DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE

In the case of	**Claim for**
J.B.K. (Appellant)	Entitlement to Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
Social Security Administration (SSA) (Agency)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision, dated June 2, 2009. The ALJ's decision found that equitable relief from the 150 percent premium penalty for delayed enrollment was not available to the appellant because there was no government error, misrepresentation or inaction. The ALJ's decision also found that the appellant was not entitled to equitable relief in the form of a retroactive special enrollment period and that the appellant's eligibility to receive Medicare Part B benefits would remain with an effective date of March 1, 2008. The appellant has asked the Medicare Appeals Council (Council) to review this action.

The Council grants the request for review. 20 C.F.R. §§ 404.967 and 404.970, *incorporated by reference in* 42 C.F.R. § 405.724. The Council hereby vacates the hearing decision and remands this case to an Office of Medicare Hearings and Appeals (OMHA) ALJ for further proceedings, including a new decision. *See* 20 C.F.R. § 404.977. The Council has entered into the record the appellant's request for review dated June 16, 2009, as Exhibit (Exh.) MAC-1.

BACKGROUND AND PROCEDURAL HISTORY

This case involves a Medicare Part B premium increase of 150% imposed on the beneficiary by the Social Security Administration (SSA) on the grounds that the beneficiary enrolled in Medicare Part B in December 2007 even though his initial enrollment period for Medicare Part B ended in July 1990.

The evidence indicates that the beneficiary, born on ***, 1945, retired from the *** Police Department in the State of New York sometime in the late 1980's. Exh. 4, at 8. On April 15, 1988, the beneficiary filed a claim for disability benefits with the SSA. Exh. 5, at 14. The SSA determined that the beneficiary was disabled and entitled to disability benefits, effective April of 1988. Exh. 7, at 33.

On April 1, 1990, the beneficiary became eligible to receive Medicare Part A and Part B benefits. Exhs. 5, at 13; 7, at 33. At this time, the beneficiary accepted Medicare Part A, but declined Medicare Part B benefits. Exhs. 4, at 8; 5, at 13; 8, at 61. According to the beneficiary's testimony, the beneficiary was receiving primary coverage through his former employer's group health plan, POMCO, at the time when he was eligible for initial enrollment into Medicare Part B. Hearing CD. The beneficiary's initial enrollment period for Medicare Part B ended on July 1, 1990. Exh. 7, at 30.

On January 1, 2005, the beneficiary's group health plan insurer changed from POMCO to UnitedHealthcare. Exh. 2, at 3. The appellant signed an application for enrollment in Medicare Part B on December 5, 2007; he requested retroactive enrollment and coverage to commence on July 1, 2005. The application was first date–stamped received on December 7, 2008, but the date stamp is crossed out and there is another received date stamp on February 11, 2008.

On January 15, 2008, the New York Department of Civil Service notified the beneficiary that his group health plan coverage through UnitedHealthcare required all Medicare eligible insured to be enrolled in Medicare Part A and Part B, because Medicare became the primary payer effective January 1, 2005. Exh. 2, at 2-3.[1] By letter dated April 1, 2008, UnitedHealthcare then requested a refund from the beneficiary in the amount of $12,306.07 for claims mistakenly covered by UnitedHealthcare as

[1] The beneficiary was enrolled in the New York State Health Insurance Program's (NYSHIP's) Empire Plan through UnitedHealthcare.

primary payer, which, according to UnitedHealthcare, should have been covered by Medicare Part B as primary payer. Exh. 3, at 4.

On May 27, 2008, the SSA assessed a 150% premium penalty and declined to make the beneficiary's enrollment retroactive. Exh. 6, at 22. The SSA also made the beneficiary's Part B coverage effective March 1, 2008. Subsequently, the SSA revised the effective date of the beneficiary's Medicare Part B coverage to July 1, 2008. Exh. 5, at 14. By a reconsideration decision dated December 23, 2008, the SSA changed the effective date of the beneficiary's Medicare Part B coverage back to March 1, 2008, because its prior error misinformed the appellant of the effective date. However, the reconsideration upheld SSA's prior determination imposing a 150% premium penalty and denying a retroactive effective date for Medicare Part B coverage.

