The Part D Enrollment Deadline Can and Should Be Lifted

April 2006

According to the last set of Part D enrollment figures released by the Centers for Medicare & Medicaid Services, only 7.2 million people with Medicare have signed up for Part D coverage since enrollment opened last November. More than twice that number, nearly 16 million, have yet to enroll. Over 1 million low-income people who qualify for zero-premium coverage, low copayments and no gap or doughnut hole in the drug benefit, have also failed to sign up and the administration will assign them a plan this month. Even if there is a surge in enrollment before the May 15 deadline, there will be millions of people with Medicare who have still not signed up for a Part D plan and who lack other coverage from a former employer. These older Americans and people with disabilities will be barred from enrolling in a plan until November, leaving them without coverage until 2007. They will then face a 7 percent late enrollment penalty that they must pay for the rest of their lives.[1]

The enrollment deadline and late penalty is designed to discourage people with Medicare who have low drug costs from delaying enrollment until an illness triggers the need for drug coverage. If only those with high drug costs enroll in a Part D plan, a tendency known as “adverse selection,” premiums for those who do enroll and the cost to Medicare will rise. As premiums rise, people with low drug costs are further discouraged from signing up for the benefit.

For similar reasons, a late enrollment penalty also applies to Medicare Part B, which covers doctor visits and other outpatient care. But there is a crucial difference. Enrollment in Part B is automatic once someone becomes eligible for Medicare; people are given the choice of opting out of Part B coverage. And Part B provides a standard, guaranteed benefit that covers all medically necessary care. Automatic enrollment and Part B’s uniform, standard coverage means that the Part B late enrollment penalty functions purely as a mechanism to counter adverse selection. The late penalty, like the standard premium, is part of the package that provides a guaranteed insurance policy for all people with Medicare. About 95 percent of those eligible are enrolled in Part B.[2]

By contrast, enrollment in Part D requires people with Medicare to choose from a bewildering array of over 40 drug plans, each charging different copayments and premiums, covering different drugs and imposing different restrictions, such as monthly quantity limits, on the drugs they do cover. But after May 15, people with Medicare, with certain limited exceptions, such as for those also receiving Medicaid, are barred from switching plans. The Part D enrollment deadline and late enrollment penalty serve as pressure points for drug plan marketers and as means of enforcing a plan selection that for most people with Medicare will be ill-informed and fraught with risk.

The risk is endemic to the structure of Part D. Plans are free to change formularies during the course of the year and there is no guarantee that a plan selection based on today's needs will provide coverage in the event of an unexpected illness. As a result, the Part D enrollment deadline and late penalty also function to lock consumers into a plan that makes coverage decisions based on maximizing plan profits. Part B coverage is based on medical necessity; lock-in is not an issue.

Clearly, there are deep flaws in the design of the Part D drug benefit that are suppressing enrollment. The Bush administration’s insistence on keeping the May 15 deadline and late enrollment penalty in place ignore those problems and guarantee that millions of people with Medicare will face another year without any drug coverage, even the inadequate Part D benefit. The Senate is on record as supporting an extension of open enrollment until the end of the year, waiving the late enrollment penalty and allowing people with Medicare and additional opportunity to switch plans after May 15.[3] But it remains unclear whether Senate Majority Leader Bill Frist, Republican of Tennessee, will allow this legislation to the floor for a vote prior to May 15, and even less likely that the House will take up similar legislation.

This issue brief demonstrates that the administration has the legal authority to extend enrollment through the end of the year through its authority to create a special enrollment period. Although there does not appear to be a legal means, absent legislation, for the administration to waive the late enrollment penalty, extending open enrollment

would reduce or eliminate the penalty for people who sign up during 2006 and allow them to begin receiving coverage before the end of the year.

The authority to create a special enrollment period also includes the authority to allow people with Medicare the opportunity to switch plans throughout the year. This would enable people with Medicare to change plans in response to formulary changes enacted by their plans or if a new illness makes the plan unsuitable.

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Polling of Americans over 65 years old conducted in March for the Medicare Rx Education Network, a group funded by drug manufacturers, provides a glimpse into some of the problems people are experiencing both before and after enrollment. The polling data show that, compared to people who have signed up for a stand-alone drug plan, people who have no drug coverage tend to have lower drug costs than people who joined a stand-alone drug plan.[4] However, the data also shows that about one quarter of those who have so far failed to enroll have high drug costs.[5]

Allowing enrollment without penalty for the remainder of 2006 would provide additional opportunities for those who need coverage to sign up for a plan **and** it could broaden the risk pool to include those with lower drug costs who have so far failed to sign up. This would lower the premiums for 10 million people with Medicare, according to the Congressional Budget Office (CBO), which estimates that an additional 1.1 million people with Medicare would up during the course of 2006.[6]

