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Medicare Part B Enrollment:

Pitfalls, Problems and Penalties

Recommendations to Improve the Medicare Enrollment System for Consumers

November 2014

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Acknowledgements

Stacy Sanders, Federal Policy Director at the Medicare Rights Center, served as the primary author of this report. Rachel Bennett, Vice President of Program & Product Development, served as the primary editor. Special thanks are due to Joe Baker, Ilene Stein, Kim Glaun, Casey Schwarz, Josh Schultz, Samantha Morales and Mitchell Clark for research, writing, advisory, editing and design support.

Mr. R: High Costs and Coverage Gaps Accompany Delayed Medicare Enrollment

In 2001, at age 55, Mr. R retired from his job, and his former employer provided him with retiree medical coverage. Mr. R did not elect to begin collecting Social Security retirement benefits when he turned 65 and became eligible for Medicare. Individuals—like Mr. R—who are not collecting Social Security benefits must actively enroll in Medicare during their Initial Enrollment Period (IEP).

During his IEP, Mr. R enrolled in Medicare Part A (inpatient coverage), but declined Part B (outpatient coverage), believing he would have adequate medical insurance under his retiree plan. What Mr. R did not know was that when he turned 65 and became eligible for Medicare, his retiree coverage became *secondary* to Medicare. While current employer-sponsored health insurance can act as primary or secondary to Medicare, retiree insurance *always* pays *secondary* to Medicare, as determined by federal coordination of benefits rules.

The Social Security Administration (SSA) called Mr. R while he was in the process of declining Part B and asked him to confirm that he wanted to decline Part B. According to Mr. R, he told Social Security, "I have medical coverage; I don't need Part B." At the same time, Mr. R's retiree health plan sent him two confusing notices in the months leading up to his 65th birthday. One notice warned that Mr. R could permanently lose his retiree benefits if he enrolled in other health coverage. The other notice said that Mr. R's retiree benefits would be significantly reduced if he did not enroll in Part B. The two notices appeared to contradict each other, and Mr. R did not act on the notice explaining the need to enroll in Part B.

When Mr. R became eligible for Medicare, his retiree plan stopped paying primary for outpatient services, essentially operating as though Mr. R had no insurance at all. During this time, Mr. R incurred at least $10,000 in medical expenses from two different health incidents. Only after these medical bills for unpaid expenses and denials from his retiree insurance started arriving did Mr. R realize that something was wrong.

But Mr. R was in a bind. Having missed his IEP, he had to wait for the General Enrollment Period (GEP) to enroll in Part B. The GEP lasts from January through March of each year, with coverage beginning July 1st of the year a person enrolls. In the end, Mr. R enrolled in Part B during the 2014 GEP—more than a year after he first became eligible for Part B—with his coverage taking effect in July, seven months later.

Reflecting on his experience, Mr. R said, "If anybody says they don't want [Medicare] coverage, they should be asked more than once [whether by Social Security, their employer, or their former employer]. They should receive more [than one clear notice] letter and have to sign it, acknowledging that they don't want Part B. I went back to Social Security about six months ago, and a couple in front of me said they didn't want Part B. It was all I could do to keep myself seated, instead of running up and explaining the consequences."

Part B Enrollment Pitfalls Explained: Trends on the Medicare Rights Center Helpline

An often-reported fact is that 10,000 Baby Boomers turn 65 and become Medicare-eligible each day.[i] Less well known, and commonly misunderstood, are the rules concerning how to enroll in Medicare. While most newly eligible Medicare beneficiaries are automatically enrolled, others must make a proactive choice to enroll in one or multiple parts of the program, including Part A, Part B, Part C and Part D. Through its direct service and educational programming, the Medicare Rights Center (Medicare Rights) regularly hears from older adults and people with disabilities who erred during this transition and struggle to cope with the consequences.

At age 65, retirees already collecting Social Security retirement benefits are automatically enrolled in Part A and Part B. The same is true for individuals ages 64 and younger who are collecting Social Security disability benefits following a 24-month waiting period. For those *not* collecting Social Security benefits, it is necessary to actively enroll in Medicare, taking into consideration specific enrollment periods and existing coverage. If this transition is mismanaged, individuals new to Medicare may face lifetime late enrollment penalties, higher health care costs, gaps in coverage and disruptions in care continuity.

