

## ELIGIBILITY AND ENROLLMENT

This section covers:

- Eligibility for Enrollment
- Deciding to Enroll in a Part D Plan
- How to Select a Plan
- Enrollment Periods
- How to Enroll
- Disenrolling and Switching

### ELIGIBILITY FOR ENROLLMENT

Given all the choices available for Medicare prescription drug coverage, it is essential for SHIP counselors to help clients determine whether they can enroll, whether they want to enroll, how to enroll, and when to enroll in a Medicare drug plan. The first step in the process is to ask if your client is enrolled in Medicare. Anyone who has Medicare Part A and/or Part B is eligible for a Part D plan.

### DECIDING TO ENROLL IN A PART D PLAN

Everyone who is eligible for Part D has a choice to make about whether to enroll in a Part D drug plan. That choice depends largely on whether they have other health insurance that covers prescription drugs. For clients who currently have no coverage for prescription drugs, enrolling in Part D can save them money over time. On the other hand, clients who already have prescription drug coverage face a different set of options based on if and how their current coverage works with Part D.

It is important for all Medicare beneficiaries to make informed decisions about their drug coverage. Medicare beneficiaries with the following types of coverage have special considerations:

- Retiree or union coverage
- Medigap or Medicare Supplement plans
- Veterans Administration (VA) and/or TRICARE for Life
- Federal Employee Health Benefit Program (FEHBP)
- Medicaid
- Medicare Savings Programs (QMB, SLMB, QI)

## Creditable Coverage

For beneficiaries with existing insurance coverage for prescription drugs, it is important to learn if that coverage is “creditable.” Creditable coverage means that the insurance benefit is as good as – or better than – the coverage in Medicare’s basic benefit.

The drug coverage in many retiree or union health plans, TRICARE for Life, the VA, and the Federal Employee Health Benefit Program (FEHBP) is creditable coverage. The drug coverage in three standardized Medigap insurance policies (Plans H, I, and J) sold between 1992 and 2004 is not creditable, but the drug coverage in some Medigap policies that pre-date 1992 is creditable. Similarly, the drug coverage in some Medigap policies sold through 2005 in Massachusetts, Minnesota, and Wisconsin is creditable. If the policy was issued before 1992 (or before 2006 in the three states), contact the benefits administrator at the insurance company to ask whether the benefit is considered creditable.

SHIP counselors often help clients learn if they have creditable coverage. The MMA requires insurers to notify people annually about the creditable status of their health plans. This notice may be an official letter, or it may appear in a health plan update, such as a newsletter. It is important for your clients who have creditable coverage to keep these notices in a safe place for possible future reference. Another way to get information on creditable coverage is to call the benefits office for the retiree health plan.

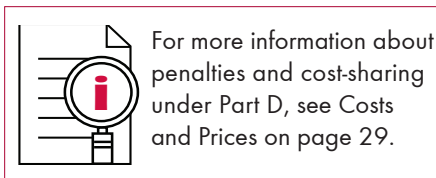
People who have creditable coverage for prescription drugs do not need to enroll in a Part D drug plan now, or perhaps ever. It is also important to know that some people who have creditable coverage through an employer or union health plan could permanently lose their retiree health benefits if they enroll in a Part D drug plan. Under the terms of some group insurance contracts, retirees may lose all of their health benefits and forfeit their creditable coverage (along with spousal coverage) by enrolling in other coverage, like a Medicare drug plan.

**EXAMPLE** *Michelle has a PPO through her union as part of her retirement package. Her current plan adequately covers her medications. The PPO’s annual newsletter announced that the coverage is considered creditable. Even though Michelle has heard of Part D and considered enrolling, a SHIP counselor reminded her that she does not need to enroll in a Part D plan.*

## Late Enrollment Penalty (LEP)

CMS charges a late enrollment penalty to Part D-eligible beneficiaries when they do not have a Part D plan or creditable coverage. The penalty is assessed if and when these beneficiaries enroll in Part D. CMS calculates the penalty based on the number of months an eligible beneficiary was not enrolled in Part D or other creditable coverage.

