part B in reliance on it. Before making this decision, those who qualify for the Part B SEP must also endeavor to understand Medicare's intricate coordination of benefits requirements. These rules govern how other types of insurance works with Medicare. Specifically, which pays first, or primary, and which pays secondary.

The rules are different for each type of insurance. For employment-based coverage, the coordination depends on the size of the employer: small employers (fewer than 20 employees) pay secondary to Medicare, while large employers (20+ employees) pay primary.

Understanding these interactions is critical because when Medicare is primary, the other insurance may not pay until Medicare does, whether the individual is enrolled in Part B or not. Accordingly, if an individual has secondary insurance—such as a small employer-based plan—and does not enroll in Part B, it is as if they have no outpatient coverage at all.

To avoid being functionally uninsured, those with secondary coverage should typically sign up for Medicare when they are first eligible, even if they could use the Part B SEP to do so later.

a. How does the growing bloc of seniors working later in life impact the number of Medicare beneficiaries exposed to possible late-enrollment penalties?

While most beneficiaries are still automatically enrolled in Medicare Part B at age 65 because they are receiving Social Security benefits, a growing number of Americans are not. In 2016, only 60% of Medicare-eligible 65-year-olds were taking Social Security, compared to 92% in 2002.[3] Many of these individuals are working later in life and deferring their retirement benefits, though they may not realize that doing so impacts their Medicare coverage.[4] Others may choose—appropriately or not—to delay signing up for Medicare because they have another source of coverage, such as an employer-based plan.

Unlike those who are auto-enrolled in Part B, these individuals must actively do so, taking into consideration specific enrollment periods, existing coverage dynamics, and complicated Medicare rules. This process is so confusing that even sophisticated Human Resources experts have trouble with it, and many employers' benefits departments lack the Medicare knowledge to effectively guide their employees and retirees. Further, the federal government provides virtually no notification to people who are nearing Medicare eligibility about their responsibilities, including if they must actively enroll.

As a result, many people bear the full burden of navigating Medicare's arduous enrollment process. If this transition is mismanaged, they can face severe consequences, including lifetime late enrollment penalties, higher health care costs, and gaps in coverage.

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[3] Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019), http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.
[4] Johnson, R.W., Urban Institute, "Older Workers: Opportunities and Challenges" (July 2010), http://www.urban.org/UploadedPDF/412166-older-workers.pdf.

Unfortunately, many people do make mistakes. Year after year, among the most frequent calls to Medicare Rights' National Consumer Helpline are those from or on behalf of people with Medicare who inadvertently and through no fault of their own failed to enroll in Part B on time and are living with the repercussions.[5]

The demographic[6] and employment[7] trends that have so significantly changed how people experience their initial Medicare eligibility show no sign of abating. As a result, more and more beneficiaries will face complex Part B enrollment decisions—and experience the pitfalls of the current system. These pressures mean the BENES Act's commonsense solutions are needed now more than ever.

b. Can you discuss the benefit of aligning the annual general enrollment period with the annual enrollment period for private Medicare Advantage and Part D prescription drug plans?

Medicare Advantage and Part D, as well as commercial and job-based insurance plans, generally conduct enrollment from October to December of each year, with coverage beginning the following January. This is a time of heightened outreach and awareness for many people, as well as a familiar timeframe. Medicare's General Enrollment Period (GEP) runs from January through March with coverage beginning July 1, making it a confusing outlier. This divergence can cause beneficiary confusion and enrollment mistakes that lead to lifelong financial penalties, heightened health care costs, and harmful gaps in coverage.

c. Under the BENES Act, the federal government can create a Part B Special Enrollment Period for "exceptional circumstances." Is this provision currently used anywhere else and why is it necessary?

Special Enrollment Periods (SEPs) for "exceptional circumstances" are currently available in Medicare Advantage (MA) and Part D. CMS relies on this statutory authority to provide some enrollment relief for beneficiaries who are impacted by natural disasters.

