

ELIGIBILITY AND ENROLLMENT

This section covers:

- Eligibility for Enrollment
- Deciding to Enroll in an MA Plan
- How to Select an MA Plan
- Enrollment Periods and Effective Dates
- How to Enroll in an MA Plan
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ELIGIBILITY FOR ENROLLMENT

Given the many choices that Medicare beneficiaries face in terms of receiving their health insurance and drug coverage, it is essential for SHIP counselors to help clients assess if a Medicare Advantage (MA) plan will meet their health insurance needs. The first step in that process is to determine if a client is eligible to enroll in an MA plan. Here are three key questions counselors should ask to assess a client's eligibility for enrolling in an MA plan.

- **Is your client enrolled in Medicare?** Generally, to be eligible to enroll in a Medicare Advantage plan, a Medicare beneficiary must be enrolled in both Medicare Part A and Part B.
- **Does your client have end-stage renal disease (ESRD)?** Except in certain circumstances, beneficiaries may not be medically determined to have end-stage renal disease (ESRD) at the time of enrolling in an MA plan. Individuals who develop ESRD while enrolled in an MA plan may continue to be enrolled in the plan. Beneficiaries who have ESRD may also enroll in a Special Needs Plan (SNP) that is open for enrollment to those with ESRD.
- **Does your client live in the MA plan's service area?** Beneficiaries must permanently reside in a Medicare Advantage plan's service area to be able to enroll in the plan. Service areas differ among the various types of MA plans. Service areas may be no larger than a few counties in a metropolitan area or they may encompass an entire state or a multi-state region. Since provider network rules vary by plan as well as by plan type, it is especially important for beneficiaries who live out of a plan's service area for some part of the year to consider this factor.

There are some extra eligibility rules for two types of MA plans, namely Special Needs Plans (SNPs) and Medicare Medical Savings Account (MSA) plans:

- SNPs require:
 - For dual-eligible SNPs, that a beneficiary must meet the plan’s Medicaid eligibility criteria, and
 - For institutional SNPs, that a beneficiary must need an institutional level of care (including skilled nursing facilities (SNF), nursing facilities (NF), SNF/NF, intermediate care facilities for the mentally retarded (ICF/MR), and inpatient psychiatric facilities) for at least 90 days.
- MSAs require that beneficiaries:
 - Reside in the United States for more than 183 days in the year of enrollment;
 - Not have additional health coverage through the Federal Employees Health Benefits Program (FEHBP) or through TRICARE or the VA;
 - Not receive benefits from their state’s Medicaid program; and
 - Not have any additional health coverage that would pay for part or all of the Medicare MSA deductible.

When eligible beneficiaries decide to join an MA plan, they must complete an enrollment form to elect, or enroll in, an MA plan. It is very important to note that Medicare beneficiaries who choose to enroll in a Medicare Advantage plan remain “in Medicare.” Often beneficiaries think that they are leaving Medicare when they join an MA plan. Counselors may need to address the sources of this confusion, which may include marketing materials and an MA plan’s use of its own membership card instead of a beneficiary’s regular Medicare card. While MA coverage through a private plan replaces the Part A Hospital Insurance and Part B Supplemental Medical Insurance that provide coverage to beneficiaries in Original Medicare, MA enrollees retain the rights of all Medicare beneficiaries, including the right to return to Original Medicare.

Finally, except for beneficiaries enrolled in Medicare Medical Savings Account (MSA) plans and those enrolled in Private-Fee-for-Service (PFFS) plans and Cost plans that do not offer qualified prescription drug coverage, individuals may not be enrolled into both an MA plan and a stand-alone Medicare Prescription Drug Plan (PDP) at the same time.

DECIDING TO ENROLL IN AN MA PLAN

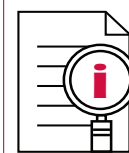
Medicare beneficiaries have the option of receiving their Medicare benefits through the Original Medicare program, also known as “fee-for-service Medicare,” or through a Medicare Advantage (MA) plan, sometimes called a “Medicare Health Plan.” MA plans are private plans that are available to most people with Medicare. MA plans may help some Medicare beneficiaries lower their out-of-pocket spending and gain access to benefits beyond those in Original Medicare.

