



Medicare Trends and Recommendations:

An Analysis of 2015 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 2015, the Medicare Rights Center’s (Medicare Rights) staff and helpline volunteers fielded more than 16,000 questions and issues through the organization’s national helpline. Clients included people with Medicare and caregivers across the country. As in previous years, clients were geographically and socioeconomically diverse, and needed help with a wide array of complex Medicare-related issues.

Medicare provides guaranteed health benefits to 57 million older adults and people with disabilities.ⁱ These individuals and their families rely on Medicare for basic health and economic security. In our 2013 report, Medicare Rights highlighted Medicare affordability challenges for beneficiaries, and in 2014 we identified two major helpline trends, including Part B enrollment issues that persist for those new to Medicare and challenges beneficiaries face when navigating the Part D appeals process.ⁱⁱ While some of these problems persist, Medicare Rights has worked with partners and policymakers to achieve important improvements to the Part B enrollment and Part D appeals processes, and to help make the Medicare program more affordable for beneficiaries.

Regarding affordability, in 2015, Congress acted to permanently fund the Qualified Individual (QI) Medicare Savings Program, a federally-funded program that pays Part B premiums for low-income Medicare beneficiaries who are between 125%-135% of the federal poverty level and have almost no savings. In addition, the Centers for Medicare & Medicaid Services (CMS) strengthened provider and Medicare Advantage plan outreach and education around inappropriate balance billing practices for very low-income people with Medicare.

With respect to Part B enrollment, in 2016, CMS established several new notifications and outreach mechanisms for current Medicare beneficiaries and for those who are approaching Medicare eligibility.ⁱⁱⁱ Using data matching, CMS is identifying and notifying Medicare beneficiaries enrolled in Qualified Health Plans (QHP) through the Federal Marketplace to inform these individuals that they are at risk of significant financial penalties and gaps in health coverage if they keep their Marketplace plan in lieu of Medicare. For individuals enrolled in QHPs nearing Medicare eligibility, CMS began sending notices via email about how to proceed with timely Medicare enrollment.^{iv} Also in 2016, Congress passed legislation requiring CMS to engage with key audiences, including beneficiaries and their advocates, to update the “Welcome to Medicare” enrollment package received by those auto-enrolled in Part A and Part B.^v

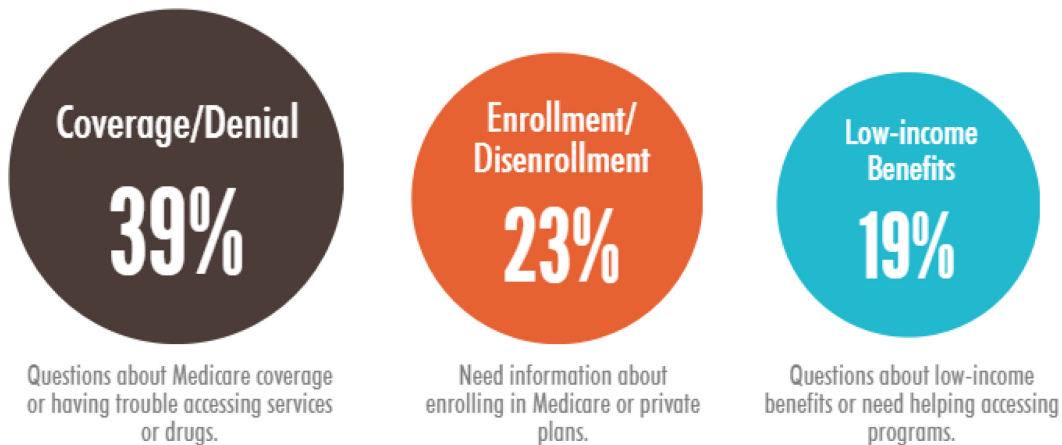
Further Congress adopted key consumer protections—advocated for by Medicare Rights—related to Part D appeals and beneficiary notice for a new program intended to identify people with Medicare who are misusing addictive medications, such as opioids. These protections include advance notification, guaranteed referrals to community-based supports, auto-escalation of unfavorable appeals, and provisions to ensure beneficiary choice of health care provider and pharmacy, among others.^{vi}

In this report, we examine 1) Part B enrollment rules and pitfalls, 2) difficulties with accessing Medicare Advantage health services and Part D prescription drug denials and coverage rules, and 3) financial hardship affording Medicare cost-sharing. All three present as persistent and continuing trends among callers to our national helpline. Our client stories appear throughout the report and the recommendations proposed here would help people with Medicare more readily access affordable, necessary care to manage chronic conditions and sudden, unexpected illness.

