



Getting Medicare right

# Medicare Trends and Recommendations:

An Analysis of 2014 Call Data from the  
Medicare Rights Center's National Helpline

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Disclaimer: All names and identifying details have been changed to protect the privacy of individuals.

## Introduction and Summary

In 2014, the Medicare Rights Center's (Medicare Rights) staff and helpline volunteers fielded more than 17,000 questions and issues through the organization's national consumer helpline. Callers included over 11,000 Medicare beneficiaries and caregivers across the country. As in previous years, callers were geographically and socioeconomically diverse, and needed help with a wide array of complex Medicare issues.



 Medicare Rights' National Helpline is operated by staff and volunteers

The helpline receives calls from every state in the country 

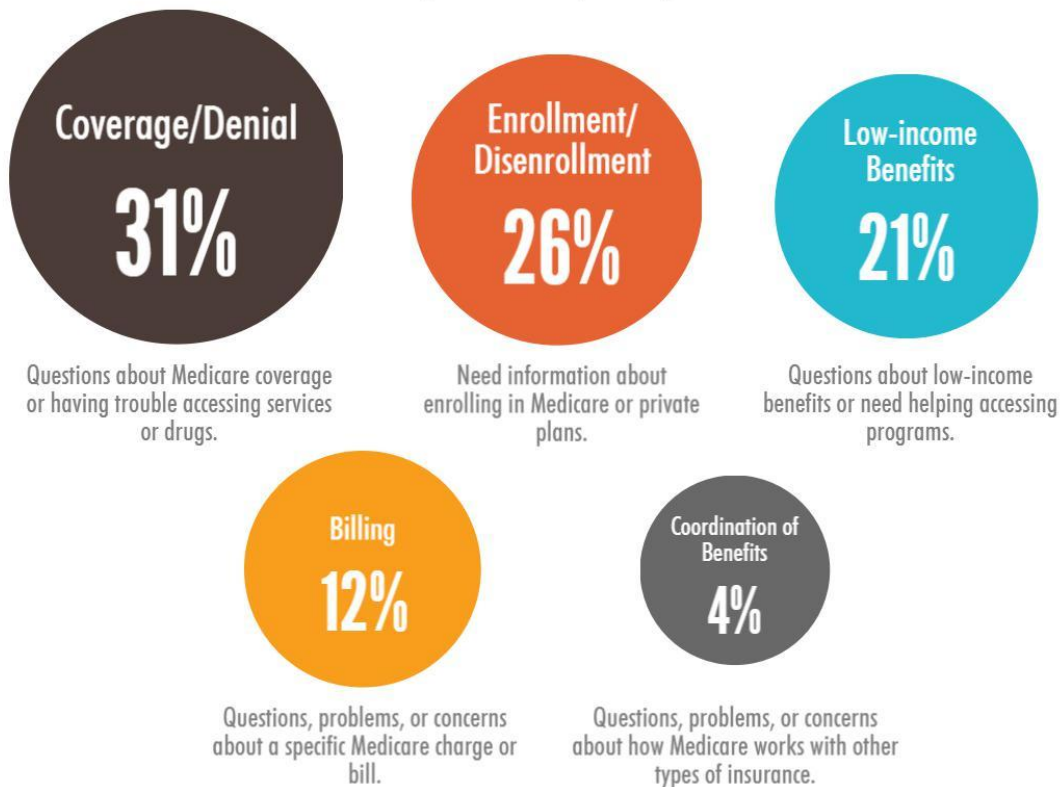
Medicare has provided guaranteed health benefits to millions of older adults and people with disabilities. These individuals and their families continue to rely on Medicare for basic health and economic security. In last year's report, Medicare Rights highlighted our major helpline trends, including Medicare Part B enrollment issues for those new to Medicare, issues affording needed health coverage and care, and challenges faced by beneficiaries attempting to navigate the Part D appeals process.<sup>i</sup> While these problems persist, Medicare Rights has also worked with partners to achieve important improvements to Medicare enrollment and appeals processes. For instance, the Centers for Medicare & Medicaid Services (CMS) has released educational content to help employers better educate their staffs on Medicare transitions. In addition, CMS and Part D plan sponsors are investigating medication access issues in Part D through a pilot demonstration program.