Some people choose not to enroll in Part D because they have no prescription drug costs now, or they are overwhelmed by the process. Because of the potential for penalties, it is very important for you and your clients to know whether their current coverage is creditable. One group exempt from the penalty is those eligible for the low-income subsidy – they will not have a late enrollment penalty.



**EXAMPLE** *Charlie has been in enrolled in Original Medicare, Part A and Part B, since 1988. He pays for an individual Medicare Supplement (Medigap) policy that costs \$120 per month and has no prescription drug coverage. Until recently he took very few medications. But when he began taking Lipitor and Hydrochlorothiazide and using Xalatan eye drops, his retail drug costs became very expensive. He wanted to keep his Medigap policy and all of his Medicare hospital and doctor coverage the same, but wanted to pay less for his medications. Charlie joined a PDP and pays a \$25.00 monthly premium for prescription drug coverage.*

*Charlie will face a penalty because he did not have creditable coverage or a Part D plan, despite being eligible for Part D.*

## HOW TO SELECT A PLAN

There are many factors to consider for beneficiaries who decide to enroll in a Part D plan. Dozens of plans are available in most areas of the country. It is incredibly difficult to compare all of the plans to each other, so many SHIPs use a number of factors to help narrow down the list of possible plans for each person they assist. This keeps the process more manageable and also helps beneficiaries choose a plan because the list of appropriate plans is often a good deal shorter than the list of all plans. To help them choose the most appropriate plan, bear in mind the following categories:

- **Original Medicare or Medicare Advantage**

The first factor beneficiaries should consider is whether they want to be in Original Medicare or in a Medicare Advantage plan. Beneficiaries who are in Original Medicare must join a stand-alone Prescription Drug Plan (PDP) to receive Medicare drug coverage. Generally, beneficiaries who are in Medicare Advantage plans must enroll in a Medicare Advantage plan with Part D coverage (MA-PD) to receive the Medicare drug benefit. Exceptions to this rule exist for some types of MA plans, the most common of which are Private Fee-for-Service (PFFS) plans and Medicare Medical Savings Accounts (MSAs).

- **Access to Needed Drugs**

Another major factor to consider when selecting a Part D drug plan is the extent to which the plan provides coverage for needed drugs. It is critically important to compare the beneficiary's prescribed medications to Part D plans' formularies (i.e., lists of covered drugs). Because so many Part D plans are available to most beneficiaries, using the formulary to narrow down that list of plans is a helpful practice.

After filtering out Part D plans that do not include all of a beneficiary's medications on their formularies, there are other factors to consider related to the formulary. Specifically, Part D plans may apply utilization management tools to certain drugs on their formularies. Some examples of these tools include prior authorization, step therapy, and quantity limits. Since utilization management may make it more difficult for enrollees to access their needed prescriptions, it is important to consider this factor when comparing the plans' formularies.

- **Access to Pharmacies**

Another factor to consider is the plans' pharmacy networks. It is important to check if a beneficiary's preferred pharmacy is in the plan's network, and if not, to make sure that convenient alternatives exist. Plan networks are important because Part D plans will not pay for prescriptions at non-network pharmacies, except in emergencies. A drug plan's network pharmacies may change from year to year. Some drug plans also have "preferred pharmacies" within the network that offer lower prices than other network pharmacies.

Other pharmacy access concerns include alternative methods of getting prescriptions. Many plans offer a mail-order program, though the law does not require it. All plans must allow access to home infusion pharmacies and to long-term care (LTC) pharmacies for those who reside in LTC facilities.

### Mind the Gap

Most beneficiaries who enter the coverage gap, or "doughnut hole," must pay the full, negotiated price for their prescription drugs until they reach catastrophic coverage. There are a few choices that may make the coverage gap easier to afford. First, beneficiaries with high prescription drug costs could consider enhanced Part D drug plans with coverage in the gap, if available. Second, some states have State Pharmaceutical Assistance Programs (SPAPs) that help beneficiaries with their drug costs. Finally, some pharmaceutical companies have programs, called Patient Assistance Programs (PAPs), to assist beneficiaries with the costs of their drugs. Both SPAPs and PAPs have requirements that differ from program to program. These assistance programs may change the time an enrollee spends in the coverage gap, so those with very high drug costs should consider this option carefully.

