

Empowering Beneficiaries and Modernizing Medicare Enrollment

WHITE PAPER

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I. Background and Overview

Medicare is the primary source of health care coverage for nearly 61 million older adults and eligible individuals with disabilities.¹ Medicare receives wide support and is credited with ensuring coverage, improving the overall health, and providing financial security for millions of seniors and individuals with disabilities. Upon initial enrollment and annually thereafter, beneficiaries are able to choose how they receive their coverage - whether through Traditional Fee-For-Service (FFS) Medicare, or Medicare Advantage. Beneficiaries are also able to supplement their coverage with Medigap if they are in Traditional FFS Medicare or add private Part D drug coverage to either Traditional FFS Medicare or to Medicare Advantage. Whether Medicare beneficiaries elect to receive their benefits through Traditional FFS Medicare or a Medicare Advantage plan, they must select from a number of different options, requiring a careful assessment based on their own individual circumstances and preferences.²

Beneficiaries often do not feel empowered to navigate the enrollment process and select coverage options that best meet their needs. Research has shown that beneficiaries often do not make optimal choices in coverage that best meets their medical and financial needs, and beneficiaries default into Traditional FFS Medicare to avoid having to navigate the complex array of coverage choices. According to a 2019 report, almost 50% of beneficiaries in Traditional FFS Medicare did not know there was an option of Medicare Advantage.³

The Administration, Congress, health plans, and advocates have taken many important steps to reduce complexity and improve beneficiaries' decision-making process. Yet, many barriers to a simpler, more consumer-oriented process remain.

In 2020, the Better Medicare Alliance (BMA), in consultation with Health Management Associates (HMA), engaged beneficiary advocates, providers and health plans, and other Medicare stakeholders in interviews and subsequent discussions to identify the existing challenges of the Medicare enrollment process and to

develop policy reforms that would better empower beneficiaries to navigate the enrollment process and make well-informed decisions regarding their coverage. Specifically, BMA sought to better understand:

1. What are the key pitfalls, challenges, and limitations of the current Medicare enrollment process, and what impacts do these have on beneficiaries and or other Medicare stakeholders?
2. What are the desired elements and mechanisms of a reformed enrollment process? How would these changes enhance the Medicare enrollment experience for beneficiaries and other Medicare stakeholders?
3. What role should the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA) play in a reformed Medicare enrollment process and what role or roles should specific stakeholder groups (e.g., beneficiaries beneficiary advocates, providers, provider advocates, counselors or brokers, policymakers, health plans) play in a reformed Medicare enrollment process?

Through this dialogue, several policy options were identified to reform the existing Medicare enrollment process that would facilitate a beneficiary-centered experience and improve decision-making before, during, and after the Initial Enrollment Period. With these changes, Medicare beneficiaries will be more informed and better able to actively choose the coverage option that best meets their needs. The recommendations for reform are offered with a sense of urgency, given the reality that over 10,000 people turn 65 years old every day in the country, and those numbers will continue for the next decade.

Recommendations to Empower Medicare Beneficiaries to Better Navigate the Enrollment Process

- 1. Designate the Department of Health and Human Services (HHS) as Solely Responsible for Medicare Enrollment**
- 2. Standardize and Modernize Educational Materials for Current and Prospective Beneficiaries**
- 3. Redesign, Simplify, and Tailor the Notice of Medicare Benefits**
- 4. Initiate Beneficiary Engagement and Education at Age 64**
- 5. Modernize a Single Comprehensive Tool to Compare all Coverage Options**

The need to act now is also compelled by the medical and financial consequences inherent in these choices for newly eligible Medicare beneficiaries. As health care costs increase, and seniors increasingly show evidence of multiple chronic conditions and unmet social needs, the choices become more meaningful for individuals and for the country. Moreover, the Medicare population continues to grow rapidly, is increasingly more racially and ethnically diverse, and has more complex medical and socio-economic needs, requiring improved approaches to help them assess their benefit options and more easily transition to Medicare. We urge policymakers and regulators responsible for outreach and enrollment to make these reforms a top priority. With better understanding of the current obstacles and the changing senior population, policymakers should seize on these reforms as an opportunity to transform systems to create a more accessible, understandable, and simpler process for all new and returning Medicare beneficiaries.

II. Existing Medicare Enrollment Process is a Source of Confusion and Complexity for Many Beneficiaries

There are three ways an individual can become eligible for Medicare. Individuals qualify for Medicare because they turn 65 years old, have a qualifying disability and received Social Security Disability Insurance for 24-months, or have certain illnesses such as End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).⁴ Those receiving Social Security benefits when they age into Medicare are automatically enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance), and Part B premiums are automatically assessed and deducted from Social Security payments. Those who are not receiving Social Security benefits when they turn 65 must actively enroll in both Medicare Part A and Part B either by applying online, in person at a SSA Office, or over the phone through SSA within the 7-month Initial Enrollment Period surrounding their 65th birthday. Regardless of receipt of Social Security Benefits, if the beneficiary does not take further action, the default coverage is Traditional FFS Medicare. Including both those who choose and those who default into Traditional FFS Medicare, over 60 percent of Medicare beneficiaries are enrolled in Traditional FFS Medicare.⁵

Individuals who want to receive their Medicare benefits through Medicare Advantage have to make an active choice. Roughly 40 percent of beneficiaries are now enrolled in Medicare Advantage and the number has been growing year over year with the Congressional Budget Office projecting it to grow to 51 percent of all Medicare beneficiaries by the end of the decade. Once a beneficiary decides to enroll in Medicare Advantage, they then have to choose a specific plan, depending on their own needs and preferences. Most beneficiaries choose a plan which includes prescription drug coverage, called an MA-PD plan; others may choose a stand-alone Part D prescription drug plan (PDP). Given that plans may offer different premiums or no premium at all, extra benefits and different networks of providers, beneficiaries have a wide range of choices.