SHIP counselors provide a unique and essential service for clients when guiding them through a process to reach sound decisions about MA plan enrollment. To continue the assessment process that began with determining eligibility, counselors should learn as much as possible about a client’s interest in particular MA plans. Here are some likely reasons for that interest:

- **Low premiums:** Some MA plans have very low monthly premiums. When compared to the cost of Medicare Supplement (Medigap) insurance policies or retiree group health plans, some of your clients could save several hundreds of dollars annually on insurance premiums by enrolling in an MA plan. The prospect of lower monthly health insurance premiums alone motivates many people to consider MA plans.
- **Extra Benefits:** Most MA plans offer benefits that the Original Medicare program excludes from coverage. Typically, these extra benefits include annual physical exams and routine dental and vision care. In some parts of the country, however, MA plans also cover hearing aids, eye glasses, and acupuncture.
- **Simplicity:** MA plans often combine the benefits that Original Medicare and Medicare Part D make available, along with some features of supplement insurance, in a complete package with one monthly premium. Some people prefer this to Original Medicare in which beneficiaries often pay separate premiums for Medigap insurance and Part D prescription drug benefits. Many MA plans also use set copayment amounts of \$10 or \$20 for each physician visit instead of Original Medicare’s less predictable Part B 20 percent coinsurance charge.
- **An Affordable Alternative to Medicare Supplement Insurance:** Because MA plans cover some of the benefit gaps in Original Medicare, and because they are billed as a modern insurance option with more “advantages,” some of your clients may believe that MA plans take the place of Original Medicare and supplement insurance, or that the MA plans and Medigap insurance are equivalent. This is a misimpression that SHIP counselors must address with patience and the use of case examples that illustrate how the out-of-pocket costs in MA plans and Medigap insurance differ.

After taking some time to listen to the reasons for a client's interest in an MA plan, it is important next for counselors to address several factors that beneficiaries should consider before joining a Medicare Advantage plan. Here are some considerations:

- **Plan Rules:** Enrollees in MA plans must follow the rules of the Medicare Advantage plan in order to receive coverage and payment. For example, a common rule in Medicare HMOs is one that requires use of network providers, including doctors, hospitals, and diagnostic facilities. Another common rule in HMOs requires patients to get referrals to see specialists. Many MA plans, including HMOs and Private Fee-for-Service (PFFS) plans, also have prior authorization or prior notification rules that apply, for example, to medical equipment and elective surgery. Enrollees who do not follow their MA plan's rules may be responsible for the entire cost of care.
- **Lock-In:** Beneficiaries who opt to join an MA plan should understand the concept of lock-in. Individuals may make changes only during limited enrollment periods (e.g., the AEP and OEP). Once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year. This lock-in feature does not apply to beneficiaries who have a SEP.
- **Out-of-Pocket Costs:** Since the majority of Medicare beneficiaries have moderate incomes, it is tempting for some people to compare MA plans and Original Medicare with a Medigap policy by premiums alone. But the true cost of an MA plan includes the monthly premium plus the cost-sharing charges for various services. MA plans set their own cost structure, so a plan could offer a low monthly premium and offset it by charging more for individual covered services. While MA plans commonly use defined copayments for inpatient hospital and physician services, many use percentage-based coinsurance charges for outpatient hospital care and medical equipment and supplies. In some plans, beneficiaries owe out-of-pocket 20 percent of the cost for outpatient surgery and other treatments. In contrast, those in Original Medicare may purchase a Medigap policy that pays all of the beneficiary's cost-sharing for inpatient and outpatient hospital services, and the entire coinsurance charge for medical equipment and supplies.
- **Beneficiary Liability for Cost-Sharing:** MA plan members must be prepared to cover the plan's out-of-pocket costs with their own income or financial resources. Thus, it is critical for people to examine an MA plan's cost-sharing structure and for counselors to show through case examples how the cost-sharing system works, before your clients enroll in an MA plan.
- **Access to Providers:** Some MA plans have health care provider networks with restricted access to "out-of-network" providers. Provider networks are common in Medicare



For more information, see Special Enrollment Periods on page 26.

HMOs and PPOs. Some HMO and PPO plans' networks are very large, while others are more limited. Medicare PFFS plans, on the other hand, make payments to any health care provider who is willing to accept the plan's payment terms. Doctors, hospitals, and other service providers can pick and choose among the PFFS plans whose payments they will accept. With respect to providers, counselors should encourage clients to think about an MA plan's ability to ensure access to the hospitals, doctors, home health agencies, and diagnostic centers they prefer to use.

- **Peace of Mind:** Some people who enroll in MA plans face surprisingly large out-of-pocket costs when an unexpected illness or accident requires a series of outpatient hospital visits for treatment or rehabilitation. Others are stunned when an out-of-town diagnostic center does not accept an MA plan's payments, leaving them to foot the entire bill for expensive procedures. To promote peace of mind, counselors can help clients weigh the benefit of an MA plan's potential savings with some of its inherent uncertainties and risks. With clients who are "on the fence," counselors should recall that those who enroll in MA plans can return to Original Medicare during an Annual Enrollment Period (AEP), the MA Open Enrollment Period (OEP), or a Special Enrollment Period (SEP). In some cases, clients have special rights to return to Original Medicare and purchase Medigap insurance.

