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Adding an Out-of-Pocket Spending Maximum to Medicare: Implementation Issues and Challenges

In an effort to simplify Medicare's cost-sharing requirements, provide beneficiaries with catastrophic protection, and achieve program savings, some have proposed to restructure Medicare's benefit design. Several recent proposals would create a unified deductible for Medicare Parts A and B, simplify cost-sharing requirements above the deductible, and add an annual limit on beneficiary out-of-pocket spending—a benefit feature typical of larger employer plans, but lacking in traditional Medicare. Within this context, some have also proposed to vary the out-of-pocket maximum, based on a beneficiary's income.

Adding an out-of-pocket maximum to traditional Medicare would strengthen financial protections under Medicare for the beneficiary population and mitigate beneficiaries' need for supplemental coverage. Varying the out-of-pocket maximum by income could achieve the policy goal of targeting resources to those most in need, but at the same time would add to the complexity of administering Medicare benefits. This brief describes the options for adding an out-of-pocket spending limit to Medicare and examines the operational issues that could arise in implementing both a uniform and an income-based out-of-pocket spending limit. Because the implementation of an income-related out-of-pocket maximum would pose somewhat greater complexity for Medicare, the operational issues associated with this approach are discussed in greater detail. The brief does not examine the implications of this proposal for federal, state, or beneficiary out-of-pocket spending, nor does it address other policy issues that may be important to consider, including the potential effects on Medicare participation by high-income beneficiaries.

BACKGROUND

Medicare's Current Cost-Sharing Structure

Under the current cost-sharing structure of traditional Medicare, there are separate cost-sharing requirements for services covered under Medicare Parts A and B that vary by the type of service, with no limit on annual or lifetime out-of-pocket spending. The traditional Medicare program provides less generous coverage on average than typical large employer health plans—including the most common plan offered under the Federal Employees Health Benefits Program (FEHBP)—largely due to Medicare's relatively high Part A deductible, the lack of a spending limit for Part A and Part B services, and less generous drug coverage.[1]

Most people with Medicare have some type of supplemental insurance to help cover Medicare's cost-sharing requirements. In 2010, more than a quarter of beneficiaries enrolled in traditional Medicare (26%) had a Medigap policy as a source of supplemental coverage and 40 percent had an employer-sponsored supplemental plan (these numbers include the 5 percent of beneficiaries with both types of coverage).[2] More than one fourth

of the Medicare beneficiary population is enrolled in a Medicare Advantage plan rather than traditional Medicare, such as a Medicare HMO or PPO, and all Medicare Advantage plans are required to include a limit on out-of-pocket spending.[3] Additionally, nearly 10 million low-income beneficiaries are enrolled in Medicaid and receive help paying Medicare's premiums and/or cost-sharing requirements.[4]

Prior to the enactment of the Medicare Modernization Act of 2003 (MMA) and the implementation of the Medicare drug benefit in 2006, Medicare's cost-sharing obligations applied uniformly to all people on Medicare, without regard to beneficiaries' income, with the exception of Medicare beneficiaries with low incomes and assets who may have qualified for wrap-around assistance under Medicaid. With the introduction of the Medicare drug benefit in 2006, Medicare offered additional financial protections for low-income enrollees in Part D plans, reducing both premiums and cost-sharing obligations for individuals with incomes below 150 percent of the federal poverty level. The MMA also introduced income-related Part B premiums for higher-income beneficiaries that went into effect in 2007. The 2010 Affordable Care Act (ACA) included an income-related Part D premium for higher-income enrollees in Medicare drug plans that took effect in 2011. Thus, previous legislation has established a precedent for reducing Medicare's cost-sharing obligations for low-income beneficiaries and increasing cost-sharing obligations for higher-income beneficiaries that some proposals would build upon, including proposals to restructure Medicare's benefit design.

OPTIONS TO RESTRUCTURE MEDICARE'S BENEFIT DESIGN AND ADD AN OUT-OF-POCKET SPENDING MAXIMUM

Recently, many policymakers and expert groups have endorsed changes to Medicare's benefit design that would simplify the program's cost-sharing requirements, provide greater protection against very high out-of-pocket spending, and reduce the need for supplemental insurance.[5] Some, but not all, of the proposals to restructure Medicare's benefit design also seek to reduce federal spending. For example, one option described by the Congressional Budget Office (CBO) would combine the Part A and Part B deductibles, establish a uniform coinsurance rate for most Medicare-covered services, and create an out-of-pocket spending limit.[6] CBO has estimated that this proposal would achieve 10-years savings of $52 billion between 2014 and 2023.

Some proposals to cap beneficiaries' annual cost-sharing liabilities would add a single spending limit that would apply uniformly to all people on Medicare. Other proposals would add an out-of-pocket spending maximum that would be adjusted higher or lower depending on a beneficiary's income (see **Appendix A** for an overview of recent proposals that include an income-related out-of-pocket spending maximum). Each of these approaches—the uniform out-of-pocket spending maximum and the income-related maximum—has relative merits, but each would also involve additional operational and administrative tasks to be undertaken by the Centers for Medicare & Medicaid Services (CMS), supplemental payers, and other agencies.

ADDING A UNIFORM OUT-OF-POCKET SPENDING MAXIMUM TO MEDICARE

Adding a uniform out-of-pocket spending maximum to traditional Medicare would strengthen financial protections under Medicare for the beneficiary population and mitigate beneficiaries' need for supplemental coverage. Adding a limit to traditional Medicare would also affect other payers that coordinate with Medicare in providing supplemental coverage to Medicare beneficiaries, namely Medicaid, Medigap insurers, and employers providing retiree health benefits.[7] Fewer claims would be submitted to these plans, resulting in savings for them, while Medicare program expenditures would increase.

To implement a uniform out-of-pocket maximum in traditional Medicare, certain administrative changes would be needed in the claims payment process. Today, the payment of provider claims for people in traditional Medicare is typically handled as follows (see **Appendix B** for details):

- The provider, such as a hospital or physician, submits a claim to Medicare.
- Medicare reviews the claim, calculates the amount it owes, and pays the provider accordingly.
- Medicare coordinates claims payment with supplemental payers, at which time the supplemental payer calculates any benefits it owes and pays the provider accordingly.
- Providers bill the beneficiary for any remainder.
- Medicare notifies the beneficiary of claims payments.

