DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
ON REQUEST FOR REVIEW

In the case of	**Claim for**
F.C. (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 August 24, 2009, which concerned a 90% Medicare Part B premium surcharge assessed on the beneficiary for late enrollment in Medicare Part B. The ALJ determined that a 90% premium surcharge was appropriate, but also directed the Social Security Administration (SSA) "to calculate the premium surcharge accordingly" based on the beneficiary's spouse's last date of employment of January 22, 1999. Dec. at 4-5. The appellant has asked the Medicare Appeals Council (Council) to review this action.

The regulations provide that the Medicare Appeals Council will grant a request for review where: (1) there appears to be an abuse of discretion by the ALJ; (2) there is an error of law; (3) the ALJ's action, findings, or conclusions are not supported by substantial evidence; or (4) there is a broad policy or procedural issue that may affect the general public interest. The regulations also provide that if new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Council finds that the ALJ's action, findings or conclusion is contrary to the weight of the evidence currently of record. *See* 20 C.F.R.

§ 404.970, incorporated by reference in 42 C.F.R. § 405.801(c) and 405.701(a)(1).

The Council has considered the record, including the audio recording of the ALJ hearing, and the appellant's arguments. As set forth below, the Council grants the request for review, and modifies the ALJ's decision.

BACKGROUND

The beneficiary's date of birth was ***, 1932. Exh. 3, at 14. The beneficiary's initial enrollment period (IEP) for Medicare coverage on the basis of age ended ***, 1997. The beneficiary was covered through his spouse's group health plan (GHP) from November of 1993, through May of 2009. Exh. 6, at 26. The beneficiary's master beneficiary record (MBR) indicates that the beneficiary's spouse's employment ended on February 7, 1998. Conversely, according to a form submitted to the SSA by the beneficiary's spouse's employer, the beneficiary's spouse was employed by her employer from April 13, 1981, through January 22, 1999.[1] Exh. 6, at 26.

In January of 2007, during a general enrollment period (GEP), the appellant applied for Medicare Part B benefits and in July of 2007 he was enrolled in Medicare Part B. Exh. 3, at 13. The beneficiary was assessed a premium surcharge of 90% because he did not enroll during the 8-month special enrollment period (SEP) after his spouse's employment was terminated. *Id.* at 8, 13. Apparently, the SSA used the employer termination date for the beneficiary's spouse listed on the MBR, February 7, 1998, to determine the 90% premium surcharge. By a letter dated April 19, 2009, SSA notified the beneficiary that they would not waive the premium surcharge.

The beneficiary appealed and an in-person ALJ hearing was held on August 6, 2009. According to the ALJ: the appellant was covered by his spouse's group health plan during and after his IEP, his spouse's employment ended on January 22, 1999 (the termination date listed on the employment information form), the appellant should have enrolled in Medicare Part B during the SEP

[1] The "Request for Employer Information" form was submitted by the appellant subsequent to the ALJ hearing. The ALJ allowed the appellant to submit additional evidence up to two weeks after the ALJ hearing. The form was originally sent to the beneficiary's spouse's employer by the SSA. The form was dated and signed by the Human Resources Coordinator of the beneficiary's spouse's employer on June 11, 2009.

after his spouse's employment ended, and the appellant's premium should be increased by 10% for each 12 months in which he could have been but was not enrolled in Medicare Part B. Dec. at 4-5. The ALJ thus determined that January 22, 1999, was the correct date to use to calculate the Medicare Part B premium surcharge; however, the ALJ did not independently determine the amount of the premium surcharge. Instead, the ALJ agreed that a 90% premium surcharge was correct, but nonetheless also directed that the SSA determine the appropriate premium surcharge. *Id*. at 5. As explained in more detail below, these conclusions are inconsistent.

RELEVANT LEGAL AUTHORITY

Section 1836 of the Social Security 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. An eligible beneficiary may elect to enroll in Medicare Part B during a seven month IEP from three months before the month in which an individual reaches age 65 through three months thereafter. Section 1837(d). If the beneficiary does not enroll during the IEP, the Act provides for enrollment during a GEP each year thereafter, from January 1 through March 31. Section 1837(e).[3] 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.

[2] 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] Beneficiaries covered by employer group health plans may enroll during certain SEPs. Section 1837(i).

Use of a SEP

The Act provides special rules for an individual enrolling outside of their IEP. Specifically, section 1837(i) provides, 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 (or the individual's spouse's) current employment status, and
> (B) has elected not to enroll … under this section during the individual's [IEP],
>
> there shall be a [SEP]….

The SEP "is the period including each month during any part of which the individual is enrolled in a group health plan . . . *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, italics added.