As evidenced by questions received on Medicare Rights' national helpline, many struggle to understand Medicare enrollment periods, coordination of benefits rules and the penalties associated with delayed enrollment. In 2013, Medicare Rights fielded more than 15,000 questions on its national helpline, and the second most common call concerned enrollment (22 percent). Nearly one-quarter of these calls were from individuals experiencing challenges enrolling in Part B, whether because they were navigating a specific hurdle (38 percent), did not understand enrollment periods (28 percent) or were unsure whether they were Medicare-eligible (13 percent). While most newly eligible beneficiaries qualify for "premium-free" Part A because they have sufficient work history, almost all beneficiaries pay a monthly Part B premium.[ii] This premium expense leads some to turn down Part B when they first become eligible—a choice that can have dire consequences.

Another common issue for callers to Medicare Rights' helpline—and by extension for all Medicare beneficiaries—involves understanding how Medicare coordinates with existing health insurance.[iii] Transitions to Medicare for those with retiree insurance, COBRA benefits and employer-sponsored coverage represent some of the most common transition points for newly eligible Medicare beneficiaries. Other transitions include the move to Medicare from traditional Medicaid, TRICARE and liability coverage. Most recently, the Affordable Care Act (ACA) introduced two new transition points: those moving from Marketplace plans to Medicare and those moving from expansion Medicaid to Medicare.[iv] In all cases, people new-to-Medicare must consider how their current health coverage will coordinate with Medicare benefits.

While each specific transition presents its own unique challenges, Medicare Rights' experience demonstrates that similar problems tend to apply across the board. Specifically, the most common pitfalls associated with delayed Part B enrollment can be broken into three categories:

1. **Navigating Coordination of Benefits Rules**
2. **Understanding Enrollment Periods**
3. **Affording Late Enrollment Penalties**

Despite these challenges, there is one limited avenue for recourse available to those who, owing to misinformation or misunderstanding, delay Part B enrollment: equitable relief. This process allows individuals to request immediate or retroactive enrollment into Part B and the elimination of late enrollment penalties from the Social Security Administration (SSA). Yet, equitable relief is only granted to people who can prove they were provided misinformation from a federal source about enrolling in Medicare. Notably, this leaves individuals who receive misinformation from other sources, like an employer or health plans, or who are simply uninformed with *no opportunity* to undo the adverse consequences resulting from innocent errors.

These problems must be fixed to spare ever greater numbers of individuals from experiencing them. From 2002 to 2012, the number of older Americans rose by 21 percent—to 43.1 million. By 2040, estimates suggest that the U.S. will be home to 79.7 million older adults.[v] Aside from this sheer increase in volume, a growing share of this population is likely to delay taking Social Security benefits at age 65 as the full retirement age raises to 67.[vi] In fact, recent data illustrate that an increasing number of seniors are working longer: between 1999 and 2009, the share of workers ages 55 and older increased from 12 to 19 percent, the largest proportion on record. It is projected that this older cohort will represent 25 percent of the labor force by the year 2019.[vii]

The Part B enrollment trends documented on Medicare Rights' helpline and elsewhere demand that employers, advocates, educators and policymakers examine enrollment pitfalls, parse existing challenges and develop fixes to simplify beneficiary transitions to Medicare. Without solutions, a growing share of newly eligible beneficiaries will experience the harsh consequences of mismanaged transitions, risking their health and financial security.

Medicare Rights Recommends:

- ✓ **Enhance Education for the Soon-to-Be-Medicare-Eligible:** A comprehensive system should be developed to notify people nearing Medicare eligibility about what steps to take and when.
- ✓ **Rationalize Medicare Enrollment Periods:** The Initial Enrollment Period (IEP) and General Enrollment Period (GEP) should be simplified, particularly by ensuring that Medicare coverage begins as quickly as possible.
- ✓ **Strengthen Avenues for Relief:** Access to equitable relief and Special Enrollment Periods (SEPs) should be more readily available to help those who make honest mistakes.
- ✓ **Fill Gaps in Knowledge:** Additional research, such as by the Government Accountability Office (GAO), on Medicare Part B enrollment periods, penalties and equitable relief is needed.

