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May 28, 2015

Nora Super
Executive Director
White House Conference on Aging
One Massachusetts Avenue NW
Washington, DC 20001

Dear Ms. Super:

On behalf of the Medicare Rights Center (Medicare Rights), I am writing to respond to the policy briefs released as part of the 2015 White House Conference on Aging (2015 WHCOA). We applaud your efforts to provide analysis and to seek input on four topic areas critical to the health and well-being of older Americans, including healthy aging, long-term services and supports, elder justice, and retirement security.

For over 25 years, Medicare Rights has provided individualized counseling to Medicare beneficiaries and their families, developed unbiased, informative educational content on Medicare, and advocated for needed policy change on behalf of older adults and people with disabilities. Our team of professional staff and volunteers has firsthand, on-the-ground experience helping seniors and people with disabilities navigate the Medicare program.

As the primary source of health coverage for older adults, Medicare plays an important role in each of the conference themes. In this historic 50th anniversary year for Medicare, we urge the White House to both celebrate this program's undeniable successes and to advance solutions to modernize and strengthen Medicare. We are eager to assist your efforts on both fronts, and we urge you to take bold steps to improve access, generate knowledge, and advance the health of people with Medicare.

Each of the 2015 WHCOA policy briefs ends with a series of important questions about how to better support older adults, future retirees, and their families. Through this comment process, we understand that you are soliciting input on executive and regulatory policy recommendations to advance through the 2015 WHCOA. Below we recommend several initiatives, including enhanced notice for people approaching Medicare eligibility, swift implementation of improvements to appeals processes, improved decision-making support for people with Medicare, and expanded coverage for skilled nursing facility and non-routine dental care.

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First and foremost, we urge the White House to act on the following:

Fill information gaps for people approaching Medicare eligibility. Individuals collecting Social Security benefits are automatically enrolled in Medicare, while others must make a proactive choice to enroll in one or multiple parts of the program. Yet, no federal agency provides notification about Medicare eligibility to individuals not yet collecting Social Security benefits.

Thus, for many people becoming Medicare-eligible, there is no official communication to provide education on when and how to enroll in Medicare or what can result from delayed enrollment. At the same time, many individuals auto-enrolled in Medicare—particularly those with coverage from a small employer, retiree insurance, or COBRA benefits—fail to grasp the harsh consequences that may result from declining Medicare, namely Part B. Additional education is needed to ensure that people are making a truly informed choice when turning down Part B.

Given this, it is no surprise that the second most common issue presented on Medicare Rights' national helpline concerns transitions to Medicare. Of these calls, we hear most often from seniors and people with disabilities facing lifetime late enrollment penalties, gaps in coverage, higher health care costs, and disruptions in access to needed care. With 10,000 people becoming Medicare-eligible each day, providing adequate notification and enhanced education around the transition to Medicare is an ever-mounting need.[1]

As reflected in the attached December 2014 letter signed by over 40 national aging and disability advocacy organizations, these issues span multiple federal departments, including the Department of Health and Human Services, the Department of Labor, and the Social Security Administration. Many other private and public sector entities also play a fundamental role in supporting people during the transition to Medicare, including health plans, employers, state Medicaid departments, and state-based Marketplaces.

The attached letter identifies specific transition points that we expect will be especially difficult for people nearing Medicare eligibility to navigate and calls on these federal agencies to address unmet messaging and notification needs. As part of the WHCOA, we strongly encourage you to develop and implement an interagency approach, involving all relevant stakeholders, to improve notification and support for individuals nearing Medicare eligibility. This same recommendation was recently identified as a priority area for the 2015 WHCOA, in both the categories of healthy aging and retirement security, by the Leadership Council of Aging Organizations (LCAO), a national coalition of 72 nonprofit organizations committed to representing the interests of older adults.[2]

Developing a notification system will ensure that fewer people new to the Medicare program are saddled with higher health care costs or go without needed health care resulting solely from honest enrollment mistakes. We urge the White House to commit to the development of notices and other standardized materials to fill sorely needed information gaps and to improve on existing enrollment-related educational content across all relevant federal agencies. These simple, low-cost fixes will reap notable benefits for current and future generations of retirees and people with disabilities.