This report will examine confusion with Part B enrollment rules and issues with the Part D appeals process. The issues discussed can, oftentimes, result in increased health care costs and problems accessing care. Though these trends represent some of the most complex and confusing issues for many Medicare beneficiaries—whose stories appear throughout the report—recommendations proposed here would help reduce the prevalence and severity of these common Medicare challenges.

## HEARD ON THE HELPLINE

### Top Helpline Issues

(Percent of all helpline calls)



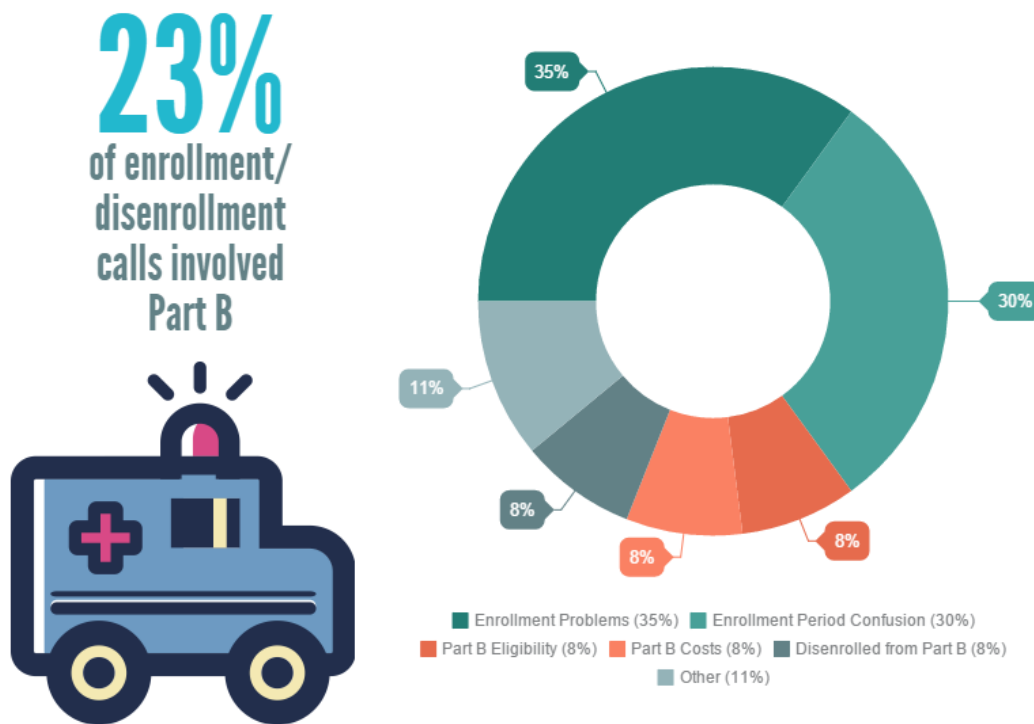
## Helping Callers Navigate Medicare Part B Enrollment

**Case Story:** When he was 59 years old, Mr. H started collecting Social Security Disability Insurance (SSDI) due to a degenerative disease and was automatically enrolled into Medicare Part A and Part B after a 24-month waiting period. At the time, Mr. H had insurance from his prior employer, so when he received his Medicare card, Mr. H called 1-800-MEDICARE to ask whether he needed to keep Part B and pay the monthly premium. The customer service representative told Mr. H that he could decline Part B once and should do so now to avoid future penalties. Believing that his employer-provided insurance was adequate, Mr. H declined Part B.

Soon thereafter, Mr. H began receiving collection notices for doctors' bills. He contacted the Medicare Rights Center after receiving a letter from his employer-sponsored insurance stating that they were no longer paying as primary insurance for claims and that they were seeking to recoup payments for the past six months. Under federal coordination of benefits rules, Mr. H's employer-sponsored plan was allowed to pay secondary to Medicare even though Mr. H was not enrolled in Part B. And because Mr. H declined Part B, Medicare would not pay anything for his doctors' bills.

The Medicare Rights helpline counselor encouraged Mr. H to apply for equitable relief—a process that allows people who are misinformed by an agent of the federal government to request to enroll in Medicare outside of the usual enrollment periods. The counselor also suggested that Mr. H explain the situation to his former employer and urge that the employer-sponsored insurance carrier pay primary (such arrangements are permitted but not required) until he could be successfully enrolled in Part B. With Medicare Rights' help, Mr. H requested equitable relief from the Social Security Administration (SSA) and also succeeded in convincing his employer-sponsored health insurer to pay as primary until he could be enrolled in Part B.