HEARD ON THE HELPLINE

Top Helpline Issues

(Percent of all helpline calls)



Helping Clients Navigate Medicare Part B Enrollment

Case Story: Mr. and Mrs. A called Medicare Rights concerned that they were not allowed to enroll into Part B. Mr. A was laid off from employment at age 67 and elected COBRA coverage since it was paid for by the company for a specified period of time. COBRA had been covering their medical claims until the health plan realized that Mr. and Mrs. A should have Part B. Mr. A explained that his Human Resources department never explained or notified him about the Part B Special Enrollment Period (SEP), the eight-month period to enroll into Medicare after losing employer-based coverage based on active employment. Since COBRA does not qualify someone to enroll into Medicare if they are outside of their eight-month window for a SEP, the helpline counselor had to relay the bad news that they would likely have a lifetime premium penalty for Part B.

In addition, the counselor informed Mr. and Mrs. A that they would not be allowed to enroll into Part B until the General Enrollment Period (GEP) with coverage not effective until the following July. Even though they were eligible for retiree benefits with a cost of over \$1,000 per month, the counselor explained that there was no obligation that the retiree coverage would pay primary without Part B. This means that Mr. and Mrs. A would not only be

subject to a higher Part B premium costs due to the lifetime premium penalty, they were also facing gaps in primary health insurance coverage since both have health care needs that require ongoing care.

Many individuals who call Medicare Rights are confused by Medicare enrollment rules, and specifically by decision-making related to taking or declining Part B. Medicare-eligible people who do not understand Part B enrollment rules or otherwise 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. Of the 2015 enrollment-related helpline calls, the most complex issues without immediate resolution involved Part B enrollment and coordination of benefits.

Coordination of benefits occurs when a person has health coverage by two or more health plans. Rules determine which plan pays for what services, and how much they are responsible for paying. Primary payers pay first, and usually pay the most. Secondary payers typically cover some of the costs that the primary payer did not pay.^{vii} These rules can be very confusing for people with or nearing Medicare eligibility and failure to understand these rules may lead to unpaid medical bills, higher health care costs, and disruptions in care continuity. Callers inquiring about these issues typically had employer-sponsored group health benefits, retiree benefits, or COBRA.

When to Enroll in Medicare

Medicare beneficiaries can enroll in Parts A and B at any time during their Initial Enrollment Period (IEP). The IEP is the seven-month period surrounding a person's 65th 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 Part B. The GEP occurs annually, from January 1 to March 31. Coverage for beneficiaries who enroll during the GEP begins in July 1 of the same year.

While many individuals are auto-enrolled in Parts A and B, people like Mr. and Mrs. A who are not yet collecting Social Security benefits must actively enroll or they will not be covered. Unfortunately, we find that both groups, people automatically enrolled or those that need to actively enroll, are not always given accurate or complete information by employers, Social Security, Medicare, and other sources.

The misinformation and confusion that Medicare Rights witnesses as newly eligible individuals transition to Medicare cannot be overstated. Medicare Rights helpline data shows people are often confused by the multiple enrollments periods (including the Initial Enrollment Period (IEP), GEP, and SEP); the mandated gaps in coverage for people who enroll during the GEP; the 24-month waiting period for Medicare based on disability; and the limited opportunities available to correct honest enrollment mistakes, namely via a process called "equitable relief."

Equitable relief is a way for people to show that they were misled about their Medicare options and responsibilities which led them to inappropriately refuse or delay Medicare coverage. To get equitable relief, a person must petition the Social Security Administration (SSA) and prove he or she was provided incorrect information or otherwise misled by an agent of the federal government. Though not frequently granted, a successful case for equitable relief can lead to immediate or retroactive enrollment into Part B and/or elimination of any Part B late enrollment penalty.^{viii}

Many people—like Mr. and Mrs. A—who are transitioning to Medicare from other types of coverage do not make fully informed decisions when it comes to Part B enrollment but have little recourse if they make a mistake.

Policy Recommendations to Support Individuals Approaching Medicare Eligibility

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

Pass the BENES Act.^{ix} The bipartisan Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act fills in long-standing education gaps for people nearing Medicare eligibility by ensuring they receive a clear and detailed notice explaining Part B enrollment rules months before their eligibility begins. Other BENES Act measures ease the enrollment process by fixing fragmented and outdated Part B enrollment periods and protect beneficiaries from coming to harm through honest mistakes by strengthening systems for equitable relief.

