

III. Eligibility and Enrollment

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A. 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 in a Medicare drug plan, want to enroll in a plan, how to enroll, and when to enroll in a plan. The first step in the process is to ask if your client is enrolled in Medicare. Anyone who has Medicare Parts A and/or B is eligible for a Part D prescription drug benefit through one of the private plan sponsors.

B. Deciding to Enroll in a Part D Plan and Existing Drug Coverage

Everyone who is eligible for Part D has a choice to make about whether or not to enroll in a Part D drug plan. That choice for your clients will depend largely on whether or not they have other health insurance that covers prescription drugs. If a client currently has no coverage for prescription drugs, then enrolling in a Part D plan can save money over time. But clients who have some form of prescription drug coverage face at least three choices: not to enroll in a Part D drug plan at all, to replace their current coverage with a Part D plan, or to extend their current coverage with a Part D plan. SHIP counselors can help beneficiaries make informed choices about enrolling in a Medicare drug plan. The choices often take a different shape for each person.

It is important for all Medicare beneficiaries to make an informed decision 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

After a SHIP counselor learns that a client has existing insurance coverage for prescription drugs, it is important to find out 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 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. Contact the benefits administrator at the insurance company to ask whether or not the benefit is considered creditable if the policy was issued before 1992.

As a SHIP counselor, how can you help your clients learn if they have creditable coverage? Ask to see a creditable coverage notice. 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 retiree health plans.

People who have creditable coverage for prescription medications need not enroll in a Part D drug plan now or perhaps ever. The Part D late enrollment penalty does not apply to them if they decide to enroll in a Medicare drug plan at a later date, as long as they had creditable coverage up until enrollment. 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 joining another health plan like a Medicare drug plan.

Counseling Tip: When it is unclear if a client has employer or retiree coverage, take whatever time you need to verify his or her coverage status. There is a good chance that if a person with group coverage signs up for another health benefit of any type, he or she could lose that benefit permanently. This can also apply to pensions, annuities, or other associated group based retiree benefits.

For Example: Ilana has a PPO through her union as part of her retirement package. She has heard of Part D, but feels her current plan adequately covers her medications. If her drug coverage is creditable, she does not need to enroll in a Part D plan to avoid a late enrollment penalty.

For Example: Vincent has had retiree group coverage through a HMO that “wraps around” Medicare. The retiree plan offers creditable coverage for drugs. He recently attended, however, a free blood pressure screening and movie screening to hear about the “Choices Galore” Medicare Advantage plan with Part D drug coverage. When they told him his medications would cost nothing, he signed up. Now Vincent no longer has his retiree group plan, because his new MA-PD plan has replaced it.

Late Enrollment Penalty

In contrast, beneficiaries who do not have creditable coverage and who decide not to enroll in a Part D plan—perhaps because they have no prescription drug costs now—may face a late enrollment penalty if they enroll in a Part D plan later on. Because of the potential for penalties, it is very important for you and your clients to know whether or not their current coverage is creditable. *Please refer to Section V “Costs and Prices” for more detailed information about penalty fees and cost-sharing under Part D.*

It is important to know that several other groups of beneficiaries are exempt from the late enrollment penalty (LEP). Beneficiaries who qualified for the Low-Income Subsidy in 2006 or 2007 do not have to pay the LEP. CMS has extended the late enrollment penalty exemption for those who qualify for the Low-Income Subsidy in 2008 through December 2008. For more information, please see the CMS press release available at:

<http://www.hapnetwork.org/assets/pdfs/2008-lep-9-24-2007.pdf>.

C. How to Select a Plan

If a beneficiary decides to join a Medicare drug plan, she will have many different options. *(Please refer to Section II “Medicare Part D: Types of Drug Plans” for specific information about Part D plan structure.)* There are at least six factors to consider in selecting a Part D plan.

