



Consumers Face Inadequate Protections

Concerning Medicare Part D Enrollment and/or Disenrollment Problems

NOVEMBER 2005

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California Health Advocates (CHA) is a nonprofit organization dedicated to timely and responsive education and advocacy efforts on behalf of California Medicare beneficiaries and the pre-retirement population.

Medicare Rights Center (MRC) is the nation's largest independent source of Medicare information and assistance for people with Medicare. Founded in 1989, MRC helps older adults and people with disabilities get high-quality, affordable health care.

NOTE: *This Issue Brief is the first in a series on Medicare drug benefit issues for consumers drafted by California Health Advocates and the Medicare Rights Center, with support from the California HealthCare Foundation.*

INTRODUCTION

The Medicare Modernization Act (MMA) of 2003 adds an outpatient prescription drug benefit to the Medicare program starting January 1, 2006. The new drug benefit signals the most profound change to Medicare since the program's inception in 1965.

The design of the benefit will require important decisions by the more than 40 million persons with Medicare across the country (including 4.2 million individuals in California). First, the benefit is voluntary, and individuals must decide whether they should enroll in the Medicare drug coverage at all. The answer will vary based on a variety of factors, including whether individuals have other coverage and whether they qualify for low income subsidies. The answer will also depend on people's willingness to risk going without drug coverage and pay premium penalties and face enrollment restrictions should they choose to sign up later. Second, because the benefit is only available through private drug plans, consumers must join a private plan if they want Medicare drug coverage. There are multiple drug plans in each area that will differ in structure, benefits, and costs (in Los Angeles County, for example, there will be approximately 80 plans to choose from). Consumers are required to compare plans and choose the most appropriate benefits from a complex array of choices.

This issue brief, the first in a series by California Health Advocates and the Medicare Rights Center, explores key

decisions concerning the drug benefit for consumers. It describes how the drug benefit's complexity and administration through private plans will cause enrollment and disenrollment problems that could leave persons without drug coverage or with inadequate drug coverage and high out-of-pocket expenses. The brief then evaluates the inadequacy of existing legal protections to address these problems and concludes with proposals to strengthen existing protections. Future briefs will explore in more detail consumer protections found in the Medicare statute, regulations and program rules.

Background

Beginning this January 1, 2006, people can obtain Medicare drug coverage by joining one of two types of private plans—stand-alone prescription drug plans that only provide drug coverage (PDPs) and private health plans (Medicare Advantage [MA]), most typically an HMO that provides all Medicare-covered services, including doctor, hospital and drug coverage. In some cases an MA plan that doesn't provide drug coverage, such as a private fee-for-service plan, will require the additional purchase of a free-standing PDP.

Individuals can only choose Medicare drug coverage or change Medicare drug plans during designated enrollment periods: their Initial Enrollment Period (IEP—when they first qualify for Part D), or during an Annual Coordinated Election Period (AEP—November 15, 2005 through May 15, 2006,

for the program's initial year, and November 15 through December 31 in 2007 and beyond). Additionally, outside of the Annual Coordinated Election Period, persons with Medicare will have one chance to change their Medicare health plan choice (Original Medicare or Medicare Advantage plan) during the Open Enrollment Period (OEP - January through June 2006 and January through March in 2007 and beyond). Certain groups of Medicare consumers will qualify for Special Enrollment Periods (SEPs) to enroll into and disenroll from plans outside of the designated periods. These include persons who lose employer-sponsored coverage, persons with full Medicaid or a Medicare Savings Program, or nursing home residents.

Outside of designated enrollment periods, most individuals will be "locked in" to their plans. If they find their drug coverage is inadequate or if their provider network changes, individuals could wait up to a year until they are able to change plans. Similarly, consumers who delay joining a plan could be forced to wait up to a year until they reach an enrollment period and can enroll in a plan.

Further, delaying enrollment in the Medicare drug coverage could expose an individual to higher costs if they decide to join a plan later. Individuals will incur a premium penalty if they enroll after their Initial Enrollment Period and did not have coverage for 63 days or more that is at least as good as Medicare's standard drug coverage (creditable coverage). The penalty will be at least 1 percent for every month that enrollment is delayed.¹

To enroll in the Medicare drug benefit, individuals need to file an application with a plan. During designated enrollment periods, plans must generally accept applicants in their service area who complete the application form and qualify for Medicare drug coverage.² Because there is no government alternative or default plan, failure to enroll in or stay enrolled in a private drug plan will prevent access to any Medicare drug coverage. In contrast, individuals who are unable to enroll in MA plans have been able to access their medical benefits under Parts A and B through original Medicare.

