SUMMER 2010

MEDICARE FACTS AND FACES

Why Consumers Disenroll from Medicare Private Health Plans

Introduction

Medicare Rights Center hotline counselors provided assistance to over 15,000 people with Medicare, their caregivers and health care professionals from all over the country last year.[1] The cases that our clients present to us contain every type of consumer problem. People call us with questions about initial enrollment in Medicare, pleas for help obtaining coverage of a particular medication or other treatment and requests for guidance in sorting out the coverage options under Medicare. Each consumer case is entered into a database that includes demographic information about the client and substantive information about his or her particular case. These case records help Medicare Rights develop policy proposals to address the consumer problems frequently presented or illuminated by these cases. The data from these cases can also serve to identify trends impacting Medicare consumers and point out the need for additional research or policy remedies. This is the first in a series of reports based on data from our casework.

Ms. H has Medicare due to a disability and was in a Medicare private health plan. She chose this particular plan because it had a cap on out-of-pocket payments. She discovered, however, that the cap did not always apply to her cancer treatments, and her out-of-pocket costs were higher than she had expected. Fortunately, Ms. H's husband was starting a new job, and she was able to disenroll and get coverage through her husband's employer.

This Report

This report analyzes data and case notes from the 475 cases presented in 2009 by consumers who called us about disenrolling from Medicare private health plans. In 2009, over 10 million people with Medicare, nearly one quarter of the Medicare population, were enrolled in Medicare private health plans, also known as Medicare Advantage plans, which are offered by private insurers.[2] The Government Accountability Office, looking at disenrollment data from January through April of 2007, cites an average disenrollment rate of 9 percent among enrollees in Medicare HMOs and PPOs, and an average disenrollment of 21 percent among people in Medicare private fee-for-service plans, with substantial variation among individual plans.[3] More recent data—from 2008—on disenrollment rates of individual plans (but not the reasons for disenrollment—see below), which vary considerably, is presented on the Medicare.gov planfinder pages and is used to calculate

plan quality ratings, although the Centers for Medicare & Medicaid Services (CMS) has not calculated average rates of disenrollment for all Medicare private health plans.

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There are various reasons why consumers disenroll from a Medicare private health plan. According to the data from our cases, provider access problems, misinformation and marketing misconduct, as well as coverage denials for medical services are the most prevalent reasons for disenrollment, followed by complaints about high cost-sharing, coverage denials for prescription drugs and premium increases. By understanding the reasons behind disenrollments, policymakers can identify problems both with the Medicare Advantage program as a whole and with individual plans.

For example, a high proportion of consumers who disenroll after joining as a result of misleading or abusive marketing, as this report finds, indicates the need for stepped-up oversight of plans' marketing conduct. If a large portion of a plan's enrollees disenroll and cite the cost of medical care as a reason, it may indicate that the cost-sharing structure under the plan is poorly suited to the needs of the Medicare population. This report presents useful data on the reasons consumers disenroll from Medicare private health plans, but is not representative on a plan-specific basis. Such data would be useful to both consumers and policymakers; this report's principal recommendation is for CMS to resume collecting and publishing plan-specific data on consumers' reasons for disenrollment. CMS has indicated it plans to reinstate a survey on reasons underlying disenrollment in late summer 2010, although it has not publicly committed to resuming the survey on a permanent basis or to providing the results to consumers.[4]

Using the data and case notes from our disenrollment clients, we assigned the disenrollment cases to six categories—misinformation/marketing abuse, provider access problems, high cost-sharing, premium increases, coverage problems for medical services, and coverage problems for prescription drugs. These categories are based on the categories used in the CAHPS [Consumer Assessment of Healthcare Providers and Systems] Disenrollment Reasons survey,[5] which was discontinued after 2005.[6] In contrast to the CAHPS survey, which grouped cost, premium and coverage concerns under one category, we treated these disenrollment reasons as separate categories to help policymakers gauge the relative importance of these consumer concerns. We also included a separate category for drug coverage concerns to replace the CAHPS survey's broader category of prescription drug coverage, which predated Part D.

