WHITMAN-WALKER Institute

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November 7, 2022

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

VIA ELECTRONIC TRANSMISSION

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes; CMS-2421-P

Dear Secretary Becerra and Administrator Brooks-LaSure:

Whitman-Walker Health and the Whitman-Walker Institute (collectively, Whitman-Walker) appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes (Proposed Rule)

We support CMS finalizing the 2022 Proposed Rule as proposed, subject to the comments below, with compliance dates as soon as is practicable. Finalizing the rule will help simplify eligibility determinations and help individuals and families who depend on these essential programs to stay enrolled. As the COVID-19 Medicaid continuous coverage requirement comes to an end, these are particularly important changes that could help reduce coverage losses as states begin acting on eligibility redeterminations for millions of people.

Implementation dates. CMS should consider the complexity of system updates when setting implementation dates and balance state workload with the overall benefit of implementing changes that can help reduce coverage losses as the COVID-19 continuous coverage requirement ends. For example, setting a near-term compliance date for proposed

requirements regarding returned mail would help avert coverage losses. Phasing compliance dates is a reasonable approach should states need additional time to come into compliance, so long as states begin system updates upon finalization of the rule.

Our comments on the provisions of the 2022 Proposed Rule are set out below. Since some of our comments apply to multiple sections, we have listed the comments in the numerical order starting with the Medicaid provisions of the Proposed Rule.

Expertise and Interest of Whitman-Walker

Whitman-Walker Health is a Federally Qualified Health Center serving the greater Washington, DC metropolitan area with a wide range of health-related services, with special expertise in LGBTQ care and HIV treatment and prevention. We seek to empower all persons to live healthy, love openly, and achieve equality and inclusion. During the 12 months from July 2021 through June 2022, Whitman-Walker provided health care services to 16,668 unique individuals living in the District of Columbia, Maryland, Virginia, and neighboring states. Our patient population is very diverse racially, ethnically, and with regard to income. Twenty-two percent of our patients – more than 3,600 individuals – were living with HIV. Substantial numbers of our patients have Limited English Proficiency – during the recent 12-month period in question, 9.5% of them were primarily Spanish-speaking, and the primary language of a significant number was Amharic or American Sign Language. Approximately 37% of patient encounters are paid for by Medicaid (DC, Maryland or Virginia).

Whitman-Walker's Legal Services Department is the nation's oldest medical-legal partnership, and over more than three decades we have become a national leader in HIV law; gender identity and sexual orientation law; medical privacy law; and Medicaid, Medicare, and other public benefits health law. Our Public Benefits and Insurance Navigation Team, under the direction of senior Legal Services managers, has played a key role in implementation of the Affordable Care Act in the District of Columbia, including Medicaid expansion. Our staff has also closely monitored, and assisted many patients, with Medicaid coverage in Maryland and Virginia. In the 12 months from September 1, 2021, through August 31, 2022, Whitman-Walker attorneys and Public Benefits and Insurance Navigators served 2,009 clients in new cases (not including continuing cases opened prior to September 1). Of the new cases opened during this time, 380 involved Medicaid (enrollment, recertification, appeals, or other issues). Forty-eight percent of all legal clients were living with HIV, and 25% relied on a language other than English to communicate.

The Whitman-Walker Institute combines clinical and public health research, public policy advocacy, and professional and community education, with the goal of expanding the body of knowledge and science needed to advance health and wellness, particularly for sexual

and gender diverse communities. Our Institute is particularly active in advocating for full implementation of the ACA and access to health care generally; researching and promoting PrEP and other HIV prevention strategies; providing culturally competent training for health care professionals; ensuring access to gender-affirming care; and identifying and addressing racial, sexual, and gender health disparities.

Many if not most of our Medicaid-eligible patients struggle with health challenges, family responsibilities, transportation difficulties, housing instability, and/or language barriers. Current Medicaid procedures and policies are complex, confusing, and inconsistently administered. Whitman-Walker staff devote substantial time and resources to enroll our patients, keep them enrolled, and appeal unjustified adverse actions. The Proposed Rule addresses many of these challenges, and simplifies and rationalizes a system badly in need of reform.