Individuals with limited income and resources can qualify for a low-income subsidy (LIS) program—or "Extra Help"—that will pay for some or all of their Medicare prescription drug plan premiums, deductibles and cost-sharing. Dual eligibles (individuals with both Medicare and Medicaid [Medi-Cal in California]), and those who have a Medicare Savings Program, or SSI will automatically qualify for Extra Help and do not need to apply for it. All other low-income Medicare consumers must actively apply through the Social Security Administration or their state Medicaid program.

Dual eligibles currently get most of their prescription drug coverage through the Medicaid program, but will lose their Medicaid drug coverage at the end of 2005. They will be automatically enrolled into Medicare prescription drug plans, effective January 1, 2006 unless they decline Medicare drug coverage altogether or chose a Medicare drug plan themselves. In late October/early November 2005, dual eligibles will receive a notice explaining what plan they will be automatically enrolled in if they do not choose a plan themselves by the end of 2005. Although they have an ongoing right to switch plans, their choices will be limited to plans with basic coverage and premiums at or below the Extra Help premium amount in the region— \$23.25 in CA —unless they are able to pay for a higher cost plan. Extra Help will not cover the full cost of premiums for basic coverage plans with a monthly premium above a state's Extra Help premium amount or for enhanced plans that provide supplemental benefits, even if such plans cost less than the Extra Help premium amount.

KEY DECISIONS

Should I Enroll in the Medicare Drug Benefit?

Since the Medicare drug benefit is voluntary, persons with Medicare must decide whether they want to enroll in it. This decision will require persons to analyze multiple issues, including: their eligibility for Extra Help; coordination between their existing coverage (if any) and a Medicare drug benefit; their current drug usage and costs; and the impact of premium penalties and enrollment restrictions with delayed enrollment. Whether the drug benefit will help an individual depends on his or her circumstances. For example, persons who qualify for the Extra Help and have no other drug coverage would probably want to sign up for the drug benefit since it will lower their drug costs significantly, and delaying enrollment could expose them to premium penalties. Similarly, dual eligibles with no other coverage will likely want the Medicare drug benefit to maintain their drug coverage once their Medicaid drug coverage terminates.

However, persons with existing coverage, such as employer-sponsored plans that have coverage that is as good as or better than Medicare's would probably want to decline the Medicare drug coverage to avoid having more limited coverage and higher out-of-pocket costs. The same is true of people with either Department of Veterans' Affairs benefits or TRICARE coverage for current or retired active duty military, which offer greater coverage than the Medicare drug benefit. Persons who lose this coverage will be able to enroll in the Medicare drug benefit through a Special Enrollment Period and avoid premium penalties as long as they enroll within 63 days of losing coverage.

Example: Mr. R

Mr. R, an individual with disabilities who is under age 65, is dually eligible for Medicare and Medi-Cal (Medicaid) and, as an adult disabled child, also receives coverage through his father's former employer. In November 2005, Mr. R receives a notice from Medicare advising him which Medicare drug plan he has been automatically assigned to. Mr. R's father realizes that if his son is enrolled in a Medicare drug plan, Mr. R will lose the retiree coverage under the former employer's health plan rules. Mr. R's father calls 1-800-MEDICARE and is told (erroneously) that he must wait until the auto-assignment is effective (1/1/06) before he can decline Medicare drug coverage. When Mr. R's auto-enrollment in a Medicare drug plan becomes effective in January 2006, he loses his retiree coverage and is unable to get it back.

Example: Mr. G

Mr. G is 70 years old and has Medicare as well as retiree coverage through his former employer. His retiree coverage supplements Medicare's medical coverage and includes prescription drug coverage. Although Mr. G's former employer offers drug coverage that is creditable (considered at least as good as Medicare's drug coverage), it chooses not to apply for the federal retiree subsidy. In late 2005 and early 2006, Mr. G is bombarded with marketing materials from various Medicare drug plans as well as advertisements and messages from the federal government, all urging him to enroll in a Medicare drug plan. Mr. G enrolls in a Medicare drug plan in May 2006, erroneously believing that it will merely supplement his retiree coverage. Once Mr. G enrolls in the Medicare drug plan, however, his former employer terminates his retiree coverage and he is unable to get it back. Not only does Mr. G lose his retiree prescription drug coverage, he loses all the supplemental medical coverage his plan provided.