## Part B Enrollment & Disenrollment



Many individuals who call Medicare Rights are confused by Medicare enrollment rules, and specifically by decision-making related to taking or declining Part B. Some clients, like Mr. H, have other coverage and need information about how that insurance may change because they are eligible for Medicare. While callers may be aware of the risk of late enrollment penalties, they may not realize that their former insurance may refuse to pay for care entirely once they are Medicare-eligible. In 2014, as in prior years, calls from individuals who made a Medicare enrollment mistake presented with high frequency on Medicare Rights' national

helpline. Medicare-eligible people who do not understand Part B enrollment rules and fail to enroll in Medicare when they first become eligible may face late enrollment penalties, gaps in coverage, and disruptions in access to needed care.

## When to Enroll in Medicare

Medicare beneficiaries can enroll in Medicare Parts A and B at any time during their Initial Enrollment Period (IEP). The IEP is the seven-month period surrounding a person's 65<sup>th</sup> birthday or, for those under age 65, immediately following their two-year waiting period. This period includes the three months before, the month of, and the three months following the person's initial month of eligibility. The date when Medicare coverage begins depends on the date the person signed up. People who miss their IEP must wait for the General Enrollment Period (GEP) to sign up for Medicare Part B. The GEP occurs annually, from January 1 to March 31. Coverage for beneficiaries who enroll during the GEP begins in July of the same year.<sup>ii</sup>

While many individuals are auto-enrolled in Part A and Part B, individuals not yet collecting Social Security benefits must actively choose to enroll or to delay enrollment. Unfortunately, even people who are automatically enrolled—like Mr. H—are not always given accurate or complete information by employers, Social Security, Medicare, and other sources of support, or they are given adequate information but still make mistakes, often not fully grasping the consequences of a decision to delay Part B.

## Primary vs. Secondary Medicare Coverage

Depending on an individual's situation, Medicare can function as primary or secondary health insurance. For Medicare-eligible people 65 and over who receive employer group health coverage through their own or their spouse's active employment, the employer will function as a primary insurer if there are 20 or more employees at the organization. If there are fewer than 20 employees, Medicare will function as primary health insurance coverage. For Medicare beneficiaries under the age of 65 who receive employer coverage through their own employment, their spouse, or a family member, the employer will provide primary health coverage if there are over 100 employees at the organization. If the employer has fewer than 100 employees, Medicare will function as primary health insurance coverage. Other types of health insurance coverage, including retiree coverage and COBRA, will generally function as secondary health insurance coverage for people eligible for or enrolled in Medicare Part B.<sup>iii</sup> Medicare-eligible people with these types of secondary health insurance coverage need to enroll in Medicare Parts A and B or risk going without primary health insurance.<sup>iv</sup>

Of 2014 enrollment-related helpline calls, the most complex issues involved the coordination of Part B with other types of coverage, including employer-sponsored group health benefits, retiree benefits, COBRA, Veteran's benefits, and new individual insurance made available through federal and state Marketplaces under the Affordable Care Act (ACA).

The misinformation and confusion that Medicare Rights witnesses as newly eligible individuals transition to Medicare cannot be overstated. When employers are involved, callers sometimes describe situations where benefits administrators or human resources representatives inform them not to enroll in Part B because they will have access to retiree insurance or COBRA—both of which pay only secondary benefits when a person is eligible for Part B. Other callers with employer-sponsored retiree coverage report being told by Medicare that they did not need to enroll because they had employer coverage. In these cases, it was not made clear that retiree coverage (which pays secondary) is entirely distinct from employer-sponsored coverage based on active employment (which pays primary or secondary based on the employer size). And callers with individual coverage through the Marketplace were not informed that they would no longer be eligible for tax subsidies and cost-sharing assistance upon becoming Medicare-eligible.

