1. Module 5: Enrollment Guidance Medicare Advantage and Part D Plans

2. Navigation

3. Terms and Conditions

4. Learning Objectives

- After reviewing Part 5: Enrollment Guidance - Medicare Advantage and Part D Plans you will be able to explain:
    - When beneficiaries can enroll or change plans
    - Who can complete an enrollment form
    - What information must be discussed with a beneficiary before accepting an enrollment
    - Post-enrollment requirements
    - Enrollee protections
    - The disenrollment process

5. Training Roadmap: Module 5

- Enrollment and Election Periods
- Election Periods: MA Open Enrollment Period
- Special Enrollment/Election Periods (SEPs)
- Open Enrollment for Institutionalized Individuals
- Enrollment Requests
- Beneficiary information, acknowledgements, and enrollee discrimination prohibitions
- Post-enrollment activities and rules
- Disenrollment

6. Title Page – Enrollment and Election Periods

7. Enrollment/Election Periods – Overview

- Beneficiaries may only enroll in or change plans at certain fixed times each year or under certain limited circumstances.
    - If the application is not received during those fixed times of the year or does not include information supporting a permissible election period, such as an attestation of eligibility to enroll, plans must contact the beneficiary to decide if enrollment is permissible.
- MA and Part D Enrollment/Election periods are:
    - MA Initial Coverage Election Period (ICEP)
    - Part D Initial Enrollment Period (IEP)
    - MA and Part D Annual Election Period (AEP)
    - MA and Part D Special Enrollment/Election Periods (SEP)
    - Open Enrollment Period for Institutionalized Individuals (OEPI)
    - MA Open Enrollment Period (MA-OEP)

8. Roadmap to Enrollment/Election Periods

- Certain election periods have fixed calendar dates and are available to all beneficiaries while others depend on an individual's circumstances.
- Fixed annual election periods:
    - Annual election period (October 15 – December 7)
    - Medicare Advantage Open Enrollment Period (MA-OEP) (January 1 – March 31)
- Election periods with dates and conditions based on individual circumstances:
    - Initial enrollment/election periods when a beneficiary is first eligible for Medicare
        - New beneficiaries who enroll in Medicare Advantage also have an MA-OEP that starts the month of entitlement to Part A and Part B
    - Special enrollment/election periods (SEPs) when special circumstances arise
    - Continuous open enrollment for institutionalized individuals (OEPI)

9. MA and Part D Enrollment/Election Periods – Summary

Election/Enrollment Period	MA Options	PDP Options
MA Initial Coverage Election Period (ICEP) / Part D Initial Enrollment Period (IEP)	Enroll	Enroll
Annual Election Period (AEP) (Oct. 15-Dec. 7)	Enroll, disenroll, or change plans	Enroll, disenroll, or change plans
MA Open Enrollment Period (OEP) (Jan. 1 – March 31 and for individuals choosing an MA plan during their ICEP, the month of entitlement to Part A and Part B through the last day of the 3rd month of entitlement)	Disenroll from an MA or MA-PD plan and return to Original Medicare, Change MA plans, change Part D option under MA plan (change from MA to MA-PD or MA-PD to MA)	After disenrolling from an MA or MA-PD plan, may enroll in a PDP
Special Election Period (SEP)	Under most SEPs beneficiaries can enroll, disenroll, or change plans. However, under some SEPs beneficiary options are limited.	Under most SEPs beneficiaries can enroll, disenroll, or change plans. However, under some SEPs beneficiary options are limited.
Open Enrollment Period for Institutionalized Individuals (OEPI)	Enroll, disenroll, or change plans	Enroll in a PDP, disenroll from a PDP, and enroll in another PDP or MAPD

10. Election Periods – MA Initial Coverage Election Period (ICEP)

- The MA ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan.
- The ICEP begins three months prior to the date the individual is both first entitled to Medicare Part A and enrolled in Part B for the first time, and ends on the later of:
    - The last day of the second month after the month in which the individual is both entitled to Part A and enrolled in Part B for the first time, or
    - The last day of the individual's Part B initial enrollment period.
        - The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility.

- During the ICEP:
    - An eligible individual may enroll in an MA plan.
    - An individual may also choose an MA-PD when the Part D IEP (i.e., an initial enrollment period for Part D) and MA ICEP occur at the same time.
- The individual can make one enrollment choice under the ICEP. Once enrollment is effective, the ICEP is used. (Note, however, that individuals choosing an MA plan during their ICEP have an MA-OEP following their election through the last day of the 3rd month of entitlement, during which they can disenroll to Original Medicare or change plans.)
- The ICEP for an MA enrollment election will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must always relate to the individual's entitlement to both Medicare Part A and Part B.