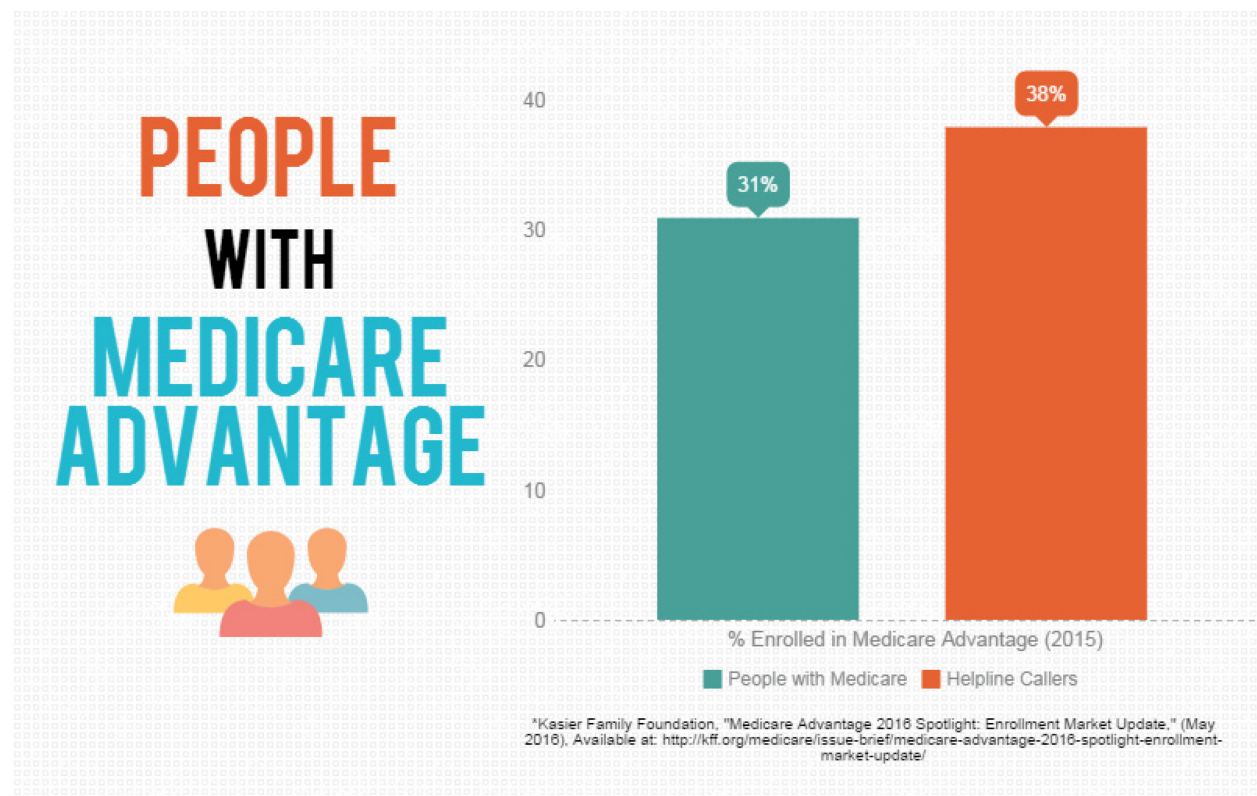
Relax the Part B late enrollment penalty (LEP). This penalty attaches when a person delays enrolling in Part B, even if the delay was a mistake made in good faith. One option to relax this penalty would be to use Part A LEP rules as a model, which limit penalties to only twice as long as an individual delayed Medicare enrollment.^x

Ease Part B enrollment pitfalls through agency actions. CMS and SSA should work together to help those approaching Medicare enrollment by providing advance notice to those not auto-enrolled about when and how to enroll in Part B; adequately funding outreach and education on newly developed CMS resources for employers; updating standard COBRA notices to include Medicare enrollment information; and continuing and expanding efforts to notify QHP enrollees about when and how to enroll in Medicare.

Part D Enrollment and the Late Enrollment Penalty

People eligible for Medicare who never enrolled into Part D can face a late enrollment penalty (LEP). Some Medicare Rights clients faced these penalties even when they had some form of creditable coverage—which is supposed to exempt new enrollees from Part D LEPs. This penalty is added to a beneficiary’s premium every month and, in many cases, may be paid for the rest of the beneficiary’s life.

How people are informed about and assessed for the Part D LEP, as well as the process for appeal, can be improved. Oversight to prevent and reverse erroneous penalties, improvements in processing creditable coverage claims, and enhanced beneficiary education and outreach can all streamline this system and end unreasonable errors.^{xi}



Helping Clients Navigate Medicare Advantage

Case Story: Ms. J has Medicare due to disability and resides in the state of Virginia. She is a retired police officer and receives disability benefits due to an on-the-job injury which continues to cause serious health care issues and pain. She lives on a moderate income that supports herself and two children. Ms. J also has serious issues with bleeding and blood clots. Her doctor felt that surgery to address the bleeding would be dangerous for her.

Instead, he wrote a letter to her Medicare Advantage plan requesting the plan authorize and cover a medically necessary procedure to treat her condition. The plan responded in writing, granting prior authorization. Ms J underwent the procedure only to later find that the plan denied coverage, leaving her with a bill for \$3,000.

The reason for the plan denial was unclear. Ms. J called the plan and they told her not to appeal as the plan would sort it out with the physician. Ms. J decided to appeal the denial anyway since she had prior authorization for the service. Her appeal was denied at what is called the “redetermination” level—which is when the person’s health plan reviews its own previous decision—without a clear reason as to why it was denied. She called and spoke with a customer service representative who informed her that the denial had to do with how the service was coded by a physician and they suggested that she contact her provider’s office.

A Medicare Rights counselor suggested Ms. J file a complaint with Medicare about having incomplete information about the denial by her plan. We explained that since the service was denied at the redetermination level that it would be auto-forwarded for review to an Independent Review Entity.