It is important to remember that those with the low-income subsidy (LIS) have continuous coverage through the gap.

## • Plan Costs

Many beneficiaries will consider costs and prices when selecting a Part D plan. The total yearly costs of being enrolled in a Part D plan depend on the monthly premium, annual deductible, copayments or coinsurance for each drug, and any drug costs that the beneficiary will owe in the coverage gap. Monthly premiums range significantly; in one state, monthly premiums may be as low as \$12 and as high as \$150. In another state, the range of costs for the same plans may be higher. Annual deductibles in 2010 will range from \$0 to \$310, annually. A deductible is the amount that an enrollee must spend out-of-pocket on formulary drugs before the plan begins to pay its share of the costs for each prescription filled. Finally, the Plan Finder lists the cost of each drug covered by Part D plans. Copayments may be as low as \$0 for certain drugs and as high as several hundred dollars for others. Coinsurance percentages vary considerably from plan to plan.

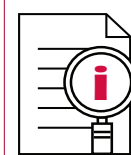
Beneficiaries who qualify for LIS have different cost considerations. Most of these beneficiaries have access to premium-free plans with no annual deductible, reduced or eliminated cost-sharing for each drug, and no coverage gap. Remember, though, that plan formularies will vary, so not all LIS plans are appropriate for all LIS beneficiaries.

## Other Considerations

Beneficiaries in the process of selecting appropriate Part D plans may consider other factors before enrolling in a plan. One consideration for these beneficiaries is service area. A plan's service area includes the counties, states, regions, or territories in which an enrollee may use the plan. Some plans are national, meaning their service area is nationwide. Others are regional and have geographic limitations on their pharmacy networks.

Another factor beneficiaries consider is the quality information that CMS makes available about each plan. The Plan Finder shows quality information for the following categories: drug plan customer service, member complaints and staying with drug plan, member experience with drug plan, and drug pricing and patient safety. These quality measures offer beneficiaries a source of objective information which they can use to compare plans.

An additional factor for beneficiaries to understand is the concept of lock-in. Beneficiaries who opt to join Part D plans should understand that after enrollment, they may have only limited opportunities to make changes to their coverage. 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.



For more information, see Special Enrollment Periods on page 18.

## ENROLLMENT PERIODS

The MMA does not allow most beneficiaries to enroll in or disenroll from Part D plans at any time. Most beneficiaries have limited time frames to enroll in, disenroll from, or switch Part D plans. Two notable exceptions are beneficiaries who qualify for LIS and beneficiaries living in long-term care facilities; these individuals may make monthly plan enrollment changes.

There are three enrollment period categories: initial, yearly, and special. A beneficiary's first chance to enroll in Medicare, and thus to join a Medicare drug plan, is called the 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 change their Part D plans. Special Enrollment Periods (SEPs) enable beneficiaries under specific circumstances to make plan changes outside of initial or yearly opportunities. SEPs are designed, for example, to permit beneficiaries who move out of a plan's service area or into a long-term care facility to make changes.

*Note:* The IEP is also referred to as the ICEP or the Initial Coordinated Election Period.

### Initial Enrollment Period (IEP)

Generally, an individual becomes eligible for Medicare on the first day of the month of the individual's 65th birthday or the 25th month of disability. The three months before, the month during, and the three months after this eligibility date are known as the Part B Initial Enrollment Period (IEP). This time frame is also the IEP for Part D benefits. Beneficiaries who do not enroll in a Medicare drug plan during their IEP generally will not be able to enroll in a plan until the following Annual Enrollment Period (AEP), unless they qualify for a special enrollment period, or SEP. Note that if a beneficiary does not have creditable drug coverage and does not enroll in a Medicare drug plan during the IEP, he will likely have a late enrollment penalty added to his Medicare drug plan's premium if and when he enrolls.