To implement a new, uniform limit on out-of-pocket spending in traditional Medicare, some additional administrative procedures would be required in traditional Medicare. CMS would need to notify beneficiaries in traditional Medicare in advance what their out-of-pocket maximum would be for the year, and likely would need to modify its existing tracking systems to monitor beneficiaries' out-of-pocket costs, so that Medicare could begin paying the full amount for services for the remainder of the year once a beneficiary's cost sharing reached the out-of-pocket maximum. Existing notifications to beneficiaries through quarterly mailings and MyMedicare.gov could be modified to reflect a beneficiary's status with respect to the annual out-of-pocket maximum.

Adding an out-of-pocket maximum to traditional Medicare (either uniform or income-related) also could require modifications in Medicare's payments to and regulations for Medicare Advantage plans if the limit also applied to Medicare Advantage plans.[8] Under current law, Medicare Advantage plans are required to provide a limit on their enrollees' out-of-pocket spending for services covered under Medicare Parts A and B of no more than $6,700 in 2014, with higher limits allowed for a combination of in-network and out-of-network providers for plans that cover services obtained out-of-network.[9] Medicare Advantage plans that adopt lower spending limits (at or below $3,400 in 2014 for in-network services) are given more flexibility by CMS in establishing cost-sharing amounts for Parts A and B services than those that do not elect the lower spending limit.[10,11] In 2013, nearly half of all Medicare Advantage enrollees were in plans with an out-of-pocket maximum that was at or below $3,400.[12] Medicare Advantage plans are required to demonstrate to CMS that they have the capacity to ensure the correct calculation and tracking of enrollees' out-of-pocket costs for all Medicare-covered benefits. Plans are also responsible for alerting their enrollees and providers when an enrollee reaches the annual out-of-pocket maximum.

If traditional Medicare included an out-of-pocket spending maximum for services covered under Parts A and B, and the out-of-pocket maximum applied to Medicare Advantage as well, some issues would need to be addressed in the administration of Medicare Advantage plans and plan payments to conform to the policy change; for example, whether to allow plans to modify (increase) the out-of-pocket maximum for enrollees who go out-of-network, or allow plans to offer a lower out-of-pocket maximum than that offered under traditional Medicare.

Adding a uniform out-of-pocket spending maximum to traditional Medicare would enhance the benefit package for people in traditional Medicare. While only a small share of beneficiaries would have spending high enough to reach the new out-of-pocket spending maximum in any given year, over a longer period of time, a larger share of beneficiaries would likely benefit from this added financial protection.[13] A uniform spending maximum, however, would not target resources in the most efficient way possible to help the most financially vulnerable people on Medicare, in contrast to an income-related out-of-pocket spending maximum.

Adding an Income-Related Out-of-Pocket Spending Maximum to Medicare

Under the proposal to add an income-related out-of-pocket spending maximum to Medicare, a lower spending limit (or limits) would apply to lower-income beneficiaries, and a higher spending limit (or limits) may also apply to higher-income beneficiaries. Varying the out-of-pocket maximum by income could achieve the policy goal of targeting resources to those most in need, but at the same time this proposal would add to the complexity of administering Medicare benefits. For example, CMS would need to obtain income information for each beneficiary to administer an income-based out-of-pocket limit—information that CMS does not currently collect or use to determine eligibility for Medicare nor to adjudicate claims under traditional Medicare. (As discussed below, CMS currently uses income information for a subset of the Medicare population to administer low-income subsidy benefits under Part D and the income-related premium under Parts B and D). This is in contrast to the Medicaid program, which ties eligibility to income and therefore requires each applicant to provide income information or demonstrate that they have attained eligibility for certain other benefit programs—information which must then be reviewed and verified to determine Medicaid eligibility status. For this reason and others, implementing an income-related out-of-pocket spending limit would be more administratively complex than implementing a uniform out-of-pocket spending limit.

Several additional administrative activities would be required to vary an out-of-pocket maximum based on beneficiary income, including: determining the income of all Medicare beneficiaries to identify the appropriate out-of-pocket maximum to assign to each beneficiary in a given year; providing advance notice to beneficiaries so they are aware of the applicable out-of-pocket maximum, and establishing a process for appeals; integrating out-of-pocket maximums that vary by beneficiary into Medicare Advantage plans; coordinating the administration of income-related out-of-pocket maximums with supplemental insurers, including Medigap and employer-sponsored retiree health plans, and between CMS and other administering agencies; and addressing issues related to beneficiary privacy. These administrative issues are discussed in greater detail below.

Determining Beneficiaries' Incomes and Assigning Out-of-Pocket Maximums

To implement a beneficiary-specific, income-related out-of-pocket maximum in Medicare, CMS would need to develop and implement new procedures for determining the income of all beneficiaries (or the subset of beneficiaries for whom it does not currently use income data) in order to assign the appropriate out-of-pocket maximum each year. The administrative complexity of assigning beneficiaries the appropriate income-related out-of-pocket maximum would depend to some extent on the policy choices made regarding the structure of the income thresholds, including the number of income categories and the definition of income that are used, and the frequency of income determinations.

One key consideration, for example, is whether to set a standard uniform out-of-pocket maximum with one lower amount that applied to lower-income beneficiaries and one higher amount for higher-income beneficiaries, or whether to establish a sliding-scale range of out-of-pocket maximum amounts for several different income groups. From the standpoint of administering claims, it would not matter how many maximums or income categories were used. Having a larger number of income categories would minimize the "cliff" effect (described below), but could also increase the likelihood of beneficiaries being assigned to a category that was inappropriate due to a change in circumstances, and who therefore might be faced with having to appeal their initial maximum amount.

Another key consideration that would have implications for administering an income-related out-of-pocket maximum is which definition of income to use. For ease of administration in determining the applicable out-of-pocket maximum, CMS could employ the modified adjusted gross income definition that is used to apply the Part B and Part D income-related premiums (for a higher limit); the alternative income definition used to establish eligibility for the Part D LIS (for a lower limit); or the modified adjusted gross income definition used to determine eligibility for premium tax credit subsidies for the non-Medicare eligible population under the Affordable Care Act; taxable income; or some other definition. Key differences among these definitions include the extent to which Social Security benefits are counted as income, whether foreign earnings or other tax-exempt income are counted, and whether some earnings are excluded.[14]

If existing definitions and thresholds are not used, a new system would need to be developed to ascertain each beneficiary's income and assign the appropriate out-of-pocket maximum.