Transitions between Medicaid, CHIP and BHP Agencies (§§ 431.10, 435.1200, 457.340, 457.348, 457.350, 600.330)

The ACA envisions a coordinated system of health coverage with seamless transitions between insurance affordability programs, including Medicaid, CHIP, BHP, and exchange coverage. Unfortunately, that seamless system has yet to be achieved. Many people still experience periods of uninsurance when their eligibility changes. We support the provisions in the Proposed Rule aimed at improving coordination between insurance affordability programs.

Currently, Medicaid agencies are not required to transfer accounts of individuals who fail to respond to requests for information at renewal or when the agency becomes aware of information that may indicate ineligibility for Medicaid. In these situations, Medicaid agencies can terminate coverage without determining eligibility or potential eligibility for other coverage. The Proposed Rule would change this by requiring account transfers whenever the agency determines ineligibility, and its information shows potential eligibility for another insurance affordability program. This is especially important because many people fail to respond when they know they are no longer eligible for Medicaid, and under current rules they do not receive information about their potential eligibility for other programs.

The Proposed Rule would also greatly improve coordination between Medicaid and CHIP and reduce disruptions in coverage and care for children as their family income and other circumstances change. We support requiring Medicaid and CHIP agencies to accept eligibility determinations from the other program. The simplest and most effective way to do this is by using a shared eligibility system for both programs, which the preamble says all states have. Using a shared eligibility system reduces the possibility of error, because of different eligibility policies and verification rules and avoids having staff of CHIP agencies determine Medicaid eligibility. We also support CMS's proposal to require that people be provided with a combined

Medicaid/CHIP eligibility notice when either the Medicaid agency determines an individual ineligible for Medicaid and eligible for CHIP, or the separate CHIP agency determines an individual ineligible for CHIP and eligible for Medicaid.

Maintenance of records (§ 431.17)

The Proposed Rule would require state Medicaid agencies to retain records for a minimum of 3 years after the applicant or beneficiary's case is no longer active. We suggest that state Medicaid agencies be required to maintain individual case records for a minimum of 10 years after the case is no longer active. This would more closely align the retention policy for these records with that of Medicaid managed care organizations under 42 C.F.R. § 438.3(u) and for drug manufacturers participating in the Medicaid Drug Rebate Program under 42 C.F.R. § 447.510(f).

We support updating CMS regulations to require state Medicaid agencies to maintain applicant and beneficiary case records in electronic format, and we support making them available on request to CMS and Federal and state auditors. However, we oppose the generally-worded provision authorizing release of records to "other parties" who request and are authorized to review such records. The regulation should specify who has a legitimate program integrity purpose for accessing individual beneficiary records. At a minimum, the regulation should require that the authorization for any "other party" to access these records be provided under federal law, so that federal privacy protections clearly apply.

Types of acceptable documentary evidence of citizenship (§ 435.407)

We support CMS' proposal regarding citizenship documentation requirements. Under current law, when an applicant's citizenship cannot be verified using data from the Social Security Administration (SSA), a two-step process is required: first verifying citizenship and then verifying identity. The proposed § 435.407 would allow two additional data sets, state vital statistics systems and data from the Department of Homeland Security (DHS), to be used as "standalone" proof of citizenship in addition to SSA data. This change would reduce burden on applicants and increase administrative efficiency without increasing the risk of erroneous eligibility determinations.