1. Original Medicare or Medicare Advantage The first factor a beneficiary should consider is whether he wants 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. Some exceptions, however, exist. *Please refer to Section IV “Relationship to Medicare Advantage.”*

2. Access to Needed Drugs One major factor to consider when choosing among Part D drug plans is the extent to which the plan provides access to drugs that a beneficiary needs. It is critically important to learn which Part D plan formularies, or lists of covered drugs, contain the largest number of the beneficiary’s prescribed medications. Formularies vary greatly in scope. It also is equally important to consider the types of utilization management requirements, such as prior authorization and quantity limits, that the plans place on the beneficiary’s drugs. Some

plans use these requirements more often than others. (*Please refer to Section VII “Access to Drugs and Formularies” for more information on these requirements.*)

Counseling Questions:

- Do you want to join a PDP and receive your Medicare-covered hospital, medical and other benefits through Original Medicare (Parts A and/or B)?
- Do you want to join an MA-PD and receive your drug benefits, along with your other Medicare-covered hospital, medical and other benefits, through a private Medicare Advantage plan?
 - This means that you need to check with your doctors and hospital to learn if they are in the plan’s provider network or if they accept the plan’s payments. An informed decision also requires an understanding of the rules that Medicare Advantage plan enrollees must follow.
- Do you understand the differences between the different types of MA plans?

3. Mind the Gap Beneficiaries who enter the initial coverage gap, or “doughnut hole,” could face thousands of dollars in out-of-pocket costs. Those who receive the Low-Income Subsidy (LIS), however, will never enter the coverage gap. Thus, some of your clients who use a lot of prescription drugs and are not eligible for the LIS should ask themselves if they need, and can afford, an Enhanced Part D drug plan that offers coverage in the gap along with a broader formulary. Because Enhanced plans may only cover generic drugs in the gap, beneficiaries should also learn if their medications are available in generic form, and if their physicians advise, switching from a brand-name drug to a generic.

4. Access to Pharmacies The Part D plans vary in the size of their pharmacy networks. It is important to learn if a beneficiary’s preferred pharmacy is in the plan’s network, and if not, to make sure that convenient alternatives exist. Some drug plans also work with “preferred pharmacies” to offer lower prices than other network pharmacies. Many plans offer access to mail-order pharmacies, though the law does not require it. The MMA does require access to home infusion pharmacies and to long-term care (LTC) pharmacies for those who reside in LTC facilities. Note that Medicare drug plans may not pay for prescriptions at non-network pharmacies, except in emergencies and a few other situations. A drug plan’s network pharmacies may change from year to year.

Counseling Tip: Pharmacies in the network of the Part D plan charge the lowest cost-sharing amount. For non-routine emergencies, beneficiaries may be allowed to use non-network pharmacies, but the plan may not pay for the drug. Additionally, the cost of the drug may not count towards TrOOP.

5. The Plan’s Cost One factor that many beneficiaries will weigh in choosing a Part D plan is the plan’s overall cost. A drug plan’s total cost depends on the amount of the monthly premium, annual deductible, co-payments or co-insurance for each drug, and any costs that the beneficiary will likely owe in the coverage gap. Further, beneficiaries who qualify for the Low-Income

Subsidy must consider the low-income premium subsidy benchmark, and decide if plans with premiums below the benchmark satisfy their needs. If not, they must also decide if they are willing and able to pay part of the premium for a plan above the benchmark. The Low-Income Subsidy amounts for 2008 are available at: <http://www.hapnetwork.org/assets/pdfs/2008-lis-amounts.pdf>.

6. Other Considerations There are more than 40 national Part D drug plans that one can use anywhere within the United States (2008). There are many more regional plans that have geographic limitations on their local pharmacy networks. Generally, once a beneficiary enrolls in a Part D plan, the plan is in effect for the next calendar year and one cannot enroll in a different plan until the next Annual Enrollment Period. Exceptions to this rule are covered later in this section. CMS permits the Part D plan sponsors to advertise and conduct other marketing activities beginning each year on October 1st, before the yearly Annual

Election Period. SHIP counselors provide a useful service in helping clients make sense of the claims they read in promotional brochures and newspaper ads or see in TV commercials.

Counseling Tip:
National plans typically have premiums that are above the subsidy amount provided to those who are receiving the Low-Income Subsidy.