Those who choose Traditional FFS Medicare coverage may add supplemental coverage, known as Medigap supplement plans to cover cost sharing (only available for Traditional FFS Medicare beneficiaries as it is unnecessary for those in Medicare Advantage) and a stand-alone PDP. To make these decisions, beneficiaries must proactively research the options, select one, and enroll within the Initial Enrollment Period.

Individuals qualifying for Medicare at age 65 typically have three months before their 65th birthday, their birthday month, and three months following their birthday month to explore their options and make choices. Thereafter, they can change their choice annually during Open Enrollment Periods which are mid-October to mid-December. Many individuals turn to family or caregivers, publicly-funded programs with volunteer counselors, or licensed insurance agents and brokers for advice.

Whether individuals choose Traditional FFS Medicare or Medicare Advantage, beneficiaries must first enroll in Part B. Beneficiaries who are actively employed and have health coverage or have health coverage as retirees may not need to sign up for Part B until their coverage ends. These individuals have 8 months after losing coverage to enroll in Part B, unless they have other coverage. Beneficiaries who delay Part B enrollment face a premium penalty when they do enroll: a 10 percent increase in premium for every 12 months delayed for the entirety of their Part B coverage. They also may not be able to receive Medicare coverage when they need it, if they do not qualify for a Special Enrollment Period, causing significant gaps in coverage. For example, if someone age 65 without other sources of coverage who did not enroll in Medicare during the Initial Enrollment Period

seeks to enroll later in the year, that individual will not be able to enroll at that time. Unless he or she qualifies for a Special Enrollment Period, he or she would need to wait until the General Enrollment Period, occurring January through March every year. Upon enrollment, coverage would not start until July 1. Similarly, if a beneficiary does not have creditable drug coverage and does not enroll in Part D upon initial eligibility, he or she must pay a Part D late enrollment penalty (LEP) upon enrollment, which is one percent per month without Part D or creditable coverage.⁶

Finally, beneficiaries who elect or default into Traditional FFS Medicare face significant benefit gaps and pay high cost-sharing amounts. Traditional FFS Medicare imposes high cost-sharing for services, which can be a heavy burden for those with chronic conditions and those with a significant acute condition, as well as those with low or modest income. A 2020 study found on average, Traditional FFS Medicare beneficiaries spend \$1,598 more than those in Medicare Advantage.⁷ Additionally, Traditional FFS Medicare does not cover routine dental, vision, or hearing, which beneficiaries may be used to as they are generally included in commercial insurance. This is the reason, many, if they can afford to, purchase supplemental insurance, even though they have Medicare. Other Medicare beneficiaries, as noted above, chose Medicare Advantage to receive additional benefits like dental, vision and hearing coverage, and wellness programs, as well as lower cost-sharing, with low or zero premiums, lower out-of-pocket costs, and annual cost sharing limits.

Medicare beneficiaries consistently describe stress and confusion when becoming eligible for Medicare and have to quickly make benefit choices that affect their health and economic well-being. As described briefly here, there are multiple decision points for beneficiaries and multiple opportunities for missteps in understanding their eligibility for enrollment, the choices they have to make, how they can find options that do not disrupt their coverage as they transition to Medicare, what actions they need to take and when, how Medicare will coordinate with other forms of coverage, and ultimately choosing and enrolling in a coverage option that works best for them.

III. Beneficiary Challenges and Barriers: Five Common Themes

Interviews with a wide array of Medicare stakeholders, including beneficiary advocates and educators, health plans, and provider organizations, reveal that the challenges and barriers of the existing enrollment process fall into one of five themes.

No Single Government
Entity Responsible for
the Entire Enrollment
Process

Significant Penalties
for the Delayed or
“Wrong” Choice

Constrained Timeline
and Resources for
Education and Outreach

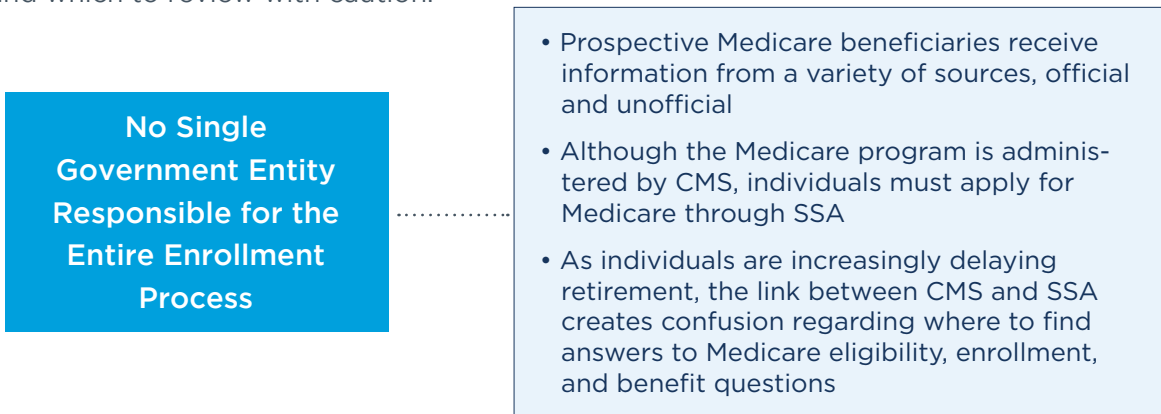
Inability to
Meaningfully Compare
Coverage Options