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A large number of our cases reflect more than one reason for disenrollment, a finding which tracks results from CMS's discontinued disenrollment survey referenced above.[7] For example, consumers who were misled about which providers they could see under a Medicare private health plan will often cite provider access, in addition to misrepresentation by plan representatives, as the reasons that prompted them to disenroll.

We also added a separate category to cover the many cases where problems stem from the computer systems plans use for enrollment to highlight the impact that these continuing systems problems have on consumers. Finally, we examined the cases where a cancer diagnosis is connected to the reason for disenrollment. These particularly troubling cases, where consumers' problems with Medicare private health plans include abusive marketing and access to specialists, illustrate the impact plans may have on timely access to treatment for a life-threatening condition.

We note that the 475 disenrollment cases in 2009 tabulated for this report are not a representative sample of all people with Medicare who disenrolled from Medicare Advantage plans in that year. People are more likely to call the Medicare Rights Center when they are experiencing a problem disenrolling—for example, if they seek to leave their plan outside the annual enrollment periods allocated for switching health and drug plans. Conversely, a savvy consumer who switches plans because of a premium increase is less likely to call our hotline. Further, our disenrollment data does not capture whether consumers switched to Original Medicare or to another Medicare private health plan.

Medicare Rights Center Data on Disenrollment

The average age of people over 65 who called our hotline about disenrolling from a Medicare private health plan was 74.7. Slightly less than 14 percent of disenrollment calls were from people under the age of 65 who are eligible for Medicare because of a disability. Slightly more than 15 percent of disenrollment cases concerned dual eligibles—low-income people eligible for both Medicare and Medicaid. Table 1 summarizes the reasons given for disenrollment. Because some cases involve more than one reason for disenrollment, the total of percentages is greater than 100.

Table 1: Reasons for Disenrollment

	Percentage of Calls
Provider Access Problems	24.8%
Misinformation/ Marketing Abuse	21.5%
Coverage Problems for Medical Services	19.4%
Systems/Data Transfer Problems	19.4%
Cost-Sharing Too High	8.6%
Part D Coverage Problems	7.2%
Premium Increase	3.2%

Provider Access Problems

Nearly one quarter (24.8 percent) of consumers requesting disenrollment cited limits on provider access as the reason they were seeking to disenroll from their Medicare private health plan. The caseworker notes from these disenrollments show that the limits on provider access in network-based Medicare Advantage plans (HMOs and PPOs) and the uncertainty of access in private fee-for-service plans, in which providers decide on a service-by-service basis whether they will accept a plan, often pose problems for consumers.

The consumer problems in this category incorporate a wide range of provider access issues. They include general complaints and lack of understanding about the limits on provider access imposed by network-based plans, as well as specific concerns, such as the potential interruption of a valued relationship with a doctor who is being dropped from the plan's network. Provider access problems are often prompted by an acute episode of illness or diagnosis; consumers seek to disenroll when their current plan will not cover care from a

home health agency, skilled nursing or other rehabilitation facility, or from a particular specialist, such as a facility or doctor specializing in cancer treatment. This category also includes cases where consumers were misinformed about the limits on provider access before joining (see below).

From the consumer perspective, the data on prevalence of disenrollments prompted by provider access problems would be more useful if it were presented on a plan-specific basis. Although consumers are advised to check whether their doctors and local hospitals accept the plan, and medicare.gov, Medicare's online planfinder, provides data on the breadth of plans' networks, consumers would find it valuable to learn how often previous plan members disenrolled because of limitations on provider access, especially in comparison to rates for competing plans.