11. Election Periods – MA ICEP Example

Mr. Nash turned 65 in May of 2020. He became entitled to premium free Part A on his 65th birthday and eligible for Part B. Because Mr. Nash had employer group coverage, he did not enroll in Part B. However, he plans to retire in June 2025 and to enroll in Part B effective July 2025. Mr. Nash may enroll in an MA plan using his ICEP if he makes an election before the end of September 2025.

12. Election Periods – Part D Initial Enrollment Period (IEP)

- The Part D IEP begins 3 months before the month an individual is first entitled to Part A OR enrolled in Part B and ends 3 months after the month of eligibility.
- Individuals eligible for Medicare before age 65 (for example, because of disability) will have another IEP when attaining age 65.
- During the Part D IEP, beneficiaries may make one Part D enrollment choice, including enrollment in an MA-PD plan if they are eligible for MA.
- The MA ICEP and the Part D IEP occur together when a newly Medicare eligible individual is both entitled to Part A and enrolled in Part B at first eligibility. If an individual delays enrollment into Part B to a later time, the ICEP and IEP occur separately with the ICEP occurring during the 3 months immediately preceding the month of both entitlement to Part A and enrollment in Part B and two months following that month.

Election Periods – Part D IEP example

Mr. Crosby will turn 65 on August 10, 2025. He will continue working. He plans to sign up for his Medicare Part A benefits, effective August 1, 2025, but has decided not to enroll in Part B. He will be eligible for Part D since he will have Part A. Even though he will not enroll in Part B, his Part D IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, May 2025 through November 2025. His MA ICEP will occur when he enrolls in Part B.

13. Election Periods – Annual Election Period: Overview

- The Annual Election Period (AEP) takes place from October 15 to December 7 each year and is available to all MA and Part D eligible beneficiaries.
- During the Annual Election Period beneficiaries may:
    - add or drop drug coverage.
    - enroll in an MA plan, MA-PD plan, or PDP.
    - change their MA plan, MA-PD plan, or PDP.
      return to Original Medicare.
- No action is needed if the beneficiary keeps their current health and/or drug plan. However, they should check for any benefit or formulary changes under the plan to confirm that staying enrolled is in their best interest.
- Beneficiaries may make more than one enrollment choice during the Annual Election Period, but the last one made before the end of the Annual Election Period, as determined by the date the plan or marketing representative receives the completed enrollment form, will be the election that takes effect.

14. Election Periods – Annual Election Period, Timeframe for Submitting Enrollment Forms

- Marketing representatives may not solicit or accept paper enrollment forms or telephone or online enrollment requests before October 15 for enrollments under the Annual Election Period.
- Brokers and Agents should also remind beneficiaries that they cannot submit enrollment requests before the start of the AEP.
- If a beneficiary sends an unsolicited AEP paper enrollment request to the plan on or after October 1 but before the Annual Election Period begins, the plan will process the application beginning on the first day of the election period (October 15).
- A beneficiary will receive an acknowledgment letter when the plan sponsor receives an early enrollment form to enroll during the AEP.
- Paper AEP enrollment requests received before the start of the AEP for which there is an indication of sales agent or broker involvement in the submission of the request (i.e., the name or contact information of a sales agent or broker) must be investigated by the Plan Sponsor for compliance.

15. Title Page –Election Periods MA Open Enrollment Period

16. Election Periods – MA Open Enrollment Period (MA OEP)

- The OEP is only available to individuals enrolled in an MA plan.
- For individuals enrolled in an MA plan on January 1 (including those renewing and those whose AEP election first becomes effective January 1) - The MA OEP takes place from January 1 – March 31 of each year.

- For new Medicare beneficiaries who are enrolled in an MA plan during their ICEP- the MA OEP begins the month of entitlement to Part A and enrollment in Part B and ends the last day of the 3rd month of entitlement and enrollment.
    - The limitation to one election or change during the ICEP does not prevent a new enrollee from changing during the MA-OEP.
- During the MA OEP:
    - An MA–PD enrollee may switch to: (1) another MA–PD plan; (2) an MA-only plan; or (3) Original Medicare with or without a PDP.
    - An MA-only enrollee may switch to: (1) another MA-only plan; (2) an MA–PD plan; or (3) Original Medicare with or without a PDP.
- There is a coordinating Part D SEP available to enroll in a standalone Part D plan for the same effective date, when an individual changes from an MA-PD to Original Medicare.