*Note:* Those who enroll in Part D in the first three months of their IEP must wait until the 1<sup>st</sup> day of the month of Medicare eligibility for coverage to begin.

Initial enrollment for Medicare works differently for some people with disabilities. For those with end-stage renal disease (ESRD), beneficiaries must file a written application for those benefits when they become eligible. Those who have had a kidney transplant and those who have had kidney dialysis for three months are entitled to Medicare Part A. Part D eligibility begins upon entitlement to or enrollment in Medicare Part A and/or Part B. Thus, upon filing an application for Medicare Part A coverage, beneficiaries are entitled to enroll in a Part D plan.

Part D eligibility and enrollment for those with Lou Gehrig’s disease (amyotrophic lateral sclerosis, ALS) is more similar to the process for those with disabilities. The 24-month waiting period that applies to most beneficiaries with disabilities does not apply to those with ALS. These individuals have a 5-month waiting period; their Part A coverage begins on the sixth month of the ALS disability. Thus, these beneficiaries have seven months of a Part D IEP. Their IEP begins in the second month of ALS disability and continues to three months past the month their Part A benefits begin.

**EXAMPLE** *Richard turns 65 on April 17. His IEP for Medicare Part B and Part D begins on January 1 and ends on July 31. If he enrolls in a Part D plan in January, February, or March, Richard’s coverage takes effect on April 1. If he enrolls in a Part D plan in April his coverage starts on May 1. Likewise, if he enrolls in July, his Part D coverage starts on August 1. If Richard does not enroll in a Part D plan during his IEP, the next opportunity to enroll in a Medicare drug plan is November 15 at the start of the AEP.*

## Yearly Opportunities for Enrollment: AEP and OEP

Beneficiaries who already are enrolled in Medicare drug plans may change plans or disenroll from their plans during the Annual Enrollment (or Election) Period (AEP). The AEP is six weeks long, and runs from November 15 through December 31 each year. A decision to enroll or disenroll during the AEP is effective usually for the entire calendar year starting on January 1. 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 sales agents can undo a plan selection made during an earlier SHIP counseling session with a client. The only exception is for beneficiaries who have a Special Enrollment Period (SEP) opportunity.

*Note:* The AEP is also referred to as the ACEP or the Annual Coordinated Election Period.

A separate yearly enrollment period for changes related to Medicare Advantage plans is called the Open Enrollment Period (OEP). It lasts for three months, from January 1 to March 31 each year. During the OEP, Medicare beneficiaries have an opportunity to make one limited change to the way they receive their Medicare benefits. Any change made during the OEP takes effect on the first of the following month.

The types of changes beneficiaries can make during the OEP are limited (see table below). Specifically, individuals cannot sign up for Medicare drug coverage if they don’t already have it. They also cannot drop Medicare drug coverage if they are enrolled in Part D plan (including an MA-PD plan). An enrollment choice made during the OEP is in effect for the entire remaining calendar year starting on the effective date of coverage, unless a beneficiary has a SEP opportunity.

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

**EXAMPLE** Erika was enrolled in Original Medicare and a stand-alone PDP last year. She did not change plans during the six-week AEP that year. On February 3 of the next year, Erika talked with a SHIP counselor about enrolling in a different Part D plan. The counselor explained that she cannot switch to another PDP, but she can change to an MA-PD plan. Erika enrolled in an MA-PD plan on February 10. Her new coverage took effect on March 1. In joining the MA-PD plan, she also must comply with the MA-PD plan's rules and is no longer in Original Medicare for the rest of that year.

## Special Enrollment Periods (SEPs)

Special Enrollment Periods (SEPs) enable Medicare beneficiaries to make Part D plan enrollment changes in special situations. CMS's *PDP Guidance: Eligibility, Enrollment, and Disenrollment* (available online at <http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/PDPEnrollmentGuidanceUpdateFINAL2010.pdf>) describes a SEP this way:

*Special enrollment 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. As detailed below, there are various types of SEPs, including SEPs for dual eligible individuals, for individuals whose current plan terminates, for individuals who change residence and for individuals who meet "exceptional conditions" as CMS may provide, consistent with §1860D-1(b) of the Act and §423.38(c) of the Part D regulations.*

(...)

