

Medicare Transitions:

Simple Steps for the Centers for Medicare and Medicaid Services to Bolster Consumer Information and Counseling

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Background

Transitioning from one form of health insurance to another is difficult. Most working Americans who have employer-sponsored health insurance receive help from their employers when their coverage changes, particularly as they change jobs. People eligible for Medicare frequently have particularly complicated transition decisions and these choices have significant consequences. When people who are eligible for Medicare do not successfully move between coverage sources or adequately supplement one form of insurance with another, they risk paying premium penalties to enroll in Medicare or going without needed health care coverage. If they end up without coverage but need medical services, they may forego necessary care or be burdened with financially devastating medical bills.

Many older and disabled people are not equipped to handle these transitions successfully because they must make complex decisions -- when to enroll in insurance and what kind of insurance is necessary -- with inadequate information. For example, when people turn 65 and become eligible for Medicare, those who are still working need to decide whether to sign up for Medicare Part B at that time or wait until they retire. They may have to decide whether to sign up for Medicare supplemental coverage at that time or wait for a later enrollment period. If they do not make the right choices at the right time, they may face lifetime premium penalties or no coverage at all.

This issue brief focuses on situations where people with Medicare face treacherous coverage transitions that can lead to great hardship: coordination between Medicare and retiree coverage and enrollment in Medicare for people with End-Stage Renal Disease. Proposed solutions include: 1) rigorous implementation of the Medicare Modernization Act's (MMA's) Medicare Ombudsman program to address known information barriers and 2) improved information and education for older individuals and people with disabilities about when to enroll in Medicare, as well as the consequences of late enrollment.

Health coverage coordination will take on greater importance as the Centers for Medicare and Medicaid Services (CMS) implements the Medicare Part D prescription drug benefit. The consequences for late

enrollment in Part D will be even more serious than those associated with Part B, given that the penalties will be more costly and will accrue more quickly. And the introduction of Medicare Part D will produce a host of new coordination issues not yet experienced by people eligible for Medicare. In particular, these may affect people who have been receiving their drug coverage through Medicaid but will receive their drug coverage from Medicare beginning in 2006. This transition is fraught with potential obstacles, which are discussed in more detail in *The Medicare Low-Income Drug Subsidy: Strategies to Maximize Participation*, another issue brief in this series. Other coordination issues include the relationship between employer-sponsored drug coverage and Part D benefits, including the determination of whether an individual's employer-sponsored coverage is "creditable" or not. This issue brief will also discuss how CMS can learn from the current problems associated with health insurance transitions and be aware of potential future problems to more effectively integrate the Medicare Part D benefit.

This report does not address coordination and information issues which are most effectively addressed through legislative changes; instead, this discussion will focus on administrative approaches that CMS can implement under current statutory authority.

Introduction

Enrollment in Medicare Part A (for hospital care, skilled nursing care and home health care) and Medicare Part B (for physician services, outpatient services and other care) is automatic for individuals who receive Social Security.¹ Most people with Medicare coverage enroll in Part A and Part B during their Initial Enrollment Period, the seven-month period that includes the three months before their 65th birthday, their birthday month, and the three months following their birthday. However, individuals may opt out of Part B coverage and not pay the monthly premium payment. In some cases, people do not know whether or when they must enroll in Medicare to ensure that they have continuous coverage. In other cases, consumers receive incorrect information from government agencies and employers and consequently make wrong enrollment decisions that may harm them medically and financially. In addition, *how* Medicare coordinates with other coverage can cause problems for people with Medicare.

Consequences of Delayed Enrollment in Part B

In 2005, people with Medicare pay a \$78.20 monthly base premium for their Part B coverage. However, premium penalties for late enrollment accrue at 10 percent a year for each year of delayed enrollment once a person is eligible for Medicare coverage. In November 2004, according to Social Security Administration data, over 700,000 people with Medicare paid premium penalties because of late enrollment. Nearly six percent of those paying the penalty pay double the amount of the monthly premium.