17. Election Periods – MA OEP

- Beneficiaries may only change plans once during the MA OEP.
- MSA, Cost Plan, and PACE enrollees may not use the MA OEP to make plan changes or disenroll.
- As eligibility to use the MA OEP is available only for MA enrollees, the ability to make changes to Part D coverage is limited to any individual who is enrolled in an MA or MA-PD plan before they change.
- As a reminder - Marketing representatives may not do targeted marketing related to the OEP, for example, marketing that mentions the OEP or that targets individuals known to be MA enrollees.

Election Periods – MA OEP: Example

Ms. Hildalgo's 65th birthday was April 20, 2024. She is entitled to Part A beginning April 1, 2024. She is currently working, has employer-sponsored coverage, and has decided to enroll in Part B after she retires. She retires in April 2025 and enrolls in Part B effective May 1, 2025. She also enrolls in an MA plan effective June 1, 2025. In this scenario, Ms. Hildalgo's MA OEP is May 1, 2025, through July 31, 2025.

18. Title Page – Special Enrollment/Election Periods (SEPs)

19. SEPs in General

- MA eligible and Part D eligible beneficiaries who experience certain qualifying events or wish to enroll in a 5-star plan are provided a special period to change their election, known as a Special Election Period or "SEP."
- Timeframes for SEPs vary.
- The SEP generally ends upon the effective date of enrollment in a new plan, or the time expires, whichever comes first.
- Where appropriate, SEPs allowing changes to MA coverage are coordinated with those allowing changes in Part D coverage.

20. Typical SEPs – Change in Residence

Beneficiaries who move out of their existing plan's service area, or who have new options available to them as a result of a permanent move, have a SEP allowing them to enroll in a MA or Part D plan.

The SEP begins:

- The date of the change in permanent residence,
- The month before the change in permanent residence, for an individual who notifies the MAO or Part D sponsor in advance of the change; or
- When the individual is being disenrolled because they have been out of the service area for over six months (Part C) or over 12 months (Part D), and the MAO or Part D plan has not been able to confirm the residency status of the individual.

The SEP ends two months following the month it begins or following the month of the move, whichever is later. A beneficiary using this SEP may choose an effective date up to 3 months after the month in which the enrollment form is received by the plan, but it may not be earlier than the date of the permanent move.

Example:
Ms. Hynds moves to Sunny Acres assisted living facility on July 15th. An IE-SNP is available only for residents of the facility who meet the applicable health criteria. Ms. Hynds has an SEP for change of residence through the end of September that would allow her to enroll in the IE-SNP if she meets the criteria, because as a result of her permanent move, she has a new option available to her (the IE-SNP).

21. Typical SEPs – Change in Medicaid or LIS Status

- Beneficiaries who are entitled to Medicare Part A and/or Part B who have a change in their Medicaid or LIS status, including the gain or loss of eligibility or a change in the level of assistance they receive are eligible for an SEP. During the SEP:
    - beneficiaries entitled to Part A and Part B can enroll in or disenroll from an MA and/or Part D plan once.
    - those entitled only to Part B can only do so for PDPs
- The SEP begins the later of the change or notification of the change and continues for 3 months.

22. Typical SEPs -- Part D SEP for Dual Eligibles and Beneficiaries with LIS

Individuals who have Medicare Part A and/or Part B and receive any type of assistance from Medicaid (dual eligibles) and individuals who qualify for a low-income subsidy but who do not receive Medicaid benefits have a SEP that allows them to make an election into a standalone PDP. This SEP does not permit enrollment into MA-PD plans or changes between MA-PD plans.

The SEP may be used once per month with an effective date of the first of the following month. An individual is not eligible for this SEP if the individual has been identified as an "at-risk beneficiary" or "potential at-risk beneficiary".

23. Typical SEPs – Limitations for At-Risk and Potential At-Risk Beneficiaries

- An "at-risk" individual is a Part D eligible individual who is determined to be at-risk for misuse or abuse of a frequently abused drug per the requirements for drug management programs under CMS regulations.
- A potential at-risk beneficiary is a Part D eligible individual who is identified as being potentially at-risk for misuse or abuse of a frequently abused drug per the requirements for drug management programs under CMS regulations.
- Once an individual is identified by the Plan Sponsor as a "potential at-risk" or "at-risk" beneficiary and the Plan Sponsor has sent written notice to the individual, they cannot use the dual eligible or LIS SEP to change plans while this risk designation is in place. The notice to the individual explains that this SEP is no longer available.
- The enrollment limitation for a "potential at-risk" or an "at-risk" individual will not apply to other Part D enrollment periods, including the AEP or other SEPs.
- Note that individuals may appeal their designation of at-risk or potential at-risk.