Complex Coordination Rules Lead to Missteps

An individual's decision to enroll in Medicare Part B (or not) largely hinges on the kind of coverage that she has prior to becoming Medicare-eligible and the rules governing whether that insurance will pay primary or secondary to Medicare. These policies are collectively known as "coordination of benefits rules." Simply put, coordination of benefits is a sharing of costs and coverage by two or more health plans. When a Medicare beneficiary has a second form of insurance, Medicare will act as either a primary or a secondary payer. Primary insurance always pays first. Whereas, secondary insurance pays after the primary insurance, typically covering cost sharing and services not covered by the primary insurer, depending on the rules of the policy. Coordination of benefits rules for three of the most common Medicare transition points are described below:[viii]

Employer-Sponsored Group Health Coverage Based on Current Employment: Whether an employer plan pays primary or secondary to Medicare is determined by two factors: 1) why a person is eligible for Medicare, owing either to age or disability, and 2) the size of the employer.

For an employee or an employee's spouse becoming eligible for Medicare at age 65, Medicare pays primary for companies with 20 employees or fewer. When there are more than 20 employees, the employer plan pays primary.[ix] For those eligible for Medicare based on disability, Medicare pays primary for companies with 100 employees or fewer.[x] In all cases, these rules apply only for those who are *currently* working.

Retiree Coverage: These health benefits—made available to a former employee from an employer as a function of retirement—*always* pay secondary to Medicare.[xi]

COBRA Coverage: These health benefits—made available when an employee loses access to an employer-sponsored group health plan—*always* pay secondary to Medicare.[xii]

One of the most common enrollment errors made by newly eligible beneficiaries occurs when an individual is misinformed, not informed or mistaken about coordination of benefits rules—like in the case of Mr. R. Delaying enrollment in Part B under the assumption that a secondary form of coverage—such as small employer, COBRA, or retiree coverage—will pay primary can have catastrophic consequences. For instance, a secondary insurer is not obligated to pay primary for health care costs, leaving individuals who only have secondary coverage essentially uninsured. Medicare Rights often hears from individuals whose secondary insurer will not pay for services received, or will limit payment to its share of costs as a secondary insurer.

In short, when a newly eligible Medicare beneficiary's existing health coverage will pay only secondary to Medicare benefits a person must enroll in both Part A or Part B—or risks having little to no health coverage. Yet, when a person's existing coverage will pay primary to Medicare benefits, like that provided by a large employer, an individual retains the option to enroll solely in Part A and delay enrolling in Part B.

In the worst case scenarios, a secondary insurer may seek to recoup payments when it erroneously acted as primary coverage and paid for services that in fact should have been covered by Medicare. In many cases, individuals expected to reimburse their secondary insurer for these health care costs struggle to do so. Some beneficiaries in these circumstances may choose to go without needed care or abandon treatment plans due to health care costs already incurred. Owing to a lack of streamlined transitions processes and clear education and assistance, many individuals do not realize that they should be enrolled in Part B until it is too late.

Enroll at the Right Time or Fall into a Coverage Gap

When a person can enroll in Medicare Part B and when their Part B coverage begins depend on when they initially sign up for coverage. Currently, there are three distinct Part B enrollment periods:

1. **Initial Enrollment Period (IEP)**
2. **Special Enrollment Period (SEP)**
3. **General Enrollment Period (GEP)**

Initial Enrollment Period: The IEP is a seven-month period that includes the three months before an individual turns 65, the month of his 65th birthday and the three months after he turns 65.[xiii] The point at which a newly eligible beneficiary signs up during their IEP determines when their Medicare coverage begins. Specifically, for those who enroll during the first three months of their IEP, coverage begins the month of their 65th birthday. For those who enroll in the fourth through seventh months of their IEP, their Part B start is delayed from one to three months, resulting in a needless gap in health coverage and potential disruptions to ongoing care. The graphic below details the Medicare coverage start dates throughout the IEP for an individual turning 65 in June.

Turning 65 in June, Medicare Start Dates during the Initial Enrollment Period:

Enroll during:	Coverage starts:
March	June 1st
April	June 1st
May	June 1st
June	July 1st
July	September 1st
August	November 1st
September	December 1st

As described above, some people decline Part B enrollment during their IEP because they have another form of health insurance. Sometimes this decision is appropriate, such as for individuals who have employer-sponsored insurance through a large employer. But in many other cases—like for those who have only secondary coverage through COBRA, a retiree policy or a small employer—this decision is ill-advised for two reasons. First, as described above, secondary insurance may offer little or no coverage for individuals lacking primary Part B coverage. Second, if an individual declines Part B during the IEP and does not have insurance through current employment, they are not eligible for a Special Enrollment Period (described below) and will face premium penalties when they do enroll in Part B.

