MEDICARE RIGHTS CENTER

Getting Medicare right

Medicare Trends and Recommendations:

An Analysis of 2013 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 2013, the Medicare Rights Center's (Medicare Rights) national helpline fielded more than 15,000 questions from Medicare beneficiaries, caregivers, and professionals across the country. Callers were geographically and socioeconomically diverse, and needed help with a wide array of problems.

This report outlines the most common and pressing concerns for Medicare Rights' callers. Top themes include Medicare denials of coverage and the appeals process (34 percent), problems transitioning into Medicare (22 percent), and difficulties affording health care costs (19 percent). Other questions involved billing issues (15 percent), coordination of benefits (4 percent), and other issues (6 percent), such as problems with Medicaid.

Despite the longstanding nature of these problems, which were also the most frequent reasons people called Medicare Rights' helpline in 2012, meaningful improvements are possible through counseling, education, and policy reforms. The solutions explored in this report would serve to reduce the prevalence and severity of the common challenges heard daily by Medicare Rights' staff and volunteers.

Review of Top Medicare Rights National Helpline Trends

Navigating Medicare Coverage and Denials of Coverage

Over one-third of questions fielded by Medicare Rights' national helpline in 2013 related to what Medicare does and does not cover (i.e. denials of coverage). Of these calls, questions about Original Medicare denials represented about 8 percent of the data, including inquiries about denials of Part A (e.g., skilled nursing facility services) and Part B (e.g., physician services) services. By comparison, calls about private plan denials were much more prevalent: about 38 percent of coverage-related calls revolved around private plan denials—including Medicare Advantage and Part D—which left many of our clients unable to afford needed services and medications.

Medicare Advantage Appeals

Problems:

Ms. A, an Illinois resident in her 60s, called Medicare Rights' helpline because she felt she had reached a dead end in her appeal with her Medicare Advantage plan, which had denied coverage for a $5,000 medical procedure. In the past, her plan had covered this procedure, but now it was denied because Ms. A's doctor's office had coded the procedure incorrectly. This denial initiated a series of resubmissions with the correct coding, as well as 14 phone calls between Ms. A and the plan. Finally, after nine months of trying to resolve the issue, Ms. A received a notice of dismissal saying that her appeal request was not timely and that she had to escalate her appeal by contacting MAXIMUS, the independent review entity that contracts with Medicare to review plan appeal decisions. When she did so, Maximus informed her that nobody had opened a file for her and that she needed to contact her plan again.

Of the Medicare Advantage-related calls to Medicare Rights' helpline in 2013, 60 percent involved denials of coverage, including denials of physician care, home health care, therapy services, durable medical equipment, lab tests, and others. Of these, physicians' services were the most common type of denial. For many beneficiaries living on fixed incomes who already pay significant Medicare costs, including premiums and other cost sharing, a denial of coverage can mean that they must forgo needed care, or choose between health care and other basic needs.

Solutions:

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

Provide better consumer education: The Centers for Medicare & Medicaid Services (CMS) and Medicare Advantage plans should provide clearer and more consumer-friendly information on coverage and access rules. For example, Medicare.gov and the annual *Medicare & You* handbook should include prominent notices that state that Medicare Advantage plans are required to cover, at minimum, all services covered by Original

Medicare. At the same time, Medicare.gov and *Medicare & You* should include sample appeal letters that showcase the type of information a person or their provider should include when writing to challenge a plan's coverage determination. Finally, coverage information and medical necessity standards should be available in more consumer-friendly language, rather than solely in the difficult-to-navigate Local and National Coverage Determination Database.

Improve plan notices: Medicare Advantage plans should also improve the delivery of information about appeal rights. Specifically, CMS should strengthen the denial notice by including standardized language to describe reasons for denials of service. In issuing a denial, the plan would select the plain language, standardized language that reflects the specific reason for the denied service. Importantly, the plan should be required to explain specifically and with excerpts from Medicare rules and guidance or plan materials why the service does not qualify for coverage and what possibly unaccounted for circumstances (e.g., a referral from an in-network doctor) might affect that determination.

Enhance monitoring and enforcement by CMS: 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.