Application of financial eligibility methodologies (§ 435.601)

Proposed § 435.601 would set a new requirement related to how state Medicaid programs define "family size" for determining Medicare Savings Program (MSP) eligibility. Currently states have flexibility in how they determine family size for the purposes of MSP eligibility and many states only include a spouse living in the household in such definition. In order to facilitate

alignment of eligibility methodologies between the Low Income Subsidy (LIS) and MSPs, and thereby increase MSP enrollment, proposed § 435.601 would require a definition of family size to include at least the individuals included in determining family size under the LIS. That would include not just the spouse but all relatives, by blood or marriage, who reside in the household and are dependent on the applicant or spouse for at least half of their financial support. This change would better align the definition of family size between the LIS and MSPs, while also ensuring MSP eligibility for more individuals who happen to live with dependent adult children, grandchildren or other relatives.

Applications for other benefits (§ 435.608)

We strongly support CMS's proposal to remove § 435.608, which requires applicants and enrollees to apply for other benefit programs as a condition of Medicaid eligibility. We agree that changes in Medicaid eligibility have made such a requirement outdated. Congress and the Clinton administration eliminated the Aid to Families with Dependent Children (AFDC) program and thereby delinked Medicaid eligibility for a significant number of enrollees. The ACA requires states to use Modified Adjusted Gross Income (MAGI) methodologies for many Medicaid eligibility categories, which must follow IRS rules and consider taxable income actually received. As CMS correctly observes, "there is no statutory mandate for the rule in § 435.608(a) that currently requires application for other benefits by Medicaid applicants and beneficiaries" (87 Fed. Reg. at 54803).

Requiring individuals and families to apply for pensions, annuities, and other benefits as a condition of Medicaid eligibility impedes access to medical care, unduly burdens applicants and enrollees, and ultimately harms people by delaying needed care. Accordingly, we disagree with the alternative approaches CMS suggests, including making the requirement a post-enrollment activity. Such a requirement may seriously limit the amount and scope of benefits for which an individual may be eligible. For example, most adults in the United States may apply for (reduced) Social Security benefits as early as age 62. However, delaying Social Security enrollment until age 67 or 72 can significantly increase the amount of benefits received. Medicaid applicants and enrollees should not have forgo their full, earned Social Security benefit to access Medicaid.

Allowing Medically Needy enrollees to deduct prospective expenses (§ 435.831)

We support the proposed provision to give states the option to make it easier for some low-income people with catastrophic medical costs to enroll and stay enrolled by expanding the deduction of prospective expenses for medically needy eligibility. Under current regulations, state can opt for institutionalized individuals to have their predictable expenses deducted at the start of their budget period, enabling them to have continuous coverage between budget periods

with no lapse in eligibility due to a spenddown period. CMS proposes to give states the option to extend this policy to other individuals with "constant and predictable" services, including prescription drugs and home and community based long-term services and support. Many individuals receive these types of services for long-term health conditions that are consistent, and such individuals should not need to document their expenses on monthly or other short periods. We support this new provision as it will improve continuity for enrollees, reduce their administrative burden, and likewise reduce the burden on states (including costs associated with eligibility determinations and churning). The provision will also reduce one of the systemic biases towards institutionalization.

Aligning Non-MAGI enrollment and renewal requirements with MAGI policies (§§ 435.907 and 435.916)

The ACA and implementing regulations streamlined eligibility determinations and renewals for people whose eligibility is determined using MAGI rules. By comparison, eligibility determinations and renewals for people who are over age 65 or who are blind or have a disability (i.e., non-MAGI groups) in many states continue to be conducted in a manner that is unnecessarily burdensome for applicants and enrollees, as well as for state eligibility workers. The failure to streamline eligibility rules for non-MAGI groups has resulted in higher rates of procedural denials, even though older adults and people with disabilities are more likely to have stable incomes. Denials are more likely because these groups are more likely to lack transportation and have health-related barriers to responding to requests for documents. Therefore, we support CMS's proposed changes to promote equity across all enrolled people by eliminating barriers to application, enrollment, and renewal for the non-MAGI groups.

