SECTION-BY-SECTION SUMMARY OF H.R. 5772
THE "BENES" ACT OF 2016

Due to the complexity of the Medicare enrollment process and the lack of clear notice, tens of thousands of older adults and people with disabilities face higher health care costs and gaps in coverage. While people with Social Security benefits are automatically enrolled in Medicare, an increasing number of Americans are working longer and deferring Social Security benefits past age 65. With fewer people automatically enrolled in Medicare—and 10,000 Baby Boomers aging into Medicare each day—more people new to Medicare must actively enroll in the benefit. Unfortunately, these individuals often fail to properly do so because they are not informed of Medicare's complex enrollment rules. A simple notice could solve much of the problem.

Different rules apply to those with different types of coverage: employer-based, retiree, COBRA and now Marketplace. The rules are so complicated that even the most sophisticated Human Resources (HR) departments of Fortune 500 companies struggle to follow them. Many older adults and people with disabilities who are paying for private coverage learn only after medical treatment that their insurance is "secondary" to Medicare and that relying on their insurance instead of enrolling in Part B has created a "gap"—which can cost hundreds of thousands of dollars in out-of-pocket spending.

Clear and simple advice to those approaching eligibility could help address the problem. Yet, the federal government does not provide any notification to people nearing Medicare eligibility age to informing them that they must actively enroll and how to do so. For those who make an honest mistake, an opaque process, known as equitable relief, requires them to prove they received erroneous advice from a federal official—a standard virtually impossible to meet. The process is simply not functional.

Enrollment errors affect tens of thousands of Americans in every state. The Medicare Rights Center (Medicare Rights) national helpline fields more than 17,000 questions annually. Year after year, more than one in four of these calls concern Medicare enrollment, most often from individuals experiencing challenges enrolling in Part B. The consequences of Part B enrollment missteps can be significant and often lead to a lifetime of higher Part B premiums. In 2014, 750,000 people with Medicare were paying a Part B Late Enrollment Penalty (LEP) and the average LEP amounted to nearly a 30 percent increase in a beneficiary's monthly premium.[1] In addition to this considerable penalty, Medicare Rights regularly counsels retirees and people with disabilities who are facing significant out-of-pocket health care costs, gaps in coverage, and barriers to accessing needed services resulting solely from honest enrollment mistakes.

SECTION 1. Name: The Beneficiary Enrollment Notification and Eligibility Simplification Act, or "BENES" Act.

SECTION 2. Eligibility and Enrollment Notification: Directs the Secretary of the Department of Health and Human Services (HHS) to work with the Social Security Administration (SSA) and the Department of the Treasury to provide notice to individuals approaching Medicare eligibility. The HHS Secretary, in consultation with relevant stakeholders (representing older adults, people with disabilities, people with End Stage Renal Disease (ESRD), low-income individuals and families, employers, States, State Health Insurance Assistance

[1] P. Davis, "Medicare: Part B Premiums," (Congressional Research Service: September 2015), available at: https://www.fas.org/sgp/crs/misc/R40082.pdf

Programs (SHIPs), and health insurers) will develop a notice to those approaching eligibility of when and how they should enroll.

Directs that notices should be sent six months prior to an individual's Initial Enrollment Period (IEP) and again one month prior to an individual's IEP and establishes a one-stop website for enrollment content, including both HHS and SSA content. To coordinate the notice process, the Secretary of the Treasury is to provide HHS and SSA all taxpayer return information necessary for the purposes of sending the notice, and the agencies are directed to enter into a computer matching agreement. The HHS Secretary is to submit a report to Congress on the development, maintenance, and updating of all notices and the one-stop website.

SECTION 3. Beneficiary Enrollment Periods: Starting January 1, 2018, eliminates current coverage gaps in the fifth, sixth, and seventh month of a newly eligible Medicare beneficiary's IEP and gaps in the annual General Enrollment Period (GEP). Establishes that Part B coverage begins the month immediately following enrollment in the fifth, sixth, and seventh months of an individual's IEP and the GEP months. Aligns the GEP with the annual Medicare open enrollment period for Medicare Advantage (MA) and Part D. Also provides the Secretary with the authority to grant a Part B Special Enrollment Period (SEP) in "exceptional circumstances"—again, aligning Part B with MA and Part D. For example, the HHS Secretary used this authority to grant an MA and Part D SEP following Hurricane Sandy.

SECTION 4. Revising Beneficiary Appeal Rights for Good Faith Enrollment Mistakes: Broadens the standard allowing an individual to request equitable relief and establishes a standardized timeline, application, and independent review process for equitable relief requests. Six months following enactment, equitable relief can be granted due to misinformation supplied by an agent of the Federal Government or its instrumentalities, an employer, a representative of a group health plan, a State, or for any other good faith reason as determined by the HHS Secretary. Having other health insurance coverage is deemed to constitute good faith, unless otherwise determined by the HHS Secretary.

In consultation with the SSA Commissioner, the HHS Secretary is to establish an application for equitable relief requests and to publish specific timelines for the timely resolution of equitable relief requests. The SSA Commissioner is required to process equitable relief applications within 15 business days and to deliver decisions with a standardized, written notice that includes an explanation. Also, the SSA Commissioner is to enter into a contract with an Independent Review Entity (IRE) for the purposes of reviewing individual requests to revisit unfavorable equitable relief decisions. Establishes that individuals must request independent review within 90 days and will receive a decision from the IRE within 45 days.

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