Information and
Process Not Adequately
Tailored to Meet
Individual Needs
and Circumstances

No Single Government Entity Responsible for the Entire Enrollment Process

Individuals approaching Medicare eligibility receive information from a variety of sources, both official and unofficial. Official information sources include those developed, disseminated and reviewed by government agencies such as SSA, CMS, Administration for Community Living (ACL), State Health Insurance Assistance Programs (SHIPs), health plans, and insurance brokers. Informal sources include family and friends.

There are also entities that market themselves as Medicare resources or educators but are not affiliated in any way with the Medicare program. These entities may disseminate materials that have not gone through any official review and approval process and may include misleading or inaccurate information. Stakeholders report that beneficiaries often have no way of knowing which materials to trust and which to review with caution.



In addition, although the Medicare program is administered by CMS, individuals must apply for Medicare through SSA. The link between Medicare enrollment and SSA worked when enrollment for Supplemental Security Income (SSI) benefits at retirement coincided with the age of Medicare eligibility. As individuals are increasingly delaying retirement past age 65, some until age 70, and subsequently, delaying the collection of SSI benefits, the link between the two agencies and processes often creates confusion among individuals regarding where to find answers to questions addressing Medicare eligibility, enrollment, and benefits. SSA staff are not equipped to assist Medicare beneficiaries in considering their many benefit choices, and beneficiaries must look to CMS or other sources for help and then enroll in Medicare through SSA. Moreover, beneficiaries who have problems with enrollment are often caught between two different agencies for answers and help in solving these problems.

Significant Penalties for a Delayed or Wrong choice

Beneficiaries who mistakenly delay Medicare Part B enrollment are required to pay multi-year penalties which can create significant financial burdens. In 2016, there were an estimated 800,000 beneficiaries, of the 55.3 million enrolled in Medicare that year who had not enrolled in Part B when they became eligible and were paying a late-enrollment penalty; about 20 percent of them may not have known about the penalties when they turned 65. In addition, although Part D prescription drug coverage is voluntary, individuals who delay or forgo enrollment and do not have other creditable drug coverage are liable for multi-year Part D late penalties if and when they do elect Part D coverage. The Part D LEP is typically added onto a beneficiary's monthly premium. The amount of the LEP is equal to one percent of the national average Part D premium multiplied by the number of months without creditable drug coverage.

Significant Penalties for the Delayed or “Wrong” Choice

- Beneficiaries who mistakenly delay Medicare Part B enrollment are required to pay lifelong penalties, creating significant financial burden
- In 2016, 800,000 beneficiaries (out of 55.3 million enrolled) who had not enrolled in Part B were paying a late-enrollment penalty
- Individuals that delay Part D drug coverage without other “creditable” drug coverage are liable for lifelong Part D late enrollment penalties if and when they do elect Part D

Constrained Timeline and Resources for Education and Outreach

Individuals approaching Medicare eligibility currently have a seven-month window, three months before their 65th birthday, the month of their birthday, and the three months after their 65th birthday, to research coverage options, select a source or sources for coverage, and enroll in Medicare. Stakeholders report that this window does not provide sufficient time for individuals to adequately research, absorb, and understand the enrollment process or conduct outreach to Medicare educators and other resources to meaningfully compare coverage options based on individual circumstances. Individuals who do not fully understand their coverage options may enroll in coverage that does not best meet their preferences and needs and may be more costly or less generous than other options. For example, a study of Part D enrollment in the first year of the program found that about 80 percent of beneficiaries could have selected a lower cost, more generous plan. Beneficiaries would have saved 31 percent on their prescription drugs if they had chosen the plan that better fit their needs.^{10 11}

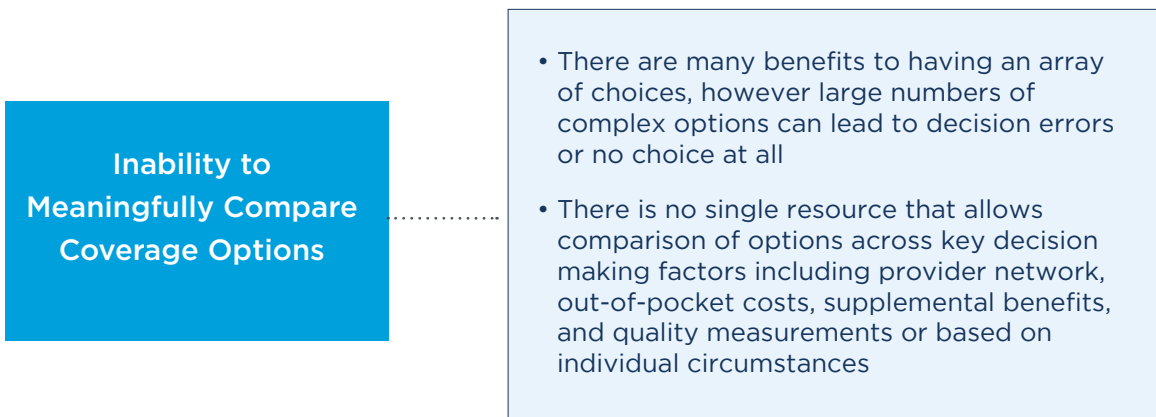
Constrained Timeline and Resources for Education and Outreach