To simplify the application process for older adults and people with disabilities, we support CMS' proposal to apply the requirement that individuals must be able to apply through all modalities currently specified in § 435.907(a). We also support prohibiting an *in-person* interview requirement for the non-MAGI groups. However, we recommend that CMS go further and prohibit all interview requirements, for both the MAGI and non-MAGI groups. Finally, renewing eligibility no more frequently than every 12 months, sending a pre-populated renewal form, giving enrollees 30 days to respond, and allowing a 90-day reconsideration period have all proven possible to implement and effective at reducing churn on and off Medicaid for MAGI groups; therefore, we support extending these policies to the non-MAGI groups. In addition, requiring agencies to accept additional verification documents at renewal through all modalities will further streamline redeterminations for non-MAGI groups. We urge CMS to finalize these proposals to provide more stable coverage for people eligible for non-MAGI groups.

Timely Determination and redetermination of eligibility (§§ 435.907, 435.912, and 457.340)

We generally support proposed changes to §§ 435.907 and 435.912, and corresponding CHIP changes at § 457.340. These changes would ensure that applicants and enrollees have adequate time to furnish all requested information, and ensure that states complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances. We support the proposal to provide most applicants with at least 15 days, from the date the request is sent, to respond with additional information; this proposal will help ensure that new applications can be acted upon in a timely manner. We also agree that applicants applying on the basis of disability should be provided with at least 30 days to return additional information, since such information may be more challenging to gather.

In general, the timelines and changes that CMS discusses in the preamble appropriately account for the need to prevent denials of coverage without an accurate determination of ineligibility, while at the same time minimizing the need to extend coverage beyond an enrollee's period of eligibility. CMS should clarify the regulatory text to ensure that the final rule accurately reflects this approach. Updated timeliness and performance standards for the state to complete redeterminations at renewal and upon changes in circumstances also are appropriate; we concur with the timelines that CMS includes in the proposed rule. Although we support giving applicants more time to return requested information, when needed, we urge CMS not to change the timeliness requirement for application processing if applicants are given more time. CMS should retain the current 45- and 90-day processing timelines to ensure that eligibility determinations are made in a timely manner, extending them could needlessly delay eligibility determinations and would not be in the best interests of beneficiaries.

In all cases, we recommend the use of calendar days to assure timely determinations and because we believe doing so is consistent with how most states currently calculate deadlines and thus would be less operationally challenging to implement. We also recommend that CMS require states to include a deadline based on when the item is expected to be sent (rather than the date the notice is generated – which can be days before it is mailed – or requiring individuals to calculate deadlines based on postmarks).

We support alignment between Medicaid and CHIP provisions regarding timely determinations and redeterminations of eligibility, as proposed. HHS specifically seeks comment on whether CHIP programs for children with special health care needs should be aligned with the longer timeframes allowed for Medicaid disability determinations, but we believe the shorter 15- and 30-day timeframes are appropriate for all CHIP eligibility determinations and redeterminations because CHIP eligibility standards are the same for all children, even if some children are eligible for additional benefits.

Automatic entitlement to Medicaid following a determination of eligibility under other programs (§ 435.909)

Proposed § 435.909 would require states to automatically enroll nearly all SSI beneficiaries into the Qualified Medicare Beneficiary program (QMB), in order to increase QMB participation and promote the proper and efficient administration of the Medicaid program. Currently, though all individuals eligible for SSI meet the income and resource eligibility limits for QMB, some eligible individuals are not enrolled into the QMB program because of procedural and technical barriers, such as a requirement to file a separate application with a state Medicaid agency for QMB benefits. According to the regulatory impact analysis for the proposed rule, automatic enrollment would increase QMB enrollment by an estimated 470,000 more people (full-year equivalents) in 2023 and by 980,000 more by 2027, who would all newly gain access to critical financial assistance with both Medicare premiums and cost-sharing and protections against balance billing. We support these proposed changes.

