Fact sheet

Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199-P)

Apr 22, 2022

On April 22, 2022 the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to implement sections of the Consolidated Appropriations Act, 2021 (CAA) that would simplify Medicare enrollment rules and extend coverage of immunosuppressive drugs for certain beneficiaries. Section 120 of the CAA makes changes to Traditional Medicare by revising the effective dates of coverage and giving the Secretary of the Department of Health and Human Services (the Secretary) the authority to establish new special enrollment periods (SEPs) for individuals who meet exceptional conditions. Section 402 of the CAA extends immunosuppressive drug coverage under Part B for certain individuals whose Medicare entitlement based on end-stage renal disease (ESRD) would otherwise end 36-months after the month in which they received a successful kidney transplant provided they do not have certain other health coverage. This rule also proposes other non-CAA related changes to improve state payment of Medicare premiums, and a technical change related to how enrollment forms are referenced in regulations.

These proposals support the Biden-Harris Administration's vision for CMS: to serve the public as a trusted partner and steward, dedicated to advancing health equity, expanding access to affordable coverage and care, and improving health outcomes. If finalized, the proposed changes to implement the CAA would expand coverage for people with Medicare and advance equity by reducing gaps of coverage, providing relief to individuals who miss a Medicare enrollment period due to an exceptional condition, and providing access to immunosuppressive drugs for individuals who are no longer

eligible for Medicare on the basis of ESRD after a successful kidney transplant and have no other coverage.

The proposed rule can be downloaded from the Federal Register at: https://www.cms.gov/files/document/cms-4199-p.pdf

Section 120 of the CAA – Beneficiary Enrollment Simplification

In general, under current rules, the date when an individual's coverage becomes effective depends on when they enroll:

- If an individual enrolls during any of the first three months of their Initial Enrollment Period (IEP), their coverage will be effective the first month of eligibility (e.g., age 65).
- If an individual enrolls during their IEP in the month they become eligible, their coverage will be effective the month after they sign up.
- If an individual enrolls during any of the last three months of their IEP, their coverage will be effective 2-3 months after they sign up.
- If an individual enrolls during the General Enrollment Period (GEP), which runs from January 1st through March 31st every year, enrollments are effective July 1st.

As mandated in Section 120 of the CAA and proposed for implementation in this rule, beginning January 1, 2023, Medicare coverage will become effective the month after enrollment for individuals enrolling in the last three months of their IEP or in the GEP, thereby reducing any potential gaps in coverage.

Section 120 of the CAA also gave the Secretary the authority to establish SEPs in the case of individuals who meet such exceptional conditions as the Secretary may provide. In this rule, CMS is proposing SEPs that would provide individuals who meet certain exceptional conditions and who missed a Medicare enrollment period an opportunity to enroll without having to wait for the GEP and without being subject to a late enrollment penalty (LEP).

Specifically, CMS is proposing the following SEPs

- An **SEP for Individuals Impacted by an Emergency or Disaster** that would allow CMS to provide relief to those beneficiaries who missed an enrollment opportunity because they were impacted by a disaster or other emergency as declared by a Federal, state, or local government entity.
- An **SEP for Health Plan or Employer Error** that would provide relief in instances where an individual can demonstrate that their employer or health plan materially misrepresented information related to enrolling in Medicare timely.
- An **SEP for Formerly Incarcerated Individuals** that would allow individuals to enroll following their release from correctional facilities.

- An **SEP to Coordinate with Termination of Medicaid Coverage** that would allow individuals to enroll after termination of Medicaid eligibility.
- An **SEP for Other Exceptional Conditions** that would, on a case-by-case basis, grant an enrollment period to an individual when circumstances beyond the individual's control prevented them from enrolling during the IEP, GEP or other SEPs.

These proposals would expand Medicare enrollment opportunities and reduce multi-month coverage gaps in Medicare.

Section 402 of the CAA - Extended Months of Coverage of Immunosuppressive Drugs for Kidney Transplant Patients and Other Renal Dialysis Provisions

The majority of individuals with ESRD are eligible for Medicare, regardless of age. When an individual receives a kidney transplant, Medicare coverage extends for 36 months but is then terminated unless the individual is otherwise entitled to Medicare (based on age or disability). As mandated by Section 402 of the CAA, and proposed for implementation in this regulation, an individual who does not have other health insurance coverage would be eligible to enroll in Part B beyond the 36-month post-transplant period for the limited purpose of getting Part B coverage for immunosuppressive drugs. CMS is referring to this benefit as the immunosuppressive drug benefit, or the Part B-ID benefit. If the proposed policy is finalized, eligible individuals can enroll in the new immunosuppressive drug benefit beginning in October 2022 and coverage would start as early as January 1, 2023.

As outlined in this proposed rule, the new immunosuppressive drug benefit would have the following features:

- There would be no specific enrollment periods; if an individual is eligible, they can enroll (or disenroll) at any time.
- The benefit would only cover immunosuppressive drugs and would not include coverage for any other Part B benefits or services.
- An individual would be required to attest that they are not enrolled in, and do not expect to enroll in, certain other types of coverage (e.g., group health plan, TRICARE, or a Medicaid state plan that covers immunosuppressive drugs) and that they will provide notification to the Social Security Administration (SSA) within 60 days if they sign up for such other coverage (thereby ending their enrollment in Medicare).
- The premium would be less than the standard Part B premium, and enrollees would not be subject to late enrollment penalties.
- Individuals eligible for certain Medicare Savings Programs (MSPs) can receive coverage of the immunosuppressive drug benefit premium, and for Qualified Medicare Beneficiaries (QMBs), cost sharing as well.

Regulations Related to Medicare Enrollment Forms

Current regulations list every form that is used to enroll in Medicare Parts A and B and provides a brief description of the use of the form. As identifying each form in regulation makes it challenging for CMS and SSA to update forms and to quickly adapt to more efficient uses of each form, CMS is proposing to revise regulations to remove these specific references. This is an administrative change that would simplify existing regulations and would have no impact on use or availability of these forms. Nor would the change affect current eligibility requirements or enrollment processes.

State Payment for Medicare Premiums

CMS is proposing to update the various regulations that affect a state's payment of the Medicare Part A and B premiums on behalf of 10 million low-income individuals (often known as "state buy-in"). These changes would better align the regulations with federal statute, policy and operations that have evolved over time. By clarifying and streamlining existing requirements, these proposals would promote access to affordable health coverage and essential medical treatment and improve health equity for underserved populations.

The proposals would simplify state administration by:

- **Defining the State Plan as Meeting the Requirement for 'Agreement' with CMS.** While the Secretary and all states initially signed free-standing buy-in agreements, none have been amended since 1992. Instead, CMS and states have used the Medicaid state plan and state plan amendments to document the buy-in policy in each state. CMS is proposing to officially replace the old stand-alone agreements by **s**pecifying that the provisions of a state buy-in agreement shall be set forth in the state's Medicaid state plan. Consolidating state buy-in policy in one document per state promotes clarity and transparency for states, the federal government, and beneficiaries, and enhances accountability for state payment of Medicare premiums on behalf of low-income individuals.

- **Limiting Retroactive Liability of States.** From time to time, SSA establishes retroactive Medicare Part A entitlement for Medicaid beneficiaries as part of disability determinations. This action can make states liable for retroactive Part B premiums going back several years. It can also increase administrative work for providers and payers involving recoupment, billing, and claims processing. CMS is proposing to limit retroactive Medicare Part B premium liability for states to 36 months for full-benefit dually eligible beneficiaries. This proposal would reduce burden on providers and would help state Medicaid programs and the Medicare program run more efficiently.

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