For Example: Sid resides in Vermont and travels a fair amount. He often takes weekend trips to other parts of New England, and spends the holidays with his family in Delray Beach, Florida. He enrolled in the “National Drugs-R-Us” plan. Sid chose a national drug plan so he can fill his prescriptions wherever he goes in the U.S.

Counseling Questions:

- Does the client need or prefer a national plan?
- Is the client’s regular pharmacy in the plan’s network? Is it a preferred pharmacy? Does the plan offer a mail-order option?
- What is the exceptions process for drugs not covered by the Part D plan or drugs it removes from the formulary during the plan year? Is the client willing and able to work through the exceptions process to gain coverage for a non-formulary drug?
- Does the Part D plan place utilization management requirements on any of the client’s drugs?
- What information is known about the plan’s performance measures (e.g., customer service records and grievance data)?

D. Enrollment Periods

The MMA does not allow continuous open enrollment for Medicare's Part D drug benefit. While some low-income beneficiaries can make monthly plan enrollment changes, most beneficiaries have limited time frames to enroll in, disenroll from, or switch Part D plans. There are three enrollment period categories: initial, yearly, and special enrollment.

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, *see below*) are set times of year when the law permits beneficiaries to change their Part D plans. Special Enrollment Periods (SEPs) enable beneficiaries with special situations 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. *See the end of this section for a chart that details the enrollment periods for Medicare Drug Coverage.*

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 (*see below*). 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.

Counseling Tip:

Those who enroll in Part B and/or Part D early in their IEP must wait until the 1st day of their month of eligibility for coverage to start.

Counseling Tip:

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

For Example: Edgar turns 65 on April 17. His IEP for Medicare Parts B and D begins on January 1 and ends on July 31. If he enrolls in a Part D plan in January, February, or March, Edgar's coverage takes effect on April 1st. If he enrolls in a Part D plan in April his coverage starts on May 1st. Likewise, if he enrolls in July, his Part D coverage starts on August 1. If Edgar 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 Annual Enrollment Period (*see below*).

Yearly Opportunities for Enrollment: AEP and OEP

The MMA permits beneficiaries who already are enrolled in a Medicare drug plan to change plans or disenroll from their Part D plan during the Annual Enrollment or Election Period (AEP). The AEP is six weeks long, and runs from November 15 through December 31. A decision to enroll or disenroll during the AEP is effective for the entire calendar year starting on January 1. The only exception is for beneficiaries who have a Special Enrollment Period (SEP) opportunity. Note that if a beneficiary does not have creditable drug coverage and does not enroll in a Medicare drug plan during an AEP, he will likely face a late enrollment penalty added to his plan’s premium if and when he enrolls in a Medicare drug plan.

Counseling Tip:
The AEP is also referred to as the Annual Coordinated Election Period.

For Example: For 2007, Edna was enrolled in “Millennium Meds,” a Medicare prescription drug plan. On December 1, 2007, she enrolled in another Medicare drug plan called “Prescription Panoply.” Her Part D coverage through Prescription Panoply starts on January 1, 2008.

A separate yearly enrollment period for **changes related 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 have both Medicare Parts A and B and who have already enrolled in a Medicare drug plan have one opportunity to make a change that takes effect on the first of the following month. 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 don’t already have it, nor can they drop Medicare drug coverage if they are enrolled in Part D 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. The following chart describes the changes that the MMA allows and prohibits during the OEP.

Type of Coverage on January 1	Allowed During OEP	NOT Allowed During OEP
MA-PD	Different MA-PD <u>or</u> Original Medicare and a PDP	MA-only <u>or</u> Original Medicare without a PDP
MA-only	Original Medicare without a PDP	MA-PD <u>or</u> Original Medicare and a PDP
Original Medicare and a PDP	MA-PD	Different PDP or MA-only

For Example: Yvette was enrolled in Original Medicare and a stand-alone PDP during 2007. She did not change plans during the six week AEP. On February 3, 2008, Yvette talks with a SHIP counselor about enrolling in a different Part D plan. The counselor explains that she cannot switch to another PDP, but she can change to an MA-PD plan. Yvette enrolls in an MA-PD called “Managed Meds and More” on February 10, 2008. Yvette’s new coverage takes effect on March 1, 2008. In joining the MA-PD plan, Yvette also must comply with the MA-PD plan’s rules and is no longer in Original Medicare for the rest of 2008.