Medicare Rights fields thousands of calls from beneficiaries across the country enrolled in Medicare Advantage plans with questions about how to switch plans, appeal a denied claim, or about plan cost-sharing. In 2015, as in previous years, questions about coverage and denial issues continue to be a major helpline trend. Within this subset, calls about Medicare Advantage plans’ denials of coverage present with the most frequency. The most recurrent type of call about Medicare Advantage plan denials of coverage was related to physician services. Calls about physician services often include situations where the denials were due to the provider being out of network. In other calls, people received a referral from an in-network provider to see an out-of-network specialist. The plan then denied coverage due to the specialist being out of network, although certain Medicare protections exist for Medicare Advantage enrollees that go out of network when referred by an in-network physician.^{xii} Other types of denials for physician services include situations where the Medicare Advantage plan imposes prior authorization restrictions for services such as urgent care services, or denials for needed services when the plan indicates a lack of medical necessity.

As featured in previous reports, callers enrolled in Medicare Advantage plans continue to express concern and confusion about how to access needed health services. In addition to physician services, our clients experience a range of denials of coverage from their plans for health-related services including diagnostic testing, durable medical equipment, and hospital services. In many cases, our clients face high out-of-pocket costs when their Medicare Advantage plan denies their care, especially among those who miss the short 60-day window of time to appeal for coverage. Unlike Original Medicare, Medicare Advantage enrollees must appeal within 60 days of the date of service. If they miss this deadline, they are held responsible for the charges.

Policy Recommendations to Remove Barriers to Care and Coverage in Medicare Advantage

Evidence demonstrates that people with Medicare do not always understand or compare their coverage options. This is true even when year-to-year changes in Medicare Advantage or Part D plan premiums, coverage rules, networks, and cost-sharing make remaining in a given plan less advantageous for beneficiaries.^{xiii} Also, those who are beginning the Medicare enrollment process are faced with numerous choices that can be extremely confusing. Additionally, as evidenced by our helpline trends, people with Medicare Advantage—like Ms. J—can face significant challenges navigating coverage denials and appeals. Medicare Rights supports the following policy reforms to help people with Medicare Advantage make the most of their coverage:

Require Medicare Advantage plans to share all materials used to arrive at a denial decision with the beneficiary and the independent review entity evaluating the appeal. This includes plain language reasons for the denial; cited excerpts from internal plan or CMS rules relied upon in the determination; and the full text of relevant rules, including those that might weigh in favor of coverage.

Enhance CMS monitoring and enforcement of the grievance and appeals process. In particular, CMS should enforce strict compliance with notice rules and requirements to effectuate timely decisions, holding beneficiaries harmless when a plan fails to meet the standards.

Personalize the Annual Notice of Change (ANOC) for Medicare Advantage and Part D plans. Plans are required to provide ANOCs by September 30 every year to highlight important changes to Medicare Advantage and/or Part D plan coverage for the next year. Medicare Rights recommends that each person receive a personalized ANOC that explains changes to physician or pharmacy networks and medication formularies based on the care they previously received. This will help people with Medicare more easily evaluate their current plan coverage and assess other options during the annual open enrollment period.

Revitalize Medicare's Plan Finder. This tool is the premier online resource for people with Medicare, caregivers, and professionals to evaluate and compare the Medicare Advantage and Part D plan options available in a given region. Taking into account input from beneficiaries and their advocates, CMS should improve basic formatting and pharmacy and cost-sharing displays as well as the addition of critical, missing information, like content on Medicare Advantage provider networks and Medigap supplemental options, to ensure people can make decisions based on complete information.^{xiv}

Helping Clients Navigate Part D Denials and Appeals

Case Story: Ms. S was prescribed a generic medication for a sleep disorder. In the new Part D plan year, her physician submitted a request for a tier exception because the medication was very costly in Tier 4, typically one of the highest cost-sharing categories in a plan's formulary, even though it was a generic drug. Ms. S is unable to take the other medications in this category. She received a denial notice from her Part D plan with no reason for the denial. Ms. S explained to our helpline counselor that it has been very difficult to obtain the criteria on which the drug denial was based. She filed a grievance about the lack of information due to the confusing language about the denial.

Unfortunately, even after filing a grievance, her plan's customer service representatives were still unable to provide Ms. S with clarifying information on what information was needed to support an appeal. Ms. S continued to go without her medication because she could not afford to pay the high tier drug copayment.

Like Ms. S, many callers are confused as to why they must leave the pharmacy without their prescribed medication. Almost no callers report or recall receiving a pharmacy counter notice about how they can appeal a denial, a CMS requirement of Part D plans and pharmacies.^{xv} Callers are sometimes charged full cost at the pharmacy counter with no clear explanation on how to ensure their plan pays for a medication. Yet, very few, if any, of our callers pay for the medication out-of-pocket since most cannot afford the medication at full cost.