- The current seven-month Initial Enrollment Period does not provide adequate time for individuals to adequately research, absorb, and understand the enrollment process
- Individuals who do not fully understand their coverage options may enroll in coverage that does not best meet their preferences and needs

Inability to Meaningfully Compare Coverage Options

In 2020, the average Medicare beneficiary is able to choose from 28 Medicare Advantage plans, and Traditional FFS Medicare plus a range of Medigap plans. There are many benefits to having an array of options, including increased choice for beneficiaries to select the coverage that best meets their needs and marketplace competition on cost, quality, and benefits. However, research also shows that large numbers of complex options can lead to decision errors or an individual making no choice at all. While there is an online tool available through CMS which has seen improvements in recent years, there is no single resource that allows individuals to compare all available Medicare coverage options across key decision factors including: provider networks; copayments and other out-of-pocket costs, including the cost protections afforded in Medicare Advantage; supplemental benefits; quality measurements; or individual circumstances, such as income and underlying medical conditions.

In addition, there are currently limited avenues for beneficiaries to seamlessly enroll in companion Medicare coverage for beneficiaries who are dually eligible for Medicaid and Medicare and previously enrolled in a Medicaid-managed care product. The Medicare Plan Finder website allows individuals to compare Medicare Advantage plans in their area, but a recent report by the Government Accountability Office found that the site is hard for beneficiaries and navigators to use and provides incomplete information¹⁴ CMS recently made changes to address these concerns, but the new site has received similar criticisms.^{15 16 17} It still does not enable beneficiaries to easily compare Medicare Advantage options with Traditional FFS Medicare or Medigap, particularly in relation to total out-of-pocket costs.



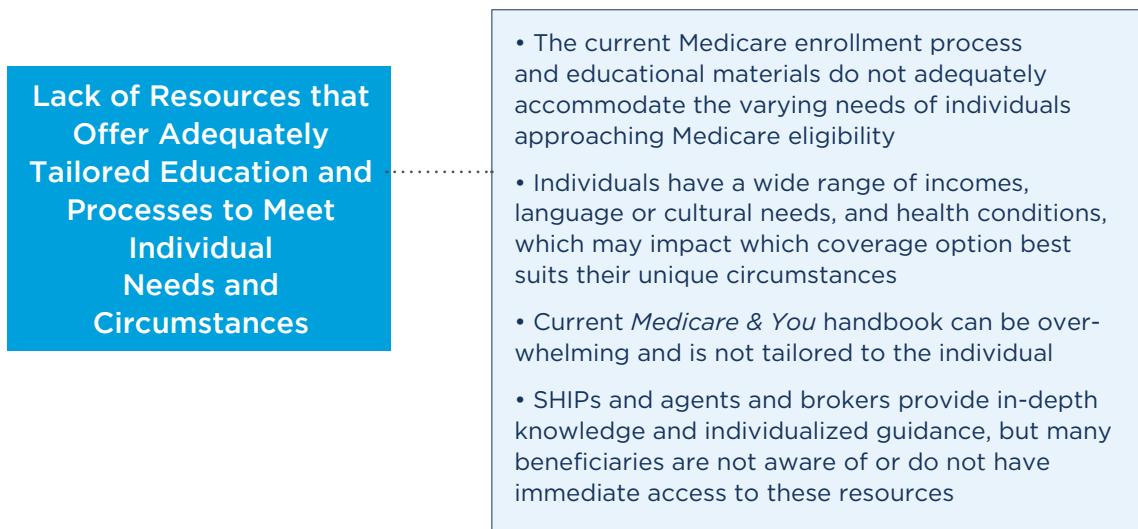
Lack of Resources That Offer Adequately Tailored Education and Processes to Meet Individual Needs and Circumstances

The current Medicare enrollment process and educational materials do not adequately accommodate the variety of circumstances and needs of individuals approaching Medicare eligibility. Individuals aging into the Medicare program and transitioning from employer-based insurance may have different needs and preferences than individuals that qualify due to disability. Even within the different eligibility categories, individuals have a wide range of incomes, language or cultural needs, and health conditions, which may impact which coverage option best suits their circumstances. Public materials promote the availability of Special Needs Plans (SNPs), which are a part of Medicare Advantage specifically tailored to beneficiaries that also receive Medicaid benefits, reside in a nursing home or other institutional setting, or have certain chronic conditions. Knowing SNPs are available is helpful, but it also has to be made clear that they are available only if you join a particular Medicare Advantage plan. In addition, despite its importance in Medicare decision-making, older adults report relatively poor health literacy compared with other age groups, reinforcing the need for more customized, tailored information.