Number of Beneficiaries Paying the Premium Surcharge in November 2004

<u>Rate of Penalty</u>	<u>Number of Affected Beneficiaries</u> [*]
10%	275,660
20%	138,380
30%	88,620
40%	62,640
50%	45,480
60%	30,620
70%	23,200
80%	17,760
90%	13,120
100%	10,220
110%	7,820
120%	5,520
130%	4,660

140%	3,660
150%	2,560
160%	2,120
170%	1,560
180%	1,100
190%	760
200%	500
210%	580
220%	440
230%	380
240%	280
250%	180
260%	120
270%	60
280%	40
290%	60
300%	20

Total Paying Surcharge: 738,120

*Note: These counts are restricted to people who have their Part B premium taken out of their Social Security check and are based on a 1-in-20 sample.

SSA Master Beneficiary Record, November 2004.

Experience with consumer hotlines across the country suggests that the reason many people enroll late is confusion or lack of knowledge about the rules governing when they must enroll.² Unfortunately by the time they do try to enroll in Part B, they have missed their designated enrollment periods and must pay a premium penalty. Other people with Medicare have indicated that initially they choose not to enroll in Medicare Part B because they cannot afford the premium payments. Many of these individuals may qualify for low-income assistance programs that help pay for Medicare premiums and co-insurance – known as Medicare Savings Programs³ – but may not be aware that these programs exist.⁴ Others may have been misinformed about whether or not they need Medicare Part B coverage.

As noted, people with Medicare face a premium penalty of 10 percent a year for each year that enrollment is delayed.⁵ If enrollment is delayed for one year then the person's monthly 2005 premium of \$78.20 would instead be \$86.02 a month; delaying enrollment for 5 years would lead to a 50 percent increase in premiums, from \$78.20 to \$107.30 a month. Of the more than 700,000 people paying penalties, more than half pay penalties of \$94 or \$188 a year. However, about 175,000 are paying \$470 or more a year in penalties. As Part B premiums increase, of course, the dollar value of these penalties will grow as well.

Timing Issues

Each General Enrollment Period takes place from January 1 to March 31, with Medicare coverage beginning in July. A person who does not take Part B during their Initial Enrollment Period, or a Special Enrollment Period related to their circumstances (such as retirement and the end of employer-sponsored coverage after age 65), but instead signs up during the General Enrollment Period, may wait up to 15 months before getting coverage.⁶ For a person in poor health, 15 months without health coverage is both medically and financially risky.

Case Study: Critical Timing for Enrollment Periods

Mr. T had retiree coverage through his employer, which he believed would provide him with health benefits for life. Therefore, he declined Medicare Part B coverage. When he was diagnosed with cancer the following year, he learned that his retiree coverage was secondary and would pay for his treatment only after Medicare. He applied for Part B coverage during the next General Enrollment Period, from January through March of the following year. By the time he received coverage from Medicare in July, he had accumulated \$28,000 in out-of-pocket health costs. He will also need to pay premium penalties for the rest of his life.

Opting Out of Part B

Roughly 5 percent of persons who qualify for Medicare Part B coverage choose to opt out of the benefit.⁷ Some individuals who are still working after age 65 have coverage from large employers and do not need to enroll in Medicare Part B. Others may believe they do not need Part B coverage, some may not be able to afford the Part B premium, and some may not realize that Medicare Savings Programs will pay their Part B premium costs if they qualify for assistance. These individuals need to understand the consequences of not signing up for Part B in the designated initial and special enrollment periods if they choose to forgo this coverage.

The Medicare enrollment packet currently includes information about premium penalties and coverage lapses, as well as the actual form where an individual must indicate that they are opting out of Part B, which is attached to the Medicare card itself. Next to the card on this form are instructions alerting the individual to “please read the enclosed material before making your choice.” On the back of the form, there is a box to check next to the words “I Do Not Want Medical Insurance,” and instructions to return the form to CMS. This form, where a person indicates that they do not want Medicare Part B, does not state that a person who does not choose medical insurance could risk gaps in coverage and premium penalties if they are not part of a group eligible for a Special Enrollment Period. This omission is serious – to be effective, most health care-related communication efforts repeat information a number of times, and it is particularly important to repeat critical information, such as the consequences of foregoing Part B coverage, at decision points.

Recommendation:

CMS should revise materials in the “Welcome to Medicare” enrollment packet to emphasize the risks related to declining or delaying Part B enrollment. That message should be repeated throughout the materials. These revisions should ensure that the form attached to the Medicare Card includes a clear explanation, presented in a hard-to-miss design, of the premium penalties and delayed enrollment process that may result from declining coverage.