24. Other Common SEPs

Medigap SEP -- Any Medicare beneficiary who dropped a Medigap policy when they enrolled for the first time in an MA plan has a SEP during the first 12 months of their enrollment in the MA plan during which they can elect to disenroll from their first MA plan to Original Medicare. They will also have a guaranteed eligibility period to rejoin a Medigap plan.

Changes in Employer Group Coverage SEP -- Any Medicare beneficiary experiencing a change in employer group coverage, such as leaving employer sponsored coverage, electing into employer sponsored MA or PDP plans or disenrolling from an MA or PDP plan to enroll in employer sponsored coverage has a SEP that begins when the employer/union plan would otherwise allow the individual to make changes to their coverage and ends 2 months after the month the employer or union-sponsored coverage ends.

Severe or Disabling Chronic Conditions SEP -- Beneficiaries who have severe or disabling chronic conditions and wish to enroll in a SNP designed to serve individuals with their specific condition have a SEP during which they can enroll in a chronic condition SNP (C-SNP) designed to serve individuals with their condition. The SEP lasts as long as the individual has the qualifying condition and ends once the individual enrolls in a C-SNP.

Loss of Special Needs SEP -- Beneficiaries enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status have a SEP that begins the month the individual's special needs status changes and ends when they make an enrollment request or three calendar months after the effective date of involuntary disenrollment from the SNP, whichever is earlier.

5-Star Plan SEP - Beneficiaries who live in the service area of a 5-star plan have a SEP during which they can disenroll from an MA plan, PDP, or Cost plan or leave Original Medicare to enroll in a 5-star MA plan, PDP, or a Cost plan. The 5-Star Plan SEP is available each year, beginning on December 8 and may be used once through November 30 of the following year.

PACE SEP – Beneficiaries may disenroll from an MA or PDP plan at any time in order to enroll in PACE. In addition, beneficiaries who disenroll from PACE have an SEP to elect an MA plan or PDP. The SEP ends 2 months after the effective date of PACE disenrollment.

Aligned Enrollment SEP -- This SEP provides a one-time-per-month election into a fully integrated dual eligible special needs plan, a highly integrated dual eligible special needs plan, or an applicable integrated plan for dually eligible individuals who are enrolled in or in the process of enrolling in the D-SNPs affiliated Medicaid MCO. This SEP is only available to facilitate aligned enrollment.

Beneficiaries enrolled in a plan by CMS or the State -- Individuals who are enrolled in a plan by CMS or a State (i.e., through passive enrollment, auto-enrollment, facilitated enrollment, and reassignment) have an SEP to disenroll from their assigned plan or enroll into a different plan. During the SEP, beneficiaries may make an election within three months of the effective date of the assignment or notification of the assignment, whichever is later.

Involuntary Loss of Creditable Drug Coverage SEP – Beneficiaries eligible for Part D who involuntarily lose creditable prescription drug coverage, including a reduction in coverage so it is no longer creditable, have an SEP allowing them to enroll in a PDP. The SEP begins with the month in which the beneficiary is advised of loss of creditable coverage and ends 2 months after the loss of creditable coverage or the date the individual received the notice, whichever is later.

25. Common SEPs – Examples

Example 1: Ms. Osbourne has trouble managing her diabetes. At her doctor's appointment in June, Osbourne's doctor tells her that he believes she would benefit from the extra care management available from a C-SNP designed for people with diabetes. Osbourne does not have to wait until the AEP to enroll because she has a special election period to enroll in a C-SNP for the first time.

Example 2: Mr. Weir is 68 years old and still working. Although he pays for Part B, he uses Medicare as his secondary insurance and pays part of his employer group coverage premium. He was recently advised that he could save money by changing from his employer coverage to an MA plan with a premium that is less than his contribution to his group coverage. Mr. Weir has an SEP that will allow him to drop his employer group coverage and enroll in MA plan.