CMS is required to prepare and distribute a notice, the “Medicare & You” handbook containing a clear, simple explanation of benefits as well as limitations on payments. CMS has made improvements in the last few years that have simplified the language, clarified descriptions, and made the initial choice between Traditional FFS Medicare and Medicare Advantage clearer and more readily available. The handbook also includes detail on coverage options available in an individual’s geographic area. It is a valuable document, yet, it is lengthy. It may be overwhelming to beneficiaries, may not readily be recognized as important and therefore not kept for reference during open enrollment, and is only printed in English and Spanish and therefore not useful to other language readers. For all of these reasons, its value is diminished for many beneficiaries.

ACL, a part of HHS, is responsible for the SHIP program. ACL works to ensure older adults, individuals with disabilities, and their families have the ability to make their own decisions and have opportunities to participate in society. SHIP volunteers provide in-depth and objective insurance counseling and assistance to individuals navigating the Medicare enrollment process. However, as the SHIP programs are administered at the state level, stakeholders report significant variation in the level of beneficiary awareness and engagement, training, availability, and quality of volunteers and supervising staff. As a result, effectiveness of programs may vary across states. SHIP counselors are seen as an important, personalized, and accessible source of information and guidance. However, there is also a significant shortage of funding for SHIPs resulting in fewer volunteers than needed to meaningfully reach all beneficiaries who could benefit from additional assistance or tailored educational support.

Insurance agents and brokers are also widely available at no cost to beneficiaries to offer information and provide individualized guidance through the enrollment process. They are certified at the state level, they must use CMS certified materials, and are required to take annual exams to maintain up-to-date knowledge. Finding an agent or broker is an informal process, possibly leaving some beneficiaries without knowledge that they are available. Most brokers offer many options, including both Medicare Advantage and Medigap plans for those who choose Traditional FFS Medicare. They also often are a resource for problem-solving on coverage questions and issues during the benefit year.



IV. Policy Recommendations to Empower Medicare Beneficiaries to Better Navigate the Enrollment Process

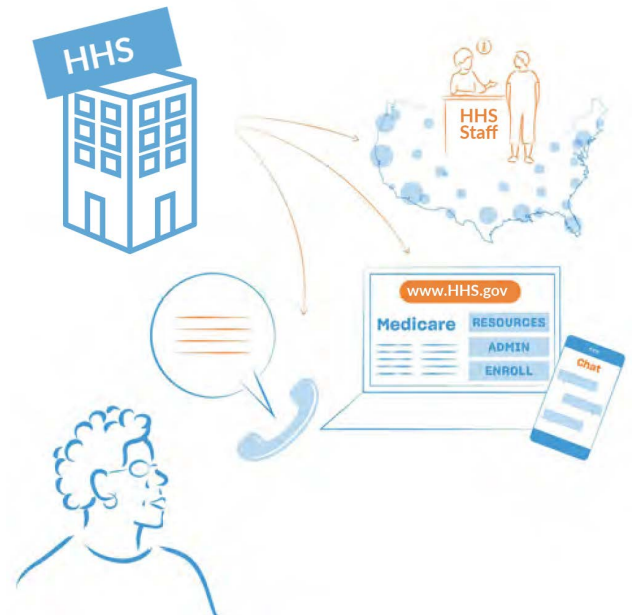
Designate HHS as Solely Responsible for Medicare Enrollment

Congress should designate HHS as solely responsible for the entirety of the Medicare program, encompassing both administration and enrollment. While SSA should retain the authority to collect Part B and IRMMA payments from beneficiaries, including having these payments automatically deducted from individuals' Social Security, the process of enrollment should be the responsibility of CMS, with ACL retaining responsibility for administration and oversight of SHIP. This change would reduce prospective beneficiary confusion regarding which agency to seek enrollment education and guidance from and would strengthen the accountability of CMS to ensure beneficiaries are informed regarding enrollment processes and coverage options. CMS would continue to handle on-line enrollment, mailings, outreach and education materials for eligible beneficiaries, and training for volunteer counselors, and requirements for agents and brokers as they do currently. Initial enrollment materials should be sent by CMS, possibly jointly with SSA. CMS should expand its presence through its ten regional offices and tailor enrollment education and outreach efforts based on varying geographic needs.



CURRENT STATE

Beneficiaries experience confusion regarding which agency, SSA or CMS, to look to for enrollment education and guidance



BMA RECOMMENDATION

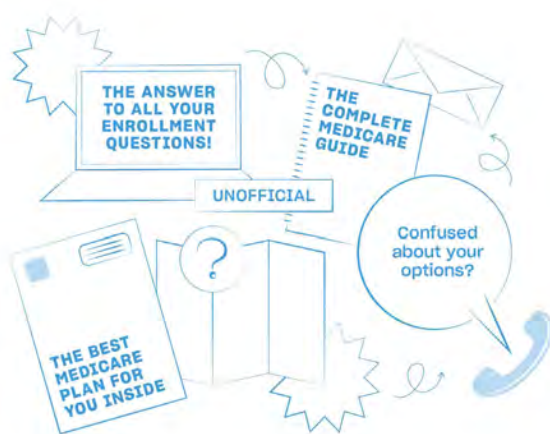
Congress should designate HHS as solely responsible for the entirety of the Medicare program, encompassing both administration and enrollment

A local physical presence of a Medicare subject matter expert is critical to ensuring beneficiaries have sufficient avenues to engage with knowledgeable staff about enrollment and issues that arise. To fully accomplish this goal, CMS should embed staff with enrollment responsibilities and coverage inquiries in existing local SSA offices to best serve the population. As part of their role, local CMS staff, as well as CMS staff dedicated to responding to inquiries that come through phone or internet channels, should receive adequate training on available options to answer questions and resolve problems on both Medicare Advantage and Traditional FFS Medicare, as well as be able to refer prospective beneficiaries to additional educational resources based on their circumstances and level and type of information needed or requested.