At the same time, we encourage the White House to advance the following:

Act swiftly to strengthen the Part D and Medicare Advantage (MA) appeals processes. Even when people are able to make careful and informed decisions about their MA or Part D benefits, we find that coverage problems often arise. Consequently, the MA and Part D appeals processes are essential to promoting the health and well-

[1] Pew Research Center, "Baby Boomers Retire," (Pew Research Center: December 29, 2010), available at: http://www.pewresearch.org/daily-number/baby-boomers-retire/

[2] LCAO, "White House Conference on Aging Documents," (March 2015), available at: http://www.lcao.org/files/2015/04/Nora-Super-policy-recommendations-for-the-WHCOA-Final.pdf and http://www.lcao.org/files/2015/04/LCAO-WHCoA-Priority-Policy-Recommendations-Final.pdf

being of Medicare beneficiaries. In 2012 and 2013, the most common and persistent concern presented on our national helpline involved denials of coverage, most often from MA and Part D enrollees.[3]

Unfortunately, as reflected in recent audits conducted by the Centers for Medicare & Medicaid Services (CMS), Medicare private health plans often mishandle beneficiary denials and appeals.[4] We continue to observe that beneficiaries, their family members, and their health care providers struggle to navigate a particularly onerous appeals process in Medicare Part D. Needless steps in the Part D appeals process result in some beneficiaries delaying access to needed treatments or going without prescribed medications altogether.[5]

As such, we were encouraged by commitments made by CMS in the final 2016 call letter. These include improvements to Part D denial notices, a pilot program on the beneficiary experience with denials at the pharmacy counter, and enhanced data collection at each stage of the appeals process.[6] We urge CMS to act quickly on these commitments and to ensure that multiple stakeholders (including consumer advocates, plan sponsors, pharmacy benefit managers, pharmacists, health care providers, pharmaceutical makers, etc.) are consulted on the implementation of these policies and programs. We encourage you to announce the formation of a multi-stakeholder advisory group at the 2015 WHCOA to advise on the MA and Part D appeals initiatives announced in the final call letter.

Increase decision making support for people with Medicare. In general, we find that older adults and people with disabilities find selecting among multiple private Medicare health plans a dizzying experience. We hear firsthand from people with Medicare that there are *too* many plans and *too* many variables, and we continue to be alarmed by empirical research that consistently illustrates how few beneficiaries revaluate their coverage options on an annual basis. According to one analysis, from 2006 to 2010, only 13% of beneficiaries switched prescription drug plans during each annual enrollment period, despite changes in premiums, cost sharing, and coverage.[7]

In part, we believe these challenges reflect an overarching need to streamline and simplify beneficiary-facing content made available by the federal government on Medicare. We encourage you to review how CMS and other federal agencies present the Medicare "brand" across multiple notices, websites, and other tools and to identify areas for enhanced clarity. People with Medicare benefit from access to several key tools, such as Medicare.gov, 1-800-MEDICARE, Plan Finder, Medicare & You, standardized notices provided by private health plans, and more. Yet, with each of these tools, we believe there is room for continuous improvement.

At the same time, we encourage the White House to strengthen beneficiary access to accurate and personalized resources to choose the Medicare option(s) best suited to a person's individual needs. Unbiased Medicare decision-making supports, such as the counseling provided by the State Health Insurance Assistance Programs (SHIPs), are critically important to the financial stability, health, and wellness of our nation's seniors. To further explore needs

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[3] Sutton, C., Bennett, R., Sanders, S., and F. Riccardi, "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline," (Medicare Rights Center: 2013), available at: http://www.medicarerights.org/2012-medicare-trends/; Morales, S., Bennett, R., and S. Sanders, "Medicare Trends and Recommendations: An Analysis of 2013 Call Data from the Medicare Rights Center's National Helpline," (Medicare Rights Center: 2014), available at: http://www.medicarerights.org/2013-medicare-trends/

[4] CMS, "The 2013 Part C and Part D Program Annual Audit and Enforcement Report," (October 2014), available at: http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2013CandDProgramAuditAnnualReport.pdf; See also: letter from 30+ consumer advocates to the Medicare Payment Advisory Commission (MedPAC) on recent audits and sanctions, (October 2014), available at: http://www.medicarerights.org/pdf/101014-medpac-part-d-appeals.pdf

[5] Medicare Rights Center letter to MedPAC on Part D appeals, (September 2013), available at: http://www.medicarerights.org/pdf/092013-part-d-appeals-medpac.pdf