Disenrollment Due to Cancer

Cancer diagnoses are implicated in a relatively small percentage—less than 5 percent—of the disenrollments, but these cases are some of the most heart-wrenching and most difficult to resolve for Medicare Rights Center caseworkers. Cancer diagnoses are noted among cases in almost every disenrollment category presented in this report. Some surface in cases when the disenrollment is initiated by the plan, based upon an erroneous claim that premiums have not been paid. Others involve high cost-sharing associated with cancer treatment, which can trigger a disenrollment request, as can coverage restrictions for Part D drugs. (Generally, these restrictions affect treatments for related conditions, such as pain management, or for other illnesses, but not the cancer treatment itself; plans are required to cover all anticancer drugs.) The majority of cancer disenrollment cases—63.6 percent—however, involve provider access. The limitations of the private plan networks become apparent after the consumer is referred to a hospital or cancer specialist that is out of network. Treatment of rare or advanced cancers in particular triggers referrals to specialty facilities, such as M. D. Anderson in Houston or Memorial Sloan-Kettering in New York City. During the open enrollment periods, the disenrollments are generally effective the following month. When a person is diagnosed with cancer outside of the open enrollment periods, however, rules that lock consumers into their Medicare Advantage plans for the year generally prevent disenrollment (unless the case also concerns misrepresentation or marketing fraud, as is sometimes the case), and therefore may impede access to the most appropriate cancer treatment facility. (See Appendix for a summary of enrollment periods.)

Marketing Abuse and Misinformation

Over one in five disenrollment cases (21.5 percent) concerned consumers who said the terms of their plans' benefits were misrepresented, or they were enrolled based on fraud or outright deception. That marketing abuse and misinformation rank as the second leading cause for disenrollment highlights the persistence of misleading and aggressive marketing in the Medicare Advantage marketplace, despite the enactment in 2008 of legislative and regulatory changes designed to curb this behavior. A recent report by the Health and Human Services Office of Inspector General (OIG) confirms this conclusion, and finds similar levels of Medicare consumer complaints in both 2008 and 2009, with about 12,000 sales agent marketing complaints in both years. The consumer complaints analyzed by OIG similarly encompass agents providing misleading information about plans, enrolling consumers without their consent and using high-pressure sales tactics.[8]

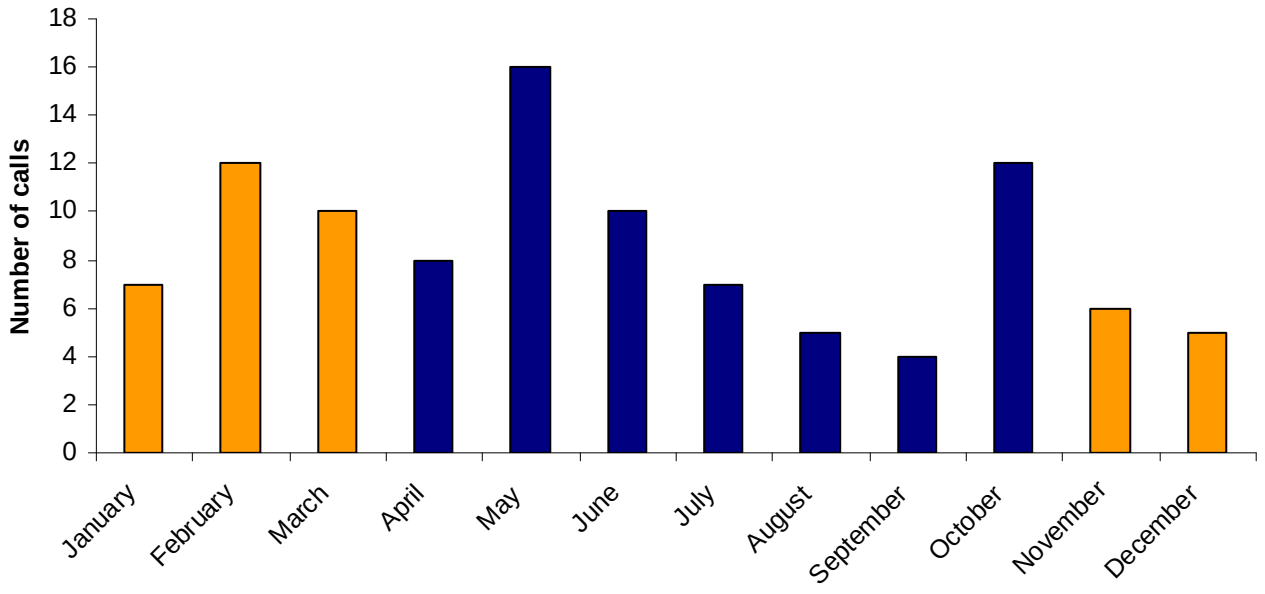
The Medicare Rights disenrollment case data also shows the consequences for consumers of marketing that leads to enrollment in an inappropriate plan. Thirty seven percent of these cases also involve provider access problems; consumers were misled about whether the care they receive from their providers would be covered, or about overall limits on provider access in network plans. In the most egregious cases, consumers were enrolled in Medicare Advantage plans while they were led to believe they were getting supplemental coverage to Original Medicare or a stand-alone drug plan. These consumers discovered that they had joined a Medicare Advantage plan only when they could not access their regular providers, often months after enrollment. Roughly 22 percent of consumers who were misinformed before enrolling faced coverage denials for medical services under their new plan, nearly 14 percent found their prescription drugs were not covered as promised and just under 10 percent found cost-sharing was higher than expected.