*Certain SEPs may be limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the PDP, the individual may subsequently enroll in*

*a new Part D plan within the SEP time period. Once the individual has enrolled in a new Part D plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, the SEP ends when the individual enrolls in a new Part D plan or when the SEP time frame ends, whichever comes first, unless specified otherwise for an SEP.*

In addition to the above-mentioned SEPs, there are certain other SEPs that correspond to Part D plans, including PDPs and MA-PDs. See the descriptions below.

- **Change in Residence**

Beneficiaries have the right to a SEP under the four following circumstances related to a change in residence:

- Those with a change in permanent residence that places them outside of their Part D plan's service area
- Those with new Part D and/or MA plans available due to a change in permanent residence
- Those not eligible for Part D because they have been living outside of the U.S. and have returned to the U.S.
- Those not eligible for Part D because they were incarcerated and are now released

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. People may request for the effective date of this SEP enrollment to be up to three months after they notify their plan but not earlier than the date of the move.

There are other procedures for those who do not notify their plans of their moves. If the plan learns from CMS (or otherwise) that an enrollee has lived outside of the plan's service areas for more than six months, the enrollee's SEP begins upon discovery of that move and continues for two months after the move.

- **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 that begins upon becoming dual-eligible and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from Part D plans, including PDPs and MA-PD plans, at any time. The effective date of the change is the first of the month following the request for the change.

- **Contract Violation**

Part D plan enrollees who demonstrate to CMS that the PDP sponsor violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another Part D plan. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS. CMS also may approve retroactive disenrollments in these cases, depending on the severity of the situation. In considering cases for retroactive disenrollment, CMS will consider certain factors. A tip sheet on retroactive disenrollment is available on HAP's Web site at <http://www.hapnetwork.org/assets/pdfs/retroactive-disenrollment-tips.pdf>.

- **Non-Renewals or Terminations**

Beneficiaries whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 to December 31 of the prior year. In these circumstances, CMS requires these plans to give a 90-day 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.

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 a 60-day 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.

*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.

- **Involuntary Loss of Creditable Coverage**

Beneficiaries who involuntarily lose creditable prescription drug coverage are eligible for a SEP. An involuntary loss includes a reduction in the amount or type of coverage that makes it no longer creditable. But a loss of coverage because an individual failed to pay premiums does not constitute an involuntary loss.

This SEP permits enrollment in a PDP and begins with the month in which the individual is advised of the loss of creditable coverage and ends two months after either the loss (or reduction) occurs or the individual received the notice, whichever is later. The

effective date of this SEP may be the first of the month after the request or, at the beneficiary's request, may be prospective; however, it may be no more than two months from the end of the SEP.

- **Not Adequately Informed about 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 a 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, including customer service representatives (CSRs) at 1-800-MEDICARE. This SEP begins upon approval from CMS and continues for two additional months.

- **Exceptional Conditions**

- **SEP EGHP:** Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect a Part D 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 a Part D plan sponsor 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.
- **PACE Enrollees:** Part D plan enrollees may disenroll at any time to join a PACE plan. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join Original Medicare and a PDP or an MA plan.
- **Trial Period SEP:** People who drop a Medigap policy to enroll in an Medicare Advantage plan for the first time are entitled to a guaranteed right to purchase another Medigap policy within the "trial period," usually 12 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 and a PDP. 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
- SEP for Institutionalized Individuals: Beneficiaries who move into, reside in, or move out of a long-term care (LTC) facility have a SEP that begins upon moving into the LTC facility and lasts through up to two months after moving out of the facility.
- SEP for Individuals Who Enroll in Part B during the Part B Open Enrollment Period (OEP): Those individuals who are not entitled to premium-free Part A and who enroll in Part B during the GEP (January – March). The SEP begins April 1 and ends June 30, with an effective date of July 1.
- 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.
- 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 in a plan.
- Qualified SPAP Enrollees: Beneficiaries in qualified State Pharmaceutical 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
- 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.
- 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.