The polling data also show that the structure of Part D—the decision by Congress to deliver the benefit through competing plans and not directly through the Medicare program—is the primary reason people have not signed up for the drug benefit. Of those who told pollsters that they are unlikely to enroll or unsure they would sign up, over half said they would probably not sign up because there are "too many plans to choose from" or because they did not want to get "stuck in the wrong plan." These are not imaginary concerns; people with Medicare face widely disparate costs under different plans because of the wide range of copayment structures and coverage limitations. In addition, 28 percent said they "probably would not qualify for a plan," betraying a fundamental misunderstanding of the Part D benefit, which is open to all people with Medicare.[7]

The poll shows that there is inadequate access to information necessary for people to select the most appropriate drug plan. Few used the internet to compare plans and many more relied on the marketing material from insurance companies touting their plans.[8] Not surprisingly, those who have not signed up for drug coverage have basic unanswered questions, such as how much it will cost and whether plans will cover "current and future medicines."[9]

For those who did sign up for a stand-alone plan, the number one reason was "I wanted to know I will have the medicines I need when I need them." Unfortunately, because of the wide latitude given plans to construct formularies and change formularies during the plan year and the fact that people cannot predict what medicines they may need in the future, there is no guarantee that Part D plans will cover the medicines their

enrollees need. Indeed, 21 percent of those enrolled in Part D plans said that their stand-alone plan did not cover all the medicines they were prescribed, and 23 percent said enrolling in a plan had not lowered the amount they spent on medicines. Three-quarters of those who had enrolled said the ability to change coverage if their medicine changed was an important feature of the plan they chose, even though there is no ability to switch plans after May 15 unless, as we recommend, a new special enrollment period is established.[10]

What this polling data shows is that it is not a desire by people with Medicare to game the system—to delay enrollment until high drug expenses make the insurance cost effective—that is suppressing enrollment. People with Medicare are faced with a confusing and difficult choice while armed with insufficient or inaccurate information and subject to high pressure sales tactics. When they do get a clear picture of the Part D benefit, many realize what a bad deal it is. Plans do not cover their medicines; joining a plan does not save them money. These are fundamental flaws in Part D that the Congress needs to address by giving people with Medicare the one choice they really want: a drug benefit delivered through Medicare just like Part B. Unfortunately, it is unlikely that Congress will act, but the administration already has the legal authority to extend enrollment and allow people to switch plans as their needs change or as their plan changes the drugs it covers.

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The Medicare Modernization Act of 2003 (MMA) gave the Secretary of Health and Human Services broad authority to establish special enrollment periods. The MMA lists a number of criteria that should trigger special enrollment periods. For example, people with Medicare and Medicaid are granted a special enrollment period that allows them to switch plans on a monthly basis. Special enrollment periods are also granted, as they are under Part B, if an individual's enrollment or non-enrollment is the result of error, misrepresentation or inaction of a government officer. However, the MMA specifically notes that the criteria in the statute are not exhaustive; the Secretary is given authority to establish special enrollment periods “including” those enumerated in the statute.[11]

In addition, the MMA specifically grants the Secretary authority to establish a special enrollment period for “individuals who meet such exceptional conditions . . . as the Secretary may provide.”[12] That authority was used to grant a special enrollment period to people entering a nursing home or other specified long-term care institutions in order to enable them to switch to a Part D plan that works with the long term care pharmacy serving the nursing home.[13]

In its final call letter outlining the regulatory requirements for Part D plans for 2007 issued on April 5, the Centers for Medicare & Medicaid Services (CMS) established a special enrollment period for people with Medicare who are determined to be eligible for the Extra Help program after May 15. Starting with the date of the award, these individuals are given a special enrollment period to select a Part D plan. If they fail to select a plan, CMS will assign them randomly to a plan with a premium low enough to qualify for a full-subsidy and they will have a special enrollment period to select an

alternative plan. The call letter does not base this special enrollment on statutory language allowing an SEP in exceptional circumstances. Rather CMS says it "believes it is important to give those individuals who qualify for the low income subsidy the immediate opportunity to be enrolled in a plan and makes use of this assistance."[14]

Either the authority granted to CMS by the MMA to establish a special enrollment period for individuals and circumstances not enumerated in the statute or the authority to grant a special enrollment period for "exceptional circumstances" provides a sound legal basis to allow people with Medicare the continued opportunity to enroll in a Part D plan or switch to another plan after May 15. The statute also provides no restrictions on the duration of any special enrollment period the Secretary may establish.