As new coverage options became available as a result of the ACA, Medicare Rights began to receive calls in 2014 related to Marketplace coverage. Some of these calls are from people with disabilities in their 24-month waiting period inquiring about access to Marketplace coverage and premium tax credits. Other callers have questions about when to enroll into Medicare, how Medicare will or will not coordinate with Qualified Health Plan (QHP) premiums, whether or not an individual would be receiving premium tax credits to pay for QHP premiums, and other general questions about Medicare costs. Yet, many people reach out to Medicare Rights with limited knowledge of Medicare enrollment and Marketplace premium tax credit rules. Often, these callers seek help only after making a detrimental enrollment mistake.

## Policy Recommendations to Support Individuals Approaching Medicare Eligibility

The following policy recommendations drawn from Medicare Rights' helpline experiences are intended to better support individuals approaching Medicare eligibility:

### **Educate newly eligible Medicare beneficiaries through targeted notice.**

Notifications and alerts about the Part B enrollment process are especially important for people who are not collecting Social Security benefits. As noted above, people not collecting Social Security benefits before they turn 65 years old will not be automatically enrolled in Part A and Part B. Yet, no federal agency is responsible for informing these individuals about their obligations and the rules related to Medicare enrollment. Medicare Rights continues to urge SSA and CMS to coordinate efforts to more fully inform newly eligible beneficiaries of the decisions they need to make around Part B enrollment, for instance through a new and specific notice sent ahead of an individual's initial Medicare enrollment period.

Medicare Rights commends improvements to existing educational materials announced during the 2015 White House Conference on Aging,<sup>y</sup> including a more prominent text box on the Social Security annual statement of benefits and the recent release of an online community, including resources designed specifically for employers to use in educating themselves and their staffs about Medicare transitions.

Medicare Rights urges a comprehensive strategy involving all affected federal agencies as well as states. It is critically important that individuals transitioning from specific types of

coverage—such as employer plans, Marketplace plans, and Medicaid—receive messaging appropriate to their specific transition.

#### **Streamline and align enrollment periods.**

As currently structured, individuals who enroll during the later months of their IEP and during their GEP face gaps in access to outpatient health coverage, sometimes for several months. Congress should eliminate these gaps to ensure that coverage begins as quickly as possible following enrollment.

At the same time, the GEP should be lengthened and aligned with the Medicare Open Enrollment period for Medicare Advantage (MA) and Part D plans. This alignment would make it easier to educate Medicare beneficiaries and newly eligible individuals about a standard and predictable Medicare enrollment season.

#### **Expand access to equitable relief.**

There are few avenues of relief available to individuals, like Mr. H, who make an honest Medicare enrollment mistake. To date, only those who can prove misinformation was provided by the federal government are able to secure retroactive enrollment in Part B and relief from lifetime late enrollment penalties. The criteria for seeking equitable relief should be expanded to include other common sources of misinformation, including employers, health insurance brokers, and health plans.

In addition, the equitable relief process should be standardized to ensure that individuals seeking a decision from SSA can expect that decision within a specified timeline and are adequately notified of the result. SSA should also implement systems to gather and publicly release data on the equitable relief process. Items that should be tracked include requests for equitable relief, common sources of misinformation, and the resulting decisions.

#### **Educate employers and others interacting with transitioning individuals.**

Strengthened employer education about Medicare enrollment and coordination of benefits is needed. Medicare Rights applauds CMS' development of employer-specific web resources, and encourages CMS to expand these efforts. CMS should also engage and support other common information sources for individuals becoming Medicare-eligible, including state Marketplaces, state Medicaid offices, and health care providers.