The beneficiary appealed and an ALJ hearing was held by telephone on May 29, 2009. The ALJ found the beneficiary was not entitled to a retroactive special enrollment period, the effective date for the beneficiary to receive Medicare Part B benefits would remain March 1, 2008, and the 150% premium penalty was proper. Dec. at 7-8.

RELEVANT LEGAL AUTHORITY

Section 1836 of the Social Security Act (Act) provides that every individual entitled to Medicare Part A benefits or who has reached the age of 65 and is either a U.S. citizen or a lawful resident alien is "eligible to enroll" in Medicare Part B. Section 1836; SSA Programs Operation Manuals System (POMS) HI § 805.005.A.2;[2] CMS General Information, Eligibility and Entitlement Manual (Pub. 100-01)(GIEEM), Ch. 2 § 40.[3] An eligible beneficiary may elect to enroll in Medicare Part B

[2] The SSA is responsible for processing claims for entitlement to Medicare, and adjudicates these claims initially and on reconsideration. 20 C.F.R. § 404.900(a). The SSA POMS can be located through the link to "Programs Operation Manual System" found in the "Employee Operating Instructions" section of the SSA website at http://www.ssa.gov/regulations/. While neither the Council nor the ALJ are bound by the POMS, these provisions would have been applicable to SSA's personnel who were handling eligibility and enrollment determinations in 2007.

[3] The Act also allows for automatic or "deemed" enrollment when a beneficiary is already enrolled and receiving Social Security benefits prior to age 65. Section 1837(f),(g); POMS HI § 805.040. A person "deemed" enrolled in Medicare Part B is sent a notice and given the opportunity to refuse Part B coverage. POMS HI § 00805.055. Neither the SSA nor the CMS is required to send notice or provide opportunity to opt out of Medicare Part B to individuals not subject to provisions for deemed or automatic enrollment.

during a seven month "initial enrollment period" from three months before the month in which an individual reaches age 65 through three months thereafter. Section 1837(d). If the beneficiary fails to enroll during the initial enrollment period, the Act provides for enrollment during general enrollment periods each year thereafter, from January 1 through March 31. Section 1837(e).[4] It is generally the beneficiary's responsibility to initiate contact with SSA, based on information in the public domain and governmental public education and outreach efforts.

Use of a Special Enrollment Period

The SSA provides special rules for an individual enrolling outside of their initial enrollment period. Specifically, in the case of an individual who –

> (A) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan . . . by reason of the individual's . . . current employment status, and
> (B) has elected not to enroll . . . under this section during the individual's initial enrollment period,
>
> there shall be a special enrollment period . . . .

Section 1837(i) of the Act. The Act is clear that the SEP "is the period including each month during any part of which the individual is enrolled in a [GHP or LGHP] by reason of current employment ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled." Section 1837(i)(3)(A) of the Act.

The implementing regulations provide, in pertinent part, further guidance on the requirements for using an SEP:[5]

> In order to use a SEP, an individual must meet the conditions of paragraph (b) and of paragraph (c) or (d) of this section, as appropriate.

---

[4] Beneficiaries covered by employer group health plans may enroll during certain "special enrollment periods." Section 1837(i).

[5] The ALJ cites to the implementing regulations at 42 C.F.R. § 406.38. However, the regulations under Part 406 specifically concern Medicare Part A. 42 C.F.R. Part 407 covers enrollment and entitlement under Medicare Part B. The Part B regulations at 42 C.F.R. § 407.32 are substantially similar to 42 C.F.R. § 406.38.

(b). *General Rule*. All individuals must meet the following conditions:

(1) They are eligible to enroll for [Supplementary Medical Insurance (SMI)] on the basis of age or disability, but not on the basis of end-stage renal disease.

(2) When first eligible for SMI coverage (4th month of their initial enrollment period), they were covered under a GHP or LGHP on the basis of current employment status or, if not so covered, they enrolled in SMI during their initial enrollment period; and

(3) *For all months thereafter, they maintained coverage under either SMI or a GHP or LGHP* . . . .