Special Enrollment Periods (SEPs)

Special Enrollment Periods (SEPs) enable Medicare beneficiaries to make Part D plan enrollment changes in several special situations. As a SHIP counselor, it is important to keep in mind that beneficiaries who qualify for the Low-Income Subsidy, or Extra Help, program through their eligibility for Medicaid or the Medicare Savings Programs (QMB, SLMB and QI) can join or switch plans monthly. The law also provides a SEP when people move into, or out of, certain long-term care facilities.

CMS’ PDP Guidance: Eligibility, Enrollment, and Disenrollment

(<http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CurrentPDPEnrollmentGuidance.pdf>) describes a SEP this way:

During a SEP, an individual may discontinue enrollment in a PDP offered by a PDP sponsor, change to a different Part D plan, or in certain cases specified below, enroll in a Part D plan. 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.**

The various Enrollment Periods, including SEPs, are detailed in the chart on Medicare Drug Coverage Enrollment Periods at the end of this section. Additionally, below are some more examples to illustrate how SEPs work, and how they might come up in your work as SHIP counselors. They are grouped into SEPs that are continuous and those that are temporary.

Continuous SEPs

- Ongoing
- Change once per month, for an effective date of the 1st of the following month
- Medicaid, Medicare Savings Program (MSP), Long-Term Care Facility Residents currently living at the facility

For Example: Edgar is eligible for one of the Medicare Savings Programs, the QI program, which pays his Part B monthly premium. He has been enrolled in the PDP “All the Drugs” plan since May, but the plan does not cover most of his prescription drugs. Edgar wants to switch to a different PDP, the “Drugs for Now” plan. In mid-July he enrolls in the new PDP, which automatically disenrolls him from his former plan without any further action on his part. His coverage in the “Drugs for Now” plan starts on August 1.

The MMA allows Edgar to make this change outside of the Annual Enrollment Period because he has a continuous SEP as a Medicare Savings Program recipient. He can change plans once per month between and among PDPs and MA-PDs alike.

For Example: Lucia has Medicaid. She qualifies through a monthly spend-down of \$350 that comprises the costs for her biweekly psychiatry visits and a benzodiazepine prescription that is not covered under Part D. Lucia has been enrolled in the MA-PD “We Serve Pills” but would like to switch to a Regional PPO, also an MA-PD, called “The Sky’s the Limit” plan. Her goal is access to a broader provider network. She enrolls in the Regional PPO MA-PD in mid-August, and her coverage takes effect on September 1st.

The MMA allows Lucia to make this change outside of the Annual Enrollment Period because she has a continuous SEP as a Medicaid recipient. She too can change plans once per month between and among PDPs and MA-PDs alike as long as she spends down each month and qualifies for full Medicaid benefits.

For Example: Scarlett cannot care for herself any longer and needs to move in to what she fondly refers to as “that nursing home.” She currently belongs to the local MA-PD, “Lots of Drugs.” But the nursing facility to which she is moving is a long distance from her network pharmacy. Scarlett switches to another MA-PD whose pharmacy network offers more convenient dispensing options.

The MMA allows Scarlett to make this change outside of the Annual Enrollment Period because she has a continuous SEP for as long as she stays at the long term care facility. Note that this SEP would not be available for a move to an assisted living facility or residential care facility.

Temporary SEPs

- One-time only
- Circumstantial
- 63 days or longer to make a change, depending on circumstance
- Involuntary loss of creditable coverage, relocating out of plan’s service area, moving out of a long-term care facility, enrolling in any Medicare Advantage plan for the first time (this is not specific to plan name or type), or losing coverage due to plan termination

Below are some common situations that arise outside of a beneficiary's initial enrollment in Medicare, when a client may have a one-time only SEP of limited duration.