Special Enrollment Period: An SEP is available to individuals with employer-sponsored group health coverage from their or their spouse's current employer. The SEP allows an individual to enroll in Part B outside of her IEP with no premium penalties. Beginning once an individual is Medicare-eligible, the SEP continues for eight months after employer-sponsored coverage or employment ends, whichever is first.[xiv] SEPs are not available to those who have delayed Part B enrollment and have other insurance types, such as individual and family insurance plans, retiree plans, COBRA policies or Veterans Administration benefits.[xv]

Medicare Rights often observes that individuals new-to-Medicare equate access to a SEP with the assumption that one should delay Medicare enrollment. Yet, due to the coordination of benefits rules described above, while delayed enrollment is allowable through a SEP, that does not always mean it is advisable. Importantly, people with health coverage from small employers should enroll in Part A and Part B when first eligible to retain primary health benefits, as opposed to delaying enrollment through a SEP.

General Enrollment Period: Individuals without access to an SEP who miss their IEP—for example, those who have COBRA coverage or retiree insurance—must wait for the annual GEP to enroll in Part B. The GEP runs from January 1 to March 31 each year, but Medicare coverage does not begin until July 1. This delay in the effective date of coverage under the GEP can create a significant coverage gap in outpatient coverage and access to care for those who have erroneously delayed Part B enrollment.

Make a Mistake, Pay for a Lifetime

Coverage gaps are not the only consequence facing individuals who mistakenly delay Part B enrollment. Higher out-of-pocket costs in the form of lifetime late enrollment penalties (LEPs) may also apply.[xvi] LEPs are intended to encourage individuals newly eligible for Medicare to enroll in the program and ultimately to ensure that a younger, healthier population balances the Medicare risk pool.[xvii] Yet because the rules concerning Medicare enrollment are so often unknown or misunderstood, many newly eligible beneficiaries are paying LEPs due solely to honest error.

Those who do not enroll in Part B during their Initial Enrollment Period and do not qualify for a Special Enrollment Period (SEP) are subject to a lifetime Part B LEP. Part B LEPs most commonly apply to those who enroll in Part B during the General Enrollment Period.[xviii] In 2012, roughly 740,000 Medicare beneficiaries paid Part B LEPs.[xix]

The Part B LEP accrues at 10 percent of the current Part B premium for every year a person should have been, but was not enrolled in Part B.[xx] Consider the case of Mrs. G, who turned 65 in 2007 but mistakenly delayed signing up for Part B until 2013 and was ineligible for an SEP. Over the remainder of her lifetime, Mrs. G will pay a Part B premium that is 60 percent higher than it otherwise would be (6 years delayed x 10 percent). This amounts to a monthly premium of $167.64 in 2014, instead of the standard $104.90.[xxi]

Other Considerations for the Newly Eligible Medicare Beneficiary: Enrolling in Part D

Common pitfalls associated with enrollment in Medicare Part B are not the only challenges facing those new-to-Medicare. Newly eligible beneficiaries must also consider enrollment in Part D. Specifically, newly eligible beneficiaries must determine whether to enroll in Part D when they become eligible or whether to delay and continue with existing prescription drug coverage.

The rules governing enrollment in Part D are distinct from those in Part B, which involve benefits coordination, insurance source, employer size and how an individual becomes Medicare eligible. Instead, an individual can delay enrollment in Part D if their existing prescription drug coverage, from whatever source, provides equal to or greater value than the standard Part D benefit. Coverage that meets this standard is called *creditable coverage*.

Individuals eligible for Medicare receive notice from their health plan as to whether or not their prescription coverage is creditable. Those with existing prescription coverage that is *not* creditable and who delay Part D (whether purposefully or mistakenly) are subject to a lifetime Part D Late Enrollment Penalty (LEP). The Part D LEP amounts to 1% of the national base beneficiary premium for each month that a person lacked creditable coverage after he first qualified for Part D. In 2014, the base premium is $32.42 per month. For instance, in Mrs. G's case, with a six-year (or 72-month) delay in Part D enrollment, she will pay $23.34 on top of her monthly Part D premium in 2014. This LEP will be recalculated and added to her monthly premium each year when the national, Part D premium rate is recalculated.