Basing the out-of-pocket maximums on income thresholds currently used in Medicare

In conjunction with the Social Security Administration, CMS currently uses income to determine which beneficiaries are required to pay the income-related Part B and Part D premiums (applied to higher-income beneficiaries) and which beneficiaries are eligible for low-income subsidies under the Medicare Part D prescription drug benefit (the low-income subsidy program, or LIS) (see **Appendix C** for details on Medicare's current income-related features). One approach to establishing an income-related out-of-pocket maximum would be to use the income-related premium thresholds (currently above $85,000 annually for individuals) to determine the income at which to apply a higher out-of-pocket maximum. Then, the Part D LIS eligibility threshold (incomes below 150 percent of poverty, or $17,235 per year) could be used to identify people who would qualify for a lower out-of-pocket maximum amount. All other beneficiaries would receive a standard out-of-pocket maximum.

One issue that could arise if current income thresholds based on LIS eligibility are used to determine who qualifies for a lower maximum amount is the potential to create a fairly steep cliff between out-of-pocket maximum amounts that would apply to beneficiaries with incomes just above and below the thresholds. For example, if the standard out-of-pocket maximum is $5,500 and a lower $3,000 maximum applies to lower-income enrollees who meet the LIS eligibility requirements, then a beneficiary with an income at 160 percent of poverty would face a maximum amount that is $2,500 higher than a beneficiary with an income below 150 percent of poverty. Another limitation of using this approach to establish the lower-income out-of-pocket maximum amount is that many beneficiaries who might qualify for the Part D LIS do not apply for this assistance. As of 2009 (the last year for which data are available), only 40 percent of the estimated 3.8 million people who had to apply on their own for Part D LIS enrolled in the program.[15] Some of these unenrolled beneficiaries may not be aware of their eligibility, despite extensive outreach efforts on the part of the Medicare program, beneficiary organizations, and other stakeholder groups. Others may be discouraged from applying by the complexity of the eligibility determination process.[16] If otherwise-qualified beneficiaries do not apply for the lower out-of-pocket maximum, they would be subject to a higher maximum and thus exposed to higher out-of-pocket costs.

Certain steps could be taken to improve the share of eligible beneficiaries who actually apply for and obtain the lower out-of-pocket maximum. For example, CMS could send notices to beneficiaries as they approach the lowest out-of-pocket maximum amount to inform them that they may be eligible for this lower limit. Because few beneficiaries would reach the out-of-pocket maximum in a given year, this type of outreach would be targeted to the people who would benefit from the lower maximum amount. CMS also could encourage providers to reach out to their patients who may be eligible for the lower maximum amount. Having no asset test for the income-related spending maximum could simplify the cost and administrative burden associated with determining eligibility and also could expand the reach of the lower out-of-pocket maximum to a larger share of the low-income population.[17] In addition, the application process would be less complex if beneficiary income only and not assets were considered for purposes of eligibility for any given out-of-pocket maximum amount.

Basing an income-related out-of-pocket maximum on other income thresholds

Several proposals would implement a sliding-scale out-of-pocket maximum, using income thresholds that do not align with current income-based policies in Medicare. Implementing an income-related out-of-pocket maximum using thresholds other than those currently used for existing purposes in Medicare would first require that CMS develop a mechanism for determining beneficiaries' incomes. In doing so, policymakers and program administrators would need to make several key administrative decisions, such as how to define income for this purpose and collect income information and how frequently to reassess beneficiaries' incomes.

Information from federal income tax returns could be used to identify the appropriate income-related out-of-pocket maximum to apply to people on Medicare, although a separate process would be needed to ascertain the income of non-filers if maximums were created for income levels that fall below the filing thresholds. The 2013 filing thresholds are $10,000 for individuals under age 65, $11,500 for individuals age 65 and older, $20,0000 for married couples under age 65 filing jointly, and $22,400 for joint-filing married couples who are each age 65 and older.[18] One option would be to allow beneficiaries who do not file tax records to attest that their income for a given year fell below the filing threshold. IRS data would be used to verify that no tax return was filed, or that the beneficiary filed a return and their income was below the filing threshold. Alternatively, rather than having a process under which a large number of beneficiaries must attest to their income, CMS could assume that if no IRS data are available for a beneficiary for a year, they are presumed to meet the criteria as a non-filer and subject to the lowest out-of-pocket maximum. (IRS penalties apply to individuals who are required to file a return but fail to do so, and an individual who willfully fails to file a return may be subject to criminal prosecution.) Because there would be a lag between IRS income data and the calendar year to which the out-of-pocket maximum applied, CMS would need to develop a process for beneficiaries to appeal income determinations that are used to determine the out-of-pocket maximum (discussed below).

If federal income tax return information is used, CMS could potentially employ the same system that has been developed for administering the income-related premium subsidies available under the Affordable Care Act. Under that process, health care Marketplaces (also known as Exchanges) are able to access a data hub that allows them to make near real-time queries of the IRS tax return data and other government data sources in order to determine whether an individual is eligible for advance payment of the premium subsidy and cost sharing subsidies, including the applicable annual limitation on cost sharing.[19] CMS could potentially access the IRS data through the data services hub to determine the appropriate out-of-pocket maximum for each Medicare beneficiary that files a tax return.

Notifying Beneficiaries and Establishing Procedures for Appeals

Once CMS identifies each beneficiary's income-related maximum, it would need to communicate that information so that beneficiaries could anticipate their benefit package for the coming year. CMS could establish a new process for providing this information or it could use existing means of communicating with beneficiaries, such as through the quarterly Medicare Summary Notices (MSN), through the online claims history provided to beneficiaries through MyMedicare.gov, or as part of annual notices sent by the SSA to Medicare beneficiaries related to their Social Security benefits and Medicare premium amounts for the coming year. In addition, CMS could routinely contact beneficiaries who incur cost-sharing amounts that are nearing the lowest out-of-pocket maximum amount and give them an opportunity to apply at that time for the lower amount.