Table 2: Secondary Issues in Misinformation/Marketing Abuse Cases

	Percentage of Calls
Provider Access	37.3%
Coverage Problems	21.6%
Part D Coverage Problems	13.7%
Cost-sharing Too High	9.8%
Premium Increase	2.0%

Although there is a cluster of marketing-related disenrollment cases in May—two months after the end of the open enrollment period—they are scattered throughout the year, surfacing both during the months most enrollees are locked into the plan for the year and during the open enrollment periods that begin and end the calendar year. This pattern indicates that merely tracking disenrollments that are effected in the special enrollment period granted to victims of deceptive and fraudulent marketing does not fully capture the whole pattern of marketing-related disenrollments. More than one third—35.3 percent—of

Figure 1: Disenrollment calls prompted by marketing abuse and misinformation, 2009



Enrollment periods are indicated in orange. (Please note that November 15 marks the beginning of the Annual Coordinated Election Period in 2009.)

Medicare Rights Center's disenrollment cases prompted by misinformation or abusive marketing occurred during the open enrollment periods (see Figure 1). Unlike disenrollments in special enrollment periods triggered by marketing complaints, these disenrollments do not serve as signals of marketing misconduct unless they are accompanied by a formal complaint.

In its 2009 report, the Government Accountability Office (GAO) argued that CMS could better gather information on the extent of plans' marketing misconduct through improved tracking of use of Special Enrollment Periods for inappropriate marketing, together with a resumption of a disenrollment survey that captures disenrollments prompted by marketing problems during the Annual Coordinated Election and Open Enrollment Periods. Collecting plan-specific reasons for disenrollment, including disenrollments prompted by misinformation from plan representatives, would help fill this gap in CMS's and consumers' knowledge about plans' marketing practices.

Marketing Fraud Can Trigger a Host of Problems

On June 3, a 78-year-old South Carolina man called the Medicare Rights Center asking for help disenrolling from his PPO. In the spring, during the Open Enrollment Period, Mr. R's insurance agent had paid him a visit and advised him to "update" his health insurance. Although he was happy with his current Medicare HMO, he switched based on the promises of better coverage made by the insurance agent. Those promises, however, proved to be false. Mr. R's doctors were not in-network, as promised, so he ran up $700 in copay bills by June 1. The promise of dental coverage also proved illusory—Mr. R could not find a dentist in his community that accepted the plan. Compared to his old plan, Mr. R's drug copays were also higher and his premium was double what he used to pay. Although Mr. R had the South Carolina governor's office advocating on his behalf, it was not until the Medicare Rights Center intervened with the CMS regional office that Mr. R. was retroactively enrolled in his old Medicare HMO, which would cover much of the accumulated bills that the PPO would not cover.