For Example: Rose was employed at the Jubilee Festival Roadhouse for over 25 years but last week they filed for bankruptcy. The Roadhouse provided a drug insurance benefit as part of its group health plan. The drug benefit provided much better coverage than the basic benefit under Medicare Part D, and has saved Rose a lot of money since she takes several medications. But the group insurance plan ends this September. The plan administrator informed Rose that she has 63 days from the termination of coverage to choose a Medicare Part D plan.

The MMA gives Rose this one time SEP because she involuntarily lost her creditable coverage.

For Example: Berman relocated from San Diego to Maryland to be closer to his grandchildren. He was enrolled in the local HMO "Health and Such" when he lived in California. He has 63 days from the date of his move from San Diego to enroll in a new plan. He chose a national PDP, "All Pills," so he can fill his prescriptions in San Diego when he returns to visit friends there.

The MMA gives Berman this one time SEP because he moved from the local plan's service area. Since he has chosen a national PDP whose service area is national covering all the states, he would not have a SEP if he moves away or lives anywhere else.

For Example: Yvette just came home from having spent nine months in a long-term care facility. She recently won a lawsuit, and has decided to pay for care at home. Within the next 63 days, Yvette is going to switch from her current PDP to a national plan. That way, she'll have coverage if she has to leave her home to live near her daughter in Arizona.

The MMA gives Yvette this SEP because she moved out of a long-term care facility.

For Example: Christyl has had Original Medicare and a Medigap policy for years. She learned that her doctors also accept payments from the MA-PD, "Because We Care." Thinking that the MA-PD would cost her less in premiums and outpatient co-pays, Christyl enrolled in this plan in March. Now it's August, and she has had many unresolved claims. She has decided to go back to Original Medicare and her former Medigap policy, even though its cost is increasing. She can return to Original Medicare and to the same Medigap policy, thanks to guaranteed issue rights in her state. She prefers now also to enroll in a PDP.

Christyl is entitled to a 12 month trial period as someone who is new to any type of Medicare Advantage plan. Because she returned to Original Medicare, the MMA gives her a SEP to enroll in a PDP at any time during that twelve month period. Medicare law also assures that she can return to her former Medigap policy. She will, however, have to pay any resulting premium increases.

Medicare Drug Coverage Enrollment Periods

Annual Enrollment Opportunities		
Enrollment Period	Dates	Details
Initial Enrollment Period (IEP)	A 7-month period	<ul style="list-style-type: none"> ▪ Individuals who are turning age 65 have a 7-month period to enroll in Medicare. The 7-month period begins on the first day of the 3rd month before the month in which they turn 65, includes the month of their 65th birthday, and ends on the last day of the 3rd month after their 65th birthday. During this 7-month period, individuals can enroll in Medicare Part A and/or Part B and a Medicare drug plan, or they may choose to enroll in a Medicare Advantage plan with drug coverage (MA-PD) or without drug coverage (MA-only).
Annual Election Period (AEP)	November 15-December 31	<ul style="list-style-type: none"> ▪ Medicare beneficiaries who have not yet enrolled in a drug plan can enroll in a plan, with coverage effective on January 1. A penalty premium may be imposed on those beneficiaries who were without creditable drug coverage for more than 63 days since June 2006. ▪ Medicare beneficiaries already enrolled in a drug plan can switch to a different plan, with coverage effective on January 1. ▪ Medicare beneficiaries can also switch to original Medicare and a PDP or to a Medicare Advantage plan with prescription drug coverage (MA-PD).
Part B General Enrollment Period (GEP)	January 1-March 31	<ul style="list-style-type: none"> ▪ Individuals who did not enroll in Part B during their Initial Enrollment Period (IEP) can enroll during the GEP (January 1-March 31). Part B is effective on July 1. ▪ They then have a Special Election Period (April 1-June 30) to enroll in a Medicare drug plan, effective on July 1.
Open Enrollment Period (OEP)	January 1-March 31	<ul style="list-style-type: none"> ▪ Medicare beneficiaries who have <i>both</i> Medicare Parts A and B and who have already enrolled in a Medicare drug plan have one opportunity to switch to a different plan, effective on the first of the following month. <ul style="list-style-type: none"> ○ Beneficiaries in an MA-PD plan can switch to another MA-PD <u>or</u> original Medicare and a PDP. They cannot switch to original Medicare without a PDP or an MA-only plan (without prescription drug coverage). ○ Those in an MA-only plan without prescription drug coverage can enroll in original Medicare. They cannot switch to an MA-PD or a PDP. ○ Beneficiaries in original Medicare and a PDP can enroll in an MA-PD. They cannot switch to a different PDP or to an MA-only plan without prescription drug coverage (unless the MA-only plan is a PFFS plan).