Determination of eligibility (§ 435.911)

As the preamble to the proposed rule observes, the Medicare Improvements and Patients and Providers Act of 2008 has long required SSA to transmit eligibility data collected from LIS applications ("leads data") to state Medicaid agencies, and has required state Medicaid agencies to treat receipt of the data as initiation of an MSP application. If the state needs more information to process the application, it should send a prepopulated application to the individual that only requests the information that has not already been provided by SSA. But according to the preamble, not all states are in full compliance, with over one million people enrolled in full LIS benefits who are not enrolled in an MSP.

Proposed § 435.911 would formally codify these requirements and implement them fully by specifying: (1) states must accept LIS leads data, (2) treat receipt of such data as a Medicaid application (for MSP benefits), (3) promptly and without undue delay determine MSP eligibility without requiring a separate application, (4) request additional information needed to determine MSP eligibility, (5) not request other information that is already included in the leads data, (6) accept any information verified by SSA without further verification, and (7) collect any additional required information including citizenship and immigration status. In addition, the state must notify individuals that they may be eligible for MSP benefits if more information is needed, if the SSA LIS data is insufficient to support a determination of MSP eligibility, and give individuals 30 days to provide such information. Furthermore, if a state has fully aligned MSP eligibility rules with LIS rules, states could then determine eligibility without additional information, except for citizenship and immigration status information. According to the proposed rule's regulatory impact analysis, these amendments would result in 240,000 more people (full-year equivalents) enrolled in MSPs in 2023 and by 520,000 more by 2027, who

would newly gain access to MSP benefits, including assistance with Medicare cost-sharing and/or premiums.

Case documentation (§ 435.914)

Currently, state Medicaid agencies are required to make a finding of eligibility or ineligibility on each application it receives and to include in each applicant's case record the facts supporting the agency's decision. The proposed rule would expand the requirements to include beneficiaries as well as applicants and extend it to renewals as well as new applications. We support these amendments, which would consolidate eligibility and enrollment information for each applicant or beneficiary in one case record.

Acting on changes in circumstances timeframes and protections (§§ 435.916, 435.919, and 457.344)

We strongly support the Proposed Rule's provisions on treatment of changes in circumstances; these modifications to existing regulation will help reduce coverage losses for procedural reasons. In particular, we support the proposed requirement that agencies may not take adverse action if an enrollee does not respond to a request for information to verify a change reported by either the individual or a reliable third party that would qualify the enrollee for more favorable coverage. Enrollees' lives are often complicated, and they may not receive the request for additional information or be able to gather the appropriate documents in a timely manner. Defaulting to keep someone enrolled, especially when there is no evidence of ineligibility, is most beneficial for continuity of coverage. Additionally, rather than give states flexibility to either act on reliable third-party information that may result in an increase in the amount of coverage or assistance a beneficiary is entitled to, or to contact the beneficiary to determine whether the information received is accurate, we recommend *requiring* action on such information from a reliable source, as that would be in the best interest of beneficiaries.

We also support the proposed requirement that states accept reports of changes in circumstances through all modalities listed in § 435.907(a); a 30-day period to verify changes in circumstances; a new 90-day reconsideration period for individuals who are terminated for failure to return requests for information about changes in circumstances; and clarification when the agency may and may not rely on third party sources of information reporting changes in circumstances. All of these proposed changes appropriately balance the goal of retaining coverage for individuals who continue to be eligible, with the goal of preventing individuals who become ineligible for Medicaid from continuing to remain enrolled.

In addition, we support alignment between Medicaid and CHIP provisions regarding changes in circumstances, as proposed.

Agency action on returned mail (§§ 435.919 and 457.344)

Current Medicaid and CHIP regulations do not specify steps states must take to follow up on mail that is returned as undeliverable, even though returned mail leads to a significant number of eligible people losing coverage. We support the provisions in the Proposed Rule that would require states to take reasonable steps to determine beneficiaries' correct addresses by checking available data sources and making multiple attempts at contacting beneficiaries, though multiple modalities, before terminating coverage. The proposed requirements for acting on mail returned with in-state, out-of-state, and no forwarding addresses represent reasonable approaches to ensure that individuals who are likely still eligible remain enrolled, and that individuals who have moved out of state do not remain enrolled.