Coverage Problems

Over 19 percent of disenrollment cases were prompted by claims denials for medical services. The coverage denials concern a wide range of medical services, including surgical procedures, outpatient visits to both primary care doctors and specialists, home health care and physical therapy, and outpatient mental health services. Information on plan coverage criteria for medical services is not readily available or understandable to consumers, but denials for needed service greatly affect the care plan members receive and their satisfaction with the plan. Information on plan disenrollments prompted by coverage denials could be a valuable tool for consumers who need to select a plan. A high incidence of disenrollments due to coverage problems could well indicate a pattern of denials that would affect enrollees' access to care.

High Cost-Sharing

Over 8 percent of disenrollments were prompted by concerns over excessive cost-sharing imposed by the Medicare private health plan. Plans vary considerably in the cost-sharing they impose for specific services. According to a recent Kaiser Family Foundation report,

for a five-day hospital stay, cost-sharing under Medicare Advantage plans ranges from $0 to $3,325; the charge for a 27-day stay in a skilled nursing facility ranges from $625 to $1,625.[9] One-third of Medicare Advantage enrollees are in plans with no annual out-of-pocket limit, although starting in 2011, all plans must set an annual limit on cost-sharing for Medicare-covered services of $6,700 or less.[10] Through medicare.gov and through the summary of benefits available before enrollment, consumers have access to information that, at least in theory, allows for comparison of the cost-sharing that plans impose across the full range of services. We have argued elsewhere[11] that such comparisons would be facilitated by standardizing benefit packages, which would allow consumers to choose among plans with identical benefits on the basis of premiums, provider access and performance measures. Even with standardized benefits, information on the rates of disenrollment prompted by cost-sharing concerns would help consumers understand how similarly situated consumers were impacted by benefit packages plans have on offer. Policymakers also would have an important gauge of how consumers are faring under the benefit packages employed by plans.

Part D Coverage Problems

Just over 7 percent of disenrollments were prompted by problems with Part D coverage, such as denials of coverage for off-formulary drugs. Consumers now have information through medicare.gov about which drugs are excluded or restricted under plans' formularies, as well as quality indicators assessing plans' handling of Part D coverage appeals. Plan-specific data on disenrollments related to Part D coverage would supplement the information currently available to consumers.

Premium Increases

A surprisingly small number—3.2 percent—of disenrollments were prompted by premium increases. Conventional wisdom holds that premium increases—since they are more transparent to consumers than changes in copayments or coinsurance—are likely to prompt disenrollment. It is likely that consumers disenrolling in response to premium hikes are less likely to require help from our hotline counselors since they can be effectuated during open enrollment, when consumers can switch to a different plan.

Problems with Enrollment Data Systems

A high proportion of hotline disenrollment cases—nearly one in five—also concern data systems problems that delay, or inappropriately cause, disenrollment. Many of these cases involve what should be relatively straightforward disenrollments—for example, those that should take effect when enrollees move out of the service area—that are held up because of problems in the plan's enrollment processing system. Of particular concern, nearly half of these cases—47.8 percent—involve involuntary disenrollments that generally are prompted either by mistaken information that the enrollee has moved out of the service area or a dispute over whether premiums have been properly paid. In these cases, proof of premium payment or residence often fails to promptly reinstate enrollment. As a result, although consumers have coverage under Original Medicare, they may go without drug coverage and supplemental coverage for all other care while awaiting resolution, frequently resulting in prohibitive out-of-pocket costs and interruption of needed care. These are among the most difficult cases handled by Medicare Rights caseworkers, as they involve repeated communication with plan and CMS representatives and can take months to resolve.