Because tax information in the data services hub will necessarily be at least one year old, it may not reflect the ability of a beneficiary to pay for their Medicare cost sharing in the upcoming year. In order to better capture beneficiaries' current income levels, CMS could establish an appeals process similar to the one used for determining the income-related premium that would allow a beneficiary to request a review if they believe they have been assigned an incorrect income-related out-of-pocket maximum. To be most helpful for beneficiaries' planning purposes, they would be able to appeal their out-of-pocket maximum amount in advance of the year to which it would apply. CMS would then also need procedures for informing beneficiaries when their out-of-pocket maximum has been reduced during the course of a year as the result of a successful appeal. In these cases, CMS would need to revise data in the Common Working File to take into account the new maximum. CMS also would need to establish a system for reprocessing claims and reimbursing beneficiaries and supplemental payers in cases where these groups paid for care that should have been covered by Medicare based on the corrected out-of-pocket maximum.

CMS may also want to establish a process for redetermining subsidy eligibility during a calendar year or making retroactive eligibility changes, and collecting any underpaid cost sharing from beneficiaries or supplemental payers in cases where a beneficiary is found not eligible for the lower out-of-pocket maximum they may have received in a given year. However, such collections could pose financial challenges for beneficiaries with modest resources.

Applying an Income-Related Out-of-Pocket Maximum in Medicare Advantage

Applying an income-related out-of-pocket maximum for Medicare Advantage plan enrollees would require a number of policy decisions and administrative changes. Medicare Advantage plans would need to obtain information from CMS to apply the appropriate income-based out-of-pocket maximum amount to each enrollee. Such information could be obtained by the Medicare Advantage plan as part of its data transaction with CMS (or a CMS contractor) when a beneficiary first enrolls in the plan. In this way, Medicare Advantage plans would know the broad ranges of their enrollees' incomes, but not the specific amounts for each individual, thereby reducing the possibility of inappropriate disclosure and perhaps mitigating privacy concerns to some extent (discussed below). Once the enrollee's maximum amount was provided to the plan, CMS or the plan would need to inform the beneficiary of their specific out-of-pocket maximum. This communication could also be required as part of plan enrollment materials sent to new and current enrollees. The plan would then track the enrollee's cost sharing in the same way as it does today. A process also would

need to be established for handling cases in which an enrollee's out-of-pocket maximum was changed during the course of a year as a result of a successful appeal of the initially assigned maximum. CMS would also need to adjust the monthly capitation payments to Medicare Advantage plans to account for the differences in expected plan expenditures for each group of enrollees by income, which may be similar to the current process of paying plans based on enrollees' health status (the risk adjustment process).

Coordinating with Supplemental Insurers: Medicaid, Medigap, and Retiree Health Plans

Compared with a uniform out-of-pocket maximum, income-relating the out-of-pocket maximum would add a layer of complexity for the Medicare program and Medicaid, employers, and other supplemental insurers. Retiree health plans and Medigap plans currently do not have or need the income of their enrollees to administer plan benefits. For beneficiaries in traditional Medicare, CMS may need to create a process for informing supplemental insurers of the applicable income-related out-of-pocket maximum, and would need new procedures for reprocessing Medicare claims and possibly repaying supplemental insurers and beneficiaries in situations where a beneficiary has successfully appealed for a lower out-of-pocket maximum after the beginning of the year.

Although Medicare's income-related premiums are determined in advance and the financial impact is predictable, the financial effects of the out-of-pocket maximum would be by definition more variable since they are tied to claims experience in a given year. Therefore, establishing an income-related out-of-pocket maximum would likely necessitate additional communications between all supplemental payers and enrollees, both through formal written communications and through call centers responding to beneficiary inquiries.

In terms of information sharing, it is unclear precisely what information CMS would need to provide to Medigap insurers or sponsors of retiree health plans. These plan sponsors may not need to know their enrollees' incomes or their applicable out-of-pocket maximum in order to pay claims because no action would be required of them when the maximum was reached. That is, the addition of an out-of-pocket maximum as a standard Medicare benefit would mean that for the small share of beneficiaries who reach the maximum, CMS would no longer forward claims to the supplemental carrier. Nevertheless, these plans may still have an interest in knowing when a beneficiary reached their out-of-pocket maximum; that is, when the plan no longer had any liability for Medicare-covered benefits for that enrollee for that year, particularly to address questions that might arise about claims for costs above the out-of-pocket maximum for which the plan had no liability. This would be true for state Medicaid programs as well. Therefore, supplemental payers may want to know each of their enrollees' out-of-pocket maximums in advance both to verify that CMS (or its contractors) handled claims accurately and, perhaps more importantly, to anticipate future liabilities. For Medigap insurers, accurately predicting enrollee expenditures is important both for setting plan premiums and for ensuring compliance with federal and state minimum medical loss ratio requirements. For retiree plans, having an accurate projection of current and future expenditures is necessary for meeting reporting and accounting rule requirements of the Federal Accounting Standards Board and the Governmental Accounting Standards Board. In the absence of enrollee-specific income information, these plans would have to make actuarial estimates in the first year of implementation based on income information on the general Medicare-age population and then subsequently adjust their expenditure projections based on actual claims experience.

Clarifying Retiree Health Plan Nondiscrimination Rules

Under an income-related out-of-pocket maximum, employer-sponsored retiree health plans that wrap around Medicare would potentially provide greater assistance to higher-income enrollees, given that such beneficiaries would receive more from the employer plan because they are getting less from Medicare until the point when they reached their higher Medicare out-of-pocket maximum. Regulatory guidance from agencies other than CMS (for example, the IRS) may be needed to clarify that retiree health plans coordinating with Medicare would not be in potential violation of federal nondiscrimination rules which apply a tax penalty in situations where a self-insured plan (or a fully-insured plan under pending regulations) discriminates in favor of highly-compensated employees with respect to either eligibility or benefits. These regulatory issues could presumably be anticipated and addressed in the underlying legislation establishing a Medicare income-related out-of-pocket maximum.