In addition to new procedures for acting on returned mail, we support CMS's proposal to permit states to accept information it receives from reliable sources, such as the Post Office or a managed care contractor, as long as the state does not receive a response from the enrollee that it is incorrect. We encourage CMS to go a step further, and require states to accept this information, even if the enrollee does not respond to a request to confirm it. Such a requirement is warranted given the reliability of the Post Office's National Change of Address database and enrollee reported/verified information shared by contracted managed care plans.

Finalizing new standards regarding returned mail will help avert coverage losses that are anticipated as the COVID-19 public health emergency comes to an end. We support alignment between Medicaid and CHIP provisions regarding agency action on returned mail, as proposed, with one exception. Proposed § 457.344(f)(5) instructs states to follow the out-of-state procedures when the new address is outside of the geographic area for separate CHIPs that are not statewide. Instead, we recommend that if the new address is out of the separate CHIP program region but still within the state, that CHIP proceed with determining eligibility for Medicaid, CHIP and other insurance affordability programs within the state and available in the region where the new address is located, then sending a combined notice, as outlined in proposed §§ 435.1200(h) and 457.350(g).

Use of information and requests for additional information from individuals (§ 435.952)

We support the proposal to modify § 435.952(b) and (c) to clarify that CMS's longstanding reasonable compatibility policy applies to the verification of financial resources for non-MAGI eligibility groups. Reasonable compatibility avoids unnecessary requests for verification by comparing the applicant's or enrollee's attestation to available electronic data sources and evaluating whether any difference identified in those data sources affects eligibility. If both the self-attestation and the data source show income or assets are at or below the

eligibility threshold, the state determines the person eligible. However, because the current reasonable compatibility requirements were issued before states had implemented asset verification systems (AVS) to electronically verify financial resources for older adults and people with disabilities, some states do not apply reasonable compatibility rules to resources identified via AVS.

The Proposed Rule clarifies that reasonable compatibility applies to resource information; the proposal should be finalized to decrease burden and reduce the number of non-MAGI applicants and enrollees who are locked out of coverage for procedural reasons. We also support CMS' proposal to establish the primacy of electronic verification of resources by requiring states to first check electronic data sources for financial resources before asking the individual for additional information and documentation.

In addition, as the preamble to the proposed rule notes, states already have the flexibility to align MSP income and asset counting rules with LIS rules. But states that have not already fully aligned eligibility rules must continue to request additional information needed to determine MSP eligibility, which is not provided through the LIS eligibility data provided by SSA. To address this issue, proposed § 435.952 would require state Medicaid programs to adopt enrollment simplification policies related to income and resources that are counted in determining MSP eligibility but not counted in determining LIS eligibility. This would simplify administration and serve the best interests of beneficiaries by allowing state programs to use the leads data more efficiently, reduce administrative burdens on states and beneficiaries and increase MSP enrollment. Specifically, proposed § 435.952 would require states to process MSP applications and determine MSP eligibility based on self-attestation (rather than requesting documentation) related to dividend and interest income, burial funds, cash value of life insurance and the value of non-liquid assets, unless states have information that is not reasonably compatible with the information provided through self-attestation. States may then, if appropriate, verify such information after enrollment, including having the option to request the individual to provide documentation if electronic verification is not available. Individuals, however, must be given at least 90 days to respond and provide any necessary information requested. In addition, for the cash value of life insurance, states would be required to assist individuals in obtaining that information from their insurers.

Verification of other non-financial information (§§ 435.956 and 457.380)

When an applicant attests to citizenship or a satisfactory immigration status but the state is unable to verify such status, the state is required to provide a reasonable opportunity period (ROP) of 90 days (or longer) for verification. During the ROP, states must furnish Medicaid/CHIP benefits. Under current law, states have the option to limit the number of ROPs an individual may receive, though no state currently does so. Proposed § 435.956 would remove

this option in Medicaid and CHIP (by an existing cross reference in § 457.380). We support this change, because allowing states to limit the number of ROPs would make it harder for eligible people to enroll, disproportionately impacting certain vulnerable groups, including survivors of domestic violence and people experiencing homelessness, for whom electronic verification of immigration status is difficult.