(c) *Special Rule: Individual age 65 or over.*

(d) *Special Rules: Disabled individual*. Individuals entitled on the basis of disability (but not on the basis of end-stage renal disease) must meet conditions that vary depending on whether they were covered under a GHP or an LGHP.

(2) For a disabled individual who is or was covered under an LGHP, coverage must be as follows:

(i) Before August 10, 1993, as an "active individual", that is, as an employee, employer, self-employed individual (such as the employer), individual associated with the employer in a business relationship, or as a member of the family of any of those persons.

42 C.F.R. § 407.20(a)(2).

The Act provides for a 10% premium increase for each full 12 month period following an individual's initial enrollment period in which the individual could have been but was not enrolled. Section 1839(b). As relevant here, the premium increase is calculated taking into account the number of months following the close of an initial enrollment period and the general enrollment period in which the individual actually enrolled.

Id. Coverage for an individual enrolled during a general enrollment period begins July 1 of such year. Section 1838(a)(2)(E).

The Act authorizes equitable remedies to correct problems with enrollment, as follows:

> In any case where the Secretary finds that an individual's enrollment or *nonenrollment* in the insurance program established by [Medicare Part A or B] is unintentional, inadvertent, or erroneous *and is the result of* the error, misrepresentation, or *inaction* of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

Section 1837(h) (italics added); POMS HI § 00805.170.A.1. *See also* 42 C.F.R. § 407.32.

The record must reflect three elements before equitable relief is appropriate:

1. Government error, misrepresentation, or inaction;
2. Prejudice to SMI rights; and
3. Evidence of the error.

POMS HI § 00805.170.B.

The record must contain documentary evidence of the error, which "can be in the form of statements from employees, agents, or persons in authority that the alleged misinformation, misadvice, misrepresentation, inaction, or erroneous action actually occurred." POMS HI § 00805.175.C. If the individual with personal knowledge of the error is not available, "the evidence can consist of a statement that there is a strong likelihood based on personal knowledge or prior experience that an error occurred." *Id*.

"Prejudice" includes missing an enrollment period, inability to pay large premium arrearages resulting from government delay, or "any other hardship." POMS HI § 00805.170.C. Evidence must show that the beneficiary --

- took such appropriate and timely measures to assert his/her rights as could reasonably be expected under the circumstances; and
- because of administrative fault, delay, or erroneous action or inaction by an employee or agent of SSA/HCFA of another Federal Government instrumentality, the enrollment or premium rights would be impaired unless relief is given.

Id. § 00805.170.D.

An "agent" of the Federal Government is someone authorized to act on the Federal Government's behalf in Medicare matters, including social security employees or employees of Medicare carriers. However, "[i]f the evidence shows that *an individual received misinformation from someone (e.g., employer, insurance company) [who] received the misinformation from an employee or agent of the Federal Government, this would also qualify for equitable relief*." POMS HI § 00805.170.D. (Emphasis added).

Historically, there was some confusion arising from changing laws with respect to whether Medicare would be secondary payer or primary payer for certain disabled individuals who were also covered by their former employer's group health plans. Consequently, the POMs contains detailed instructions for granting a special enrollment period after the CMS carrier certifies to the employer that Medicare is the primary payer. The employer should then advise the beneficiary of the opportunity to enroll immediately in Medicare during a special enrollment period. *See, e.g.,* POMS HI §§ 00805.300, 00805.310, and 00805.315.

Specifically, a disabled beneficiary's employer is required to give qualified disabled beneficiaries a notice that includes the date Medicare becomes the primary payer, the opportunity for immediate enrollment in Medicare Part B, and all months the beneficiary was covered under the Large Group Health Plan

(LGHP). Additionally, the disabled beneficiary's employer is required to give the disabled beneficiary a copy of the Medicare carrier letter that certifies that Medicare is the primary payer. POMS HI § 00805.300.B.