Some clients call us after leaving the pharmacy counter empty handed, while others call us after they receive a plan notice and are confused about how the Part D appeals process works. Often times, it is difficult for our helpline counselors to ascertain which level of appeal a given caller is at. Many callers struggle to answer our questions about whether their appeal has been filed with the plan, what level of appeal they are at, and what their doctors may have done on their behalf.

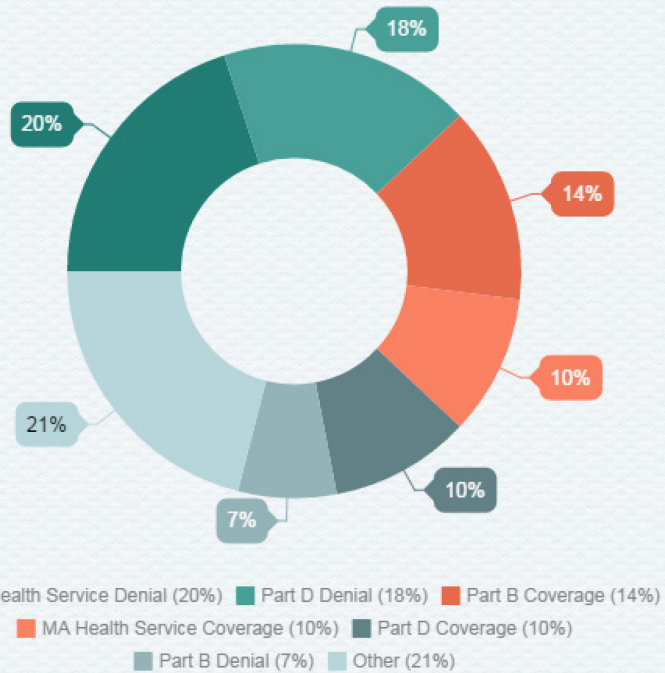
Continued difficulties accessing medications demonstrate a need for improved information in real time at the pharmacy counter and plans to better communicate with both beneficiaries and their prescribing providers to resolve medication access issues.

38%
of coverage/
denial calls involved
Medicare Advantage health
service/Part D denials



Coverage & Denial Questions

Questions about Medicare coverage or having trouble accessing services or drugs



Policy Recommendations to Remove Barriers to Care and Coverage in Part D

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

Require the presentation of a prescription to count as a coverage determination request. This eliminates the need for a beneficiary to formally request coverage after leaving the pharmacy empty handed.

Provide notice at the pharmacy counter explaining the reason for a denial. Beneficiaries currently do not receive any information about the reason for the denial, leading to beneficiary confusion and loss of access to their medications.

Improve denial notices, tailoring such notices to the specific reason for the denial and information about lack of medical necessity. This will enable beneficiaries to understand why the denial happened and how to push for an appeal if they decide to do so.

Enhance outreach on tiering exceptions, which allow requests for lower cost-sharing for high-cost drugs. Many beneficiaries do not understand the plan tiers and their right to request exceptions when a high-cost drug is the most appropriate one to treat their condition.

Allow tiering exceptions for medications on the Part D specialty tier. Currently, beneficiaries cannot request a tiering exception for medications on the specialty tier, and these are often the most expensive drugs. Allowing beneficiaries to request tiering exceptions could increase the affordability of these drugs, which can be the most appropriate treatment under some circumstances.

Auto-forward final plan denials to the Independent Review Entity (IRE). An auto-forward, as exists for Medicare Advantage plans, reduces the burden on the beneficiary who otherwise has to independently begin or continue the appeals process.

Clients Struggle to Pay for Prescription Drugs

Medicare Rights continues to receive calls where people with Part D are challenged to afford the cost of their medications during all phases of their Part D coverage. Many callers are unclear as to why prescription drug prices remain costly, and why they cost different amounts across plans. We listen to bewildered, and sometimes angry, beneficiaries about the cost of their prescription drug coverage. People are confused by sometimes wildly fluctuating costs from year to year. Many clients complain that they cannot afford their medications but do not qualify for Extra Help, the federal program that lowers the cost of Part D medications. The Part D coverage gap, also known as the donut hole, is slated to end by 2020 when individuals will pay approximately 25% of the cost of a prescription drug up to the point of catastrophic coverage, when beneficiaries will pay either a 5% coinsurance on the cost of covered drugs or a small copay, whichever is greater.

Case Story Ms. R is an older beneficiary who was prescribed an expensive but potentially life-saving medication. According to her physician and social worker, alternative and less expensive medications failed to prevent her illness. When Ms. R's caregiver went to pick up the medication for her, she was unable to purchase it. Confused, the caregiver thought that the medication was denied until she called the Part D plan, which did not receive an explanation that the medication was costly and that Ms. R had a deductible. The physician was unable to provide samples of this medication and she went without the medication. Within weeks, Ms. R was readmitted to the hospital for a potentially catastrophic acute illness that the medication was prescribed to prevent.