HOW TO SELECT AN MA PLAN

Since MA plans vary greatly, it is important to understand the options before selecting and enrolling in a plan. Counselors provide an important service by helping their clients to narrow their selection decision to one of the several types of MA plans, while keeping in mind that all MA plan types are not available in some communities. An in-depth counseling guide, *Making Informed Decisions: Navigating Medicare Advantage*, is available at the Health Assistance Partnership website at <http://www.hapnetwork.org/assets/docs/ma-tools/ma-counseling-guide.pdf>. Potential enrollees should answer a specific set of questions about each type of MA plan. Examples of questions that counselors can ask about the types of plans include the following:

- **Health Maintenance Organization (HMO)**
 - How important is it for me to go to any doctor I choose?
 - What rules does the plan use to approve costly tests, specialty care, and surgery?
 - Which covered benefits have a fixed copayment? Which have coinsurance charges?
- **Preferred Provider Organization (PPO)**
 - Are my current doctors, including specialists, and hospital part of the PPO's provider network?
 - Does the PPO have network facilities that are conveniently located for me?
 - Am I prepared to cover the PPO's copayments for hospital stays?

- **Private Fee-for-Service Plan (PFFS)**
 - How important is it for me to be sure that my physicians, including specialists, will provide services to me and accept insurance payments on my behalf?
 - What rules does the plan have for notification about hospital admissions, outpatient surgery, and other costly services?
 - Can doctors, hospitals, and other care providers bill me for the difference between the plan's payment and the provider's actual bill?
- **Special Needs Plan (SNP)**
 - Do I qualify for the special needs status of this SNP?
 - Does the SNP offer services that are not covered by Medicare (and Medicaid, if I am dual-eligible) that are useful for me?
 - Does the SNP provide care coordination?

Other factors are important to consider, regardless of the type of MA plan. Generally, beneficiaries who would like an MA plan AND drug coverage must enroll in an MA plan with drug coverage (MA-PD) to receive the Medicare Part D drug benefit. Since many MA plans are MA-PDs, counselors should help their clients assess the drug coverage portion of MA-PDs just as they would with a stand-alone Prescription Drug Plan (PDP). Like PDPs, MA-PDs set their own formularies, or lists of covered drugs, so it is important for beneficiaries to examine plans' formularies to ensure they cover as many of a person's prescribed medications as possible. Also, MA-PDs may limit drug coverage through the use of utilization management tools, such as prior authorization and quantity limits. Further, many MA-PD plans will have a coverage gap, or "doughnut hole." Like PDPs, MA-PDs' pharmacy networks vary in size, and their cost-sharing structures for prescription drugs differ as well.

CMS has an online tool that provides information about Medicare Advantage plans, called *Medicare Options Compare*. It is available at <http://www.medicare.gov/>. Coverage and cost information about each plan is located in the Medicare Options Compare tool by clicking on the plan's name. Through this online tool, SHIP counselors can help beneficiaries narrow the list of available MA plans in their state. The tool allows you to further limit the list of MA plans in a state with additional screening criteria – including but not limited to:

- Plans available in a county
- Plans that charge no more than a certain monthly premium
- Plans that allow an enrollee to visit any doctor

SHIP TIP When counseling, consider using the *Medicare Options Compare* tool to help sort through the plans. It is important to remember, however, that the tool is not the only source of plan information. Counselors should remind clients to call the plans directly, prior to joining, to verify that the plan information and cost estimates are accurate.

While *Medicare Options Compare* gives a lot of information about the coverage and cost features in MA plans in summary and detailed forms, even the detailed information may not provide all of the specifics that a client needs to make an informed decision. Thus, further research may be required. Typically, you can find more information about an MA plan through its website or toll-free number.

The *Medicare Options Compare* tool also has a comparison tool for Medigap policies available in the state. Since beneficiaries sometimes enroll in a Medicare Advantage plan as an alternative to buying Medigap insurance, this tool does provide a method to evaluate both sets of options.

ENROLLMENT PERIODS AND EFFECTIVE DATES

The MMA does not allow continuous open enrollment for the Medicare Advantage program. While some low-income beneficiaries may make enrollment changes more often, most beneficiaries have limited time frames to enroll in, disenroll from, or switch MA plans. In effect, most people who enroll in MA plans are “locked in” to their plans for a calendar year. Beneficiaries must complete an enrollment form to elect, or enroll in, an MA plan.