Qualified disabled beneficiaries may enroll in Medicare Part B during a 7 month disabled special enrollment period (D-SEP) if Medicare was changed from their secondary payer to their primary payer. POMS HI § 00805.300.C. The D-SEP begins either "the month in which the employer notifies the beneficiary that Medicare is the primary payer, or the month Medicare becomes the primary payer," whichever is later. *Id*. For qualified disabled beneficiaries, entitlement to Medicare Part B may be established "retroactive to the month Medicare becomes the primary payer provided the beneficiary makes arrangements to pay the past due premiums." POMS HI § 00805.300.D.

DISCUSSION

The Council is remanding this case for further factual development by the ALJ and/or the SSA to determine whether the appellant is eligible for relief, if any, of his 150% premium surcharge and his effective date of Medicare Part B coverage, and for recalculation of the surcharge if necessary.

First, it is not clear what dates were used to formulate the 150% premium surcharge. The ALJ indicates that the beneficiary's initial enrollment period for Medicare Part B benefits terminated on July 1, 1990. Dec. at 5. The ALJ then determined that the beneficiary submitted an application for enrollment into Medicare Part B following a town hall meeting that was held in December 2007. A review of the SSA reconsideration sheds no further light on how the premium penalty was determined. The ALJ decision and the reconsideration use the dates of July 1990 as the beginning of the initial enrollment period and December 2007 as the date of application, but using these dates would cause a premium penalty of 170% instead of the lower 150% actually imposed. Exh. 7, at 30. There is no further explanation how the 150% premium penalty was calculated.

In addition, the record lacks the development the POMs mandates in order to provide the beneficiary with a fair and complete analysis of his rights with regard to a surcharge penalty waiver or reduction. There is a substantial question as to whether the SSA, *** Police Department, POMCO, and/or

UnitedHealthcare met their duty to inform the beneficiary of his right to apply for Medicare Part B once it became the primary payer of the beneficiary's benefits. In this regard, there are several key documents missing from this record which the ALJ should have obtained and admitted to the record.

As noted, there are specific provisions that employers are required to follow for certain qualified disabled beneficiaries. *See* POMS HI 00805.300. There is nothing in the record to indicate that the Medicare carrier provided the employer with a letter certifying that Medicare became the primary payer of the beneficiary's benefits. Moreover, documentation indicating that the beneficiary's employer notified the beneficiary of the change in Medicare payer status is not in the record. Thus, the ALJ should seek to obtain evidence of a letter from the Medicare carrier certifying that the change in Medicare primary payer status and a letter from the beneficiary's former employer notifying the beneficiary of Medicare as primary payer.

Finally, we note that the ALJ referred to the SSA printout in Exhibit 5 as the SSA call log history. This document is instead the SSA AACT (Abbreviated Account Inquiry) derived from the MBR (Master Beneficiary Record), which is a summary computer extract of the appellant's application, entitlement and payment history. The SSA no longer allows open public access to the Systems and Methods volumes of POMS, which contain the legend to this query. The ALJ should enlist the assistance of a SSA office if needed to decipher this query.

DIRECTIONS ON REMAND

The ALJ shall contact and obtain testimony or statements, and documentation from the beneficiary's former employer, POMCO, or UnitedHealthcare as to when the beneficiary was notified of his right to apply for Medicare Part B after it became the primary payer of his benefits consistent with the POMS sections cited above. The ALJ shall then afford the beneficiary the opportunity for another hearing.

The ALJ should determine whether the carrier, SSA, *** Police Department, POMCO, and UnitedHealthcare fulfilled their duties under the law and regulations to the beneficiary. In the event that the ALJ determines that SSA, *** Police Department, POMCO, and UnitedHealthcare did not fulfill their responsibilities to this beneficiary, the ALJ should order equitable relief only if there was government error, misrepresentation, or inaction and

that failure resulted in the beneficiary's failure to enroll in Medicare Part B back in 2005. As pertinent herein, misinformation from non-Federal sources may create a basis for equitable relief if it is due the Federal government misinformation. POMS § HI 00805.170.D.

If applicable, the ALJ shall also explain how the 150% premium penalty was determined. If the ALJ determines that the premium penalty is incorrect, the ALJ will provide appropriate relief along with proper explanation of the discrepancy.

The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: November 18, 2009