We recommend CMS engage in oversight on states' implementation of this provision to ensure that states utilize ROPs correctly and individuals receive benefits during the ROP.

Prohibit waiting periods (§§ 457.65, 457.340, 457.805, 457.810)

States currently are permitted to establish waiting periods of up to 90 days before children can enroll or reenroll in CHIP. Waiting periods disrupt continuity of coverage and are administratively difficult to implement. A waiting period may only apply to a child following the loss of group health coverage (not Medicaid or another insurance affordability program) and only in limited circumstances. If a waiting period does apply, states must transfer the child to the Marketplace temporarily and then transfer the child back to CHIP once the waiting period ends. We support eliminating waiting periods in CHIP as proposed at §§ 457.65, 457.340, 457.805, 457.810. This policy is unique to CHIP, burdening low- to moderate-income families. HHS should not simply reduce the allowable length of waiting periods to 30 days or some other time period but eliminate waiting periods altogether.

Prohibited coverage limitations, preexisting condition exclusions, and relation to other laws (§ 457.480)

CHIP is also unique in continuing to allow annual and lifetime dollar limits on benefits, which are not permitted in Medicaid or on essential health benefits in the Marketplace. Health care costs typically grow faster than the economy, and inflation is expected to hit the health care sector especially hard soon, which could bring the real value of covered benefits down over time unless properly indexed. Proposed § 457.480 would eliminate annual and lifetime dollar limits in CHIP. We support eliminating annual and lifetime dollar limits in CHIP. Such limits are not allowable in Medicaid or other insurance affordability programs, and continuing to allow them in CHIP is unjustified.

Improving Participation in the Medicare Savings Programs

We strongly support the provisions in the proposed rule that would significantly improve participation in MSPs. These programs – the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, and the Qualifying Individual (QI) program – provide critical financial assistance to low-income older adults and

people with disabilities also eligible for Medicare. For individuals with incomes below 100 percent of the federal poverty line, the QMB program covers Medicare Part B premiums (and Part A premiums, if applicable) and Medicare deductibles and other cost-sharing. The SLMB and QI programs pay for Part B premiums for individuals with incomes between 100 and 120 percent of the federal poverty line and 120 and 135 percent of the poverty line respectively. To give a sense of the value of these benefits, the standard monthly Part B premium in 2022 is $170.10 or $2,041.20 annually.

Despite legislative and administrative improvements over the past two decades that were intended to increase MSP participation among eligible low-income Medicare beneficiaries, participation remains relatively low. As the Medicaid and CHIP Payment and Access Commission (MACPAC) has previously reported, QMB participation is estimated to be only 53 percent. Among those eligible for SLMB, participation is only 32 percent and among those eligible for QI, participation is only 15 percent. Moreover, participation is lower among older adults on Medicare than those under age 65 who are eligible for Medicare due to disability. For example, QMB participation is 48 percent among those aged 65 and older, compared to 63 percent among those aged 18-64. SLMB participation is 28 percent among those aged 65 and older, compared to 42 percent among those aged 18-64. MACPAC finds that along with a lack of beneficiary awareness, barriers to enrollment, such as differences between state Medicaid eligibility rules and those for the Medicare Part D Low Income Subsidy (LIS) — which covers Medicare premiums and cost-sharing related to prescription drugs — and lack of automated and streamlined enrollment, were key factors in low participation.[1]

[1] Medicare and CHIP Payment and Access Commission, "Report to Congress on Medicare and CHIP," June 2020, https://www.macpac.gov/publication/june-2020-report-to-congress-on-medicaid-and-chip/.

Conclusion

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Erin Loubier at eloubier@whitman-walker.org.

Sincerely,

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