There are three enrollment period categories: initial, yearly, and special enrollment. A beneficiary’s first chance to enroll in Medicare, and thus to choose a Medicare Advantage plan, is called the Initial Coverage Election Period (ICEP). The ICEP often coordinates with a beneficiary’s Part D Initial Enrollment Period (IEP). Yearly scheduled enrollment periods (including the Annual Enrollment Period and Open Enrollment Period) are set times of year when the law permits beneficiaries to make changes to their Medicare coverage. Special Enrollment Periods (SEPs) enable beneficiaries with special situations to make plan changes outside of initial or yearly opportunities. For example, SEPs permit beneficiaries who move out of a plan’s service area or who lose other health coverage to make changes to their Medicare benefits.

Initial Coverage Election Period (ICEP)

The Initial Coverage Election Period (ICEP) is the 7-month time frame during which a person who is newly eligible for Medicare Advantage (enrolled in both Medicare Part A and Part B) may choose to enroll in an MA plan for the first time. The ICEP begins three months before entitlement to both Part A and Part B and ends either on the last day for the beneficiary’s Part B initial enrollment period or the last day of the month preceding entitlement to both Part A and Part B, whichever is later.

EXAMPLE *Ron turns 65 on May 15. He has decided to enroll in Medicare Part A and Part B beginning May 1. Ron will have a 7-month period surrounding his birthday month to enroll in a Medicare Advantage plan (Part C). His Initial Coverage Election Period (ICEP) will therefore begin on February 1 and end on August 31.*

EXAMPLE Leigh, who delayed her Part B enrollment because she was still working, recently retired and enrolled in Part B effective August 1. She will have 3 months prior to this date to join a Medicare Advantage plan. Her Initial Election Coverage Period (ICEP) will therefore begin on May 1 and end on July 31.

Generally, a person becomes eligible for Medicare on the first day of the month of his or her 65th birthday or the 25th month of disability. Part B enrollment may not occur upon entitlement to Part A for a variety of reasons; thus, the ICEP typically coordinates with Part B entitlement or enrollment.

Yearly Opportunities for Enrollment: AEP and OEP

The MMA permits Medicare beneficiaries to make changes to their Medicare enrollment during the Annual Enrollment (or Election) Period (AEP) each year. Medicare Advantage-eligible beneficiaries may use the AEP as an opportunity to enroll in or disenroll from an MA plan. They can use the AEP to switch from one MA plan to another or to leave the MA program for Original Medicare. The AEP is six weeks long and runs from November 15 through December 31 each year. The new coverage choice becomes effective on January 1 of the following year. Beneficiaries who make more than one enrollment choice during the AEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change their minds throughout the AEP. While this may be helpful for some individuals, keep in mind that unscrupulous plan sales agents can undo the results of a counseling session with a SHIP's clients. Note that employer/union sponsored MA group plans need not conform to the AEP rules that apply to other MA plans.

SHIP TIP During the AEP, counselors may assist beneficiaries to enroll or disenroll through the "Plan Finder" or by calling 1-800-MEDICARE.

The AEP is also a chance for all Medicare beneficiaries to enroll in or disenroll from a Medicare drug plan. A decision to enroll in or disenroll from Medicare drug coverage during the AEP is effective for the following calendar year, beginning on January 1. Only beneficiaries who have a Special Enrollment Period (SEP) opportunity may change their Medicare drug plan enrollment during the plan year.

A separate yearly enrollment period for limited changes specific to Medicare Advantage plans is called the Open Enrollment Period (OEP). It runs for three months from January 1 to March 31. During the OEP, Medicare beneficiaries who are eligible for MA have one chance to make a change in MA plan enrollment. However, the MMA limits the kinds of changes that beneficiaries can make. During the OEP they cannot sign up for Medicare drug coverage if they do not already have it, nor can they drop Medicare drug coverage if they are enrolled in a Part D plan (including MA-PD plans). An enrollment choice made during the OEP will take effect on the first day of the month following the enrollment

and is in effect for the remainder of the calendar, unless a beneficiary has a SEP opportunity. Individuals cannot use the OEP (including the OEPNEW and the OEPI) to enroll in a Medicare Medical Savings Account (MSA) plan. The following chart describes the changes that the MMA allows and prohibits during the OEP.

There is an additional enrollment opportunity, called the OEPNEW, for new MA-eligible beneficiaries. The OEPNEW allows beneficiaries who make an enrollment decision during their ICEP to change their enrollment. The OEPNEW begins in the month of entitlement to Medicare Part A and Part B and ends on the last day of the third month afterwards, or December 31, whichever comes first. Beneficiaries entitled to the OEPNEW are subject to the same restrictions as those in the OEP (see the chart below).