[6] http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf

[7] Hoadley, J., Hargrave, E., Summer, L., Cubanski, J., and T. Neuman, "To Switch or Not to Switch: Are Medicare Beneficiaries Switch Drug Plans to Save Money?" (Kaiser Family Foundation: October 2013), available at: http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicarebneficiaries-switching-drug-plans-to-save-money/?special=footnotes - footnote-87213-9

in this area, we encourage you to release a Request for Information (RFI) as part of the 2015 WHCOA. Intended for multiple stakeholders (including Medicare beneficiaries, consumer advocates, plan sponsors, academic institutions and researchers, SHIPs, etc.), this RFI should seek research and insights on how to better support beneficiaries with making decisions about how to access and optimize their Medicare benefits.

Close antiquated gaps in coverage. The Medicare program provides comprehensive coverage in some areas, yet in others, coverage is restricted by outdated limitations—including for skilled nursing facility and dental care. The 2015 WHCOA provides a venue to revisit these coverage rules and consider areas for expansion that may be possible without legislation. We encourage the White House to consider the following:

- **Count time spent in "observation" status towards coverage for skilled nursing facility care.** Medicare requires an inpatient, hospital stay of at least three days for coverage of subsequent skilled nursing facility (SNF) stays. Beneficiaries who receive observation services are technically not admitted to the hospital, meaning they are unable to secure coverage for SNF care, even when they are in the hospital for three or more days. We encourage CMS to revise the agency's existing rules to permit all days where a person is receiving services in the hospital—inpatient or outpatient—to count towards the three-day coverage rule and to announce this change at the 2015 WHCOA.

- **Reconsider coverage for health-related, non-routine dental care:** Another common theme heard among our clients concerns access to dental care. Each year, Medicare Rights receives over 1.5 million visitors to its online learning tool, Medicare Interactive.[8] The most popular webpage on this site is entitled, "Does Medicare cover dental services?" In most cases, the answer is a resounding no. Yet, oral health is increasingly recognized as a cornerstone for good health.[9] Poor dental care can increase the risk of breathing diseases and malnutrition.[10]

  While Medicare law explicitly excludes coverage for some dental services, we find that CMS' current interpretation of this section is unduly restrictive. For example, under CMS rules, coverage for a bone-graft to address severe osteoporosis because the damaged bone was in the jaw would likely be denied, when a similar graft performed elsewhere would likely be covered. We encourage CMS to actively explore options to expand access and to announce those changes at the 2015 WHCOA.

In closing, we believe that enhancements to the Medicare program and its service to beneficiaries have the potential to fulfill multiple stated goals of the WHCOA. We would welcome the opportunity to discuss this input with you in greater detail and to share more specific recommendations in areas of interest to you. Thank you.

Sincerely,

Joe Baker
President
Medicare Rights Center

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[8] Available at: http://www.medicareinteractive.org

[9] National Institute of Dental and Craniofacial Research, "Chapter 6: Effects on Well-being and Quality of Life," (2014), available at: http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/sgr/chap6.htm

[10] Terpenning, M., "Geriatric Oral Health and Pneumonia Risk," (*Clinical Infectious Diseases*: 2005), available at: http://cid.oxfordjournals.org/content/40/12/1807.short

December 11, 2014

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

The Honorable Thomas Perez, Secretary
U.S. Department of Labor
200 Constitution Ave NW
Washington, DC 20210

The Honorable Carolyn Colvin, Acting Commissioner
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Secretary Burwell, Secretary Perez and Acting Commissioner Colvin:

The undersigned organizations are writing to urge the Department of Health and Human Services to work with the Social Security Administration and the Department of Labor to notify individuals approaching Medicare eligibility about their rights and obligations as they near enrollment. Together, our organizations represent the 54 million older adults and people with disabilities who rely on Medicare for basic health and economic security.

Individuals collecting Social Security benefits are automatically enrolled in Medicare. Yet, no federal agency provides notification about Medicare eligibility to individuals not yet collecting Social Security benefits. Thus, those who must proactively enroll are not directly informed about enrollment rules and policies. In fact, many individuals who are nearing eligibility only receive information on Medicare from insurance companies marketing private health plans.