Example: Mr. C

Mr. C is a 75 year-old nursing home resident who is dually eligible for Medicare and Medi-Cal (Medicaid) and has retiree coverage. His wife, age 63, relies on Mr. C's retiree coverage as her primary and only health insurance. Mr. C's former employer notified him that his retiree coverage is creditable, but that he will lose it if he enrolls in a Medicare drug plan. Since Mr. C is a dual eligible, Medicare has assigned Mr. C to a Medicare drug plan. If he does not opt out of the plan before January 1, 2006, his retiree coverage will terminate and his wife will lose her coverage. If he does opt out of the Medicare drug plan, he will pay more for his medications because Medicaid will no longer supplement his retiree coverage.

will offer Medicare's basic coverage while others will offer enhanced coverage with supplemental benefits. Further, some plan sponsors have contracts with other companies to "co-brand" their drug plan. A dozen or more insurance companies may be selling the same drug plan, some in combination with other products they sell, such as a Medigap policy, making it even more difficult for consumers to differentiate among the Medicare drug benefit packages and other products.

Benefits, plan designs, formularies and cost utilization tools will vary considerably from one private plan to another. In practice, consumers will be unable to make side-by-side comparisons. Instead, comparing one plan with another will be similar to trying to compare apples with beefsteak. Comparisons and plan selection from among scores of plans and combinations of plans and benefits will challenge even the savviest individuals. Complicating the selection process is the fact that many persons with Medicare have limited or low functional literacy³ and 23 percent are cognitively impaired.⁴ The process of comparing health plan benefits gets harder as an individual ages regardless of income or education.⁵

Additional Challenges to Making an Informed Choice

Making an informed choice about Medicare drug coverage will be further complicated by the information and marketing materials consumers receive. The market system created by the MMA and the Centers for Medicare and Medicaid Services (CMS) dictates that the self-interests of private drug plans, third party contractors, marketers, and agents

will be to sell to consumers their product, rather than determine the best choice for the individual. (CMS will pay plans per enrollee without regard to whether or not a plan is suitable for a particular enrollee.) Although CMS will monitor complaints involving marketing abuses by prescription drug plan sponsors, it is allowing plan sponsors immense latitude in their marketing, which opens the door to aggressive or misleading marketing practices. For example, cold telephone calling is

Which Plan Is Best for Me?

If individuals decide to enroll in the Medicare drug benefit, they will have to overcome many challenges in selecting the best plan for them. In California, there will be numerous plans that differ in structure, benefits, and cost-sharing (18 sponsors will offer 47 different stand-alone prescription drug plans (PDPs); in addition, there will be between 2 and 34 different Medicare Advantage plans to choose from, varying by county). Some plans

permitted by plans and their third party contractors and companies can also market non-health and non-Medicare-related products and services to Medicare consumers. People could mistakenly believe that Medicare had endorsed the products and feel pressured to purchase them to get Medicare drug coverage. Alternatively, people may decline to join a Medicare drug plan because they do not want the additional services. Further, there is a danger that people could be tricked or coerced into releasing personal information, leaving them vulnerable to identity theft. Individuals may also unknowingly agree to face-to-face meetings at home where they will be more vulnerable to high-pressure sales tactics.

In addition, since the program is new, complicated, and needs to get off the ground quickly, consumers are bound to receive incorrect information about it—even from official sources. For example, during the month of October 2005, CMS made notable errors in widely circulated materials for consumers. A CMS Parade Magazine insert inflated the value of the drug benefit⁶ and contained a dangerously inaccurate statement about when people could safely decline coverage. And in the Medicare & You 2006 handbook sent to every person with Medicare, CMS incorrectly stated that persons who receive Extra Help would pay no Medicare drug plan premium, regardless of the plan they enrolled in.⁷

Further, a prime source of information will come from the 800-Medicare hotline, but the Government Accountability Office has noted a high error rate in the information conveyed by the hotline.⁸ CMS is also relying on multiple community-based organizations to counsel consumers. This means that groups with limited funding and little prior Medicare experience may end up giving inaccurate or incomplete information to consumers. Other organizations that purport to provide “educational” services, are funded by pharmaceutical and health insurance companies or have exclusive arrangements with chain pharmacies with incentives to either steer people toward certain products or increase the overall number of enrollments into Medicare drug plans, even if such enrollment is not the best option for individuals. Confusion about the complex new drug benefit will lead to misinformation given to individuals by both government and private entities, which could lead people to make inappropriate choices about whether to enroll in the drug benefit and which plan is best for them.

Inadequate Consumer Protections

CMS regulations and policy guidance do not adequately protect consumers who are affected by enrollment and disenrollment mistakes and actions (including misinformation from Medicare drug plans, the government or other entities).