Medicare Drug Coverage Enrollment Periods

Population/Circumstance	Special Enrollment Periods
Limited Income Individuals	
Full Dual-Eligibles, ¹ Enrollees in Medicare Savings Programs (QMB, SLMB, and QI) ² , and Other Beneficiaries with the Low-Income Subsidy (LIS)	<ul style="list-style-type: none"> ▪ Continuous: Can join a plan or switch plans at anytime, effective on the 1st day of the following month.³ ▪ Begins the month the beneficiary becomes dually-eligible and continues as long as he remains a full dual
Beneficiaries Losing LIS Eligibility Mid-Year	<ul style="list-style-type: none"> ▪ A 3-month period after the date they are no longer eligible for full Medicaid benefits during which beneficiaries may switch plans.
Beneficiaries Losing LIS Eligibility At the End of the Plan Year	<ul style="list-style-type: none"> ▪ A specific 3-month period (January 1 to March 31) during the following plan year in which beneficiaries may switch plans.
Qualified SPAP Enrollees Not Eligible for LIS	<ul style="list-style-type: none"> ▪ SPAP enrollees have a SEP to enroll in a plan at any time during the calendar year. They may use the SEP to join a Part D plan or to switch to a different Part D plan.
Institutionalized Individuals	
Beneficiaries in Long-Term Care Facilities ⁴	<ul style="list-style-type: none"> ▪ Upon moving into certain long-term care facilities, beneficiaries receive a continuous SEP during their entire stay. ▪ Upon moving out of these long-term care facilities, beneficiaries have a SEP for up to 2 months, effective on the 1st day of the following month.
Creditable Coverage	
Beneficiaries Involuntarily Losing Creditable Coverage	<ul style="list-style-type: none"> ▪ Begins with the month of notification of a loss in creditable coverage (including a reduction in coverage so that it is no longer creditable). ▪ Ends upon enrollment into a drug plan, 60 days after the loss (or reduction) occurs, or 60 days after notice, whichever is later.
Beneficiaries Not Adequately Notified About Creditable Coverage Status ⁵	<ul style="list-style-type: none"> ▪ Requires CMS approval; following approval, beneficiaries have 90 days to enroll in a new plan.
Beneficiaries Enrolling in Creditable Coverage	<ul style="list-style-type: none"> ▪ Requires CMS approval; beneficiaries may disenroll from a drug plan to enroll in or maintain creditable coverage at any time.
Beneficiaries with Coverage Through an Employer Group Health Plan (EGHP)	<ul style="list-style-type: none"> ▪ During EGHP's open season, beneficiaries have a SEP to disenroll from a Medicare drug plan to enroll in the EGHP plan or to disenroll from an EGHP plan to enroll in a Medicare drug plan. <ul style="list-style-type: none"> ○ Beneficiaries may choose the effective date, as long as it is within 3 months.