Conclusion

Disenrollment represents the consumers' ultimate verdict on the suitability of the coverage and their level of satisfaction with a Medicare private health plan. High overall disenrollment rates are an important signal of plan performance both for consumers and policymakers. CMS now factors in overall disenrollment rates in its quality measures—the star ratings—which consumers view on the medicare.gov plan finder pages and which will serve as a basis for payment calculations in the coming years.[12]

The Government Accountability Office argues that CMS has a legal obligation to mail plan-specific disenrollment rates to plan members, although CMS disagrees that it is legally required to do so.[13] We believe that consumers would benefit if CMS explores ways of highlighting information on overall disenrollment rates, which is now subsumed in the star ratings. Alerting consumers to plans with inordinately high disenrollment rates—above 20 percent, for example—would provide a valuable signal to consumers, remind them that disenrollment is an option if they are dissatisfied with their plan, and further encourage plans to improve performance to retain members.

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Beyond overall disenrollment rates, the reasons consumers give for quitting their Medicare private health plan can provide important signals to consumers, policymakers and the plans themselves. While the data collected from our hotlines is not sufficiently representative to provide definitive conclusions on the reasons consumers disenroll from specific plans, it does include important indicators of the problems consumers face in the Medicare Advantage program. The relatively high incidence of disenrollment due to misrepresentation or abusive marketing highlights the continuing problem of marketing misconduct and should spur CMS to strengthen oversight and close loopholes in marketing rules, such as rules that govern marketing by third parties.[14] The prominence of provider access and coverage problems as reasons for disenrollment should alert consumers, caregivers and counselors to the problems consumers may encounter when they confront network and coverage restrictions.

The resumption of a survey that captures the reasons that consumers disenroll from Medicare private health plans would provide consumers and policymakers with representative data on what prompts consumers to quit specific plans. We are encouraged that CMS has indicated to the GAO that it plans to restart the survey in 2010, at least on a temporary basis.[15] The categories used in this report to group the reasons for disenrollment—marketing abuse and plan misinformation, provider access restrictions, medical service coverage denials, high cost-sharing, plan premiums, and drug coverage problems—are useful starting points for a new survey that provides plan-specific information. It is important, in particular, that the survey capture the reasons that consumers disenroll, distinguishing in particular among concerns about coverage, cost-sharing and premiums. While premium differences among plans are more readily apparent to consumers, the impact on access to care of plan cost-sharing levels and coverage denials is not. Survey data on disenrollments prompted by coverage denials and cost-sharing would provide consumers with valuable data in selecting plans. **We recommend that CMS resume the Medicare private health plan disenrollment survey and provide the results to consumers in an accessible and easy-to-understand manner.**

Appendix

Enrollment Periods

During 2009, the period covered by this report, people with Medicare had the right to switch their health plan options:

- **During the Annual Coordinated Election Period (ACEP)[16]**
  November 15 through December 31
  People with Medicare can change their Medicare health and drug coverage options without restriction. The change will go into effect on January 1.

- **During the Open Enrollment Period (OEP)[17]**
  January 1 through March 31
  Medicare consumers can change their health coverage option ONCE. This means that they can switch from Original Medicare to a Medicare private health plan or vice versa. They can also switch from one Medicare private health plan to another. (They cannot, however, add or drop Medicare drug coverage.) The change will go into effect on the 1st of the month after the person makes a selection.

Medicare consumers can also switch health plans:

- **If they qualify for a Special Enrollment Period (SEP)[18]**
  There are a number of circumstances under which a Medicare consumer qualifies for a Special Enrollment Period. The new coverage will usually start the first of the month after the person signs up for or disenrolls from a Medicare private health plan. Examples of situations that are addressed by SEPs include:
    - The consumer is misled into joining a Medicare private health plan (CMS may determine that the consumer is eligible for retroactive disenrollment)
    - A federal employee made a mistake in the enrollment or disenrollment process involving a Medicare private health plan
    - The consumer permanently changes their home address.
    - The consumer is enrolled in both Medicare and Medicaid or is enrolled in the Part D Low-Income Subsidy (Extra Help).