Part B Covered Medications

Mrs. K was recently diagnosed with Stage IV cancer. Frightened, sick, and exhausted, Mrs. K explained to a helpline counselor that her treatments were not affordable and she cannot afford a Medigap plan to cover her Part B coinsurance since she lives on a limited income. She receives chemotherapy treatments composed of different Part B infusion drugs more than once a week, amounting to over \$2,000 a month. Mrs. K called the helpline to find out whether there was any help for her. Not eligible for federal assistance, Medicare Rights referred Mrs. K to seek charity care and foundation assistance as her medical bills accumulate.

Research and polling affirms the stories heard on our national helpline. Many older adults struggle to afford their prescriptions. According to a recent poll, 11% of adults over 65 did not fill a prescription over the last two years due to cost, and people who are approaching Medicare eligibility are even more likely (22%) not to fill a prescription due to cost.^{xvi}

We receive many calls from people like Ms. R and Mrs. K who are looking for ways to afford needed medications. They employ strategies like requesting assistance from drug manufacturers and asking for charity. Some beneficiaries apply for assistance and are denied because there is limited funding available, depending on their specific illness and the medication.

Policy Recommendations to Help Beneficiaries Afford Prescription Drugs while Increasing Savings and Value for the Medicare Program

Unaffordable prescription drugs are among the most persistent and intractable problems we hear on the Medicare Rights national helpline, whether covered under Part B or Part D. As such, we support the following recommendations:

Continue to close the Part D donut hole. The Affordable Care Act (ACA) took a historic step toward making prescription drugs more affordable by closing the Part D prescription drug coverage gap (or donut hole). Until 2010, while in the donut hole, beneficiaries were responsible for the full cost of needed medications. Over time, this obligation is gradually diminishing, and the donut hole will be fully closed by 2020. Nearly 12 million people with Medicare have saved over \$26 billion in prescription drugs since 2010.^{xvii} However, repeal of the ACA may stop this progress and open the donut hole again.

Restore Medicare prescription drug rebates. Prior to the creation of Medicare Part D, the federal government benefited from rebates (or discounts) on prescription medicines for people covered by both Medicare and Medicaid. When Congress created Part D, dually eligible beneficiaries switched from Medicaid drug coverage to Part D, meaning the federal

government could no longer benefit from Medicaid’s rebate system for this population. These prescription drug rebates should be restored in Medicare.

Allow Medicare to negotiate Part D prices. Both the Veterans Administration and state Medicaid programs directly negotiate on prescription drug prices, but the legislation that created Part D expressly prohibited the Medicare program from participating in the same kind of negotiations. This prohibition limits the federal government’s ability to secure the best prices on Medicare prescription drugs. The federal government’s ability to achieve savings would be significantly enhanced by both allowing the federal government to negotiate prices and letting Medicare operate its own prescription drug benefit.

Create a publicly-administered Part D benefit. The Medicare prescription drug program is operated solely by private health plans. Adding a public drug benefit to the Part D program would diminish confusion among beneficiaries who now must navigate a complicated maze of private health plans and year-to-year formulary changes. In addition to enhancing beneficiary choice, a Medicare-administered plan also has the potential to create federal savings through simplified administrative processes and price negotiations.

Promote cost-effective prescribing for Part B prescription drugs. Most Medicare drugs are covered through the Part D program, but a small percentage, most often medicines that must be administered by a doctor, such as those that treat cancer, macular degeneration, anemia, and arthritis, are covered under Part B. These prescription drugs tend to be very costly, but there are several savings options available. The most straightforward option would simply reduce the percentage at which Part B drugs are reimbursed. Another option would restore the federal government’s ability to set prices for Part B medicines based on the price of the “least costly alternative” among multiple drugs that treat the same condition.

Adopting value-based pricing tools for Part B medications that attach payment for the medications to their clinical effectiveness (as discussed below) are yet another option, along with other proposals such as allowing the federal government to negotiate Medicare Part B prescription drug prices or requiring drug companies to provide a rebate (or discount) for these medications.^{xviii}

Require transparency around major price increases. Increased transparency in how prescription drug manufacturers determine prices would help create incentives to keep prices down and provide context for policymakers, taxpayers, and consumers about the costs and value of medications.^{xix}

Test value-based pricing initiatives to address rising prescription drug costs. Initiatives in the private sector—such as indications-based pricing, outcomes-based risk-sharing agreements, and lowered cost-sharing for high-value medications—aim to tie reimbursement and/or cost-sharing to evidence on clinical effectiveness. We encourage testing these concepts in Medicare, so long as any such testing is designed with robust consumer and patient input, incorporates adequate beneficiary protections, and ensures that all data, metrics, and outcomes are made fully transparent.