Addressing Concerns Related to Privacy of Beneficiary Income Information

Under an income-related out-of-pocket maximum, privacy of income information could be a concern to some beneficiaries. While Medicare Advantage and supplemental plans would not need to know their enrollees' specific incomes, knowing a beneficiary's out-of-pocket maximum—either because CMS provided it for all enrollees or because CMS provided notice regarding those who reached the limit—would disclose to insurers the approximate magnitude of their enrollees' income. A greater number of narrow income categories would be more revealing of personal information than a small number of broad income categories. To address privacy concerns, it has been suggested that beneficiaries who did not want their income category shared with supplemental insurers could be given the option to elect to have the highest out-of-pocket maximum apply to them regardless of the out-of-pocket maximum amount to which they might otherwise be entitled based on their actual income.[20]

Coordinating Activities among Administering Agencies

CMS, which oversees the Medicare program, is the logical agency to have primary responsibility for assigning beneficiary out-of-pocket maximums, either directly or indirectly through a contractor. Requisite administrative functions for this purpose might include: coordinating with the IRS for the purposes of obtaining beneficiary-specific income information; managing an application process to the extent that IRS data are not used for determining beneficiary income; determining the appropriate out-of-pocket maximum for each beneficiary; communicating that information to beneficiaries; and handling requests for redeterminations.

Other agencies may also need to play a significant role, particularly in carrying out functions relating to income determinations and appeals. As described above, CMS may need to obtain income tax information from the IRS. Depending on how the program is designed, CMS might also coordinate efforts with the SSA, which withholds Medicare premiums from beneficiaries' Social Security checks and administers the income-related Part B and Part D premiums and the Part D LIS. Assigning additional Medicare-related functions to the SSA for the income-related out-of-pocket maximum would add to the SSA's administrative caseload.

Applying a "TrOOP" Cost Methodology to the Medicare Out-of-Pocket Maximum

A limit on out-of-pocket spending, whether uniform or income-related, could be designed in a manner that would count only the direct contributions from beneficiaries toward the out-of-pocket maximum, excluding any payments made on behalf of the beneficiary by a supplemental payer. Under this so-called "true out-of-pocket" (TrOOP) methodology, a version of which is used in Medicare Part D, cost-sharing amounts covered by a supplemental insurer on behalf of a beneficiary would not count toward the beneficiary's annual out-of-pocket maximum.[21]

Using the TrOOP approach, federal expenditures associated with a new out-of-pocket spending limit for Medicare would be lower than they would otherwise be if third-party payments were taken into account. This is because beneficiaries who have some or all of their cost-sharing liabilities covered by supplemental payers would not reach the out-of-pocket maximum at the same spending level as beneficiaries without supplemental coverage, delaying the point at which Medicare becomes fully liable for their costs.

While federal savings would be greater under the TrOOP approach to the out-of-pocket maximum, administering the out-of-pocket maximum using this approach, whether uniform or income-related, would be more complicated for CMS, supplemental insurers, and beneficiaries. CMS would need to develop and use systems to track not only the beneficiaries' cost-sharing requirements, but also how much of those liabilities were paid by the beneficiary and how much by other payers. When Medicare forwards a claim to a supplemental payer, the payer would need to inform Medicare of the payments they are making to providers on a beneficiary's behalf. This would need to be done quickly so that Medicare claims systems properly recognize at all times whether a beneficiary has reached the out-of-pocket maximum, and so that beneficiaries could be promptly notified of their status with respect to the maximum. Within Part D, for example, there is a TrOOP facilitation process that functions in real time when beneficiaries submit a prescription to be filled at a pharmacy.[22]

Setting up a similar process for receiving information on supplemental payments made to the myriad medical providers of non-drug benefits would conceivably be much more complex and challenging. It also would add more administrative cost burdens to retiree health and Medigap plans for a process that would in fact prevent these plans from realizing significant savings from the out-of-pocket maximum. If similar real time interactions between Medicare and supplemental payers are not practical, CMS might have to reconcile claims for beneficiaries as they reach the TrOOP maximum. That is, if a beneficiary has in reality reached the TrOOP but Medicare systems do not record that event because the correct amount covered by supplemental payers has not yet been reported, Medicare would not be paying the full amount that it should. This could result in confusion for beneficiaries as to their out-of-pocket liability, as well as payment reconciliations with providers and supplemental payers. With respect to unassigned claims, such payment reconciliations may involve beneficiaries as well.

Processing claims for individuals who reach the out-of-pocket maximum would therefore be more administratively complex under the TrOOP approach, and could further discourage employers and unions from offering retiree health benefits—even more than with a new out-of-pocket maximum by itself. Under the TrOOP cost method, supplemental insurers, including Medicaid and employer plans, would continue to be

liable for cost sharing beyond the point at which their Medicare enrollees would have exceeded the Medicare out-of-pocket maximum. Thus, the TrOOP approach reduces the incentive among supplemental insurers, particularly employers and unions offering retiree health plans, to cover cost sharing for Medicare services because their contributions would not count toward the limit. Some have speculated that employers would respond by modifying benefits to ensure that retirees' high-end expenses were covered by Medicare, rather than the employer plan; by moving toward facilitated purchases of individual Medicare Advantage plans, stand-alone prescription drug plans, or Medigap policies to supplement traditional Medicare, or by dropping retiree coverage altogether. In contrast, an out-of-pocket maximum that does not use the TrOOP methodology would be expected to reduce the liability of third-party payers since Medicare would assume liability for costs above the maximum.

CONCLUSION

Some policymakers and analysts have expressed interest in modifying Medicare by adding a limit on beneficiary out-of-pocket spending. Adding an out-of-pocket maximum to Medicare would align Medicare with many large employer plans, provide beneficiaries with financial protection against catastrophic medical expenses, and potentially reduce the demand for supplemental coverage among beneficiaries. In adding a uniform out-of-pocket spending limit to Medicare, CMS would have relatively few new administrative tasks to implement. Adding a uniform out-of-pocket spending limit alone would require new federal expenditures for Medicare, however, absent other changes in Medicare's benefit design or unless other cost offsets were implemented concurrently.

One way to target resources to those with the greatest need would be to implement an income-related out-of-pocket maximum, rather than a uniform maximum. On the one hand, income-relating the out-of-pocket maximum, with lower maximum amounts for lower-income people, higher maximum amounts for higher-income people, or both, would provide greater protection against high medical expenses for those with limited incomes, thereby targeting federal dollars to beneficiaries with the greatest financial need. On the other hand, creating an income-related benefit structure would require new administrative procedures that might pose challenges for Medicare, supplemental payers, and beneficiaries. As recent experience with implementation of the ACA suggests, it would be important to consider these administrative issues carefully and establish procedures that would ensure smooth implementation prior to rolling out this new benefit.