Medicare and Employer Coverage

In a survey of State Health Insurance Information and Assistance Program directors about their clients’ concerns relating to the Medicare program, 63 percent reported that people with Medicare do not understand how their employer coverage coordinates with Medicare.⁸ When asked about the kinds of issues that people are most confused about, SHIP directors gave the following answers:

- Beneficiaries are unaware of which policy is the primary payer
- Retirees believe they will get the same insurance they had while they were working.
- Individuals are confused about when to sign up for Medicare Part B.

These issues are significant because they help determine when and whether an individual should enroll in Medicare Part B coverage. For example, many people retain access to employer-sponsored insurance when they retire. However, Medicare serves as the primary payer, or the principal source of payment, for retirees’ health care needs. Employer-sponsored retiree coverage serves as a secondary payer, picking up the costs that their primary insurance, Medicare, does not cover. But because many people do not understand that their

customary health insurance converts to retiree coverage, they do not know that they need to enroll in Medicare Part B for primary coverage. When they later try to enroll in Medicare – often because their retiree coverage has refused to pay for a health care service – they learn that they must pay a lifetime premium penalty for failing to enroll during their Initial Enrollment Period.

Individuals who continue to work after turning 65 face similar choices, and have similar opportunities for confusion. For someone who continues to work, and works for an employer with 20 or more employees, their employer-sponsored plan remains their primary source of insurance, with Medicare serving as the secondary payer. (Employers with fewer than 20 workers may choose to have their coverage remain the primary payer for these older workers, but are not obligated to do so.)⁹ Because their employer coverage continues to pay their medical bills, they may not realize that they will need to have Medicare coverage when they eventually retire. When this individual retires, if they still have access to their employer-sponsored coverage, this insurance will convert to retiree coverage, which is secondary to Medicare, so they must be enrolled in Medicare Part B to have primary coverage. Unless people understand that they must enroll in Medicare either as they turn 65 or during a Special Enrollment Period that runs for eight months from the time they retire, they may end up paying lifetime premium penalties.

Different rules apply to people who qualify for Medicare because they have End-Stage Renal Disease (ESRD) and also have medical coverage through an employer group health plan. After a person is diagnosed with ESRD and is eligible for Medicare, their employer plan remains the primary payer during the first 30 months they have Medicare coverage. These 30 months are considered the coordination of benefits period.¹⁰ When this 30-month period ends, Medicare becomes the primary payer and the employer plan becomes secondary. The coordination of benefits period can end earlier than 30 months if the employer coverage terminates earlier.

People with ESRD can enroll in Medicare at any point from the beginning of treatment through the 30-month coordination of benefits period, but they must be sure to enroll before this 30-month window closes, because there is no special enrollment period for people with ESRD once employer-based coverage ends. This means that people who do not elect Part B coverage during the coordination of benefits period, but later want to enroll in Part B, must wait for the next General Enrollment period to apply. They will also have a lifetime premium penalty after missing their initial enrollment period.

People with ESRD may struggle with the nuances of when, and if, to elect Part B coverage. For example, if a person with ESRD has very comprehensive coverage from an employer, taking Part B early in the coordination of benefits period may be unnecessary and costly, as Medicare only covers those services that the employer plan does not cover. However, if someone initially enrolls in Part B during the coordination period, then drops Part B coverage and stops paying Part B premiums because, at this point, their employer plan covers all of their needs, they will not be able to sign up for Part B at *any time* in the future.

Coordinating COBRA with Medicare may also confuse people eligible for Medicare. In general, under COBRA, individuals who leave a job with an employer with 20 or more employees that provides group health insurance, or experience other kinds of qualifying events such as divorce from or death of a covered spouse, may continue to purchase this coverage themselves from their former employer and receive the group rate for a limited period of time. Many people erroneously believe that they may enroll in Medicare through a Special Enrollment Period once their COBRA coverage ends. However, the Special Enrollment Period actually begins once their regular employer coverage terminates and they begin COBRA coverage. Picking up Part B during the Initial or Special Enrollment Periods is critical because once a person becomes Medicare eligible, the COBRA coverage becomes secondary. People who miss their opportunity to enroll in Part B will face premium penalties and potential lapses in coverage. Employers may or may not provide employees with information about how COBRA coordinates with Medicare. COBRA enrollment forms explain that COBRA coverage ends once a person has Medicare, however these forms do not typically give information about the terms of the Special Enrollment Period.