This flexibility allows CMS to account for situations that may leave people unable to meet enrollment deadlines, obtain necessary paperwork, or access assistance. Since this authority was established, CMS has granted MA/Part D exceptional circumstances SEPs only three times—for Hurricane Sandy in 2012, for those affected by snowstorms in New York in 2014, and due to the hurricanes and wildfires in 2018.

However, similar administrative flexibility does not currently exist in Part B. Because that statute significantly pre-dates the creation of Medicare Parts C and D, it lacks the clarity of and parity with the newer language. As a result, Medicare rules do not reflect the reality that this enrollment

[5] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2017 Call Data from the Medicare Rights Center's National Helpline" (April 2019), https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf.
[6] Administration for Community Living, "A Profile of Older Americans: 2018" (April 2018), https://www.acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans.
[7] Mitra Toossi and Elka Torpey, Bureau of Labor Statistics, "Older Workers: Labor Force Trends and Career Options" (May 2017), https://www.bls.gov/careeroutlook/2017/article/older-workers.htm.

relief is just as necessary for people with Part B as it is for people with MA or a prescription drug plan.

This asymmetry leads to enrollment relief being inconsistently applied. It allows people with Part B to be treated differently than people with MA or Part D, despite living in the same area and experiencing the same natural disaster. For example, CMS did not view Hurricane Sandy as justifying a special enrollment period for Part B, but did grant one for MA and Part D.

The BENES Act would correct this misalignment by extending the Secretary's authority to issue an exceptional circumstances SEP to Part B. This would help avoid future conflicting policy interpretations and better ensure all people with Medicare have the opportunity to make optimal, timely coverage choices.

The Honorable Larry Bucshon (R-IN)

1. **If the NEMT benefit is eliminated, unintended consequences will include people skipping their medical treatments until they can arrange transportation. Have any experts examined the potential cost implications of this?**

A number of studies have demonstrated the vital role that NEMT plays in ensuring that people with Medicaid can attend medical appointments, comply with treatment plans, and receive needed care. For example, the National Academies of Sciences published the "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation" which found that NEMT increased attendance at appointments, reduced the length of hospital stays, and led to fewer emergency room visits.[8] Similarly, a separate study found that Medicaid beneficiaries with chronic conditions were significantly more likely to attend their routine appointments if they used NEMT.[9]

Medicaid NEMT facilitates access to medical services for low-income beneficiaries who have no other means of transportation, allowing them to receive routine and preventive care they might otherwise go without. Due to the program's strict eligibility requirements, those who qualify tend to have higher and more complex health needs than the general population.[10] Mental health problems, hypertension, heart disease, asthma, chronic obstructive pulmonary disease, diabetes, and end-stage renal disease are especially prevalent. But because these conditions are particularly responsive to appropriate care—including regular and sustained physician visits[11]—NEMT plays an outsize role in helping these individuals build and maintain their health, as well as avoid more costly medical emergencies, hospitalizations, and institutionalizations. In so doing, the program lowers individual and system-wide health care costs.[12]

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[8] National Academies of Sciences, Engineering, and Medicine, "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation," The National Academies Press, p. 14 (2005), https://doi.org/10.17226/22055.
[9] Michael Adelberg & Marsha Simon, "Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?," Health Affairs Blog (September 2017), https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/.
[10] National Academies of Sciences, Engineering, and Medicine, "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation," The National Academies Press, p. 34 (2005), https://doi.org/10.17226/22055.
[11] *Id.*, p. 61.
[12] Kara E MacLeod, et al., "Missed or Delayed Medical Care Appointments by Older Users of Nonemergency Medical Transportation," Gerontologist, 55(6), pp. 1026–1037 (December 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4668763/.