In its final rule, CMS rejected requests for a blanket 18 month special enrollment period (SEP) or for enrollees in plans that enact substantial formulary changes, saying it did not believe these qualifies as "exceptional" circumstances. However, the agency noted that it "retained the right to establish additional SEPs in the future."[15]

The establishment by the administration of a new special enrollment period does not waive the late enrollment penalty. The late enrollment penalty is based on separate statutory language, which imposes the penalty on people who were eligible but not enrolled in Part D, and did not otherwise have creditable coverage (coverage as good as Part D). In its final rule on the drug benefit, CMS notes that "there is nothing in the statute that would provide us with the authority to waive or delay the late enrollment penalty at any time unless an individual was not adequately informed that his or her prescription drug coverage . . . was not creditable." CMS further notes that "the provision of an SEP is not directly related to, nor does it have a direct effect upon, the imposition of late enrollment penalties."[16]

However, the extension of a special enrollment period extending from May 15 to the end of the year may eliminate or reduce the late penalty for those who enroll during that period. A penalty of 1 percent of the average national Part D premium is imposed for each month without Part D or other creditable coverage on any person eligible but not enrolled in Part D or other creditable coverage for at least 63 days from May 15.[17] For example, if enrollment were extended through an SEP, a person that enrolled in late May or June would not face a penalty since they went less than 63 days without coverage. Someone who enrolled in July would faced a 2 percent penalty (for the months of June and July) once their enrollment took effect August 1. Without an SEP, people with Medicare would face a minimum 7 percent enrollment penalty since they could not enroll until November 15 and their enrollment would not take effect until January 1, 2007.

Recommendation: The Secretary of Health and Human Services should establish a special enrollment period running from May 15 until December 31, 2006. All people with Medicare shall have the right to enroll in a Part D plan during this period. In addition, all people with Medicare shall have the right to switch plans during this period if their needs are not adequately met by their current plan. This right to switch plans shall apply, at a minimum, whenever a plan changes its formulary by eliminating or restricting coverage of drugs (with the exception of brand name drugs with newly approved generic

equivalents) or if a new illness, diagnosis or prescription makes the current plan inappropriate.

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[1] Penalty rises with annual average premium. The national average premium used to calculate the late enrollment penalty is $32.20, yielding a 7 percent late penalty of $2.25. As the average premium rises, the penalty that applies to individuals who delayed enrollment in 2006 will also rise.
[2] Centers for Medicare & Medicaid Services, HHS Announces Medicare Premium and Deductible Rates for 2004, October, 2003.
[3] The Senate voted 76-22 in favor of an amendment offered by Senator Chuck Grassley, Republican of Iowa, giving the Secretary of Health and Human Services authority to extend the enrollment period, waive the late enrollment penalty and allowing people with Medicare an additional opportunity to switch plans after May 15.
[4] Twenty-four percent for people in stand-alone plans had difficulty paying for prescriptions over the last year compared to 19 percent without drug coverage. More people without drug coverage also have monthly drug costs below $100 compared to people who chose a stand-alone plan (69 percent vs. 51 percent, KRC Research, *Medicare Rx Education Network Survey of Seniors*, March 30, 2006.
[5] Of those who have still not enrolled in drug coverage, 24 percent have monthly bills of over $100, 25 percent take more than six prescription drugs, and nearly that proportion (19 percent) had trouble paying for their prescriptions. Ibid.
[6] Nancy Pelosi et al. letter to President George W. Bush, March 14, 2006.
[7] By contrast only 45 percent said that they would rather wait to sign up until they "really need" drug coverage. A similar number (44 percent) said they did not use any or many medicines and so would probably not sign up. KRC Research, *Medicare Rx Education Network Survey of Seniors*, March 30, 2006.
[8] Only about one quarter of those polled used the internet or the Medicare.gov web site to choose a plan, which are essential, if imperfect tools to, compare out-of-pocket spending under the various plans. A little more than half called 1-800-Medicare, which despites widespread reports that it has provided incorrect information, can also provide a means to compare plan. The number one source of information was the "Medicare & You" handbook, which provides only a list of plans and their premiums, and contains incorrect data on which plans qualify for full premium subsidies under the Extra Help program. The second most used source of information is the insurance companies. Ibid.
[9] Ibid..
[10] Ibid.
[11] Section 1860D-1 (b) (3), Medicare Prescription Drug, Improvement and Modernization Act of 2003.
[12] Ibid.
[13] Centers for Medicare & Medicaid Services, *Final Part D Enrollment and Disenrollment Guidance,* 2005.
[14] Centers for Medicare & Medicaid Services, Final 2007 PDP Call Letter, April 2006.
[15] Centers for Medicare & Medicaid Services, Preamble to the Final Rule on the Medicare Prescription Drug Benefit, 2005.
[16] Centers for Medicare & Medicaid Services, Preamble to the Final Rule on the Medicare Prescription Drug Benefit, 2005.
[17] Persons with incomes below 135 percent of the federal poverty limit with limited assets who qualify for full premium subsidy pay only 20 percent of the assessed penalty. Individuals who become eligible for Medicare after February 1, 2006 have an initial enrollment period of 7 months.