This issue brief was prepared by Juliette Cubanski and Tricia Neuman from the Kaiser Family Foundation and Zachary Levinson, a former policy analyst at the Foundation.

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APPENDIX A: PROVISIONS RELATED TO RESTRUCTURING MEDICARE'S BENEFIT DESIGN THAT INCLUDE AN INCOME-RELATED OUT-OF-POCKET MAXIMUM IN RECENT DEFICIT-REDUCTION PROPOSALS

Erskine Bowles and Former Senator Alan Simpson (April 19, 2013). Would replace current Medicare cost sharing with a unified deductible, and uniform coinsurance up to an initial out-of-pocket maximum, with 5 percent coinsurance required for expenses between the initial limit and the out-of-pocket maximum. Would make the modifications to the benefit package such that the average out-of-pocket costs (including premiums) are held constant. Out-of-pocket maximums would be income-adjusted and low-income beneficiaries would have lower deductibles than higher-income beneficiaries.
Source: Moment of Truth Project, "A Bipartisan Path Forward to Securing American's Future," April 19, 2013

Senator Richard Burr and Senator Tom Coburn (February 16, 2012). Would unify Parts A and B with combined annual deductible of $550; set coinsurance rate equal to 20 percent up to an annual out-of-pocket total of $5,500 and coinsurance rate equal to 5 percent for out-of-pocket expenses between $5,500 and $7,500 per year; and establish an annual out-of-pocket maximum at $7,500. The out-of-pocket maximum would be greater for beneficiaries with incomes greater than $85,000/individual, $170,000/couple (ranging from $12,500 and $22,500). Includes a higher unified deductible for beneficiaries with incomes exceeding $1 million.
Source: Senator Richard Burr and Senator Tom Coburn, "The Seniors' Choice Act," February 16, 2012.

Center for American Progress (November 13, 2012). Would set annual out-of-pocket limits, ranging from $5,000 per year to $10,000 per year, based on beneficiaries' incomes. Would direct the Institute of Medicine to recommend additional improvements to align incentives with high-quality care. Would implement the changes such that average cost-sharing would not increase and the value of the benefit package would not decrease.
Source: Center for American Progress, "The Senior Protection Plan," November 13, 2012.

Commonwealth Fund (May 2013). Proposes a new option called Medicare Essential, which would combine Medicare's hospital, physician, and prescription drug coverage into an integrated benefit with an annual limit on out-of-pocket expenses for covered benefits. The standard limit of $3,400, would be reduced to $2,000 for individuals with incomes below 150 percent of the FPL.
Source: Karen Davis, Cathy Schoen, and Stuart Guterman, "Medicare Essential: An Option to Promote Better Care and Curb Spending Growth," Health Affairs, May 2013 32(5):900–9.

The Hamilton Project at the Brookings Institution (February 26, 2013). Would unify Parts A and B with a combined annual deductible of $525 and set the coinsurance rate above the deductible equal to 20 percent up to an annual out-of-pocket maximum. The maximum would vary by income, ranging from $1,983 for beneficiaries with incomes between 100 percent to 200 percent of the FPL to $5,950 for beneficiaries with incomes above 400 percent of the FPL. Deductibles for beneficiaries with incomes below 200 percent of the FPL would be reduced to $250. (Proposal authored by Jonathan Gruber)
Source: The Hamilton Project, "15 Ways to Rethink the Federal Budget," February 26, 2013.

Robert Berenson, John Holahan, and Stephen Zuckerman of the Urban Institute (March 7, 2013). Would set a maximum on beneficiaries' out-of-pocket expenses that would vary by income. Would reduce premiums and deductibles for beneficiaries with incomes below 300 percent of the FPL.
Source: Robert Berenson, John Holahan, and Stephen Zuckerman, "Can Medicare Be Preserved While Reducing the Deficit?" March 2013.

APPENDIX B: MEDICARE'S CURRENT CLAIMS PAYMENT PROCESS

Today, the payment of provider claims for people in traditional Medicare is typically handled as follows:

1. ***The provider, such as a hospital or physician, submits a claim to Medicare.*** A physician or supplier who does not "accept assignment" is not required to submit the claim to Medicare, in which case the beneficiary pays the provider and submits the claim. (Fewer than 1 percent of Medicare claims are unassigned.[23])
2. ***Medicare reviews the claim, calculates the amount it owes, and pays the provider accordingly.*** Medicare contractors record and process claims and track beneficiary cost sharing (e.g., a beneficiary's spending towards the Part B deductible) in the electronic "Common Working File."
3. ***Medicare coordinates with supplemental payers.*** The Common Working File contains information on beneficiaries' supplemental coverage (provided by beneficiaries and providers on Medicare claims and supplemented by information from insurers and Medicaid under a Coordination of Benefits Agreement). If a beneficiary has supplemental coverage, the Common Working File prompts the Medicare contractor to forward adjudicated claims to the Coordination of Benefits Contractor, which in turn transmits the information to supplemental payers.[24] Alternatively, if a claim is first submitted to a beneficiary's retiree plan, the claim will be transmitted by the plan to Medicare.
4. ***Supplemental payers wrap around Medicare coverage.*** After receiving an adjudicated claim from Medicare, the supplemental payer calculates any benefits it owes and pays the provider accordingly. (This discussion assumes that Medicare is the beneficiary's primary health coverage. That is generally the case, but is not true for beneficiaries who are working and covered by an employer health plan, or covered by an employer health plan as a dependent. In that case, and some others, Medicare is the secondary payer, and pays claims after the group health plan.) Supplemental payers have various methods for wrapping around Medicare's coverage:
    - *Medicaid* covers Medicare's cost-sharing requirements for "full duals" and some "partial duals," although cost sharing is only covered up to the amount Medicaid pays at states' discretion.[25]
    - The majority of *Medigap* policyholders are enrolled in either Plan C or Plan F, both of which cover all beneficiary cost sharing for Medicare-approved charges under Medicare Parts A and B.[26]
    - The vast majority of *employer-sponsored retiree health plans* that pay benefits directly coordinate with Medicare through the "carve-out" approach, under which the employer first calculates the benefit it would pay if the enrollee did not have Medicare, and then subtracts or "carves out" the Medicare payment. The result under this method is that retirees still have out-of-pocket obligations unless they reach the retiree plan's out-of-pocket maximum.[27]
5. ***Providers bill the beneficiary for any remainder.*** The beneficiary owes the provider either the full Medicare cost-sharing amount if they do not have supplemental coverage or the balance if their supplemental coverage does not cover the full cost-sharing amount. For an unassigned claim, the beneficiary pays the provider and is reimbursed by Medicare and any supplemental insurer.
6. ***Medicare notifies the beneficiary of claims payments.*** Medicare beneficiaries may review claims status through MyMedicare.gov, and receive a quarterly Medicare Summary Notice (MSN) through the mail or online.