No Appeal Rights

People harmed by enrollment and disenrollment disputes lack adequate appeal rights to challenge plan actions. Because people can only get Medicare drug coverage by joining a private drug plan, individuals kept out of or dropped from plans will lose access to Medicare drug coverage altogether. Fundamental constitutional principles buttressed by U.S. Supreme Court precedent require adequate notice and legal recourse when persons lose access to a governmental benefit, such as the Medicare drug benefit. Yet, CMS procedures do not comply with these constitutional requirements.

At a minimum, legal procedures must allow individuals to present evidence and have a decision reviewed by an independent entity that did not make the initial decision.⁹

However, individuals' Medicare drug benefit enrollment/disenrollment problems are only subject to plan “grievance” processes. Unlike Medicare appeals, Medicare grievance processes are handled entirely by plans (the same profit-driven entities that made the challenged decisions in the first place) and are not subject to independent review. In addition, Supreme Court precedent requires that appeal rights for individuals losing a means-tested benefit, such as the Extra Help, include a hearing prior to the termination.¹⁰ While CMS does require the grievance process to include a hearing in disenrollment cases, it does not require that the hearing occur before the termination or include the opportunity to present evidence.

While enrollment disputes for Parts A and B are subject to appeal, CMS has explicitly rejected requests to create an appeals process for individuals who are denied enrollment by a Part D plan. Instead, the Medicare drug benefit is modeled after the Medicare Advantage program, which does not allow for such appeals.¹¹ However, much more is at stake for individuals who fail to enroll in a Medicare drug plan than those who fail to enroll in a particular MA plan but still have their Parts A and B medical benefits. Simply put, there is no government alternative to provide a drug benefit if an individual fails to enroll in a Medicare drug plan. Instead, as with persons denied Medicare Parts A and B, persons kept out of a Medicare drug plan will lose access to the Medicare drug benefit altogether.

Special Enrollment Periods

Short of an appeals process, CMS could mitigate harm from enrollment errors by allowing persons a special enrollment period (SEP) to enroll outside of designated enrollment periods. CMS could also waive any premium penalty due to gaps in coverage caused by enrollment errors. Currently, CMS regulations provide an SEP and an opportunity for a premium penalty waiver only in cases where persons receive inaccurate information

about whether their insurance is creditable or not.¹² CMS regulations do allow for a special enrollment period for Part D if an individual's enrollment (or non-enrollment) is "unintentional, inadvertent, or erroneous because of the error, misrepresentation, or inaction of a Federal employee, or any person authorized by the Federal government to act on its behalf."¹³ But CMS fails to waive premium penalties in these cases even though the statute clearly envisions this protection.¹⁴ Also, except for gross marketing abuses and errors caused by plans or other entities, CMS will not permit an SEP or premium penalty waivers when such non-governmental entities fail to act or provide misinformation.

persons could end up paying more or forgoing needed medications.

Existing protections fail to adequately protect consumers from the consequences of these problems. CMS should strengthen these protections by:

- √ establishing an appeals process for enrollment and disenrollment cases;
- √ allowing premium penalty waivers due to gaps in coverage when the government causes an enrollment error;
- √ providing Special Enrollment Periods when private plans and other entities give incorrect information that cause enrollment mistakes or inappropriate choices by consumers.

Future issue briefs in this series will further explore these, and other, issues.

Example: Mrs. H.

Mrs. H., seeking general information about enrollment into Medicare prescription drug plans, calls the Medicare-800 hotline. She is told (erroneously) by a 1-800-Medicare customer services representative that the last day to apply without a penalty is August 15, 2006. Mrs. H. waits until August 1, 2006 to try to enroll in a Medicare drug plan, but is told by the plan that she missed the designated enrollment period (which ended on May 15, 2006). Mrs. H. complains to her regional CMS office and files a request for a special enrollment period (SEP) allowing her to enroll in a Part D plan outside of a designated enrollment period. Because she was misled by a government actor (the Medicare-800 customer service representative), CMS grants Mrs. H's SEP, but she must still pay the premium penalty because of the gap in coverage.

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Example: Mrs. P

Mrs. P knows that a new Medicare prescription drug benefit is coming, but she is hesitant to commit to any one plan for an entire year. While shopping around and comparing different Medicare prescription drug plans, she is told (incorrectly) by an Acme PDP representative that she will be able to change PDPs on a monthly basis. Based on this information, she enrolls in Acme's PDP but later learns in August 2006 that she cannot, in fact, change plans on a monthly basis. In addition, she discovers that her PDP does not cover the drugs she is increasingly relying upon. Since her incorrect information came from the private plan, not a federal employee or representative, under CMS rules, Mrs. P. does not get a Special Enrollment Period and must wait until the next Annual Enrollment Period (November 15 through December 31, 2006) to select a new plan, and until January 1, 2007, for the new coverage to start.