Change of Residence	
Beneficiaries Permanently Moving From a Plan's Service Area, Beneficiaries Who Have Moved Back to the US, and Beneficiaries No Longer Incarcerated	<ul style="list-style-type: none"> ▪ If the beneficiary notifies the plan before the move, the SEP begins the month prior to the month of the move, continues during the month of the move, and ends 2 months after the move. ▪ If the plan learns from CMS or the US Post Office that the beneficiary has been out of the service area for over six months and the plan is not able to confirm otherwise, the SEP begins at the beginning of the sixth month and continues through to the end of the eighth month.
New Part B Enrollees	
Beneficiaries Enrolling in Part B During the General Enrollment Period (GEP) ⁶	<ul style="list-style-type: none"> ▪ Begins April 1 and ends June 30, with coverage effective July 1 (the same date Part B coverage becomes effective).
MA and MA-PD Coordinating	
Beneficiaries Who Drop a Medigap to Enroll in MA	<ul style="list-style-type: none"> ▪ Beneficiaries over age 65 already enrolled in original Medicare who drop a Medigap policy to enroll in a Medicare Advantage plan for the first time have a 12-month SEP. This SEP permits beneficiaries to return to original Medicare and join a prescription drug plan (PDP).
Beneficiaries During Initial Enrollment Period Who Enroll in MA	<ul style="list-style-type: none"> ▪ Beneficiaries who, upon turning 65, enroll in an MA plan. This 12-month SEP permits beneficiaries to disenroll from an MA plan and have original Medicare. If the MA plan is an MA-PD plan, the beneficiary must also choose a PDP at the same time.
Beneficiaries Who Qualify for a Special Needs Plan	<ul style="list-style-type: none"> ▪ This SEP allows beneficiaries to disenroll from a PDP at any time to enroll in an MA SNP. ▪ An additional SEP allows those no longer eligible for a SNP because they no longer meet special needs status to enroll in a PDP
Other	
Enrollment/Non-Enrollment Due to an Error by a Federal Employee	<ul style="list-style-type: none"> ▪ Requires CMS approval; following approval, beneficiaries have 90 days to enroll in a new drug plan after receiving notification from CMS.
Contract Violations ⁷	<ul style="list-style-type: none"> ▪ Begins once CMS determines the violation has occurred; the end date will vary case-by-case.
Plan Terminations	<ul style="list-style-type: none"> ▪ Plans with contracts terminated by CMS (or modified by mutual consent) must notify their enrollees at least 60 calendar days prior to the date of termination (or modification). ▪ The SEP begins 2 months prior to the termination (or modification) date and ends 1 month after the month in which it occurred, effective on the 1st of the month following enrollment.
Other Circumstances	<ul style="list-style-type: none"> ▪ Other circumstances give CMS discretion to create a SEP. The length of the SEP is dependent upon CMS' decision.

Note: Special Enrollment Periods (SEPs) allow Medicare beneficiaries to enroll in a Medicare drug plan or to change enrollment into a different plan (thereby disenrolling from the first plan) outside of the AEP and the OEP. In most instances SEPs are situated to prevent the imposition of a penalty premium, because they occur at common instances which otherwise would create a 63-day gap in creditable drug coverage. This may not be the case for the continuous SEPs. Typically, most SEPs end when the beneficiary enrolls in a new plan or when the SEP timeframe ends, whichever comes first.

Chart Notes

¹ Includes Medicare beneficiaries who spend-down to full Medicaid as well as Medicare beneficiaries who receive full Medicaid benefits through a Medicaid home and community-based services (HCBS) waiver. New full duals are automatically (and randomly) assigned to a Medicare drug plan, usually within 2 months of the state notifying CMS of the enrollee's Medicaid status. They can choose a different plan.

² MSP enrollees (as well as other Medicare beneficiaries who get the "extra help") are automatically (and randomly) assigned to a Medicare drug plan, usually within 2 months of the state notifying CMS of the enrollee's MSP status. They can choose a different plan.

³ In effect, these enrollees can switch plans once a month as the effective date for coverage under a new plan is the first of the month after a switch.

⁴ For the purpose of Medicare drug coverage, long-term care facilities include: skilled nursing facilities, nursing facilities, inpatient psychiatric hospitals, intermediate care facilities that are residential facilities for developmentally disabled adults (called "ICF/MR"), rehabilitation units or hospitals, long-term care hospitals, and swing-bed hospitals.

⁵ Includes both a notice about creditable coverage status and a notice about a loss or reduction of coverage.

⁶ Individuals who enroll in Part B during the Part B General Enrollment Period (Jan. 1-March 31) have an effective Part B date of July 1.

⁷ Contract violations include (but are not limited to) failure to provide benefits in a timely manner and material misrepresentation of the plan by the sponsor.