CMS should build on ACL’s tremendous work in the development of a national-level standardized training and certification program for SHIP counselors to be used by all states. ACL is then responsible for implementing the training and oversight of the SHIP program. Also, as more and more Medicare-eligible beneficiaries are working past the age of 65 years, both employers and employees need to know more about Medicare enrollment options and timing for enrollment. CMS, working with other government agencies where appropriate, should standardize trainings and other appropriate materials to be made available to human resources departments and employees in both public and private employers to educate them on the coverage choices available to Medicare eligible employees.

Standardize and Modernize Educational Materials for Current and Prospective Beneficiaries

In order to reduce confusion regarding which informational materials come from trusted sources, CMS should ensure that all materials provided by the Agency or organizations affiliated with the Medicare program (excluding health plans and providers which are regulated separately) are appropriately branded as approved resources. Unaffiliated entities seeking to market themselves as Medicare educators should be required to meet specified requirements and undergo CMS review. Materials that meet the new CMS requirements would be able to include a predetermined seal of approval indicating that it meets CMS’ standards of accuracy and completeness. Employers and other entities (e.g., retirement planners) that provide unofficial enrollment education to prospective Medicare beneficiaries should be encouraged to use only CMS-developed or CMS-approved materials in their education efforts. Enforcement actions should be increased for those that misrepresent Medicare’s brand and information.



CURRENT STATE

It is not always clear which Medicare enrollment informational materials come from Medicare-affiliated sources and which do not



BMA RECOMMENDATION

CMS should ensure that all materials provided by the Agency or organizations affiliated with the Medicare program are appropriately branded as official resources

Redesign, Simplify, and Tailor the Notice of Medicare Benefits

CMS should continue to revise and update the Medicare & You handbook to ensure that beneficiaries can easily access and understand the information included and can obtain information on the choice between Traditional FFS Medicare and Medicare Advantage, as well as the array of other options and decisions to be made and the timeframe for decisions. The redesign process must ensure adequate input and engagement from Medicare beneficiaries and Medicare beneficiary advocacy groups, including surveys, focus groups, consumer testing, and other methods of primary research to ensure that the revised format meets the needs of the individuals it is intended to inform. The beneficiaries and beneficiary advocacy groups involved in these efforts must represent those with different language, health, and socioeconomic needs.

Representation of different age cohorts should also be included to ensure CMS addresses a complete array of perspectives and preferences. CMS should further take into consideration adult learning principles, ensuring that the educational materials are easy for beneficiaries to understand. Overall, CMS materials should be translated into more languages, accommodate limited literacy levels, be culturally appropriate, and reflect the increasingly diverse Medicare-eligible population. In addition, materials could be tailored to distinct populations of beneficiaries such as those who continue to be employed, those who are Medicaid-eligible, those who may need assistance from a family member or caregiver, etc.



CURRENT STATE

The current Medicare & You handbook contains valuable information but is lengthy and not fully tailored to meet unique circumstances



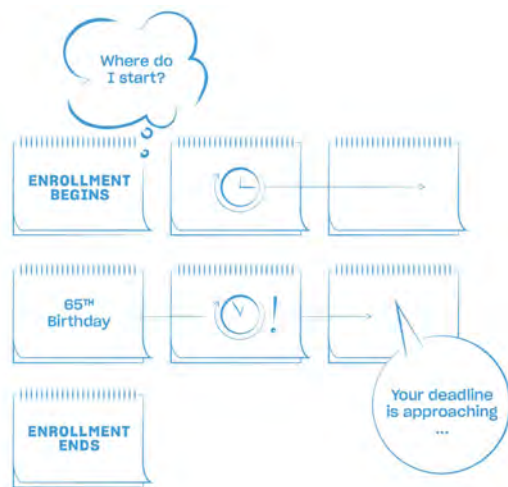
BMA RECOMMENDATION

CMS should revise the Medicare & You handbook to further tailor the resource and ensure that beneficiaries can easily access and understand the information

Initiate Beneficiary Engagement and Education at Age 64

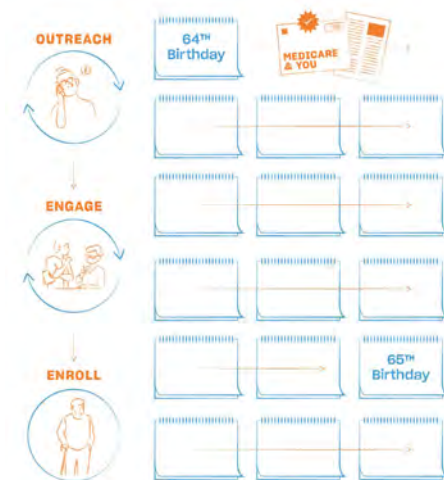
In order to address the inadequacy of the current seven-month enrollment window for beneficiaries aging into Medicare, Congress should extend the timeline for beneficiary engagement and education to begin at age 64. CMS should issue official notices to individuals regarding upcoming Medicare eligibility that directs them to the appropriate tools and resources to begin the information and exploration process. This extended timeline will provide individuals, particularly those with unique or special circumstances, with additional time to review their options and conduct outreach to educators (e.g., agents and brokers or SHIP counselors). This increases the likelihood they are making a coverage decision that best meets their needs.