APPENDIX C: MEDICARE'S CURRENT INCOME-RELATED FEATURES

How CMS Administers Income-Related Part B and D Premiums

Under Part B and Part D, Medicare beneficiaries are subject to higher premium amounts if their modified adjusted gross income (MAGI) exceeds a certain threshold. In 2014, the income-related thresholds are $85,000 for an individual and $170,000 for a couple. The Part B income-related premium ranges from 35 percent to 80 percent of total Part B per capita costs; the Part D income-related premium amounts are based on similar percentages.

The Social Security Administration (SSA) determines which beneficiaries are required to pay the income-related premium each year based on income tax data provided electronically by the Internal Revenue Service (IRS). When doing so, SSA relies on information from two to three years prior to the year in which the premium is being applied. For example, when determining the Part B and Part D income-related premiums in 2013, SSA relied on 2012 tax returns (reflecting 2011 income) or 2011 tax returns (reflecting 2010 income) if 2012 returns were unavailable. If a beneficiary is required to pay an income-related premium, SSA will send a notice informing them of the amount of the premium and how the premium was determined. SSA does not apply an income-related premium to beneficiaries who do not file income taxes. Such "non-filers" are mostly individuals who are not required to file tax returns because their incomes fall below certain thresholds.

The use of lagged tax return data means that actual beneficiary income for the year in which the income-related premium is applied may be lower or higher than it was during the year from which the electronic data base is available. No reconciliation is made on subsequent tax returns. However, under certain circumstances, an individual may request to base the determination of income on more recent income information. For example, if the beneficiary believes that the IRS has more recent information, the beneficiary may seek a correction from the IRS. Additionally, if a beneficiary can provide evidence that a qualifying life-changing event—such as the death of a spouse or retirement—significantly reduced his or her MAGI, the SSA will determine the Part B or Part D income-related monthly adjustment based on data from a more recent tax year.[28]

How Medicare Determines Eligibility for the Part D Low-Income Subsidy

The Part D Low-Income Subsidy (LIS) program assists enrollees with premiums and cost-sharing requirements under a Part D prescription drug plan. Beneficiaries can receive LIS benefits through either:

- **Automatic eligibility.** Beneficiaries may be automatically eligible for Part D LIS benefits if they already receive Supplemental Security Income benefits, full Medicaid coverage, or partial Medicaid coverage through the Medicare Savings Programs.
- **Application.** Medicare beneficiaries who are not automatically eligible may still receive LIS benefits if they have incomes below 150 percent of the federal poverty level and resources below a certain threshold.[29] In this scenario, beneficiaries need to apply annually through their state Medicaid agency or with the Social Security Administration (SSA).

ENDNOTES

[1] Kaiser Family Foundation," How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans: A 2012 Update," April 2012.

[2] Estimates from Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary Survey 2010 Cost and Use file.

[3] Marsha Gold, Gretchen Jacobson, Anthony Damico and Tricia Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," Kaiser Family Foundation, November 2013, http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums.

[4] Kaiser Family Foundation, "Medicaid's Role for Dual-Eligible Beneficiaries," August 2013, http://kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/.

[5] For an overview of recent Medicare deficit reduction proposals, see Kaiser Family Foundation, "Medicare and the Federal Budget: Comparison of Medicare Provisions in Recent Federal Debt and Deficit Reduction Proposals," October 2013, http://www.kff.org/medicare/issue-brief/medicare-and-the-federal-budget-comparison-of-medicare-provisions-in-recent-federal-debt-and-deficit-reduction-proposals/. For an analysis of the distributional implications of a restructured Medicare benefit design, see Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," November 2011, http://www.kff.org/medicare/report/restructuring-medicares-benefit-design/.

[6] Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023*, November 2013, http://www.cbo.gov/budget-options/2013/44687.

[7] A Medicare benefit redesign that puts in place a limit on combined Parts A and B cost sharing would also need to address the treatment of individuals who are not enrolled in both Parts A and B. Currently, about 4.2 million, or 8.3% of beneficiaries have Part-A only coverage and 330,000 or 0.6% have Part B only coverage. Individuals who are enrolled in Part A only often have employer-based coverage that is primary to Medicare. Unless all Medicare beneficiaries were treated as if they are enrolled in both parts, different out of pocket maximum amounts would need to be applied to these individuals. Data on numbers of enrollees from CMS, Medicare and Medicaid Statistical Supplement, 2013 Edition, "Table 2.1: Medicare Enrollment: Hospital Insurance and/or Supplementary Medical Insurance Programs for Total, Fee-for-Service and Managed Care Enrollees as of July 1, 2012," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013.html.

[8] Even if the out of pocket maximum for traditional Medicare was not applied to the Medicare Advantage program, changes would be needed to account for the increased actuarial value of the Part A and Part B benefit packages. This is because Medicare Advantage plans must provide benefits that are equal to those benefits.

[9] A higher "combination" amount of $10,000 applied in 2013 in the case of Medicare Advantage plans that are not closed network HMOS where beneficiaries may obtain covered services from out of network providers.

[10] Medicare Advantage plans cannot count Medicaid coverage of cost sharing towards the spending limit, meaning that enrollees with such coverage rarely reach the limit. Whether the limit applies to all Medicare Part A or B services received out-of-network as well as in-network depends on the type of Medicare Advantage plan.