In addition to lifetime premium penalties, gaps in coverage may also be problematic for those with delayed Part D enrollment, as people are unable to enroll in Part D until the annual open enrollment period (October 15 to December 7). In short, newly eligible Medicare beneficiaries face many of the same severe consequences in Part D as in Part B—including lifetime late enrollment penalties, gaps in coverage and disruptions in care—when the transition to Medicare is mismanaged. Also similarly, these individuals face an array of complex rules and timelines, often leading to honest errors and enrollment mistakes.

Minimal Avenues for Relief Risk Beneficiary Health and Economic Security

The only routes to assistance available to those who erroneously delay Medicare Part B enrollment include enrollment into a Medicare low-income program or a request for equitable relief.

Low-Income Enrollment: Individuals with limited income and assets who mistakenly delay enrolling in Part B can enroll in a Medicare Savings Program (MSP), which will enable them to enroll in Part B outside of the General Enrollment Period and avoid the Part B Late Enrollment Penalty (LEP). Enrolling in an MSP, however, is not retroactive and so does not undo health costs incurred when an individual is without Part B coverage. Further, MSPs are only available to individuals with extremely low incomes and very limited assets. As such, these programs are not viable solutions for most people.

Equitable Relief: Created through federal law, equitable relief is an administrative process that allows people with Medicare to request relief from the Social Security Administration (SSA) in the form of immediate or retroactive enrollment into Part B and the elimination of a Part B LEP.

For equitable relief to be granted, SSA must determine that a person's failure to enroll in Part B was "unintentional, inadvertent or erroneous," and was the result of "error, misrepresentation or inaction of a federal employee or any person authorized by the federal government to act in its behalf."[xxii] Given this, equitable relief provides no remedy for individuals becoming eligible for Medicare who are misinformed by, for example, an employer, employment-based or individual market health plan or insurance broker, about the rules surrounding Medicare enrollment.[xxiii]

No formal process exists for equitable relief: there is no explicit mechanism to request relief, no timelines for SSA decisions and no clear route for challenging decisions. Instead, an individual must write a letter to SSA explaining that they received misinformation from a federal employee, such as a 1-800-MEDICARE counselor, an SSA caseworker or a customer service representative for a Medicare private health plan. The letter must provide evidence that a federal employee or agent provided misinformation, including details on dates, times and information provided. As noted, no timeframes govern when SSA must make a determination of equitable relief, and there is no formal requirement that SSA provide notification on its decision.

Without appropriate pathways for relief, people who mistakenly delay Medicare enrollment must live with the consequences, potentially including higher out-of-pocket health care costs, lifetime premium penalties, gaps in health coverage and disruptions in care continuity. Occurring alone or in combination—as is often the case—these circumstances can prove detrimental to the health and financial security of seniors and people with disabilities, forcing some to go without needed health care or other basic needs.

Fixing the Fragmented Medicare Enrollment System

As the American population ages at an unprecedented rate and increasing numbers of individuals experience difficulties transitioning to Medicare from other types of insurance, it is critically important that the Medicare Part B enrollment process be made as clear and simple as possible. A combination of administrative and legislative fixes are needed to strengthen education, streamline Part B enrollment periods and expand relief mechanisms. Toward this end, Medicare Rights recommends the following:

Strengthen Education for the Soon-to-Be Eligible: A comprehensive system should be developed to notify people nearing Medicare eligibility about whether they need to actively enroll in Medicare, who can appropriately delay Medicare coverage, the potential consequences of delayed enrollment and the rules concerning coordination of benefits, enrollment periods and premium penalties. This system should involve the following:

> **Notify people nearing Medicare eligibility.** No federal entity is currently responsible for notifying people nearing Medicare eligibility about the need to enroll if they are not already receiving Social Security benefits. The challenges presented by lack of notice are consistent across coverage type (e.g., employer-sponsored coverage, COBRA, Medicaid).
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> Not only is it important to support people like Mr. R—who make a mistake by choosing to decline Part B—it is also critical to ensure that individuals turning age 65 are made aware of their rights and responsibilities nearing Medicare eligibility. Without notification from the federal government, some individuals may turn 65 and *do nothing* with respect to Medicare enrollment, simply because they are unaware. Not knowing whether an enrollment decision is needed can be just as detrimental as wrongly choosing to decline Part B.
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> Administrative agencies, most notably the Social Security Administration (SSA) and the Centers for Medicare & Medicaid Services (CMS), should collaborate to ensure that appropriate notice about Medicare eligibility and enrollment is provided to seniors nearing age 65 and to people with disabilities nearing the end of their two-year waiting period for Medicare. The notice should be made available both electronically and in print at least three months prior to a person's IEP and should clearly explain the full scope of consequences that may result if Medicare enrollment is delayed. This consumer-friendly notice should be developed by the federal government in consultation with relevant stakeholders, including beneficiaries, consumer advocates, employers, communications and design experts, and private health plans. Clear sets of standardized instructions and checklists should be developed providing information on circumstances where an individual should enroll in Medicare Part B or decline coverage.
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> Further, this notification should be supplemented by a broad-based educational campaign, targeted at consumers and those who advise them, such as State Health Insurance Assistance Programs (SHIPs) and the 800-MEDICARE and SSA call centers. The campaign should include trainings and resources that explain how insurance coordination and enrollment rules interact, as well as the consequences of not following rules properly. Additionally, Congress should