Making an informed decision about whether and when to enroll in Medicare remains a complicated task for many individuals because it requires them to identify and understand a complex set of rules, along with the implications of these rules for their personal situations. The consequences of missteps can be significant, including a lifetime of higher Medicare premiums. Many of our organizations hear firsthand from retirees and people with disabilities who are facing higher health care costs, gaps in coverage and barriers to care continuity resulting from enrollment mistakes. With 10,000 people becoming Medicare-eligible each day, notification and enhanced education around this transition is an ever-mounting need.

This need affects people who currently receive health care coverage through a variety of health plans. For example, while individuals transitioning to Medicare from employer-sponsored coverage may receive guidance directly from their employers, the quality and accuracy of this support varies greatly, and the information supplied is neither required nor standardized. Targeted Medicare enrollment notices are needed to adequately educate this population, but also to inform individuals transitioning from new coverage options made available through the Affordable Care Act (ACA), including Marketplace plans and expansion Medicaid. Individuals transitioning from individual market Qualified Health Plans (QHPs) are unlikely to receive any notice about nearing Medicare eligibility. Similarly, employers new to the Small Business Health Options Program (SHOP) may be not be prepared to adequately assist aging or disabled employees, retirees and dependents.

Additional information and notice is particularly important for people who will be navigating the transition from expansion Medicaid to Medicare. Expansion Medicaid recertification and disenrollment may not be appropriately synchronized when a beneficiary is nearing Medicare eligibility. Furthermore, eligibility requirements for low-income assistance programs that work with Medicare, including Medicaid for aged, blind and disabled individuals, Medicare Savings Programs and the Low-Income Subsidy of Part D (or Extra Help), are more varied and more complicated than the relatively straightforward income threshold used for expansion Medicaid.[1]

In sum, for many people becoming Medicare-eligible, there is no official communication that provides education on when and how to enroll in Medicare or what may result from delayed enrollment, nor is there any trigger to spur the individual to seek out this information. As a result, many of our organizations hear from individuals who wrongly believed that because they had existing insurance, like COBRA benefits, retiree insurance or employer-sponsored coverage from a small employer, they did not need to enroll in Medicare. These individuals face severe consequences, including lifetime premium penalties, delays in access to essential low-income benefits and gaps in coverage that may prevent them from receiving urgently needed care. Further, without authoritative, reliable sources of information on Medicare basics and how to enroll, older adults and people with disabilities are more vulnerable to fraud and scams.

As a solution, we urge your agencies to develop a system to ensure that all individuals nearing Medicare eligibility receive timely and complete notice about Medicare enrollment. We recognize that your agencies will need to devote resources to implement this process, and we are committed to working with you to devise a notification system that is both high-impact and cost-effective. Standardized, federally required notices from employers and insurers about health coverage rights and responsibilities already exist in the Part D and COBRA contexts and could serve as models for a general notice about nearing Medicare eligibility.

In short, we believe this simple, low-cost fix will reap notable benefits for older adults and people with disabilities. Most importantly, a notification system will ensure that fewer people new to the Medicare program are saddled with higher health care costs or go without needed health care services resulting solely from honest enrollment mistakes. In particular, we suggest the following:

Provide notice about nearing Medicare eligibility to *all* individuals turning age 65. In particular, notice should be provided to people not already collecting Social Security benefits. We suggest sending this notice six months before a person's Initial Enrollment Period (IEP) and again at the start of the IEP, three months before an individual's 65th birthday. These notices could be combined with existing beneficiary-facing communications, like annual Social Security statements or notices related to creditable prescription drug coverage. Ideally, this notice should be sent by mail and made available in other formats, including online at mysocialsecurity.gov.

Ensure that notices include key messages. Federal notices should include information on the following: who should enroll in Medicare when they turn 65; what factors to consider before delaying Medicare Part A and Part B enrollment, like employer size for those covered by an employer plan; when Medicare or other insurance (e.g. employer-based, retiree, COBRA, QHP, SHOP, etc.) pays first; what consequences may result from delayed enrollment, like lifetime late enrollment penalties and gaps in coverage; what factors to consider when deciding to enroll in Part D; and where to seek out additional, unbiased information, including 1-800-MEDICARE, the State Health Insurance Assistance Program (SHIP) network, local Social Security offices, and local Medicaid offices.