[11] The Medicare Advantage annual maximum spending limits are based on a beneficiary-level distribution of Parts A and B cost sharing for individuals enrolled in traditional Medicare. The mandatory spending limit represents approximately the 95th percentile of projected beneficiary out-of-pocket spending for Calendar Year (CY) 2013. That is, five percent of traditional Medicare beneficiaries are expected to incur $6,700 or more in Parts A and B deductibles, copayments and coinsurance in CY 2013. The CY 2013 voluntary spending limit is $3,400. This level is based on the 85th percentile of projected traditional Medicare out-of-pocket costs. "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter", Centers for Medicare & Medicaid Services, April 2012, http://cms.gov/medicare/health-plans/healthplansgeninfo/downloads/2013-call-letter.pdf.

[12] Marsha Gold et al., "Medicare Advantage 2013 Spotlight: Plan Availability and Premiums," December 2012 http://kff.org/medicare/report/medicare-advantage-2013-plan-availability-and-premiums/.

[13] Kaiser Family Foundation/Medicare Payment Advisory Commission, "An Analysis of the Share of Medicare Beneficiaries Who Would Benefit from an Annual Out-of-Pocket Maximum Over Multiple Years," June 2013.

[14] For example, the modified adjusted gross income definition used for determining eligibility for a premium tax credit under the ACA counts all Social Security benefits. (See Internal Revenue Code §36B(d)(2)(B).) This is not true of the definition of adjusted gross income used for income tax reporting, or for the modified adjusted gross income definition used to determine Medicare's income-related premium. In those definitions, some or all Social Security benefits are excluded, depending on the individual's income level. At most, 85 percent of benefits are counted as income for these purposes. See Internal Revenue Service, "Are Your Social Security Benefits Taxable?", http://www.irs.gov/uac/Are-Your-Social-Security-Benefits-Taxable%3F.

[15] Laura Summer, Jack Hoadley, and Elizabeth Hargrave, "The Medicare Part D Low Income Subsidy Program, Experience to Date and Policy Issues for Consideration," The Henry J. Kaiser Family Foundation, September 2010, http://kff.org/medicare/issue-brief/the-medicare-part-d-low-income-subsidy.

[16] Laura Summer, Jack Hoadley, and Elizabeth Hargrave, "The Medicare Part D Low Income Subsidy Program, Experience to Date and Policy Issues for Consideration," The Henry J. Kaiser Family Foundation, September 2010, http://kff.org/medicare/issue-brief/the-medicare-part-d-low-income-subsidy.

[17] A report by the U.S. Government Accountability Office (GAO) examining requirements to increase enrollment in the Medicare Savings Programs (MSPs) for low-income beneficiaries cited the historically low level of participation in MSPs, attributable to lack of awareness about the programs and cumbersome enrollment processes through state Medicaid programs. The GAO report suggested that differences in how income and assets are counted for Medicare's LIS and MSPs can require additional work by implementing agencies at the state and federal level and can present a hurdle to applicants. See *Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment*, September 2012, http://www.gao.gov/products/GAO-12-871.

[18] Other thresholds may apply. See Internal Revenue Service, "Exemptions, Standard Deduction, and Filing Information For use in preparing 2013 Returns", Publication 501, Dec 3, 2013. http://www.irs.gov/pub/irs-pdf/p501.pdf.

[19] Oral Statement of Danny Werfel, Principal Deputy Commissioner, on the Affordable Care Act Before the House Ways and Means Committee, August 1, 2013. http://www.irs.gov/uac/Newsroom/Oral-Statement-of-Danny-Werfel,-Principal-Deputy-Commissioner,-on-the-Affordable-Care-Act-Before-the-House-Ways-and-Means-Committee.

[20] Jonathan Gruber, "Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare," The Hamilton Project, 15 Ways to Rethink the Federal Budget, February 26, 2013.

[21] In Part D, costs paid by a beneficiary or on behalf of the beneficiary by certain entities count towards TrOOP, but not payments by group health plans or other forms of insurance. For more information about how TrOOP works in Part D, see Centers for Medicare & Medicaid Services, "Understanding True Out-of-Pocket Costs," November 2012, http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11223-P.pdf.

[22] For additional detail about coordination of benefits and the TrOOP facilitation process in Part D, see Centers for Medicare & Medicaid Services, "Medicare Prescription Drug Benefit Manual, Chapter 14 – Coordination of Benefits," http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/PDMChapt14COB.pdf.

[23] CMS, CMS Data Compendium, 2011, "Table VI.7: Medicare Assigned Claims Selected Fiscal Years" http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html.

[24] A Medicare beneficiary who has a Medigap policy may authorize a Medicare-participating physician, provider, or supplier of services to file a claim on his or her behalf and to receive payment directly from the insurer instead of through the beneficiary.

[25] Gretchen Jacobson, Tricia Neuman, and Anthony Damico, "Medicare's Role for Dual Eligible Beneficiaries," Kaiser Family Foundation, April 2012, http://kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries.

[26] However, Plan C doesn't pay the 15% cost sharing that some providers charge over and above the Medicare-approved charge. See Jennifer T. Huang et al., "Medigap: Spotlight on Enrollment, Premiums and Recent Trends," Kaiser Family Foundation, April 2013, http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries.

[27] For most retiree plans, the carve-out method has replaced the standard coordination of benefits method used in the past under which retirees would generally pay no cost sharing. Under the standard method, the plan pays the balance due the provider after Medicare has paid, up to a limit equal to the total the plan would ordinarily pay. Of the 57% of retiree plans that pay claims directly, only 5% use the standard coordination of benefit method; 53% use the carve-out method and 1% use the exclusion method, under which the retiree obligation falls somewhere in between. Other forms of employer retiree coverage include providing Medigap plans (25%), Medicare Advantage plans (7%), individual plans (3%), and health care accounts (6%). See Dale H. Yamamoto, "Employer-Sponsored Retiree Health Coverage," April 2013, http://nhpf.org/uploads/Handouts/Yamamoto-slides_04-12-13.pdf.

[28] To appeal a SSA determination related to the income-related monthly adjustment amount (IRMAA), the beneficiary or his or her representative must file a request for reconsideration within 60 days of receipt of an IRMAA determination notice. For requests received outside of the allowable timeline, SSA or HHS (for appeals beyond reconsideration) determines whether to establish good cause for late filing. Social Security Online, Overview of the Appeals Process for the Income-Related Monthly Adjustment Amount, https://secure.ssa.gov/apps10/poms.nsf/lnx/060114000.

[29] 42 CFR 423.773(b)(2)(ii).