26. Title Page – Open Enrollment Period for Institutionalized Individuals

27. MA Open Enrollment Period for Institutionalized (OEPI) Individuals/Part D SEP for Institutionalized Individuals

- The OEPI is available for individuals who move into, reside in, or move out of an institution. For example, a skilled nursing facility, nursing facility, rehabilitation hospital, intermediate care facility for individuals with intellectual disabilities (ICF/IID), psychiatric hospital or unit, or long-term care hospital.
- The OEPI is NOT available for individuals who are institutional-equivalent, that is, who meet the institutional level of care but do not reside in one of the facilities listed above. For example, the OEPI does not apply to individuals in assisted living facilities.
- The OEPI is a continuous open enrollment period as long as an individual is in an institution.
- The OEPI ends two months after the month the individual moves out of the institution.
- Beneficiaries eligible for the OEPI can:
    - make an unlimited number of MA enrollment requests and may disenroll from their MA plan.
    - enroll in or disenroll from a Part D plan.
    - return to Original Medicare.
- Note that an MA organization is not required to accept requests to enroll in its plan during the OEPI. However, if it is open for these enrollment requests, the organization must accept all OEPI requests to enroll in the plan.
- Individuals may not enroll in an MSA during an OEPI.

28. Election Periods for Medicare MSA Plans

- Beneficiaries may enroll in Medicare MSA plans only during the ICEP or the AEP.
- They may not enroll in Medicare MSA plans during an SEP with the exception of the SEP for the employer group health plan (EGHP) SEP. Individuals may request enrollment into an employer or union sponsored MSA plan using the EGHP SEP.
- Individuals may disenroll from Medicare MSA plans only during the AEP or a SEP.
- MSA enrollees may not use the MA OEP to disenroll from the MSA. An individual who elects an MA MSA plan during the AEP and has never before elected an MA MSA plan may revoke that election, no later than December 15 of that same year.

29. Cost Plan Enrollment Periods

- Generally, Cost plans must establish an annual open enrollment period of at least 30 days.
- Most Cost plans allow enrollment year-round.
- For Cost plans that offer an optional supplemental Part D benefit, beneficiaries may select this benefit only during valid Part D enrollment periods. Cost plans must accept Part D enrollments during these periods.
- A beneficiary who is enrolled in an MA plan must have a valid MA disenrollment period to switch to a Cost plan.

30. Title Page – Enrollment Requests

31. Format of Enrollment Requests

- During valid enrollment/election periods, Plan sponsors must accept enrollment requests, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS from individuals eligible to enroll in the plan.
- All plans must make available and accept a CMS-approved paper enrollment form appropriate to the plan type (MA, PDP, MA-PDP, MSA, or PFFS).
- Plans may also accept enrollments electronically or telephonically.
- Most enrollments must be completed using the standard enrollment form, regardless of the format of the request.
- However, a short enrollment form/process may be used in certain circumstances.
    - A short form or plan selection form may be used when an individual changes between plans offered by the same parent organization (but not for MSAs).
    - A simplified process known as the “opt-in” process may be used when an individual new to Medicare who is already a member of the organization’s non-Medicare coverage (e.g., commercial or Medicaid) wishes to enroll in an MA plan.

32. Enrollment Mechanism Chart

Enrollment Mechanism	MA	Part D	Initiated by:
Paper Enrollment Forms: Required mechanism for all plans	X	X	Individual
Electronic Enrollment	X	X	Individual
Medicare.gov Online Enrollment Center (OEC) (not available for MSAs)	X	X	Individual
Telephonic Enrollment (Incoming telephone call to a plan representative or agent)	X	X	Individual
Default Enrollment process (For individuals newly eligible for Medicare Advantage and enrolled in a Medicaid managed care plan offered by the MAO or its affiliate.	X		MAO
Passive Enrollment	X	X	CMS
Simplified (Opt-in) Enrollment Mechanism	X		MAO
Auto- or Facilitated Enrollment processes	X	X	CMS/MAO
Reassignment of LIS Beneficiaries		X	CMS
Employer or Union Group Health Plans (EGHPs)	X	X	EGHP
State Pharmaceutical Assistance Plan (SPAP)		X	SPAP

33. Formats of Enrollment Requests – Electronic Enrollment

- Plan sponsors may develop and offer electronic enrollment mechanisms made available via an electronic device or a secure internet website.
- Plans also have the option of obtaining technical support (e.g., licensed software) and related services from downstream entities, such as a broker or third-party website, as a means of facilitating and capturing the electronic enrollment request.
- Plans may also accept enrollment requests via electronic communications, including email, provided consent to use email to send enrollment information or other protected health information (PHI) has been obtained from the individual in advance.