Conclusion

The Medicare drug benefit will require complicated decisions by people with Medicare to get the medications they need. Individuals will have difficulty getting correct information in a short period of time, through a myriad of public, private and commercial entities. The challenges of making an informed choice could lead people to make inappropriate decisions about whether to participate in the drug benefit at all or to choose plans that do not meet their needs. As a result,

FOOTNOTES

- 1 42 C.F.R. §423.286(d)(3). In 2006 and 2007, the premium penalty will be 1 percent of the national average premium amount for every month of delayed enrollment. After 2007, CMS may choose to increase the premium penalty. 70 Fed. Reg. 13397 (March 21, 2005). In 2006 the national average premium amount is \$32.20 whereas CA's average premium amount is \$25.41.
- 2 Centers for Medicare and Medicaid Services, "Part D Enrollment and Disenrollment Guidance" -- Final (08/30/05) November 8, 2005 found at http://www.cms.hhs.gov/pdps/PDP_enrollmentguidance+exhibits_FINAL_8-29-05.pdf; Centers for Medicare and Medicaid Services, "Medicare Managed Care Manual, Chapter 2" November 8, 2005 found at http://www.cms.hhs.gov/manuals/116_mmc/mc86c02.pdf
- 3 Kristen M. Kiefer, "Health Literacy: Responding to the Need for Help", Center for Medicare Education, February 2001. This brief indicates that, although no national studies have been conducted, smaller studies indicate that low health literacy is particularly problematic for the Medicare population. A study conducted at two public hospitals found that 81 percent of patients age 60 and older have inadequate or marginal functional health literacy (Williams, 1995); sixty-six percent of adults age 60 or over have inadequate or marginal health literacy based on findings in the National Adult Literacy Survey, Center for Health Care Strategies, Who Has Health Literacy Problems, 1997, on November 8, 2005 found at http://www.chcs.org/usr_doc/FS2.pdf
- 4 Stuart and Briesacher, estimates based on 2000 MCBS; Medicare Current Beneficiary Survey, 1997-2002; Low-income estimate from Urban Institute based on March 2003 Current Population Survey; Presented by Tricia Neuman on January 2005 for KaiserEDU.org, November 8, 2005 found at www.kaiseredu.org/uploadedFiles/Medicare_Rx_Bill.ppt
- 5 Judith H Hibbard and Slovic, P, Peters, E, Finucane, M.L., and Tusler, M. "Is the Informed-Choice Policy Approach Appropriate for Medicare Beneficiaries?," Health Affairs, May/June 2001; 20(3): 199-203.
- 6 The national circulation of an insert in the Sunday, September 25, 2006, Parade magazine. The insert, introducing "Medicare Rx, Prescription Drug Coverage," CMS Publication No.11160, is an announcement and general overview of the Medicare Part D benefit.
- 7 NOTICE OF ERRATA "MEDICARE & YOU 2006" HANDBOOK; November 8, 2005 found at <http://www.cms.hhs.gov/partnerships/tools/materials/publications/erratas/noe100305.pdf>
- 8 Government Accountability Office "Medicare: Call Centers Need to Improve Responses to Policy-Oriented Questions from Providers," July 16, 2004, found at <http://www.gao.gov/docsearch/abstract.php?rptno=GAO-04-669>
- 9 Mathews v. Eldridge 424 U.S. (1976)
- 10 Goldberg v. Kelly, 397 U.S. (1970)
- 11 CMS states in the preamble to its Medicare drug benefit regulations, "We do not believe that a formal appeals process is necessary. Instead, we intend to address beneficiary complaints regarding enrollment in a similar manner as we have done under the MA program." 70 Federal Register 4193 at 4204 (January 28, 2005).
- 12 42 CFR §423.38(c) (2)
- 13 42 CFR §423.38(c) (3)
- 14 Social Security Act §1860D—1(b) 3(c). This provision requires that SSA §1837(h) concerning enrollment errors operate "in the same manner as such section applies to part B." Section 1837(h) allows the government to grant equitable relief, including premium penalty waivers and SEPs, when Part B enrollment has been delayed as a result of government misinformation, inaction, or error. Social Security Program Operations Manual System (POMS), HI 00830.000, et seq.