Case Study: COBRA Transitions

Upon retiring in January of 2001, Mr. S's employer group health plan coverage ended,

and he became eligible for COBRA benefits. Mr. S. incorrectly believed that that enrollment in COBRA would allow him to qualify for a Special Enrollment Period for Medicare Part B. Mr. S waited until his COBRA coverage expired to enroll in Part B and was told that he missed his Special Enrollment Period, which began when his employer coverage ended. As a result, he would have to wait for the next General Enrollment Period in 2003 to enroll in Part B. Consequently, he would also be without Part B coverage until July of 2003 and would incur a penalty for delayed Part B enrollment.

Recommendation:

CMS should use available intermediaries to help people with employer-sponsored insurance understand their coverage options and make transition decisions that best meet their needs. Potential intermediaries include employers, dialysis centers, other providers and insurance carriers.

- ***For example, CMS should work more closely with employers to ensure that workers receive accurate, easy-to-understand information on the coordination between large and small group employer-sponsored health insurance, retiree coverage, COBRA coverage and Medicare. At a minimum, CMS should post suggested language and model handouts on Medicare.gov for employers to download and provide to employees during significant transition periods. CMS should also hold periodic information sessions – similar to listening sessions – for human resources executives, union representatives and others who deal with employee health insurance.***
- ***Similarly, CMS should coordinate with dialysis centers to ensure that people with ESRD receive accurate, timely information on their enrollment choices once they receive an ESRD diagnosis. CMS should receive client contact information from dialysis centers and outreach directly to ESRD patients.***
- ***CMS should also work with insurance companies to establish effective outreach mechanisms to educate workers who continue to work and be insured through employer group coverage past age 65. These carriers must understand how their plans coordinate with Medicare for their own reimbursement functions. Insurers could send workers detailed information about changes in primary and secondary coverage and the consequences of late Part B enrollment.***

Inadequate and Inaccurate Information and Counseling

Answering survey questions on potential sources of enrollees' confusion about Medicare's coordination with other insurance, 40 percent of the SHIP responders stated that the Social Security Administration provides information that is inaccurate and unclear. This poor information can lead older adults and people with disabilities to opt out of Part B coverage. In some cases, individuals can appeal late enrollment sanctions if they can demonstrate that they were misinformed by a responsible Social Security Administration agent. However, if they do not prevail, they will face lifetime premium penalties and potential gaps in coverage.

Case Study: Incorrect Information from Public Agencies

Mr. W had health insurance through his employer until he retired at age 82. When his group health coverage ended, Mr. W was eligible to enroll in Part B during his eight-month Special Enrollment Period. However, the Social Security office staff incorrectly told him that he would have to wait for the next General Enrollment Period, which occurs every year from January through March. The Social Security office also told him that he would have to pay a Part B premium penalty for delaying Part B enrollment for the 17 years since he turned 65. If not addressed, this misinformation would have resulted in a 170 percent premium penalty, or \$133 per month in addition to Mr. W's standard Part B premium.

Mr. C, who is 67 years old, was still working and receiving health insurance through

his wife's retiree plan when he turned 65. When Mr. and Mrs. C went to their local Social Security office, the Social Security representative told him he did not need to enroll in Medicare if he was currently working. Later that year, Mr. C went into the hospital for surgery. His wife's insurance plan denied payment, and the hospital billed him for more than \$70,000. Mr. C called Social Security, who told him that because his coverage was through his wife's retiree plan and not from his current job, Medicare had to be the primary payer. Because Mr. C had documented his earlier visit to Social Security, including the name of the representative he met with, SSA signed him up for Part B retroactive to the day he initially visited the Social Security office to enroll. Medicare paid its share of his hospital bills and his wife's plan, as his secondary insurance, paid the rest.