establish and provide dedicated funding for a National Medicare Transitions Resource Center. Operated by CMS, the Center's charge should involve providing technical assistance to multiple audiences, including employers, health plans, beneficiaries, SHIPs and other counselors.

Educate employers. For individuals transitioning to Medicare who are still working, employers and human resources departments are often a primary source of information about coordination of benefits and other Medicare enrollment rules. Serving in this role can be particularly challenging for small employers, many of whom lack a sophisticated human resources infrastructure and staffing. And, as evidenced by Medicare Rights' helpline experience, employers sometimes provide incorrect or incomplete guidance to their employees and retirees about when and how to enroll in Medicare.

CMS should be required to actively engage employers to ensure that correct information is delivered to employees who are nearing Medicare eligibility. In particular, CMS should be required to develop standardized, easy-to-read materials that employers are then required to provide to their employees approaching Medicare. Similar requirements already exist with respect to prescription drug coverage, as employers are required to notify employees about whether or not their current coverage is creditable to Medicare Part D.[xxiv]

As noted above, with appropriate financial support from Congress, CMS should launch a technical resource center, including consumer-friendly descriptions of Part B enrollment periods and rules, Frequently Asked Questions (FAQs) on enrollment rules, summaries of the consequences of delayed enrollment, and other materials, to help human resources departments and others better serve their employees.

Streamline Medicare Enrollment Periods: The Medicare Initial Enrollment Period (IEP) and General Enrollment Period (GEP) should be simplified, namely by ensuring Medicare coverage begins as quickly as possible post-enrollment.

Fix the Initial Enrollment Period. Currently, if a newly eligible beneficiary enrolls in the fourth through seventh month of their IEP, the initiation of Medicare coverage is needlessly delayed, resulting in unnecessary and harmful gaps in health coverage.

Congress should restructure the IEP so that Medicare coverage begins on the first of the month or the first of the following month when a person enrolls. Coverage start dates for the IEP should mirror those under the Affordable Care Act, where a Marketplace plan's coverage start date is determined by when a person enrolls, either before or after the 15th of a given month.

Fix the General Enrollment Period. Similar to the IEP, the annual GEP includes a significant gap between enrollment and the start of an individual's coverage—up to a seven-month delay. Congress should restructure the GEP to start coverage as quickly as possible. At the same time, the GEP should be lengthened to minimize coverage gaps for those who mistakenly delay Part B enrollment.

Align Medicare enrollment periods. The annual GEP to enroll in Medicare Parts A and B does not match the annual open enrollment periods for private Medicare plans, including Medicare Advantage and Part D. Congress should align the start of the GEP with the start of the annual election period in October.

Strengthen Avenues for Relief: Access to equitable relief should be extended to individuals who receive misinformation from an employer or employer-based or individual market health plan—not only from federal sources, such as SSA or 1-800-MEDICARE. At the same time, Special Enrollment Periods (SEPs) should be available to people with pre-Medicare coverage other than employer-sponsored group health plans.

Recognize misinformation from more sources as basis for equitable relief. As noted above, newly eligible Medicare beneficiaries who are not collecting Social Security benefits receive no formal notification from the federal government about the rules associated with Medicare enrollment. As a result, many individuals look to sources other than the federal government—most notably employers, private health plans, and insurance brokers—for information about how benefits coordinate and when or whether to enroll in Medicare.