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

> 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.
>
> (b) *General Rule*. All individuals must meet the following conditions:
>
> (1) They are eligible to enroll for [Supplementary Medical Insurance (SMI or Medicare Part B)] 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 [Large Group Health Plan] LGHP on the basis of current employment status or, if not so covered, they enrolled in SMI during their [IEP]; 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.* For an individual who is or was covered under a GHP, coverage must be by reason of the current employment status of the individual or the individual's spouse.
>
> (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.

42 C.F.R. § 407.20(a)(2).

"Current Employment" Defined

An individual has "current employment status" if he/she is actively working as an employee . . . or is associated with the employer in a business relationship. POMS HI § 00805.266.A.

Calculating the Premium Surcharge

The Act provides for a 10% premium increase for each full 12-month period following an individual's IEP in which the individual could have been but was not enrolled. Section 1839(b) of the Act. As relevant here, the premium increase is calculated taking into account the number of months following the close of an IEP and the close of the GEP in which the individual actually enrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan by reason of the individual's or the individual's spouse's current employment status. *Id., see also* 42 C.F.R. § 408.24. Coverage for an individual enrolled during a GEP begins the following July. Section 1838(a)(2)(E).

Government error, misrepresentation, or mistake resulting in enrollment or nonenrollment

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 or 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.

DISCUSSION

The appellant does not assert that he was misled with respect to Medicare Part B enrollment requirements as the result of an error, misrepresentation, or inaction by the SSA. But the appellant does assert that the SSA erred in calculating the Medicare Part B premium surcharge. Exh. MAC-1. The appellant provided support for his contention that the 90% premium surcharge was incorrect, by submitting a document which shows that the beneficiary was continuously covered by his spouse's group health plan from November of 1993, through May of 2009, and that his spouse was continuously employed from April 13, 1981, through January 22, 1999. Exh. 6, at 26. In light of the above, the Council has concluded that the ALJ erred in agreeing that a 90% premium surcharge for the beneficiary's Medicare Part B benefits was correct.

According to the Act, the months for which the individual was enrolled in a group health plan by reason of the individual's or the individual's spouse's current employment status are not taken into account when determining the premium surcharge. *See* Section 1839(b) of the Act. Current employment is defined as when an individual is actively working as an employee or has a business relationship with an employer. *See* POMS HI § 00805.266.A. Although the SSA used the February 7, 1998, date on the MBR as the date the beneficiary's spouse's current employment ended, the Council agrees with the ALJ that the spouse's current employment terminated on January 22, 1999. Therefore, January 22, 1999, was the last day the beneficiary

was covered by a GHP based on current employment, and this date should be used to determine the amount of the beneficiary's Medicare Part B premium surcharge.

Although the ALJ determined the correct date to use for the Medicare Part B premium surcharge, the ALJ did not determine the appropriate premium surcharge for the beneficiary. Instead, the ALJ agreed that a 90% premium surcharge was correct, but nonetheless also directed that the SSA determine the appropriate premium surcharge. These conclusions are inconsistent. The Council finds that the ALJ should have determined the beneficiary's appropriate premium surcharge as this was the issue before the ALJ. 20 C.F.R. § 405.946.

Pursuant to the Act, the SEP period for the beneficiary ended on September 30, 1999, the last day of the eighth month after he was no longer covered by health insurance based on his spouse's current employment. *See* section 1837(i) of the Act, and 42 C.F.R. § 407.20(a)(2). The beneficiary did not enroll during either the IEP at age 65 or the SEP, and must pay a premium surcharge. The beneficiary applied for Medicare Part B benefits during the GEP of 2007.[4] The beneficiary was enrolled in Medicare Part B effective July 1, 2007. The premium increase is calculated taking into account the number of months following the close of the IEP and the close of the GEP in which the individual actually enrolled, but does not take into account months for which the beneficiary was enrolled in a group health plan by reason of his spouse's current employment. The Council finds that an 80% premium surcharge is proper, because there were eight full 12-month periods between January 1999 (the end of health insurance coverage based on his spouse's current employment) and March 2007 (the close of GEP in which he actually enrolled). Thus, the appellant must pay an 80% Medicare Part B premium surcharge.

DECISION

It is the decision of the Medicare Appeals Council that the beneficiary must pay an 80% Medicare Part B premium surcharge.

[4] The Medicare Part B general enrollment period of 2007 is from January through March of 2007. According to the Master Beneficiary Record, the beneficiary enrolled in January of 2007. Exh. 3, at 13.

It is the further decision of the Council that the appellant is not entitled to any equitable relief from the Medicare Part B premium surcharge. The ALJ's decision is modified accordingly.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ M. Susan Wiley
Administrative Appeals Judge

Date: October 21, 2009