Medicare Part D Appeals

Problems:

Ms. F, an 83 year old New Jersey resident, has been suffering from severe Crohn's disease for over 40 years and relies on a particular course of treatment to control her symptoms. Over the years, doctors attempted treatment with other therapies that were either ineffective at controlling her symptoms, had intolerable side effects, or both. Her health deteriorated: she was malnourished, suffering from frequent gastrointestinal issues, dehydration, and extreme weight loss. After Ms. F's first surgery to treat her disease in 1985, her doctors prescribed a specific drug that controls her symptoms and enables her to eat without experiencing pain.

Recently, Ms. F's prescription drug plan terminated, and she enrolled in a new Part D plan offered by the same insurance company. While Ms. F's previous plan covered her medication, her new plan refused coverage. After reducing her dose to about half of the prescribed amount because she had to pay out of pocket and could not afford more, Ms. F began experiencing significant weight loss and gastrointestinal symptoms as her disease worsened.

Ms. F contacted Medicare Rights, and a counselor helped her appeal the medication coverage denial. The first and second level appeals were unsuccessful, and Medicare Rights escalated the appeal, ultimately representing Ms. F at an Administrative Law Judge (ALJ) hearing. The ALJ hearing was successful, and Ms. F's Part D plan was directed to cover her medication and to reimburse her for her out-of-pocket expenses. Now, Ms. F can access this much-needed medication without risking her health or financial security. Unfortunately, however, Ms. F's health and well-being was compromised for nearly eight months because multiple plan-level appeals were unsuccessful.

The majority of Part D denials of coverage calls to Medicare Rights' helpline in 2013 involved off-formulary denials where the beneficiary's medication was not listed on the drug plan's list of covered medications. In addition to off-formulary restrictions, 2013 call data spotlight other common Part D coverage restrictions, including step therapy, where the Part D plan requires

the beneficiary to try cheaper generic medications before being able to access the prescribed medication, and prior authorization, where beneficiaries must receive permission from the plan before the plan authorizes coverage of the prescribed medication. As with other Medicare denial issues, Medicare beneficiaries have the right to appeal Part D plan denials, but this can be a complex and daunting process requiring the assistance of the prescriber and other advocates.

Solutions:

Ms. F's experience with her Part D plan's drug denial and the appeals process illustrates the barriers that beneficiaries may face in accessing needed prescription medications. Medicare Rights supports a number of policy reforms to make it easier for millions like Ms. F to navigate Part D coverage denials. These include:

Require that clearer information be provided at the pharmacy counter: When prescription medications are refused coverage, the beneficiary is typically informed at the pharmacy counter. It is imperative that beneficiaries be fully informed of the reason their medication is denied and what steps they need to take to address the issue. CMS should require that individually tailored language be added to the existing standardized notice at the pharmacy. In addition to the plan's contact information, including phone and online access information and clear guidance on the next steps in the appeals process, the denial notice should include a clear explanation of the reason the drug is being refused.

Streamline the appeals process[1]: If an appeal is appropriate, Medicare beneficiaries must navigate several needless and burdensome steps before an appeal is officially filed. Medicare Rights' experience demonstrates that beneficiaries would be best served by initiating the coverage determination request at the pharmacy counter, as opposed to requiring beneficiaries to formally request a coverage determination from their health plan. Other options to streamline the appeals process include eliminating redetermination (the second level of appeal made to the health plan) or requiring a pharmacy counter denial to trigger an inquiry by the plan to the prescribing provider about medical necessity. Any one of these options would remove a burdensome step in the appeals process for Medicare beneficiaries.

Continue to release plan-level appeals data and expand on data collection: Plan-level data recently released by CMS on pharmacy transactions, coverage determinations, and appeals represent an important step forward in enhancing the transparency of the Part D appeals process. Medicare Rights recommends that CMS regularly release this information and consider issuing summary analyses and reports to make the information accessible to audiences beyond academic and research institutions. Additional data collection is needed to fill gaps in knowledge, including on how often prescriptions go unfilled altogether, how frequently low-income beneficiaries (namely Extra Help enrollees) are turned away at the point-of-sale, how consistently required notices on appeal rights are delivered at the pharmacy counter, how well beneficiaries fare at each stage of the appeals process, and more.