Type of Coverage on January 1	Allowed During OEP	NOT Allowed During OEP
MA-PD	<ul style="list-style-type: none"> • Different MA-PD • Original Medicare + PDP • MA-PFFS + PDP 	<ul style="list-style-type: none"> • MA-only • Original Medicare only
MA-only	<ul style="list-style-type: none"> • Different MA-only • Original Medicare only 	<ul style="list-style-type: none"> • MA-PD • Original Medicare + PDP
MA-only PFFS + PDP	<ul style="list-style-type: none"> • MA-PD • Original Medicare + Same PDP • Different MA-only PFFS +same PDP 	<ul style="list-style-type: none"> • MA-only • Original Medicare only
Original Medicare + PDP	<ul style="list-style-type: none"> • MA-PD • MA-only PFFS + Same PDP 	<ul style="list-style-type: none"> • MA-only • Different PDP
Original Medicare only	<ul style="list-style-type: none"> • MA-only 	<ul style="list-style-type: none"> • MA-PD • Original Medicare + PDP
Medicare Medical Savings Account (MSA)	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A

Another OEP enrollment opportunity, called the OEPI, exists for people in institutions. The OEPI is a continuous enrollment period for all Medicare beneficiaries who move into, reside in, or move out of an institution. The OEPI permits them to make unlimited changes to their MA or Original Medicare enrollment. The limits outlined in the chart do not apply to those who are eligible for the OEPI. For the purpose of the OEPI, the term “institutionalized” includes those residing in the following facilities:

- Skilled nursing facilities (SNFs)
- Nursing facilities (NFs)
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Psychiatric hospitals
- Rehabilitation hospitals
- Long-term care hospitals
- Swing-bed hospitals

Special Enrollment (Election) Periods

Special Enrollment (Election) Periods (SEPs) enable Medicare beneficiaries to make certain enrollment changes in several special situations. As a SHIP counselor, it is important to keep in mind that these SEP opportunities exist because they may enable some of your clients to make changes in their MA enrollment outside of the AEP and OEP.

CMS's enrollment guidance describes a SEP this way:

Special election periods constitute periods outside of the usual IEP, AEP, or OEP when an individual may elect a plan or change his or her current plan election.... Depending on the nature of the particular special election period, an individual may:

- Discontinue an enrollment in an MA plan and enroll in Original Medicare
- Switch from Original Medicare to an MA plan
- Switch from one MA plan to another MA plan

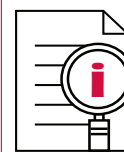
Certain SEPs are limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may subsequently elect a new MA plan within the SEP time period.

Once the individual has elected the new MA plan, the SEP ends for that individual

even if the time frame for the SEP is still in effect. **In other words, the SEP for the individual ends when**

the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within a SEP. (emphasis in original).

(See *Medicare Managed Care Manual* (CMS Pub. No. 100-16, Chapter 2, Section 30.4, available online at <http://www.cms.hhs.gov/MedicareMangCareEligEnrol/01Overview.asp>.)



For more information, see Part D corresponding SEPs on page 28.

In addition to MA-specific SEPs, there are certain other SEPs that correspond to Prescription Drug Plans (PDPs).

• Change in Residence

Two circumstances give persons the right to a SEP for a change in residence. This includes those who have a change in permanent residence that places them outside of their MA plan's service area and those who have new MA and/or Part D plans available as a result of a change in permanent residence.

This SEP has certain notice procedures. For people who notify their plan in advance of their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months.

For individuals who do not notify the plan of their move and the plan learns from CMS or otherwise that they have lived outside of their plans' service areas for more than six months, their SEP begins in the sixth month and continues through the eighth month after the move. Persons may request for the effective dates of their SEP enrollments to be up to three months after the notification but not earlier than the date of the move.

- **Contract Violation**

MA plan enrollees who demonstrate to CMS that the MA organization violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another MA plan or to Original Medicare. SHIPs can help plan enrollees submit requests for Contract Violation SEPs to their CMS Regional Office. CMS will process some of these enrollment requests as retroactive disenrollments/enrollments. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS.

- **Non-Renewals or Terminations**

People whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 of the prior year to January 31 of the following year. CMS requires these plans to give 90 days of notice to enrollees. The effective date of the enrollment may be on November 1, December 1, January 1, or February 1, but not before the plan receives the enrollment request.

Note: In some instances plans may terminate their contracts mid-year. CMS also can terminate a plan's contract if there are multiple contract violations or if the plan is insolvent.