34. Formats of Enrollment Requests – Electronic Enrollment

- All online enrollment mechanisms must be CMS-approved. This includes all materials, web pages, and images.
- Similar to the non-electronic enrollment format, individuals must be provided with all required pre-enrollment information.
- Enrollment via the internet:
    - CMS offers an online enrollment center through www.medicare.gov
        - CMS online enrollment is disabled for MA and Part D plans with a low performer icon (LPI), which means the plan received less than 3 stars for three consecutive years.

35. Formats of Enrollment Requests – Telephone

- Plan Sponsors may accept telephonic enrollments where the following requirements are met:
    - Plans may accept telephonic enrollments only on incoming calls from individuals with whom the plan sponsor does not have an existing business relationship**.**
    - An existing business relationship includes an individual who leaves a message wishing for a call back, fills out a business reply card, or other way in which an individual might initiate the relationship with the organization.
    - Plans may also accept enrollment requests during communications initiated by the plan when, during outreach to provide information about their Medicare plan offerings to individuals with whom they have an existing business relationship, the individual expresses a desire to enroll in one of the organization's plans.
    - All telephonic enrollment and marketing calls must be recorded.
    - If someone other than the beneficiary makes the enrollment request, the recording must include the attestation regarding the individual's authority under state law to complete the request, in addition to the required contact information.

36. Formats of Enrollment Requests – Telephone

- Individuals must be advised that they are completing an enrollment request.
- Calls must include a statement of the individual's agreement to be recorded.
- Telephonic enrollments must include all required elements necessary to complete an enrollment
    - If the criteria for using a short enrollment form are met, the shorter list of required elements would apply.
    - The "Beneficiary Signature and/or Authorized Representative Signature" element for a telephone request is satisfied with a verbal attestation of intent to enroll.
- CMS also offers telephone enrollment through 1-800-Medicare (1-800-633-4227) TTY 1-877-486-2048.

37. MA Opt-in Enrollment Requests

- MAOs may conduct outreach to individuals enrolled in its non-Medicare lines of business who are nearing Medicare eligibility or recently Medicare enrolled and offer them the opportunity to enroll in their plan.
- The opt-in mechanism is a simplified enrollment method that allows a Medicare Advantage Organization (MAO) to use data it has from its non-Medicare lines of business to obtain some of the information it would normally need to receive from the beneficiary in the enrollment request. The organization is required to obtain any data necessary from the individual that it doesn't have from its data sharing.
- MAOs may only offer simplified opt-in enrollment to individuals who:
    - are in their ICEP based on their initial enrollment in Medicare.
    - are enrolled in any type of non-Medicare plan under the same organization (or an entity under the same parent organization as the MA organization).

    - do not have a break in coverage between the non-Medicare plan and the MA plan.
- MAOs may offer simplified opt-in enrollment via paper, telephone, or electronically. For telephonic or electronic requests, the plan may limit the data it collects from the applicant to only the items it does not already have.

Opt-in Enrollment example

Mr. Nash is turning 65 in June 2024 and is enrolled in an Affordable Care Act (ACA) plan offered by GoodCare. GoodCare identifies in its records that Mr. Nash's Medicare Part A and B ICEP begins March 2024. Based on its data from Mr. Nash's ACA plan, GoodCare knows that Mr. Nash lives within the service area of several of its MA plans. A representative of GoodCare calls Mr. Nash in May 2024. She informs Mr. Nash that because he'll be eligible for Medicare soon, he can enroll in a plan that GoodCare offers just for people with Medicare. She provides information on GoodCare MA plans available in Mr. Nash's area and asks if he is interested in enrolling in one of these or learning more. Mr. Nash expresses his interest in enrolling in GoodCare's MA plan with prescription drugs. GoodCare already has Mr. Nash's personal information via its internal systems and, while on the call, the representative obtains what is needed for the MA enrollment that GoodCare doesn't already have. The representative uses this information to complete the telephonic enrollment request. GoodCare confirms the MA plan Mr. Nash wants to enroll in and asks for his Medicare number. GoodCare explains the legal requirements for enrollment, release of information, and confirms Mr. Nash's understanding and acknowledgement/approval to process the request.