Transitioning to Medicare

Calls involving Medicare enrollment and how Medicare coordinates with other types of health insurance accounted for the second highest trend on Medicare Rights' helpline in 2013. Among enrollment-related calls, the majority had to do with Medicare Part B (22 percent),

changing Medicare Advantage coverage (24 percent), and choosing a Medicare Part D plan (17 percent). More recently, Medicare Rights is receiving questions related to transitioning to Medicare from new health insurance Marketplaces, underscoring the need to streamline and simplify enrollment processes wherever possible.

Delaying Medicare Part B

Problems:

Mr. S, a New York senior, enjoyed comprehensive health insurance benefits through his employer, a major pharmaceutical manufacturer. The benefits continued for a year after Mr. S retired, at age 70. A few months before his employer benefits were to end, Mr. S contacted the Social Security Administration (SSA) to enroll in Part B and received some difficult news: though he had signed up for Part A at his 65th birthday, he had declined Part B because he was covered by his employer's policy—and had now missed his Special Enrollment Period (SEP). Typically, retiring individuals have an eight-month SEP in which to enroll in Medicare with no penalties. Mr. S did not realize that once his status changed from employee to retiree, he should have signed up for Part B during this eight-month SEP, as Medicare becomes the primary insurance for most retired individuals. Mr. S learned that he would have to wait until January 1 to sign up for coverage that would not begin until July 1. This meant that he faced nearly half a year without health insurance as well as a lifetime late enrollment penalty on his Part B premium.

The most complex enrollment issues addressed by Medicare Rights' helpline in 2013 involved calls about enrolling in the Medicare Part B outpatient benefit, and the coordination of Part B with other types of coverage, including employer group health benefits, retiree benefits, COBRA, Veteran's benefits, and new Marketplace coverage. Medicare-eligible individuals who do not understand Part B enrollment rules and fail to enroll in Medicare when they first become eligible may face late enrollment penalties, costly duplicative coverage, gaps in coverage, and disruptions in access to needed care.

While many individuals are auto-enrolled in Medicare Parts A and B, individuals not yet collecting Social Security benefits must actively choose to enroll or to delay enrollment. Unfortunately, people aging into Medicare or becoming eligible due to a disability are not always given accurate or complete information by employers, local Social Security offices, Medicare, and other sources of support—or they are given adequate information but still make erroneous choices, often not fully grasping the consequences of a decision to delay Part B.

The confusion that Medicare Rights witnesses around Medicare transitions cannot be overstated. When employers are involved, callers sometimes describe situations where benefits administrators or human resources representatives informed them not to enroll in Part B because they will have access to retiree insurance or COBRA. Other callers with employer-sponsored retiree coverage state that they called Medicare requesting information about enrolling in Part B and were told that they did not need to enroll because they had employer coverage. Medicare representatives and others in these cases failed to probe beneficiaries about the type of employer coverage they were receiving (e.g., retiree vs. employer group health benefits), the size of their employer, and whether beneficiaries were still working. While not intentionally harmful, this type of misinformation or incomplete counseling about Medicare Part B enrollment can result in very difficult situations for beneficiaries including costly Part B late enrollment penalties and gaps in primary health insurance coverage.

Depending on an individual's situation, Medicare can function as primary or secondary health insurance. For Medicare-eligible individuals 65 and over who receive employer group health coverage through their own employment or their spouse's active employment, the employer will function as a primary insurer if there are 20 or more employees at the organization. If there are fewer than 20 employees, Medicare will function as primary health insurance coverage. For Medicare beneficiaries under the age of 65 who receive employer coverage through their own employment, their spouse, or a family member, the employer will provide primary health coverage if there are 100 or more employees at the organization. If the employer has fewer than 100 employees, Medicare will function as primary health insurance coverage. Other types of health insurance coverage, including retiree coverage and COBRA, will generally function as secondary health insurance coverage for Medicare beneficiaries.[2] Medicare-eligible individuals with these types of secondary health insurance coverage need to enroll in Medicare Parts A and B or risk going without primary health insurance.[3]

Solutions:

More information about Part B transitions difficulties and ways to improve enrollment, disenrollment, and coordination processes can be found in Medicare Rights' recently released paper, "Medicare Part B Enrollment: Pitfalls, Problems, and Penalties."[4] Included here are select policy recommendations drawn from this report, intended to better support individuals approaching Medicare eligibility and smooth the transition to Medicare:

Educate newly eligible Medicare beneficiaries: Notifications and alerts about the Part B enrollment process could be especially important for people who are not yet collecting Social Security benefits, because these individuals will not be automatically enrolled in Medicare. No federal agency is responsible for informing these individuals about their obligations and the rules related to Medicare enrollment. The SSA and CMS should coordinate efforts to inform newly eligible beneficiaries of the Part B enrollment process in a timely fashion. Medicare Rights urges a comprehensive strategy involving all affected federal agencies, as well as states. It is critically important that individuals transitioning from specific types of coverage, such as employer plans, Marketplace plans, or Medicaid, receive messaging appropriate to their specific transition.

Medicare beneficiaries can enroll in Medicare Parts A and B at any time during their Initial Enrollment Period (IEP). The IEP is the seven-month period surrounding the month of person's 65th birthday or 25th month of receiving Social Security Disability payments. This period includes the three months before, the month of, and the three months following the person's birthday month or date of Medicare eligibilty. 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 enroll in Medicare Part B. The GEP occurs annually, from January 1 to March 31. Coverage for beneficiaries who enroll during the GEP begins in July of the same year.[5]

Educate employers and others interacting with transitioning individuals: More employer education about Medicare enrollment and coordination of benefits is needed. All too frequently Medicare Rights receives calls where employers have not fully informed new retirees about rules around Part B enrollment. CMS should be required to disseminate educational materials to employers about Part B enrollment. Similar to Part D enrollment notifications, CMS should require employers to provide their Medicare-eligible employees with standardized information about Part B enrollment. CMS should also engage and support other common information sources for individuals becoming Medicare-eligible, including state Marketplaces, state Medicaid offices, health plans, and others.

Streamline and align enrollment periods: As currently structured, individuals who enroll during the later months of their IEP and during their GEP (see above) face gaps in access to outpatient health coverage, sometimes for several months. These gaps should be eliminated to ensure that coverage begins as quickly as possible following enrollment. At the same time, the GEP should be lengthened and aligned with the Medicare Open Enrollment period for Medicare Advantage and Part D plans. This alignment would make it easier to educate Medicare beneficiaries and newly eligible individuals about a standard and predictable Medicare enrollment season.

Changing Medicare Advantage Coverage

Problems:

Mr. H, who has a Medicare Advantage plan, required care from a specialist to manage and treat his Lyme disease. During the Open Enrollment Period, Mr. H had been told by a plan representative that his specialist would continue to be in-network with his Medicare Advantage plan the following year. Subsequently, Mr. H learned that the information he received from his plan was wrong and that the specialist would no longer be covered. Mr. H could not find another in-network specialist for his Medicare Advantage plan, and he continued to see the same physician that used to be in the plan's network. When the claim for his out-of-network visit was denied, Mr. H called Medicare Rights.

A Medicare Rights counselor advised Mr. H that because he was misinformed by his Medicare Advantage plan, he might be eligible for a Special Enrollment Period that would allow him to switch to a different Medicare Advantage plan that does have his specialist within its network. Mr. H came away from the call with steps that he could take to appeal the Medicare Advantage plan's denial and to enroll in a new health plan.

In 2013, a significant proportion of Medicare Rights' helpline calls related to switching Medicare Advantage plan coverage, which could include switching to a new Medicare Advantage plan or to Original Medicare. The following are some of the reasons clients cite for wanting to make these changes to their coverage:

- Services under their current plan are too expensive
- They are moving outside their current plan's coverage area
- Their current plan is denying coverage, and they hope a new plan will cover needed care
- Their current plan has dropped or reclassified their providers as out-of-network
- They are having customer service issues with their current plan
- They received unclear explanations of cost-sharing responsibilities when they enrolled in their current plan

Solutions:

Mr. H's story illustrates not only some of the challenges people can face when enrolled in a Medicare Advantage plan, but also how inaccurate plan information can affect a person's ability to access needed health care services and providers. Incomplete information or misinformation can hinder a person's ability to make informed plan enrollment decisions during the Medicare Open Enrollment Period. To make it easier for beneficiaries to navigate Medicare Advantage decision-making, Medicare Rights suggests the following policy recommendations:

Improve review of network adequacy and eliminate mid-year network changes: Under Medicare rules, plans must meet minimum levels of network adequacy. Yet following an initial review by CMS, plans are merely required to self-attest to the adequacy of their networks, while changes to plan networks on a year-to-year basis are commonplace. Medicare Rights encourages CMS to conduct more regular reviews of plan networks.