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month

past the termination effective date. These plans are required to give 60 days of notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

- **Exceptional Conditions**

- **SEP EGHP:** Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect an MA plan or vice versa during the period of time when the EGHP allows plan changes. The effective date of the enrollment may be up to three months after the request for enrollment or disenrollment but not before the plan receives the request.

- **Disenrollment Connected to a CMS Sanction:** If CMS sanctions an MA organization and enrollees disenroll due to the issue that led to the sanction, CMS may authorize a SEP on a case-by-case basis for those enrollees.
- **Non-Renewing Cost Plans:** Enrollees in Cost plans that are not renewing their contracts are given a SEP that begins 90 days before the end of the contract year and ends on January 31 of the following year. The enrollee may choose an effective date of enrollment of November 1, December 1, January 1, or February 1, but not before the plan receives the request.
- **PACE Enrollees:** MA enrollees may disenroll at any time to join a PACE program. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join an MA plan.
- **Dual-Eligible Beneficiaries and upon Losing Dual-Eligibility:** All dual-eligible beneficiaries (including those with both Medicare and Medicaid and those who are in Medicare Savings Programs) have a SEP opportunity that begins upon becoming a dual-eligible beneficiary and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from an MA plan, including an MA-PD plan, at any time. The effective date of the change is the first of the month following the request for the change.
- **Trial Period SEP:** People who drop a Medigap policy to enroll in an MA plan for the first time are entitled to a guaranteed right to purchase their own Medigap policy back or buy a new one within the “trial period,” usually twelve months. The Trial Period SEP permits them to disenroll from an MA plan at any time during this trial period to return to Original Medicare and to purchase the Medigap policy. The SEP begins upon disenrollment from the MA plan and continues for two additional months, with an effective date depending on the situation.
- **Retroactive ESRD Entitlement**
- **Retroactive Medicare Entitlement**
- **Part D Coordinating:** These SEPs permit eligible persons to make an election into or out of an MA-PD plan (or as it applies below).
 - **Involuntary Loss of Creditable Coverage:** Medicare beneficiaries who experience an involuntary loss of creditable coverage or a reduction in such coverage that makes it no longer creditable have a SEP to permit enrollment into a Part D plan (including an MA-PD plan). The SEP begins upon notification of the loss (or reduction) and ends two months after the loss (or reduction) or the notice, whichever is later. The effective date is the first of the month following the request or may be up to three months prospective.

- **Not Informed of Creditable Coverage:** Those not adequately informed of a loss of (or that they never had) creditable coverage have a SEP to enroll in a Part D plan (including an MA-PD plan). Established on a case-by-case basis, this SEP begins upon approval from CMS and continues for two additional months.
- **Error by Federal Employee:** On a case-by-case basis, CMS may grant a SEP to those whose enrollment or non-enrollment in a Part D plan (including an MA-PD plan) is not valid due to the action, inaction, or error of a Federal employee. This SEP begins upon approval from CMS and continues for two additional months. SHIPs can help plan enrollees submit requests to their CMS Regional Office.
- **Disenroll from a Cost Plan and the Cost Plan's Optional Supplemental Part D Benefit:** Beneficiaries have a SEP to enroll in a Part D plan. The SEP begins the month the request for disenrollment from the Cost plan is made and ends two months after the Cost plan membership ends.
- **Disabled Medicare Beneficiary Turning 65:** Beneficiaries eligible for Medicare due to a disability have an additional IEP for Part D upon turning 65. The coordinating SEP with this IEP may be used to disenroll from an MA-only or MA-PD plan and return to Original Medicare, or to enroll in an MA-only plan (regardless of whether the Part D IEP to enroll in a PDP is used). The SEP begins and ends concurrently with the additional Part D IEP.
- **Beneficiaries Losing Special Needs Status:** Those enrolled in a Special Needs Plan (SNP) who no longer meet the specific special needs status are eligible for a SEP. The SEP begins upon the change in status and continues for three more months.
- **Qualified SPAP Enrollees or Loss of SPAP Eligibility:** Beneficiaries in qualified State Pharmacy Assistance Programs (SPAPs) are eligible for a SEP throughout the calendar year. These enrollees may make one additional enrollment election each year. Optional election choices include:
 - from an MA-PD plan to another MA-PD or a PDP
 - from Original Medicare-only to Original Medicare and a PDP or to an MA-PD
 - from a PDP to another PDP or an MA-PD; from an MA-only plan to a PDP or an MA-PD

SHIP TIP Because MA-PD plans cover both health care and drug benefits, there are more SEP opportunities for enrollees in MA-PDs than for those in Original Medicare and PDPs.