E. How to Enroll

After a beneficiary determines that he is eligible for the Part D drug benefit and has decided to enroll in a plan during an available enrollment period, the next step is to start the process of enrolling in the chosen Part D plan. There are several ways to enroll in a Part D drug plan. These include mailing an enrollment form to the plan sponsor, enrolling on-line, and enrolling by phone.

Because CMS makes it fairly easy for beneficiaries to compare and enroll in Part D plans on its www.medicare.gov website, 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.

Counseling Tips:

CMS allows beneficiaries to enroll into a Medicare drug plan through these methods:

1. Paper Enrollment Forms
 - a. Mailed or faxed to the Part D plan sponsor
 - b. Delivered in person to a sales representative
2. Internet Enrollment
 - a. Through the Part D plan sponsor website*
 - b. Through the Medicare.gov website
3. Telephone Enrollment
 - a. Through the Part D plan sponsor *
 - b. Through 1-800-MEDICARE
4. Enrollment with a sales representative

* Part D plan sponsors are not allowed to ask a beneficiary who is enrolling in a plan via the phone to make a payment.

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' *PDP Guidance on Eligibility, Enrollment and Disenrollment* (<http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CurrentPDPEnrollmentGuidance.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.¹

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. Nevertheless, SHIP counselors who assist a Medicare beneficiary 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.

F. Disenrolling and Switching

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

Annual Election Period (AEP) Disenrollment

During the AEP, a Medicare beneficiary can make only one choice among two options affecting her drug plan enrollment. He can enroll in a different Part D plan, or disenroll from her current plan. Enrolling in a different Part D plan effectively switches the beneficiary from one plan to the other. Be aware that disenrolling from a plan counts as that one choice. This choice results in no coverage on January 1.

For Example: Claude enrolled in the Olympus Insurance Bronze drug plan, a PDP, for 2007. On December 1, 2007, he decides he wants to switch to the Platinum Prescriptions Medicare drug plan for 2008. To make this change during the AEP, Claude should simply enroll in the Platinum Prescriptions plan, exercising his one choice. He does not need to take extra steps to disenroll from the Olympus Bronze plan. By enrolling in Platinum Prescriptions, Claude automatically disenrolls from the Olympus Insurance Bronze plan.

For Example: Gene was enrolled in the AtlanticCare basic drug plan for 2007. He disenrolled on November 30, 2007 from the AtlanticCare plan, during the AEP. In December, he read an ad for a Columbia Gem Part D plan, and immediately visited a

¹ *PDP Guidance on Eligibility, Enrollment and Disenrollment*, CMS, at 51-52: [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 effect an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Plans cannot require such documentation as a condition of enrollment; and
- c) Provide contact information.

SHIP counselor to ask for help with enrolling. Although Gene's enrollment in the Columbia Gem plan seemed to go through the computer system, he later received a notice explaining that he could not enroll with Columbia Gem because his disenrollment from AtlanticCare was his one choice for the AEP.

Special Enrollment Period (SEP) Disenrollment

During any applicable SEP, a beneficiary may disenroll from a Part D plan. In contrast to the AEP, an SEP allows for both one disenrollment and one enrollment. While a beneficiary needs only to 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. A person who moves out of a drug plan's service area, for example, has a SEP of up to four months. In contrast, a person who moves out of a certain type of nursing facility has a SEP that lasts up to two months after discharge. *Please refer to subsection D of this section for more information about enrollment periods.*

For 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 Primara. She notifies Canterbury Primara 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.

For Example: Paulette is returning home on March 4 after a four-month stay at the Pine View Nursing Home. She receives a two-month SEP. Because her drug needs have changed since she entered the nursing facility, her husband helps her to disenroll on March 6 from the Gibraltar Straight Rx Plan, a Medicare PDP with a basic benefit. One week later, they visit a local SHIP counselor who helps them look for the best plan by using Medicare's Plan Finder and other research tools. The counselor helps her enroll in Everest Insurance Company's Summit drug plan on March 13, well within the SEP's two-month window. Paulette's new coverage takes effect on April 1.