Given the complexity of the rules associated with Medicare enrollment, it is not surprising that these sources often provide people with incorrect guidance. For these individuals there is no avenue for relief from the higher health care costs and gaps in coverage that result from mismanaged transitions. Congress should expand SSA's authority to grant equitable relief to individuals who receive misinformation from employers, employer-sponsored or individual market health plans and insurance brokers.

Simplify and standardize the process for seeking equitable relief. Lack of access is not the only hurdle for people who attempt to file for equitable relief. Congress should formalize the equitable relief process to include: a clear process for requesting equitable relief, mandated timelines for SSA to process decisions, and a formal appeals process with an independent reviewer. Models for such an appeals process already exist in Original Medicare and within the Medicare Advantage and Part D programs, and all are governed by specific timelines for adjudication and notice rights.[xxv]

Expand SEP rights and timeframes. Federal law only grants a SEP to individuals currently working with existing employer-sponsored group coverage and for eight months after that coverage ends. As reflected in the Medicare Enrollment Protection Act of 2011 (111th Congress; H.R. 5588), Congress should make a SEP available to people who have COBRA or retiree insurance prior to becoming eligible for Medicare and to those who are misinformed about Medicare enrollment policies by the federal government or a health plan.[xxvi] As noted above, these SEP rights should be coupled with improvements to the equitable relief process. Congress should also authorize the Secretary of Health and Human Services to grant Part B SEPs in limited circumstances, much like the authority available to the Secretary to provide SEPs for Part C and Part D enrollment.[xxvii]

Revisit the Part B lifetime late enrollment penalty. As noted above the Part B late enrollment penalty (LEP) is intended to encourage individuals newly eligible for Medicare to enroll in the program and to balance the Medicare risk pool. Alongside improvements related to notification, SEPs and equitable relief, Congress should explore whether a lifetime premium penalty is too punitive. It is important that a penalty appropriately deter individuals who might actively seek to avoid Medicare enrollment but not punish those who make honest mistakes when first becoming eligible for Medicare.

H.R. 5588 also includes provisions to allow for continuous open enrollment for individuals who do not enroll during their IEP or an SEP, with a mandated Part B premium increase to be determined by the Secretary of Health and Human Services. Additionally, legislation introduced by Congressman Barney Frank in the 111th Congress (H.R. 2235) would reduce the Part B LEP and exclude COBRA and retiree insurance from the Part B LEP.[xxviii] Part B premium increases coupled with the elimination of the GEP or adjustments to the Part B LEP may be warranted, but these policies require actuarial analysis to ensure the appropriate incentives are in place to encourage Medicare enrollment by younger, healthier beneficiaries.

Fill Gaps in Knowledge: Unfortunately, the true impact of enrollment challenges on newly Medicare-eligible seniors and people with disabilities is difficult to discern. Without access to more comprehensive records it is difficult to discern the number of beneficiaries affected and potentially affected. In particular, information should be made publicly available on an ongoing basis about the numbers of Medicare beneficiaries paying lifetime late enrollment penalties, including information on the beneficiaries themselves (i.e., race, ethnicity, education completed, gender, pre-Medicare coverage source) and the average penalty amount. Information and trends on the average gap in coverage resulting from Part B enrollment mistakes should also be made available.

At the same time, there are many questions that should be explored surrounding equitable relief, including: On average, how many beneficiaries request equitable relief and, if at all, how have these trends changed over time? What entities are most commonly cited as providing misinformation? How often does SSA grant or deny equitable relief? On average, what is the agency's timetable for processing a request? And, most importantly, how do SSA and CMS use this information to improve education and outreach to beneficiaries, employers, and others?

Congress should take steps to analyze the true scope of these issues, such as a through a request to the Government Accountability Office (GAO). Current federal policies involving beneficiary notification and general education, enrollment periods, late enrollment penalties, and equitable relief deserve careful scrutiny.

Conclusion

With 10,000 Baby Boomers aging into the Medicare program each day, ensuring smooth transitions to Medicare is of vital importance.[xxix] As federal and state governments continue to implement the Affordable Care Act—most notably by extending access to coverage through private health plans and

expansion Medicaid—it will be more important than ever that seniors and people with disabilities have a clear path to access Medicare.

On its national helpline, the Medicare Rights Center regularly witnesses that, despite the diversity of circumstances among newly eligible Medicare beneficiaries, the transition traps they fall into are very much the same. These include difficulties understanding how Medicare coordinates with other types of insurance, navigating enrollment periods, and affording lifetime premium penalties.