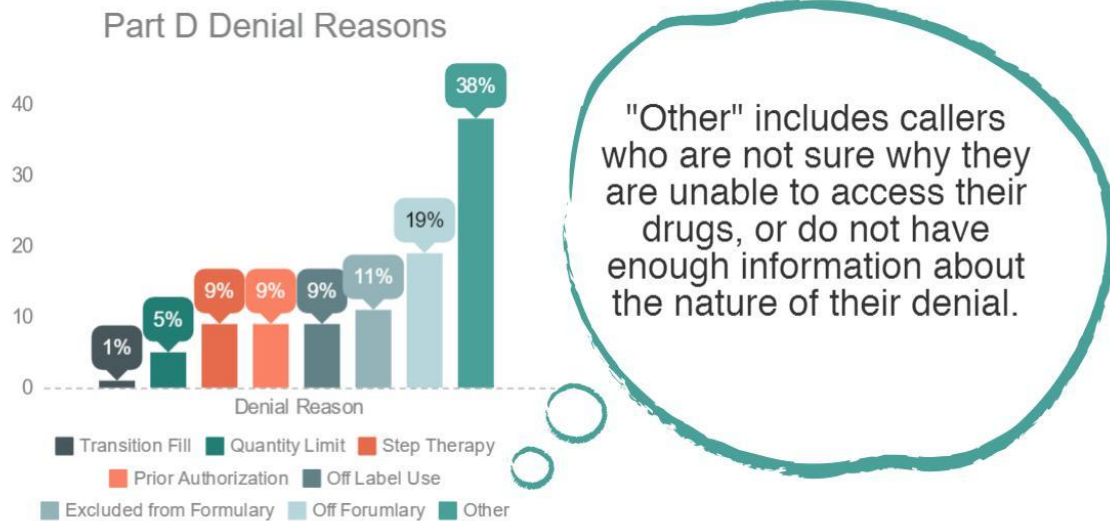
## Helping Callers Navigate Prescription Drug Appeals

**Case Story:** Ms. L called the Medicare Rights Center helpline for assistance with her MA plan, specifically to secure plan payment for a hypertension medication that she was taking for many years with good results. She called after being told she would need to pay full price—nearly \$150 per month—at the pharmacy. Ms. L lives on a fixed income and could not afford to pay out of pocket for long. She was confused about why her plan would not cover the medication when in the past it had.

With the Medicare Rights counselor's help, Ms. L realized that her prescription drug was no longer on her plan's formulary. Ms. L was distraught. When she had tried other hypertension medications, including some of those on the formulary, she experienced adverse reactions. In addition, her cardiologist told her that he was tired of calling her plan—he had tried to appeal before and it was denied—and wouldn't help anymore. The

counselor recommended that Ms. L compile a list of the medications she had tried—four in total—and the reactions. The counselor also suggested that Ms. L ask her primary care physician to assist with the appeal. Working with Ms. L and this doctor, Medicare Rights helped Ms. L submit an appeal. After two months of paying out of pocket for her medicine—and first enduring the adverse effects of other drugs—Ms. L’s appeal was successful and she could now access her medicine at an affordable price.

## Types of Denials



Questions about prescription drug denials and appeals made up a substantial percentage of calls to Medicare Rights’ helpline in 2014. The largest subset of these calls consisted of individuals, like Ms. L, whose needed prescription is off-formulary. Frequently, in addition to not knowing why their prescription drug was denied, callers are confused by the Part D appeals process, unsure as to whether their appeal has been filed, what level of appeal they are at, and what their doctors may have done on their behalf.

## Policy Recommendations to Simplify Part D Appeals

In order to simplify the Part D appeals process for beneficiaries like Ms. L, Medicare Rights supports the following policy reforms:

### Require that the presentation of a prescription at the pharmacy counter counts as a request for a coverage determination.<sup>vi</sup>

After being turned away at the pharmacy counter, a Medicare beneficiary must formally request coverage from their prescription drug plan, and frequently this action requires support from the prescriber.

Many Medicare Rights clients are confused by this process, and equate walking away from the pharmacy counter empty-handed as a formal denial by their prescription drug plan. CMS should require that plans treat the prescription itself as a request for a coverage determination, prompting either coverage of the medicine or a written, appealable denial that includes the reason for non-coverage.



Medicare Rights supports the CMS launch of a pilot program to lessen the burden on beneficiaries resulting from the need to formally request coverage. The results of this pilot will help inform future policy efforts and recommendations.<sup>vii</sup>

### **Include the reason for the prescription drug denial in the pharmacy counter notice.**

Absent allowing the presentation of a prescription to serve as a request for a coverage determination, the beneficiary experience at the point-of-sale would be improved if people with Medicare received more comprehensive information before being turned away empty-handed. CMS should require health plans to include the reason for a prescription drug denial in the standardized pharmacy counter notice.

Trends heard on the Medicare Rights helpline year after year demonstrate that people with Medicare receive too little information when refused a prescription drug at the point-of-sale. Specific information about why a drug is not being covered, how to secure lower cost-sharing for high-cost medications, and the appeals process would allow beneficiaries to more easily secure coverage, either by obtaining an alternative medication with the help of their prescriber or through the formal appeals process.