Those no longer eligible for SPAP benefits will have a SEP beginning with the month they lose eligibility plus two additional months to make an enrollment choice in another PDP or MA-PD.

- **Non-Dual Eligible Beneficiaries with LIS and Upon Losing LIS:** LIS eligible beneficiaries who are not dual-eligible have a SEP opportunity that begins upon qualifying for LIS and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from a Part D plan, including an MA-PD plan, at any time. The effective date of the change would be the first of the month following the request for the change.
- **Enrollment in a Chronic Care SNP:** A SEP exists for individuals who qualify for a Chronic Care Special Needs Plan (SNP) to enroll in an SNP. The SEP applies to all beneficiaries who qualify for these SNPs and ends upon enrollment into a plan.
- **Beneficiaries Who Require a New Chronic Care SNP:** An additional SEP exists for beneficiaries currently enrolled in a Chronic Care SNP who require a new SNP due to a new chronic care focus. The SEP ends upon enrollment into the new SNP.
- **Disenrollment from Part D to Enroll In or Maintain Creditable Coverage:** Any enrollee in a Part D plan (including PDPs and MA-PDs) may disenroll at any time from the plan to obtain or maintain other creditable coverage. The effective date of disenrollment would be the first of the month following the request. This SEP permits those leaving MA-PD plans also to enroll in an MA-only plan.

SEP65

Beneficiaries who enroll in an MA plan (excluding an MSA plan) during their Initial Enrollment Period for Part B (the seven months around their 65th birthday) have a SEP65 to try out the Medicare Advantage program. These individuals may disenroll from the MA plan into Original Medicare at any time during the first twelve months of enrollment in the MA plan. They have a guaranteed issue right to any Medigap policy (not just plans A, B, C, and F).

HOW TO ENROLL IN AN MA PLAN

After beneficiaries decide to enroll in a Medicare Advantage plan during an available enrollment period, the next step is to start the process of enrolling in the chosen plan. MA organizations must accept enrollments through various methods – paper enrollment forms, online enrollment tools, and telephone enrollments. All individuals wishing to enroll in an MA plan must complete an enrollment election to enroll in the plan (see Note). Beneficiaries must follow this process when changing enrollment to a different plan offered by the same MA organization.

Note: CMS provides two systems for MA plan enrollment. The Medicare Options Compare tool at <http://www.medicare.gov> accepts enrollment requests; the toll-free call center at 1-800-MEDICARE also processes these elections.

Beneficiaries eligible for the Part D low-income subsidy, and thus have auto or facilitated enrollment, may occasionally be auto or facilitated enrolled into a Medicare Advantage plan with drug coverage. This process only occurs in certain exceptional instances when a beneficiary is enrolled into an MA-only plan upon becoming eligible for the LIS. At that point, these beneficiaries would be facilitated into MA-PD plans to ensure their access to Medicare drug coverage.

EXAMPLE *Marco is currently enrolled in a HMO plan without drug coverage (MA-only). Realizing his sudden need for prescription medicines and considering his limited income and assets, he completes an application on August 4 for “Extra Help” at his local Social Security Administration (SSA) office. Within 10 days he receives a notice from the SSA that says he is indeed eligible for the low-income subsidy (LIS) for help with prescription drug coverage (Part D).*

He soon receives a notice from his HMO advising him of his options: 1) accept their HMO plan with drug coverage (MA-PD), 2) select a different Part D plan (either another MA-PD or change to Original Medicare and a PDP), or 3) opt out of drug coverage at this time. If Marco does not respond to the notice, the HMO plan will facilitate enrollment into their MA-PD. Marco now has an HMO plan with drug coverage (MA-PD) effective October 1. He also has a SEP to change plans if he chooses.

Who Can Help a Medicare Beneficiary Enroll?

In most cases, Medicare beneficiaries themselves must complete applications to enroll in MA plans. CMS’s MA Enrollment and Disenrollment Guidance (online at http://www.cms.hhs.gov/MedicareMangCareEligEnrol/01_Overview.asp) explains that anyone other than the beneficiary who completes an enrollment request must state that she or he has the legal authority under state law to execute the enrollment.

Plan Must Provide Certain Information to Enrollee

Prior to the effective date of enrollment (or within 10 calendar days of enrolling) an MA plan must provide all enrollees with the following documents:

- A copy of the enrollment form, where applicable
- A notice acknowledging receipt of the completed enrollment election showing the effective date of coverage
- Proof of health insurance coverage, including, where applicable, the 4Rx data necessary to access prescription drug benefits

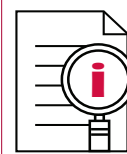


SHIP counselors who assist clients with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. Instead, SHIP counselors who help clients with Medicare Advantage plan enrollment are merely facilitating the process. Counselors can avoid problems by making sure that they do not indicate that they represent their clients, or sign enrollment forms on a client’s behalf.