38. Beneficiary Acknowledgements When Enrolling

Enrollment mechanisms must require the applicant's acknowledgement/consent that they:

- must keep Medicare Part A and Part B if enrolling into an MA plan and must keep Part A or Part B if enrolling into a Part D plan.
- consent to the disclosure and exchange of information between the U.S. Department of Health and Human Services (HHS), its designees, and the MA or Part D plan and acknowledge that information may be used to track enrollment and for other purposes, as allowed under federal law.
- understand that enrollment in another MA plan, PDP, or MA-PD plan automatically disenrolls them from their current plan (the model PFFS and MSA enrollment mechanisms provide modified language as appropriate).
- attest that the information provided in the enrollment request is correct; intentionally falsifying information will result in disenrollment.
- acknowledge that their signature indicates an understanding of the enrollment application, and that (if applicable) authorized representatives have legal authority to complete the enrollment request.
- understand that benefits and services (excluding hospice and kidney acquisition costs for transplants) must be obtained from the plan to be covered as Medicare benefits.

39. Who May Complete the Enrollment?

- A Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from an MA plan. However, state law may allow another individual to execute an enrollment or disenrollment request on behalf of the beneficiary.
- CMS will allow a legal representative or another individual to execute an enrollment or disenrollment request on behalf of a beneficiary if authorized under state law.
    - Depending on state law, this may include court-appointed legal guardians, individuals with a durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws if they have the authority to act in this manner.
- When someone other than the eligible individual completes an enrollment or disenrollment request, they must: 1) attest to having the authority under State law to do so; 2) sign the completed form, or under other approved enrollment mechanisms, indicate their relationship to the individual; and 3) provide their contact information.
- If there is uncertainty regarding whether another person may sign for a beneficiary, Agents should check with the Plan Sponsor.

40. Title Page-Beneficiary Information, Acknowledgements, and Enrollee Discrimination Prohibitions

41. Beneficiary Pre-enrollment Information

Plan Sponsors must ensure that, before enrollment, CMS' required questions and topics regarding beneficiary needs related to their health plan choice are fully discussed by agents with the beneficiary or their authorized representatives. The agent must ask:

- The kind of health plan in which the beneficiary wishes to enroll (such as low premium and higher copay, or vice versa).
- Does the beneficiary require hearing, dental, and/or vision coverage?
- Does the beneficiary have any other health care needs, such as needing durable medical equipment or physical therapy?
- Does the beneficiary have any other specific health care needs?

42. Beneficiary Pre-enrollment Information – Network Providers and Out-of-Network Coverage

Prior to enrollment the agent must also:

- check to see if the beneficiary's PCP and Specialists are in network. If not, the agent must explain that the beneficiary will need to choose new ones or pay out of pocket.
- check to see if the beneficiary's preferred hospital is in-network. If not, the agent must explain that the beneficiary will need to choose a new one.
- check to see if there are other facilities the beneficiary prefers that need to be in the plan's network.
- review coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, the plan does not cover services by out-of-network providers (i.e., doctors who are not listed in the provider directory)).
- review PPO or PFFS out-of-network coverage

43. Beneficiary Pre-enrollment Information –Drugs

The agent must discuss prescription drug coverage and costs with the beneficiary prior to enrollment if the beneficiary wishes to obtain Part D coverage. Specifically, the agent must:

- check to see if the beneficiary's prescriptions are on the formulary. If not, the agent must explain that the beneficiary may have to pay the full price of the prescription.
- check to see if the beneficiary's pharmacy is in network. If not, the agent must explain that the beneficiary will need to choose a new pharmacy.

44. Beneficiary Pre-enrollment Information –Other Benefit Information

The agent must discuss a variety of other information about plan benefits with the enrollee prior to enrollment. The agent must:

- review coverage for services furnished by providers outside of the United States.
- explain the potential effect that enrolling in the plan will have on other, current coverage, which may in some cases mean that the beneficiary is disenrolled from their current health coverage (for example, another MA plan, Medigap).
- explain that the plan is not a hearing/dental/vision "rider" but a full health plan covering all Medicare benefits.
- explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- explain that Evidence of Coverage provides all of the costs, benefits, and rules for the plan.

45. Beneficiary Pre-enrollment Information –Cost

Agents must also discuss costs with beneficiaries or their authorized representatives prior to enrollment. The agent must:

- go over plan premiums (if the plan has one) and the Part B premium.
- if applicable, review the current plan premium vs. another plan premium.
- go over cost-sharing such as deductibles, copayments, and coinsurances including PCP copay, specialist copay, inpatient hospital copay, and any other copays for services/items the beneficiary needs.
- discuss the costs/limitations on dental, vision, and hearing.