Additionally, greater protections are needed to prevent beneficiaries from losing access to trusted physicians in the middle of a plan year. Ideally, plans should be prohibited from making these mid-year changes without sufficient cause. In the absence of this, improved beneficiary notification about these changes and how to request a Special Enrollment Period is needed.

Better communicate annual coverage changes: Increased personalization is needed in the annual notice of change (ANOC), sent to beneficiaries annually, to notify them of plan changes. Specifically, this document should highlight changes that are likely to be important to the beneficiary, for instance related to specific providers they have used in the previous year and that might not be covered in the coming year.

Ensure that up-to-date provider network information is more readily accessible: Information on the Plan Finder tool and on plan websites must be accurate, understandable, and updated. CMS should require plans to current provider directories directly on Plan Finder and to maintain up-to-date directories on their websites. Lists of network doctors should reflect which doctors are currently accepting new plan patients as well as the languages spoken by specific health care providers.

Selecting a Part D plan

Problems:

Ms. L, a 66-year-old beneficiary living alone on a fixed income, called Medicare Right after being diagnosed with breast cancer. She was new to Medicare and needed help choosing a Medicare Part D prescription drug plan because she takes several medications, including a recently prescribed and very expensive oral anti-cancer medication. Ms. L also suffers from severe anxiety and was overwhelmed by her cancer diagnosis, her financial situation, and the need to find a Part D plan that would cover her medications. Further, given the expense of her Part D covered anti-cancer medication, she was extremely worried about what she would do when she reached the Part D coverage gap.

A Medicare Rights counselor used the Plan Finder tool to conduct searches for Part D plans that would cover Ms. L's drugs at the most affordable price with the fewest restrictions over all phases of Part D drug coverage and cost, including the coverage gap. Ultimately, the

counselor identified a plan that covered all of Ms. L's drugs, albeit subject to restrictions like prior authorization. Medicare Rights explained how Ms. L could work with her doctor to request prior authorization and how to appeal denials or restrictions posed by other utilization management tools if the need arose.

Calls to Medicare Rights' helpline about selecting a Part D plan typically fall into two categories: people who are new to Part D and those who already have Part D coverage. Those new to Part D, like Ms. L, typically need help choosing a Part D plan. Many of these callers are transitioning out of other drug coverage, such as employer-sponsored coverage. Those who are already enrolled in a Part D plan often call for reasons similar to clients who seek help with Medicare Advantage changes, for example:

- Prescribed medications under their current plan are too expensive (e.g., drugs are in higher, more costly tiers)
- They are moving outside their current plan's coverage area
- Their current plan is denying drug coverage, and they hope a new plan will cover needed prescription medications
- Their current plan has dropped their medications from its formulary
- Their plan has imposed utilization management restrictions that affect beneficiary access to needed prescriptions
- They are having customer service issues with their current plan

Solutions:

In addition to highlighting Part D-specific concerns of callers to Medicare Rights' helpline, Ms. L's story reflects the consistent issue of affordability across calls. For individuals like Ms. L who must take very expensive medications, choosing the right Part D plan both ensures access to lifesaving treatments and helps provide essential economic stability during times of crisis. Medicare Rights recommends the following to help beneficiaries more easily select among multiple Part D plans:

Plans should better communicate annual coverage changes: As with Medicare Advantage plans, increased personalization in the annual notice of change (ANOC) is needed to more clearly and adequately notify beneficiaries about formulary changes. Specifically, this document should highlight changes that are likely to be important to the individual beneficiary, for instance related to specific medications he or she used in the previous year and that might not be covered in the coming year.