[1] Medicare Rights Center, *2009 Annual Report*, April 2010. http://www.medicarerights.org/pdf/2009annualreport.pdf
[2] The Henry J. Kaiser Family Foundation, *Medicare Health and Prescription Drug Plan Tracker*. http://healthplantracker.kff.org/
[3] Government Accountability Office, *Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans*, December 2008. http://www.gao.gov/new.items/d0925.pdf
[4] Ibid.
[5] Medicare Payment Advisory Commission (MedPAC), *Benefit Design and Cost Sharing in Medicare Advantage Plans*, December 2004.
[6] Government Accountability Office, *Medicare Advantage: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue*, December 2009. http://www.gao.gov/new.items/d1036.pdf
[7] Lauren McCormack et al., *Disenrollment from Medicare Advantage Health Plans: A Qualitative Assessment*, June 2005. http://www.cms.gov/CAHPS/Downloads/2004CAHPSDisenrolSvyFocusGrpsFinalRPT.pdf
[8] Department of Health and Human Services Office of Inspector General, *Beneficiaries Remain Vulnerable to Sales Agents' Marketing of Medicare Advantage Plans*, March 2010. http://oig.hhs.gov/oei/reports/oei-05-09-00070.pdf
[9] Marsha Gold, Maria Hudson, Gretchen Jacobson, and Tricia Neuman, *Medicare Advantage 2010 Data Spotlight: Benefits and Cost-Sharing*, Henry J. Kaiser Family Foundation, February 2010. http://www.kff.org/medicare/upload/8047.pdf
[10] Danielle Moon, Centers for Medicare & Medicaid Services, Memorandum, "Benefits Policy and Operations Guidance Regarding Bid Submissions; Duplicative and Low Enrollment Plans; Cost Sharing Standards; General Benefits Policy Issues; and Plan Benefits Package (PBP) Reminders for Contract Year (CY) 2011," April 16, 2010. http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Documents/04%2023%2010/CMS_memo.pdf
[11] Medicare Rights Center, *Role Models and Cautionary Tales: Three Health Insurance Programs Demonstrate How Standardized Health Benefits Protect Consumers*, July 2009. http://www.medicarerights.org/pdf/Benefits-Standardization.pdf. See also Medicare Rights Center and California Health Advocates, *Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans*, September 2007. http://www.medicarerights.org/pdf/Informed_Choice.pdf
[12] Henry J. Kaiser Family Foundation, *What's in the Stars?: Quality Ratings of Medicare Advantage Plans, 2010*, December 2009. http://www.kff.org/medicare/upload/8025.pdf
[13] Government Accountability Office, *Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans*, December 2008. http://www.gao.gov/new.items/d0925.pdf
[14] National Senior Citizens Law Center, Center for Medicare Advocacy, Medicare Rights Center, California Health Advocates, Health Assistance Partnership, Families USA, Comments and Responses to 2011 Draft Medicare Marketing Guidelines—Revised, March 2011. http://www.medicarerights.org/pdf/Marketing-Guidelines-2011.pdf
[15] Government Accountability Office, *Medicare Advantage: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue*, December 2009. http://www.gao.gov/new.items/d1036.pdf
[16] Beginning in 2011, the ACEP and OEP will be eliminated and replaced by an Annual Enrollment Period (AEP), during which people with Medicare can make changes to both their health and drug plan options without restriction. The AEP is from October 15 through December 7, and will begin in 2011 for the 2012 plan year.
[17] There will also be an Annual Disenrollment Period (ADP), also called the Medicare Advantage Disenrollment Period, beginning in 2011. During the ADP, which will run from January 1 through February 15, Medicare consumers will be able to switch from a Medicare private health plan to Original Medicare (or a Medicare private health plan with drug coverage to Original Medicare with a stand-alone drug plan).
[18] 42 C.F.R. § 422.62 (2005).