Additionally, CMS should be required to develop and provide standardized materials for employers to use for worker education about the upcoming Medicare enrollment process and the general options and decisions their employees need to consider. Employers should use only CMS-developed or CMS-approved materials for employee education to ensure accuracy and consistency in materials.



CURRENT STATE

The current seven-month enrollment window does not provide adequate time and opportunity for individuals to explore, comprehend, and select coverage options



BMA RECOMMENDATION

Congress should extend the timeline for beneficiary engagement and education to begin at age 64; CMS should issue official notices regarding upcoming Medicare eligibility and references to education

Modernize a Single Comprehensive Tool to Compare all Coverage Options

CMS should build off the work already done on the Medicare Plan Finder tool in development of a single comprehensive tool to allow beneficiaries to evaluate all the Traditional FFS Medicare, Medicare Advantage, and Medigap options in their area to facilitate informed decision-making. This tool should incorporate filters to allow beneficiaries to tailor their search based on their unique circumstances such as income or chronic condition, and take into account factors such as out-of-pocket costs, provider network, supplemental benefits, programs for specific conditions or disease states, and quality ratings.

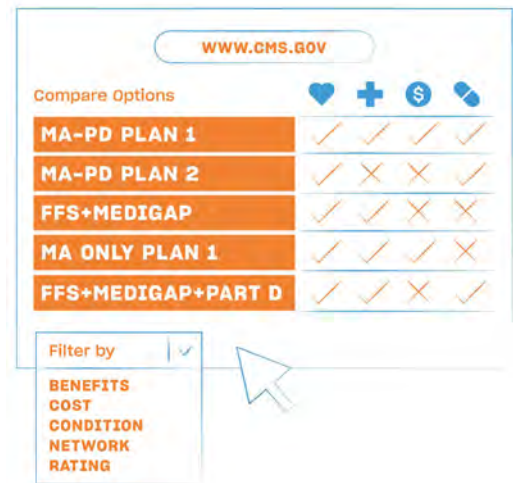
The tool should enable individuals transitioning from Medicaid or private coverage to more easily find coverage options based on their preferences regarding continuity of care and care delivery model, such as integrated care. Such filtering tools would serve to identify choices available to beneficiaries, streamline the process, and reduce the number of beneficiaries who fail to make a choice and default into Traditional FFS Medicare. The tool should also be available to caregivers, family members, or others authorized to assist the beneficiary in exploring options. Searches should be able to be saved and returned to by the beneficiary or designee.

In addition, in order to facilitate ease of comparison and reduce the volume of text, the tool should use standardized and easily recognizable symbols including “\$” representing low beneficiary out-of-pocket costs and “\$\$\$” representing high beneficiary out of pocket costs. Similar to the above recommendation to revise the Medicare & You handbook, beneficiaries and their representatives must be consulted and included in the development and implementation of the tool to ensure it meets the needs and preferences of the consumer.



CURRENT STATE

Individuals must review information from multiple resources for to evaluate coverage; there is no single resource to compare all options



BMA RECOMMENDATION

CMS should build off the work already done on the Medicare Plan Finder tool in development of a single comprehensive tool to allow beneficiaries to evaluate all the Traditional FFS Medicare, Medicare Advantage, and Medigap options in their area to facilitate informed decision-making.

V. Conclusion

Individuals who qualify for Medicare coverage have two options to receive their benefits, either Traditional FFS Medicare or Medicare Advantage, with an array of options for their coverage once that decision has been made. While beneficiaries now have the ability to identify and select a coverage option that best suits their circumstances, the existing challenges and barriers often impede beneficiary selection of and enrollment into an optimal Medicare coverage option that best meets their unique needs and preferences. Systemic solutions and reforms such as those recommended in this report are critical to ensure that all Medicare beneficiaries have timely, trusted, complete and clear information about their enrollment options and confidence that they can make the coverage choice that will best meet their health and financial needs. Given the increasing numbers of Medicare beneficiaries anticipated in the coming years, action now will better ensure millions of informed beneficiaries are able to make the best choice for themselves.