To ease these enrollment burdens, Congress, CMS and SSA ought to prioritize notification and education for those nearing Medicare eligibility. Additional policy changes are needed to rationalize Medicare enrollment processes while simultaneously making it easier for individuals who mistakenly delay Part B enrollment to access relief. To secure the health and financial stability of today's and future generations of retirees and people with disabilities, steps must be taken now to ensure seamless Medicare transitions.

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[vii] Johnson, R.W., "Older Workers: Opportunities and Challenges," (Urban Institute: July 2010), available at: http://www.urban.org/UploadedPDF/412166-older-workers.pdf .

[viii] Coordination of benefits rules for other transition points summarized here, see: Medicare Rights Center, "Moving to Medicare," (2014), available at: http://www.medicarerights.org/pdf/Transitions-to-Medicare.pdf.

[ix] 42 C.F.R. § 411.172(a); Medicare as Secondary Payer Manual, Chapter 1, Section 10.1, Chapter 2, Section 10.

[x] 42 C.F.R. § 411.204; Medicare as Secondary Payer Manual Chapter 1, Section 10.3; Chapter 2, Section 30.

[xi] 42 U.S.C. § 300b-2(2)(D); If an individual is eligible for Medicare due to End Stage Renal Disease (ESRD) employment-based coverage, including retiree insurance, pays primary to Medicare for 30 months, after which Medicare becomes primary; See: Centers for Medicare & Medicaid Services, "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services," (2014), available at: http://www.medicare.gov/pubs/pdf/10128.pdf.

[xii] 42 U.S.C. § 300b-2(2)(D).

[xiii] 42 C.F.R. § 407.14(a).

[xiv] 42 C.F.R. §§ 407.20, 406.24 (b)(2); Social Security Administration (SSA) Programs and Operational Manuals System (POMS) at HI 00805.275; Individuals who are eligible for Medicare due to disability may be eligible for the Part B SEP

because of coverage as a result of their or their spouse's current work for any employer, or a family member's work for a large-group employer.

[xv] SSA now defines the SEP based on group health coverage to expressly include coverage from a national health system in the foreign country where the person or their spouse works; See, SSA, "Are You Covered Under A Group Health Plan?" (May 2014), available at: http://www.socialsecurity.gov/hlp/isba/10/hlp-isba080-grphlth.htm#a0=3.

[xvi] Those who are eligible for Medicare as a result of disability and who are not yet 65 have an IEP when they turn 65. During this IEP, a previously assigned late enrollment period for wrongfully delayed enrollment upon becoming eligible for Medicare due to disability may be removed. POMS at HI 00805.015.

[xvii] Davis, P.A., "Medicare: Part B Premiums," (Congressional Research Service: March 2014), available at: http://fas.org/sgp/crs/misc/R40082.pdf .

[xviii] 42 C.F.R. § 408.22; POMS at HI 01001.010; HI 00805.330.

[xix] Davis, P.A., "Medicare: Part B Premiums," (Congressional Research Service: March 2014), available at: http://fas.org/sgp/crs/misc/R40082.pdf.

[xx] 42 C.F.R. § 407.15; POMS at HI 00805.025.

[xxi] Medicare Interactive, "Medicare Part B Late Enrollment Penalty," (Medicare Rights Center: 2014), available at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=316.

[xxii] 42 U.S.C. § 1395p (h); POMS at HI 00805.170.

[xxiii] Equitable relief may be available for those given misinformation from their employer or insurer if the inaccurate information was about whether the insuerer would be primary or secondary to Medicare, and if the person is eligible for Medicare due to disability, not age. POMS at HI 00805.320.

[xxiv] 42 C.F.R. § 423.56.

[xxv] 42 C.F.R. § 422; 42 C.F.R. § 423.

[xxvi] Medicare Enrollment Protection Act of 2011 (H.R. 5588; 11th Congress).

[xxvii] 42 C.F.R. § 423.38(c)(8)(ii).

[xxviii] H.R. 5588; 111th Congress; H.R. 2235; 111th Congress.

[xxix] Kessler, G., "Do 10,000 baby boomers retire every day?," Washington Post, July 24, 2014, available at: http://www.washingtonpost.com/blogs/fact-checker/wp/2014/07/24/do-10000-baby-boomers-retire-every-day/; Pew Research Center, "Daily Number: Baby Boomers Retire," (December 2010), available at: http://www.pewresearch.org/daily-number/baby-boomers-retire/.