Incomplete Information Infrastructure

To its credit, CMS has developed information both in print and on its website about who should enroll in Part B and when they should enroll as well as a clear warning about the costs associated with delaying enrollment. CMS also has a coordination of benefits hotline and accompanying website that is available to both consumers and employers to field questions. However, these resources appear to be underutilized and poorly publicized. A survey of Medicare Rights Center's Consumer Action Board, a group of national community leaders who all have Medicare, revealed that few members were even aware that a Coordination of Benefits Hotline existed. Some explained that they had not used it because they understood the hotline was solely for employers' use. Medicare consumer counselors who have used the Coordination of Benefits hotline on behalf of clients report that hotline workers usefully assist with which coverage is primary and secondary in a given situation, but that hotline staff cannot provide more detailed information about how various forms of coverage coordinate. The coordination of benefits website should also provide more comprehensive information. For example, in the website's section on end-stage renal disease, the text fails to mention the need for someone to apply for both Medicare Part A and Part B within the 30-month coordination of benefits period or face a lapse in coverage.

The complex relationship between SSA and the Medicare program intensifies the need for improving the information infrastructure. While SSA has direct involvement in some aspects of Medicare administration, such as withdrawing the cost of the Part B premium from Social Security checks, and making SSA branch offices available for Medicare enrollment, SSA traditionally views its involvement with Medicare administration as a low priority. The agency has never made Medicare information and education a prime focus, in part because CMS is responsible for these functions. However, Medicare enrollees naturally turn to SSA staff – people who work in their communities and are thought to be well-versed in the Medicare program – for information about coordination of benefits and other coverage issues. But those who have turned to SSA for education and counseling often receive inadequate or incorrect information.

New Opportunities

The Medicare Modernization Act of 2003 included a new authorization for a Medicare Beneficiary Ombudsman. Congress directed that this function include, among other duties, responding to requests for information from Medicare enrollees and providing assistance to people with Medicare on any aspect of the Medicare program.¹¹ While the Ombudsman is specifically required to provide assistance with appeals, disenrollment from Medicare Advantage plans and income-related premiums, the Ombudsman is also required to provide direct assistance to people with Medicare on any other issue. This broad authority permits CMS to greatly enhance its information dissemination, education and counseling efforts on behalf of people with Medicare.

As this paper has discussed, multiple stakeholders – employers, providers, insurers and public agencies – provide critical enrollment and coordination of benefits information to people eligible for Medicare. CMS should use this new authority to ensure that these stakeholders and information brokers have access to accurate, timely and easy-to-understand information to disseminate to people with Medicare coverage.

Recommendation:

CMS should vigorously implement the Medicare Beneficiary Ombudsman program and include within its purview upgrading the information infrastructure that serves Medicare beneficiaries. This office should ensure that Medicare enrollees can experience a seamless, painless entry into Medicare as part of its mission, consistent with Congressional intent that the Ombudsman provide assistance to Medicare enrollees.

The Medicare Ombudsman should become a focal point for beneficiary education and counseling about coverage transitions, coordination of coverage and other coverage issues. Ombudsman staff should exert direct responsibility for coordinating with intermediary organizations, developing and disseminating appropriate consumer materials and making these materials available to and through intermediaries, upgrading the coordination of benefits hotline, revising the “Welcome to Medicare” packet and exploring other strategies for improving consumers’ understanding of their coverage choices.

Lessons for the Future

The pending implementation of a significant new benefit within the Medicare program, the Part D benefit for prescription drugs, poses immense administrative challenges for CMS. However, the agency’s years of experience with a pre-existing voluntary benefit, Part B, should provide solid grounding for many of the decisions CMS must make in the near future. Specifically, CMS should consider the confusion and costs associated with delayed Part B enrollment when creating the enrollment process for Medicare Part D drug coverage. For example, under the new benefit, people will have to know whether their existing drug coverage is actuarially equivalent to or better than the standard Part D benefit. Individuals with “creditable coverage” equal to or better than Part D may choose not to enroll in Part D without risking a premium penalty if they subsequently enroll at a later date. However, those with less generous drug coverage must either join Part D in the first six months or pay a premium penalty if they enroll at a later time. In addition, because enrollment in Part B is on an opt-out basis and enrollment in Part D is generally on an opt-in basis, individuals are likely to be confused about what actions they must take to enroll. (According to the draft regulations, people with existing Medicaid drug coverage will be automatically enrolled into a Part D plan if they fail to choose a plan.)¹² Part D enrollment will also be more complex than enrolling in Part B, because individuals will need to compare competing drug plans and complete enrollment in their chosen plan. All of these enrollment components have important implications for consumers, because Part D premium penalties will be larger than those for Part B late enrollment, and the penalties will accrue more quickly, on a monthly rather than yearly basis.