Clients Struggle to Afford Medicare Coverage

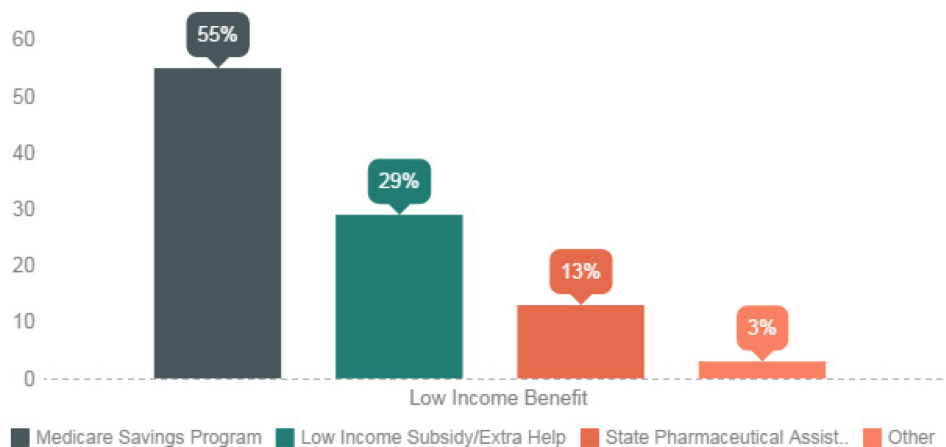
Case Story: Ms. R, a 70-year-old widow and retired public school employee, lives on a fixed income of Social Security and a small monthly union pension. She has multiple chronic conditions, including rheumatoid arthritis, and is enrolled in a Medicare Advantage plan. She takes multiple medications covered by Part D and struggles to pay for the copayments and co-insurance related to physician services, diagnostic testing, and Part B covered infusions. Her infusion treatments would cost the Medicare Advantage plan close to \$80,000 a year. Although Ms. R has a maximum out-of-pocket limit with the Medicare Advantage plan that she likes, she is unable to pay her \$800 deductible and the additional \$700 copayment until she reaches her maximum out-of-pocket limit. She goes without her Part B infusion until she reaches the out-of-pocket limit at a later point in the year. Without her treatments, she lays in bed for most of the year and is unable to leave her home because of excruciating pain.

Ms. R. does not qualify for Medicaid or a Medicare Savings Program to pay for her cost-sharing. She does not qualify for charity care as she has been rejected multiple times because there are no funds available through copayment assistance programs for her condition. Ms. R's physician has been unwilling to put her on a payment plan to spread the costs over the year because of the high cost of the medication that he needs to purchase.

Ms. R makes tough choices and sacrifices to survive. She feels ashamed that she has to go to a food pantry for a bag of food every month. She also has no computer access because she cannot afford to fix her broken computer.

Low-Income Benefits

Questions about low-income benefits or need help accessing programs



People with Medicare have very modest incomes and many have little to no savings. In 2014, half of all people with Medicare lived on annual incomes of \$24,150 or less.^{xx} They already pay a significant amount toward health care—in 2012, they paid 14% of household expenses toward health care costs, nearly three times as much as those not yet on Medicare.^{xxi} In 2014, half of all people with Medicare had \$63,350 or less in savings, one in four had less than \$11,900 in savings, and 8% had no savings altogether or were living with debt.^{xxii}

We speak to beneficiaries, like Ms. R, who cannot bear their current medical costs associated with copayments, coinsurance, and deductibles. They make tough choices about obtaining necessary health care. Some have limited mobility and it is difficult to leave or get around in their homes, and they cannot afford to pay for additional help for cleaning, grocery shopping, or preparing meals. An unexpected \$50 copayment to follow up on medication management with a physician can altogether upend a person's monthly fixed budget.

Policy Recommendations to Help Beneficiaries Afford Medicare Coverage

Though Medicare is a life-saving program with many benefits, it can still be too expensive for people with low to moderate incomes. We support the following reforms to improve affordability:

Add a standard out-of-pocket maximum for beneficiary cost-sharing. While Medicare Advantage has an out-of-pocket maximum, Original Medicare does not.^{xxiii} Congress should establish a standard out-of-pocket maximum, applicable to both Original Medicare and Medicare Advantage plans. Ideally, it should be lower than the \$6,700 maximum currently in place for Medicare Advantage given relatively low and fixed incomes among most people with Medicare.

Increase the income thresholds for Medicare Savings Programs (MSPs). MSPs are low-income assistance programs that help pay for Medicare premiums, coinsurance, and deductibles. The current income thresholds for these programs exclude millions of vulnerable Medicare beneficiaries who neither qualify for MSPs nor can afford the pay out of pocket.

Eliminate the asset test for Medicare Savings Programs. MSP asset thresholds are also unreasonably low in most states, where even a very small emergency nest egg may disqualify an applicant. Other states have chosen to eliminate asset tests, and Congress should follow their lead or, at a minimum, raise the asset limit. This will help ensure vulnerable Medicare beneficiaries can access needed assistance.

Streamline the application process for Medicare Savings Programs. Beneficiaries must navigate multiple state and federal agencies to apply for MSPs. This can result in unnecessary delays and improper denials. Congress should integrate the application processes, qualifying criteria, and administration of these interrelated low-income assistance programs without diminishing access.