### **Improve plan notices.**

CMS should improve the notices that beneficiaries receive when their request for a coverage determination or subsequent appeal is denied. Notices should include standardized language to describe reasons for denials, including explicit reference to Medicare rules and standards.

Medicare Rights encourages CMS to create separate model notices for the most common types of denial letters, such as, off-label, step therapy, and quantity limits,—so that the information provided is relevant and specific. Notices should explain why a medicine does not qualify for coverage and the possibly unaccounted for circumstances (e.g., adverse reactions to formulary alternatives) that might affect the determination.

### **Streamline the appeals process.**

If an appeal is appropriate, Medicare beneficiaries must navigate several needless and burdensome steps before their appeal is officially filed. As noted above, beneficiaries would be best served by initiating the coverage determination request at the pharmacy counter, as opposed to requiring beneficiaries to formally request a coverage determination from their health plan.

Other options to streamline the appeals process include eliminating redetermination (the second level of appeal made to the health plan) and/or requiring a pharmacy counter denial to trigger an inquiry by the plan to the prescribing physician about medical necessity. Both of these options would remove a burdensome step in the appeals process for Medicare beneficiaries.

### **Continue to release plan-level appeals data and expand on data collection.**

Plan-level data released in 2014 by CMS on pharmacy transactions, coverage determinations, and appeals represents an important step toward enhancing the transparency of the Part D appeals process. Medicare Rights recommends that CMS regularly release this information and issue summary analyses and reports to make the information accessible to audiences beyond academic and research institutions.

Additional research is needed to fill gaps in knowledge, including on how often prescriptions go unfilled altogether, how frequently low-income beneficiaries (namely Extra Help enrollees) are turned away at the point-of-sale, and how consistently required notices on appeal rights are delivered at the pharmacy counter.

## Conclusion

Medicare Rights' national helpline call data for 2014 provide a snapshot into some of the issues Medicare beneficiaries and their families face as they become Medicare eligible. We continue to highlight the need for policy reforms that streamline Medicare enrollment rules so that newly eligible Medicare beneficiaries avoid penalties and gaps in coverage. At the same time, we continue to press for improvements to the Part D appeals process to ensure that people with Medicare can access the prescription drugs they need and adhere to treatment plans. The 2014 data—like the 2013 data—reflect the demographic challenges facing a growing aging population and the persistent challenges facing older adults and people with disabilities as they navigate the Medicare program.

For more information about issues facing current and future Medicare beneficiaries, and potential policy solutions to improve access to affordable health coverage for people with Medicare, visit <http://www.medicarerights.org/policy/priorities>.

If you are enrolled in a QHP through the Marketplace and have questions about when to enroll into Medicare, how Medicare will or will not coordinate with QHP premiums, whether or not an individual would be receiving advanced premium tax credits to pay for QHP premiums, and other general questions about Medicare costs, please visit [Medicare Interactive](#).

## References

<sup>i</sup> For more information about the 2013 Helpline Trends Report, read more here:

<http://www.medicarerights.org/2013-medicare-trends>

<sup>ii</sup> For more information about the IEP and GEP, refer to the Medicare Interactive information here:

[http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script\\_id=259](http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=259)

<sup>iii</sup> Other coordination of benefits rules apply to people diagnosed with End Stage Renal Disease (ESRD) who have retiree or COBRA coverage. Read more information here:

[http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script\\_id=1652](http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1652)

<sup>iv</sup> For more information about Medicare coordination of benefits rules, read more here:

[http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script\\_id=317#notes](http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=317#notes)

<sup>v</sup> For more information about the 2015 White House Conference on aging, read more here:

<https://www.whitehouse.gov/the-press-office/2015/07/13/fact-sheet-white-house-conference-aging>

<sup>vi</sup> For a detailed discussion of these policy recommendations, see Medicare Rights' "Refused at the Pharmacy Counter: How to Improve Medicare Part D Appeals." See the link here: <http://www.medicarerights.org/pdf/2013-Facts-and-Faces-Pharmacy-Counter.pdf>

<sup>vii</sup> 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter <https://www.cms.gov/medicare/health-plans/medicareadvtspeccratestats/downloads/announcement2016.pdf>