Ensure up-to-date formulary and pharmacy network information: In order for Medicare beneficiaries to make informed Part D enrollment decisions, it is imperative that they have access to accurate plan information for the coming year. CMS should ensure that the Plan Finder tool and plan websites maintain accurate, understandable, and updated information about coverage and costs for specific treatments, medications, and pharmacies. Up-to-date lists of in-network and preferred pharmacies should be accessible throughout the year—especially during the Open Enrollment Period. This information should also include clear, consumer-friendly drug cost information.

Consolidate plan options: CMS should continue to review plan offerings to ensure that they are meaningfully different. CMS should not renew plans that are substantially similar to others offered by the same sponsor or those with formularies that fail to cover commonly needed medications. In addition, CMS should favor those formulary designs that encourage adherence to clinically preferred maintenance medications, for instance

through lower cost-sharing and well-administered medication therapy management programs.

Affording Medicare

In 2013, thousands of questions to Medicare Rights' national helpline involved difficulty affording Medicare premiums and cost-sharing. While the Medicare program provides essential benefits to those enrolled, unmet costs can impose an undue burden on beneficiaries living on fixed incomes. Significantly, on average, Medicare household spend roughly 14 percent as a share of annual income on health care costs, compared to 5 percent among non-Medicare households.[6]

Problems:

Ms. M, a Bronx resident who lives on a fixed income, is enrolled in Medicare Parts A and B and, owing to a recent fall at her part-time job, short-term disability insurance. She is not yet collecting Social Security benefits and therefore currently lives on a very low income. Ms. M called Medicare Rights because she needed help affording her health care costs.

The Medicare Rights counselor learned that Ms. M was paying a monthly Part B premium, even though she was likely eligible for a Medicare Savings Program (see below). Further, Ms. M was not enrolled in Medicare Part D, instead paying out of pocket each month for her needed medicines.

The Medicare Rights counselor advised Ms. M on the Part D plan selection process and provided assistance enrolling in the Extra Help program and the Medicare Savings Program (specifically the Qualified Medicare Beneficiary or QMB program). Now that Ms. M is enrolled in a Part D plan, Extra Help, and QMB, she receives assistance on prescription drug costs, the Part B premium, and other Medicare related cost-sharing. These benefits help ensure that Ms. M has access to needed health care services and medications—and can afford other basic needs.

The Medicare Savings Programs, are programs that help cover a beneficiary's Medicare Part B premium costs, and sometimes, based on income and asset tests, can assist with coinsurances and deductibles. There are three main Medicare Savings Programs: Qualified Medicare Beneficiary (QMB), Specified Low- Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI). Beneficiaries who are automatically enrolled in a Medicare Savings Programs automatically are enrolled in Extra Help, the federal program that helps cover most of a beneficiary's Part D prescription drug costs. It is important to note that these programs are available to a limited subset of Medicare beneficiaries, based on exceedingly low income and asset tests. Under federal rules, in 2014, to be eligible for the QMB program, which provides full Part B premium and cost-sharing assistance, an individual must have less than $993 in monthly income and less than $7,160 in personal assets.[7]

For beneficiaries who meet very low income and asset limits, the Part D Extra Help program and Medicare Savings Programs ease financial burdens. Year after year, many beneficiaries eligible for these programs remain un-enrolled for a variety of reasons, including a lack of awareness of the programs, stigma around applying, and lengthy application processes.[8]

Given the need, Medicare Rights' helpline counselors are trained to screen all callers for these benefits. In New York City, Medicare Rights submits MSP applications directly to the city's Medicaid office for processing, which provides valuable insights into how and why benefits are accepted and denied.

Solutions:

In 2013, Medicare Rights submitted benefits for clients resulting in $4.8 million in savings—and access to needed health care services and medications.[9] As noted, however, many people eligible for these programs do not apply, and administrative and legislative reforms are needed to improve MSP and Extra Help enrollment outcomes.

Medicare Rights recommends strengthening protections and benefits for low- and middle-income Medicare beneficiaries who struggle to afford Medicare related costs[10]:

Make permanent a critical MSP, the Qualified Individual (QI) program: Unlike other MSPs, the amount of federal funding available for the QI program does not automatically increase based on inflation and growing need, and Congress must act annually to ensure that federal funding for QI continues. States receive block grants based on their need to provide QI benefits, meaning that once a state's funding is spent, no new eligible beneficiaries can enroll. The QI program should be made permanent to provide needed stability to state governments and to low-income people with Medicare.