Recommendation:

CMS must make clear and objective information available to people eligible for the new Part D coverage. Dissemination strategies must include written materials, new scripts for CMS’s 800-Medicare hotline, and additional training for hotline staff. It is particularly important that individuals understand the standard against which they must evaluate their existing employer-based or other drug coverage when they decide whether or not to enroll in Part D, as well as the consequences of not enrolling in Part D if they do not have creditable coverage. The Medicare Ombudsman can facilitate this information development and dissemination and work with employers to ensure that they fulfill their educational obligations towards their employees as outlined in final CMS regulations.¹³

Conclusion

The relationship between Medicare coverage, employer-based retiree coverage and other sources of health insurance coverage is complicated and confusing to Medicare enrollees. It is not surprising that many individuals need help evaluating their coverage options to figure out when they must enroll in Medicare Part B to ensure that they are protected from devastating health care costs. Today, people with Medicare do not get the help they need with these questions. Information and instructions from CMS itself are inadequate, employers are not required to provide accurate and thorough information to their retirees or assist their employees with these decisions, and representatives of public agencies often provide misinformation. CMS can use the Medicare Beneficiary Ombudsman to begin to repair these holes in the information infrastructure that serves people with Medicare. It will also be important to glean lessons about information development and dissemination from these coordination of benefits experiences as the agency moves forward with Part D

implementation.

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1. If a person is not receiving Social Security or Railroad Retirement benefits when he turns 65, he has to apply for Medicare coverage with the Social Security Administration. A person enrolling in Medicare at age 65 receives the enrollment packet three months before her 65th birthday. A person who is eligible for Medicare because of a disability receives a letter from the Social Security Administration two to three months prior to the possible beginning of their eligibility for Medicare which will include a Medicare card and a form for refusing the Part B coverage.
 2. Medicare Rights Center Practical Changes Project SHIP Survey.
 3. The Medicare Savings Programs include the Qualified Medicare Beneficiary (QMB) program, which pays Medicare premiums and cost-sharing for persons with incomes below the poverty level; the Specified Low-Income Beneficiary (SLMB) program, which pays Part B premiums for persons with incomes between 100-120 percent of the poverty level; and the Qualifying Individual Program (QI-1), which pays Part B premiums for persons with incomes between 120-135 percent of poverty. The federal asset level for the Medicare Savings Programs is \$4,000 for individuals and \$6,000 for couples.
 4. Less than one third of people eligible for these programs nationwide are enrolled in them. CBO, July 2004. These estimates exclude persons who are also eligible for full Medicaid benefits.
 5. Premium penalties are effectively waived when persons enroll in the Medicare Savings Programs.
 6. If a person wanted to enroll in Medicare in April, right after the General Enrollment Period ended, he would have to wait from April to January to enroll (9 months) and 6 months (until July) to get coverage. Persons can enroll in the Medicare Savings Programs and Part B at any time of the year.
 7. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," Dahlia K. Remler and Sherry Glied, *American Journal of Public Health* 93, 1 (January 2003): 67-74
 8. Medicare Rights Center Practical Changes Project SHIP Survey. SHIPs are part of a national network of trained staff and volunteers that help people with Medicare understand their rights under the Medicare program.
 9. For people with disabilities the same rules apply though the critical number of employees is 100 or more in the first instance, and less than 100 in the second.
 10. Because Medicare for ESRD patients usually begins after a three-month waiting period, the 30-month coordination of benefits period usually starts the fourth month of dialysis. However, Medicare begins earlier for patients who participate in a self-dialysis training program or receive a kidney transplant, and the coordination of benefits period therefore begins with first month of dialysis or the kidney transplant for these patients.
 11. MMA Conference Report, section 923(a); Social Security Act, section 1808(c)
 12. Final regulations on the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), 42 CFR 423.34(d)
 13. Final regulations for 42 CFR 423.56(c) require each "entity" that offers prescription drug coverage through a group health plan, qualified retiree prescription drug plan, Medigap plan, State Pharmaceutical Assistance Program, military coverage and other arrangements to disclose to all Part D-eligible individuals whether or not this coverage is actuarially-equivalent to Part D coverage offered by a Prescription Drug Plan or Medicare Advantage-Prescription Drug program.

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