Conclusion

As shown above, Medicare Rights' 2015 helpline data provides a snapshot of the issues that our clients face and provides the template for our policy endeavors. Many of these challenges can be resolved with practical policy solutions, and we make progress in these goals every year. Today's health care climate, including the threat of ACA repeal without a viable replacement, proposals to cut Medicaid funding, and calls to undo the Medicare guarantee, put recent gains at risk.

Still, we will continue to listen as our clients inform us about what is working for them in the Medicare program and what improvements and enhancements they need. Medicare is strong and vital, but we will continue to support ways the program can be strengthened to protect current beneficiaries and generations to come.

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ⁱⁱⁱ White House Conference on Aging (WHCOA), "What You Need to Know First about Enrolling in Medicare," (July 2015), available at: <https://archive.whitehouseconferenceonaging.gov/blog/post/white-house-conference-on-aging-what-you-need-to-know-first-about-enrolling-in-medicare.aspx>; Cavanaugh, S., "Helping You Help Your Employees with Medicare," (CMS: September 2015), available at: <https://blog.cms.gov/2015/09/25/helping-you-help-your-employees-with-medicare-enrollment/>

^{iv} Centers for Medicare & Medicaid Services, "Press Release: Strengthening the Marketplace – Actions to Improve the Risk Pool," (June 2016), available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html>; Centers for Medicare & Medicaid Services, "Medicare Periodic Data Matching," (August 2016), available at: <https://marketplace.cms.gov/technical-assistance-resources/medicare-periodicdata-matching.pdf>

^v See, Section 17003, 21st Century Cures Act of 2016 at: <http://docs.house.gov/billsthisweek/20161128/CPRT-114-HPRT-RU00-SAHR34.pdf>

^{vi} See, Section 705, CARA at: <https://www.congress.gov/bill/114th-congress/senatebill/524?q=%7B%22search%22%3A%5B%22CARA%22%5D%7D&r=1>

^{vii} For more information about primary and secondary payers, see Medicare Interactive: <https://www.medicareinteractive.org/get-answers/medicare-and-other-types-of-insurance/enrolling-in-medicare-when-you-have-other-types-of-insurance/medicare-can-be-primary-or-secondary-to-employer-insurance>

^{viii} For more information on equitable relief, see <https://www.medicarerights.org/PartB-Enrollment-Toolkit/Equitable-Relief.pdf>

^{ix} Introduced in the 114th Congress in the House of Representatives by Congressmen Raul Ruiz (D-CA) and Patrick Meehan (R-PA) and in the Senate by Senators Bob Casey (D-PA) and Chuck Schumer (D-NY) (H.R. 5722 and S. 3236)

^x See, Medicare Affordability and Enrollment Act of 2016 introduced in the 114th Congress by Senator Ron Wyden (D-OR) (S. 3371)

^{xi} Medicare Rights Center, "Part D Enrollment: Penalty Pitfalls," (October 2016), available at: <http://www.medicarerights.org/medicare-snapshot-october-2016>

^{xii} Centers for Medicare & Medicaid Services, "Medicare Managed Care Manual," Chapter 4, p. 160 – Beneficiary Protections Related to Plan-Directed Care, Rev. 121 (April 2016), available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>

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- ^{xiii} Kaiser Family Foundation, “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?” (October 2013), available at: <http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money>
- ^{xiv} For more detail on Medicare Rights’ recommendations for Plan Finder, see <https://medicarerights.org/pdf/plan-finder-observations-091216.pdf> and <https://www.medicarerights.org/pdf/plan-finder-observation-chart-%20091216.pdf>
- ^{xv} 42 CFR §423.562(a)(3)
- ^{xvi} AARP, “2015 Survey on Prescription Drugs,” (January 2016), available at: http://www.aarp.org/content/dam/aarp/research/surveys_statistics/health/2015/prescription-drug-report-2015.pdf
- ^{xvii} Centers for Medicare & Medicaid Services, “Press Release: Nearly 12 million people with Medicare have saved over \$26 billion on prescription drugs since 2010,” (January 2017), available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-13.html>
- ^{xviii} Medicare Rights Center and Social Security Works, “A Winning Strategy for Medicare Savings: Better Prices on Prescription Drugs,” (July 2014), available at: <https://www.medicarerights.org/pdf/drug-savings-brief-july-2014.pdf>.
- ^{xix} For example, see the “Fair Accountability and Innovative Research Drug Pricing Act of 2016,” available at <https://www.congress.gov/bill/114th-congress/senate-bill/3335>
- ^{xx} Kaiser Family Foundation, “Income and Assets of Medicare Beneficiaries, 2014 – 2030,” (Sep 2015), available at: <http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030/>
- ^{xxi} Kaiser Family Foundation, “Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households,” (Jan 2014), available at: <http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/>
- ^{xxii} Kaiser Family Foundation, “Income and Assets of Medicare Beneficiaries, 2014 – 2030,” (Sep 2015), available at: <http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030/>
- ^{xxiii} Centers for Medicare & Medicaid Services, “Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,” (April 2016), available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>