Absent access to NEMT, multiple studies suggest health outcomes would plummet while expenses would rise. One recent review found that for the estimated 3.6 million people who miss or delay medical care each year due to lack of transportation, NEMT is a cost-effective way for them to manage their conditions.[13] Another found that adults who lack transportation to medical care are more likely to have chronic health conditions that can escalate to a need for more costly emergency care if not properly managed.[14] And another concluded that NEMT yields impressive returns on investment, providing a "payback of 835%, or $8.35 per each dollar invested in these [transportation] programs."[15] Were Medicaid beneficiaries who rely on NEMT, for example beneficiaries on dialysis, forced to forgo or delay the care the benefit allows them to receive, their conditions would likely worsen.

2. **As a representative from a rural region and state, I recognize the value of the NEMT benefit to Medicaid beneficiaries who lack access to transit and who must travel great distances for many medical appointments. I would welcome your thoughts as to the potential impact on transportation access and on the transportation infrastructure in rural regions were the federal guarantee to this benefit to go away.**

Medicaid NEMT and broader community transportation services are interdependent. They are commonly provided by the same transportation agencies, especially in rural communities. To achieve efficiencies, these operating agencies often "commingle Medicaid NEMT with other essential services, including para-transit for people with developmental and physical disabilities, senior rides for older adults, and services for other vulnerable citizens who rely on public transportation to get to work, grocery stores, vocational training, and other destinations necessary to maintaining community engagement."[16]

As a result of this interdependence, "cuts to Medicaid NEMT would undermine entire communities'—not just Medicaid beneficiaries'—access to transportation." Localities already experiencing transportation funding challenges, as many rural areas are, would be particularly hard hit.[17] Eliminating the program entirely would only amplify these impacts.

3. **The recently passed appropriations package calls for the Department of Health and Human Services (HHS) to freeze any new regulation until MACPAC completes a study on the NEMT benefits. Do you know when this study will be completed, or when HHS' rule-freezing will be implemented?**

We do not have an official timeline for the completion of the MACPAC study but look forward to its conclusion as the appropriations language asks the commission to "examine, to the extent data are available, the benefits of NEMT from State Medicaid programs on Medicaid beneficiaries, including beneficiaries with chronic diseases including end stage renal disease

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[13] National Academies of Sciences, Engineering, and Medicine, "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation," The National Academies Press, p. 14 (2005), https://doi.org/10.17226/22055.
[14] Richard Wallace, et al., "Access to Health Care and Nonemergency Medical Transportation: Two Missing Links," 1924 Transportation Research Record: Journal of the Transportation Research Board, pp. 76-84 (2005), http://www.researchgate.net/publication/39967547_.
[15] Michael Adelberg & Marsha Simon, "Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?," Health Affairs Blog (September 2017), https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/.
[16] Michael Adelberg & Scott Bogren, "The Hidden Risk of Cutting Medicaid NEMT: An Examination of Transportation Service Interdependency at the Community Level," https://mtaccoalition.org/wp-content/uploads/2020/01/NEMT-Co-dependency-final.pdf.
[17] *Id*.

(ESRD), substance abuse disorders, pregnant mothers, and patients living in remote, rural areas, and to examine the benefits of improving assisted transportation services" and "directs HHS to take no regulatory action on availability of NEMT service until the study is completed."[18]

Currently, the OMB unified agenda indicates that CMS plans to begin the rulemaking process with a request for information at any time.[19] Given the devastating impact changes to NEMT could have on people with Medicaid, we agree that it is important to wait for MACPAC's study and other relevant data before considering whether any regulatory actions are appropriate.

[18] Division A—Departments of Labor, Health, and Human Services, and Education, and Related Agencies Appropriations Act, 2020, https://docs.house.gov/billsthisweek/20191216/BILLS-116HR1865SA-JES-DIVISION-A.pdf.
[19] Office of Management and Budget, Office of Information and Regulatory Affairs, "Request for Information: Assurance of Medicaid Transportation (CMS-2481-NC)," https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201910&RIN=0938-AT81.