Note: *The 4Rx data are numbers used by a pharmacist to accurately bill both the beneficiary and the plan when filling a prescription.*

Materials must explain the following information to new enrollees:

- The costs associated with the MA plan, including but not limited to the premium, coinsurance, copayments, or fees and the amount that the plan contributes to the Medicare premium and deductible, if applicable.
- The lock-in requirement, including an acknowledgement from enrollees that they understand about the plan's provider network requirements.
- The effective date of coverage and steps to take to obtain services prior to the receipt of an ID card, if necessary.



For more information about lock-in, see Yearly Opportunities for Enrollment on page 24.

DISENROLLMENT

Medicare beneficiaries who are currently enrolled in a Medicare Advantage plan may only disenroll from that plan during certain periods: the Annual Enrollment (or Election) Period (AEP) from November 15 through December 31; in certain situations during the Open Enrollment Period (OEP) from January 1 through March 31; and any applicable Special Enrollment Period (SEP).

There are a few ways for a Medicare beneficiary to disenroll from an MA plan:

- By enrolling in another plan
- By sending or faxing a signed written notice to the MA organization
- By requesting disenrollment online to the MA organization (if the MA organization offers this option)
- By calling 1-800-MEDICARE

CMS's disenrollment policy guidance states that "if a member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above. [...]"

The disenrollment request must be dated when it is initially received at the MA organization's business offices." (See *Medicare Managed Care Manual* (CMS Pub. No. 100-16, Chapter 2, Section 50.1, available online at http://www.cms.hhs.gov/MedicareMangCareEligEnrol/01_Overview.asp.)

Note:

CMS's guidance uses the word "verbally" instead of the word "orally." This means that CMS requires plans to provide other options for disenrollment to people who request to disenroll from an MA plan over the phone.

The effective date of most disenrollment requests is the first of the month following the request for disenrollment. There are certain exceptions to this rule based on the enrollment period during which enrollees request the disenrollment. Plans must send written acknowledgement of the disenrollment request to the enrollee within 10 days of the request.

MA plans may also process involuntary disenrollments in certain circumstances. Examples of situations where plans have the option to disenroll individuals include the following:

- Failure to pay premiums timely
- Engaging in disruptive behavior
- Providing fraudulent information to the plan

There are also certain situations when CMS requires a plan to process an involuntary disenrollment:

- Moving out of an MA plan's service area
- Losing entitlement to Medicare Part A and/or Part B
- Losing special needs status, for Special Needs Plans
- Death
- Plan terminating or discontinuing

POST-ENROLLMENT ACTIONS

Even after a beneficiary requests enrollment or disenrollment, there are certain changes that may be made related to the enrollment or disenrollment.

Cancellations

Both enrollment and disenrollment requests may be cancelled before the effective date of the change. Those wishing to request such a cancellation must request this directly from the MA organization.

Reinstatements

Enrollment in an MA plan may be reinstated if a disenrollment was processed and the disenrollment was not legally valid. CMS processes reinstatements on a case-by-case basis, but common reasons for reinstatements include the following circumstances:

- Disenrollment due to mistaken death indicator
- Disenrollment due to mistaken loss of Medicare Part A or Part B
- Mistaken disenrollment

Retroactive Enrollments

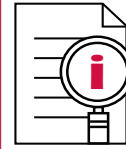
If an MA organization does not process a valid request for enrollment within the appropriate time frame, then CMS may perform a retroactive enrollment.

Retroactive Disenrollments

If an enrollment in an MA plan was never legally valid or if a beneficiary makes a valid disenrollment request and it is not processed, a retroactive disenrollment may be performed by CMS. Enrollments that are not legally valid could include the following:

- An incomplete enrollment request
- An attempted enrollment for an individual who did not meet eligibility requirements at the time of enrollment
- If the member or his/her legal representative did not intend to enroll in the MA organization. Evidence of a lack of intent to enroll could include:

- An enrollment form signed by the individual when a legal representative should have signed,
- A request by the individual for cancellation of enrollment before the effective date,
- An enrollment in a supplemental insurance program after enrolling in the MA plan, or
- Receiving services out-of-network after enrolling in an MA plan.



For more information on retroactive disenrollment, go to <http://www.hapnetwork.org/medicare-advantage/ma-disenrollment.html>.