Increase income thresholds for MSPs and Extra Help: Increasing the very low income thresholds for MSPs and Extra Help would ease the burden of unaffordable out of-pocket costs for low- and middle-income Medicare beneficiaries. Already, premium and cost-sharing assistance is graduated, with only those with the very lowest incomes receiving comprehensive help. Income thresholds should be adjusted to provide partial premium and cost-sharing assistance through MSPs and Extra Help. At a minimum, income thresholds should be raised to match those available for expansion Medicaid, as implemented by the Affordable Care Act, to 138 percent of the Federal Poverty Level (FPL). Ideally, income thresholds should be more significantly expanded, up to or beyond

200 percent of the FPL, or about $23,540 annually for an individual in most states in 2015.[11]

Eliminate asset tests for MSPs and Extra Help: Asset tests, already excluded from MSP requirements in some states, should be universally eliminated in order to help states more efficiently process applications for MSPs and to streamline the beneficiary application process. If asset tests remain intact, beneficiaries should be permitted to attest to their assets, as they can on the Extra Help application, and burdensome requirements to submit paper copies of financial records and other proof of eligibility should be reduced to the greatest extent possible. To this end, states should accept information transmitted from SSA after a person completes an Extra Help application. Additionally, states should work to eliminate any application requirements that obligate the beneficiary to complete additional steps to enroll in the MSP if, based on the Extra Help application data transmitted by SSA, her or she is eligible.

Automate renewal procedures for beneficiaries enrolled in MSPs: Many beneficiaries who call the Medicare Rights' helpline because they have been disenrolled from their MSP experience no change in their income. Indeed, most people with Medicare live on fixed incomes from Social Security Retirement or a small pension. Incomes for this population

are unlikely to fluctuate year to year, and even when they do, can be readily shared by SSA with local departments of health or social services without any action from the beneficiary. We urge states to adopt passive renewal models to ensure that once enrolled in critical benefits, individuals do not lose them for purely administrative reasons.

Conclusion

Medicare Rights' national helpline call data for 2013 afford a unique glimpse into the challenges faced by Medicare beneficiaries as they try to obtain and afford insurance coverage, understand their benefits, and contest denials of needed coverage. These data magnify the need for policy reforms to simplify Medicare eligibility, transitions, and appeals processes. Critically, the 2013 data—like the 2012 data—reflect the demographic challenges facing a growing aging population.

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

References

[1] For a detailed discussion of these policy recommendations, see Medicare Rights' September 2014 letter to the Medicare Payment Advisory Commission (MedPAC). See the link here: http://www.medicarerights.org/pdf/092013-part-d-appeals-medpac.pdf

[2] The full paper is available here: http://www.medicarerights.org/pdf/PartB-Enrollment-Pitfalls-Problems-and-Penalites.pdf.

[3] For more information about the IEP and GEP, refer to the Medicare Interactive information here: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=259.

[4] The full paper is available here: http://www.medicarerights.org/pdf/PartB-Enrollment-Pitfalls-Problems-and-Penalites.pdf.

[5] For more information about the IEP and GEP, refer to the Medicare Interactive information here: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=259.

[6] Read more about the financial burden on Medicare beneficiaries in the recent KFF study: http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/.

[7] Some states have more generous eligibility standards. For more information about these programs, see the Medicare Rights Center information here: http://www.medicarerights.org/fliers/Medicare-Savings-Programs/How-to-Get-Help-Paying-Your-Medicare-Costs.pdf.

[8] See "Medicare Trends and Recommendations: An Analysis of 2012 Call Data From the Medicare Rights Center's National Helpline." http://www.medicarerights.org/pdf/2012-helpline-trends-report.pdf

[9] For a summary of estimated benefits generated through casework interventions by Medicare Rights, see: Medicare Rights Center "Annual Report," (2013), available at: http://www.medicarerights.org/pdf/2013-annual-report.

[10] For a detailed discussion of these policy recommendations, see "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Consumer Helpline": http://www.medicarerights.org/pdf/2012-helpline-trends-report.pdf.

[11] "2015 Poverty Guidelines." 2015 Poverty Guidelines. Accessed March 2, 2015. http://aspe.hhs.gov/poverty/15poverty.cfm.