[1] Expansion Medicaid uses a relatively simple income calculation, the Modified Adjusted Gross Income (MAGI) to determine eligibility and includes no asset test. Yet, once turning 65, an individual cannot be evaluated for Medicaid under these eligibility rules. Instead, the individual must meet the income and asset limits established by the State Medicaid authority. Similarly, eligibility for Medicare Savings Programs (MSPs) varies from state to state, above a federal floor. At the same time, income and asset test eligibility for Extra Help is distinct from the MSPs. These misaligned income and asset tests may result in delayed access to essential low-income benefits for individuals transitioning from expansion Medicaid to Medicare.

Carefully engage other messengers, including health plans, employers and states. In addition to establishing a notice from the federal government, we suggest that you consider leveraging Marketplace plans, employer-sponsored group health plans and Medicaid managed care plans to disseminate standardized, uniform notices to enrollees approaching their 65th birthday. These notices should be easy-to-understand and should direct people to independent sources of information like 1-800-MEDICARE, the SHIP network and local Social Security offices.

We also ask that you empower and better support employers to provide comprehensive and accurate information to employees nearing Medicare eligibility through educational initiatives and standardized materials. It will also be critical to coordinate with and provide direction to state Medicaid offices and Marketplaces to ensure uniform notice is provided for those managing specific transitions. Additionally, we suggest that you review and update model notices related to the election of COBRA benefits to ensure that the appropriate messages about Medicare enrollment are incorporated. In particular, individuals with COBRA who are approaching Medicare eligibility must be made aware that COBRA benefits pay secondary to Medicare and that COBRA coverage does not insulate a person from Part B late enrollment penalties.

Strengthen notice for beneficiaries who are auto-enrolled. Revisit and improve the notice and information sharing made available to those automatically enrolled into Medicare after 24 months of Social Security disability benefits or because they turn 65 after they begin receiving Social Security retirement benefits in order to minimize errors by those who actively decline Part B. Improved information about which insurance pays first and the Part B Special Enrollment Period timing is particularly important for this group.

Develop notices and educational materials in threshold languages and alternate formats. Include multi-lingual inserts with notices. Explore ways to target non-English notices and alternate format materials to individuals who have already expressed language or format preferences to Social Security, Medicaid, or Marketplace or employer-sponsored plans.

The development of a comprehensive system to support individuals approaching Medicare eligibility should be a paramount concern for the Department of Health and Human Services, the Department of Labor and the Social Security Administration. Improved notice and information will help individuals newly eligible for Medicare avoid many of the pitfalls—including unaffordable health care costs and gaps in coverage—that we regularly hear about from people who are uninformed or misinformed about the Medicare enrollment process. We would welcome the opportunity to meet with you to discuss these issues, and we are eager to support your agencies in strengthening education for individuals approaching Medicare eligibility. Thank you for your ongoing and steadfast commitment to promoting the health and well-being of people with Medicare.

Sincerely,

ACCSES
Alliance for Retired Americans
American Association of Kidney Patients
American Association on Health and Disability
American Federation of Government Employees (AFGE)
American Society on Aging
B'nai B'rith International
California Health Advocates
Campaign for America’s Future

Center for Elder Care and Advanced Illness
Center for Medicare Advocacy, Inc.
Christopher and Dana Reeve Foundation
Families USA
The Jewish Federations of North America
LeadingAge
Lutheran Services in America (LSA)
Medicare Rights Center
National Academy of Elder Law Attorneys, Inc. (NAELA)
National Active and Retired Federal Employees Association (NARFE)
National Adult Day Services Association (NADSA)
National Alliance for Caregiving
National Association of Area Agencies on Aging (n4a)
National Association of Nutrition and Aging Services Programs (NANASP)
National Association of Professional Geriatric Care Managers
National Association of Social Workers (NASW)
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-term Care
National Council on Aging
National Health Law Program (NHeLP)
National Multiple Sclerosis Society
National Organization for Women (NOW)
National Senior Citizens Law Center
National Women's Law Center
OWL—the Voice of Women 40+
Paralyzed Veterans of America
Services and Advocacy for GLBT Elders (SAGE)
Social Security Works
State Health Insurance Assistance Program (SHIP) Steering Committee (Kris Gross, Chair)
Strengthen Social Security Campaign
Texas Transplantation Society
Transplant Recipients International Organization (TRIO)
United Spinal Association
Wider Opportunities for Women (WOW)
Women's Institute for a Secure Retirement (WISER)

CC: Marilyn Tavenner, Administrator, Center for Medicare & Medicaid Services
Kathy Greenlee, Administrator, Administration for Community Living
Shaun Donovan, Director, Office of Management & Budget