## HOW TO ENROLL

After beneficiaries determine they are eligible for the Part D drug benefit, decide to enroll in a plan during an available enrollment period, and choose an appropriate plan, the next step is to start the process of enrolling. There are several ways to enroll in a Part D drug plan. These include mailing an enrollment form to the plan sponsor, enrolling online, enrolling by phone, and enrolling with a sales representative.

CMS makes it fairly easy for beneficiaries to compare and enroll in Part D plans on the Plan Finder located online at <http://www.medicare.gov>. SHIP counselors who are able to guide clients through the internet enrollment procedure are in a position to provide a warmly welcomed service for those who are not computer savvy.



Part D plans may not enroll beneficiaries on an outbound call from the plan to the beneficiary. CMS allows enrollments by phone only if the beneficiary called the plan to enroll. Plans are not permitted to transfer their outbound calls

## Who Can Help a Medicare Beneficiary Enroll?

In most cases a Medicare beneficiary must complete the application to enroll in a Medicare drug plan. CMS's *PDP Guidance on Eligibility, Enrollment and Disenrollment* (online at <http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/PDPEnrollmentGuidanceUpdateFINAL2010.pdf>) 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 and that the documentary proof of such legal authority will be made available to CMS or the plan upon request.

SHIP counselors who assist Medicare beneficiaries with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. SHIP counselors who assist beneficiaries with Part D 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 unless the client is unable to write. If clients are not able to write, counselors should follow the standard rules for such cases. This means that the client should make an "X" in the signature box and the witness should write "By" and his name and address with a short description of reason the patient cannot sign.

*CMS's PDP Guidance on Eligibility, Enrollment and Disenrollment states [w]hen somebody other than the Medicare beneficiary completes an enrollment request, he or she must:*

- a) Attest that he or she has the authority under State law (e.g. Power of Attorney) to make the enrollment request on behalf of the individual;*
- b) Attest that proof of authorization, if any, required by State law that empowers the individual to effectuate an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Part D sponsors cannot require such documentation as a condition of enrollment; and*
- c) Provide contact information.*

## DISENROLLING AND SWITCHING

Most Medicare beneficiaries who currently are enrolled in a Part D drug plan may only disenroll from that plan during certain periods: the AEP from November 15 through December 31, certain situations during the Medicare Advantage OEP from January 1 through March 31, and applicable SEPs. Generally, once an enrollment choice is effective, most beneficiaries are “locked-in” to their selected plan for the remainder of the plan year.

There are a few ways for a Medicare beneficiary to disenroll from a Part D plan:

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

### Annual Enrollment Period (AEP) Disenrollment

During the AEP, Medicare beneficiaries can make only one choice among two options affecting their drug plan enrollment. They either can enroll in a different Part D plan (PDP or MA-PD) or disenroll from their current plan. Enrolling in a different Part D plan effectively switches the beneficiary from one plan to the other.

### Special Enrollment Period (SEP) Disenrollment

During any applicable SEP, a beneficiary may disenroll from a Part D plan. Beneficiaries need only enroll in a new Part D plan to be disenrolled from a previous one. A disenrollment during the SEP does not prevent a beneficiary from subsequently enrolling in another plan as long as the SEP’s timeframe has not expired. The length of an SEP varies according to the situation. People who move out of their drug plan’s service area, for example, can have a SEP of up to four months. In contrast, people who move out of a certain type of nursing facility have a SEP that lasts up to two months after discharge.

**EXAMPLE** *Margaret is planning to move to a new area of the country in April. In doing so, she will leave the service area of her Part D drug plan, Canterbury Prime PDP. She notifies Canterbury Prime PDP in February of her impending move, and receives a SEP. The SEP begins in March, the month before her move. It will end in June, two months after her move. If Margaret enrolls in a new plan in March, its effective date is April 1. Her SEP ends when she enrolls in the new plan. She must enroll before the end of June.*