Recommendations to Empower Beneficiaries and Modernize the Medicare Enrollment Process

1. Designate the Department of Health and Human Services (HHS) as Solely Responsible for Medicare Enrollment
2. Standardize and Modernize Educational Materials for Current and Prospective Beneficiaries
3. Redesign, Simplify, and Tailor the Notice of Medicare Benefits
4. Initiate Beneficiary Engagement and Education at Age 64
5. Modernize a Single Comprehensive Tool to Compare all Coverage Options

VI. Methodology

Better Medicare Alliance commissioned Health Management Associates to conduct a literature review, as well as a series of stakeholder interviews to inform the development of policy recommendations to empower Medicare beneficiaries to better navigate the enrollment process. HMA reviewed more than 40 publications, as well as legislative and regulatory proposals addressing the Medicare enrollment process. Results were used to help identify the challenges and complexities of the existing enrollment process, as well as the financial and health impacts of these challenges and complexities for Medicare beneficiaries. HMA also conducted structured interviews with key stakeholders to confirm the challenges and barriers identified in the literature and to gain insight into potential reforms to the Medicare enrollment process that would promote more informed decision-making and engagement. Interviewees included individuals from plans, providers, senior hotline advocacy organizations, associations that represent SHIP counselors, and agents and brokers. They were selected based on their knowledge of Medicare enrollment processes and coverage options, as well as their experience working with Medicare beneficiaries navigating the enrollment process.

ACKNOWLEDGEMENTS

Better Medicare Alliance would like to thank the individuals and organizations representing an array of stakeholders who agreed to be interviewed and shared their time, expertise, and valuable insights. This report used these interviews to inform the findings and recommendations, and while the report sought to be true to the input, the report is the opinion of Better Medicare Alliance and should not be attributed to the specific organizations or individuals who participated. These organizations include:

Alliance of Community Health Plans
America's Physician Groups
Atrius Health
BlueCross BlueShield Association
Center for Advocacy for the Rights and Interests of the Elderly
CVS Health
Humana
Iora Health
Medicare Rights Center
National Association of Area Agencies on Aging
National Association of Health Underwriters
National Council on Aging
University of Maryland School of Public Health

CITATIONS

- ¹ [Centers for Medicare & Medicaid Services. \(2020 February\). *CMS Fast Facts* \[Data File\].](#)
- ² Factors to consider in determining whether a plan meets the beneficiary's needs include the beneficiary's existing health conditions, the plan's out-of-pocket costs for premiums and cost sharing, the provider network, prescriptions available on the plan's formulary, and other factors.
- ³ [Morning Consult poll commissioned by Better Medicare Alliance. Released November 2019.](#)
- ⁴ People can also qualify for Medicare under age 65 when they have End-Stage Renal Disease, Lou Gehrig's disease, or have been on Social Security Disability Insurance for two years.
- ⁵ HMA analysis of CMS State/County Penetration Enrollment files. April 2020.
- ⁶ In order to qualify as creditable coverage, Medicare must consider it comparable to Part D coverage (e.g., from a current/former employer, Medicaid, or private insurance)
- ⁷ [Better Medicare Alliance. \(2020 March\). *Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Modest- Income Populations*.](#)
- ⁸ [Kaiser Family Foundation. \(2016\). *Total Number of Medicare Beneficiaries* \[Data Table\].](#)
- ⁹ [Medicare Advisory and Payment Commission. \(2019 June\). *Beneficiary enrollment in Medicare: Eligibility notification, enrollment process, and Part B late-enrollment penalties* \[Chapter 1\].](#)
- ¹⁰ [Trivedi, A. \(2016\). Understanding Seniors' Choices in Medicare Advantage. *Journal of General Internal Medicine*, 31\(2\), 151-152.](#)
- ¹¹ [Abaluck, J. & Gruber, J. \(2011\). Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program. *American Economic Review* 101, 1180-1210.](#)
- ¹² [Kaiser Family Foundation. \(2019\). *2020 Spotlight: First Look* \[Data Table\].](#)
- ¹³ In one study, Medicare Advantage enrollment declined at above 30 plans within a county. (Within-county increases of up to fifteen in the number of available plans were associated with significant increases in Medicare Advantage enrollment (p=0.004). However, increases from fifteen to thirty in the number of available plans were not associated with significant changes in enrollment (p=0.84), and increases above thirty plans were associated with significant decreases in Medicare Advantage enrollment (p<0.001). [McWilliams, J.M., Afendulis, C.C., McGuire, T.G., & Landon, B.E. \(2015\). Complex Medicare Advantage Choices May Overwhelm Seniors — Especially Those With Impaired Decision Making. *Health Affairs*, 30 \(9\).](#)
- ¹⁴ [U.S. Government Accountability Office. \(2019 July\). *Medicare Plan Finder: Usability Problems and Incomplete Information Create Challenges for Beneficiaries Comparing Coverage Options*. \(GAO Publication No. 19-627\).](#)
- ¹⁵ [Brady, M. \(2019 August 27\). CMS refreshes much-used Medicare plan finder tool. *Modern Healthcare*.](#)
- ¹⁶ [Centers for Medicare & Medicaid. \(2019 April 27\). Medicare Plan Finder Gets an Upgrade for the First Time in a Decade.](#)
- ¹⁷ [Medicare Rights Center. \(2019 August 27\). Letter received by Seema Verma, Administrator, Centers for Medicare & Medicaid Services.](#)
- ¹⁸ [Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. \(2006\). *The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy*. U.S. Department of Education.](#)
- ¹⁹ There are multiple avenues through which individuals become eligible for Medicare coverage. These policy recommendations, while in many cases are applicable to several or all eligibility pathways, are largely focused on those aging into Medicare at age 65. These recommendations were informed by interviews and subsequent discussions with beneficiary advocacy organizations, provider group organizations, and health plan representatives but were developed by BMA and do not necessarily reflect the views of all organizations interviewed.