46. Beneficiary Pre-enrollment Information – Complaints, Cancellation, and Items Applicable to Only Certain Types of Plans

- Prior to enrollment agents must review with beneficiaries how they can file a complaint.
- They must also explain the right to cancel the enrollment and provide the date through which cancellation can occur.
- If a beneficiary is interested in/eligible for enrollment in an MSA, the agent must review with the beneficiary the need to maintain a trust/custodial account to remain enrolled in the MSA.
- If a beneficiary is interested in/eligible for enrollment in a special needs plan, the agent must discuss the following with the beneficiary as applicable:
    - The need to qualify for chronic/disabling condition requirement for C-SNPs
    - The need to have Medicaid to qualify for D-SNP.
    - The need to require an institutional level of care to qualify for I-SNP.

47. Enrollment Discrimination Prohibitions

- Marketing representatives may NOT:
    - Deny or discourage beneficiary enrollment based on:
        - anticipated need for health care services.
        - race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, or evidence of insurability.
        - geographic location within the service area.
- Marketing representatives must comply with their obligations under other federal anti-discrimination rules and requirements.
- Marketing representatives may not engage in any discriminatory activity such as attempting to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas, or vice versa.
- Marketing representatives may not ask health screening questions during the completion of the enrollment request unless it is necessary to determine eligibility to enroll in a SNP.
- MA organizations are only permitted to send health assessment forms after enrollment.

48. Title Page – Post-Enrollment Activities and Rules

49. Post-Enrollment Request: Beneficiary Notifications Prior to Effective Date

After the plan receives the request for enrollment and before the effective date of coverage, all plans must provide the enrollee with:

- a notice acknowledging receipt of the complete enrollment request and showing the effective date of coverage (must be provided no later than 10 calendar days after receipt of the completed enrollment request).
- a copy of the completed paper enrollment if the beneficiary requests the form.
- evidence that the enrollment request was received (e.g., a confirmation number), for enrollment requests submitted via the internet or telephone.
- proof of health insurance coverage so that they may begin using plan services as of the effective date (must include the data necessary to access benefits).

50. Post-Enrollment Request: Beneficiary Notifications, Prior to Effective Date

- If an individual's enrollment request includes a request for Social Security Administration (SSA) or Railroad Retirement Board (RRB) premium withhold plan must inform the individual that:
    - if approved, their request for premium withholding will start in one to two months.
    - the effective date for premium withholding will not be retroactive.
    - they will be responsible for paying the organization directly for all premiums due from the enrollment effective date until the month in which premium withholding begins.
    - failure to pay premiums for months in which premium withholding is not yet in effect can result in disenrollment from the plan.

Once the Plan Sponsor receives a reply from CMS indicating whether the individual's enrollment has been accepted or rejected, the Plan must notify the individual in writing of CMS' acceptance or rejection of the enrollment within ten calendar days.

51. Post-Enrollment Request: Beneficiary Notifications, Prior to Effective Date

Regardless of how an enrollment request is made, the Plan Sponsor must provide information about being an enrollee of the plan, the plan rules, and the member's rights and responsibilities generally prior to the effective date of enrollment. During this period Plan Sponsors must also:

- explain the charges for which the prospective member will be liable, including premiums, late enrollment penalty, coinsurance, deductible and any other amounts (including general information about the low-income subsidy).
- explain the prospective member's authorization for the disclosure and exchange of necessary information between the MA organization and CMS.
- explain the potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B at the time coverage begins and they have used MA plan services after the effective date.

- provide the effective date of coverage and explain how to obtain services before the receipt of an ID card (if the MA organization has not yet provided the ID card).
- (For MAOs) obtain an acknowledgment by the individual that they understand that care will be received through designated providers except for emergency services, urgently needed care, out-of-area dialysis services, and cases in which the plan authorizes use of out-of-network providers.

52. Post-Enrollment Request: Beneficiary Notifications

- In some instances, the Plan Sponsor will be unable to provide the materials and required notifications to new enrollees before the effective date (usually only when an enrollment request is received by the plan in the last few days of a month, and the effective date is the first of the upcoming month). In these cases, all materials described in the previous slide must be provided no later than 10 calendar days after receipt of the completed enrollment request.

53. Post-Enrollment: When does coverage begin?

Election Period	**Enrollment Effective Date**
Initial Coverage Election Period (ICEP) and Initial Enrollment Period for Part D (IEP)	First day of the month of entitlement to Medicare Part A and Part B or the first of the month following the month the enrollment request was made if after entitlement has occurred.
Annual Election Period	January 1 of the following year.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request.
Medicare Advantage Open Enrollment Period (MA OEP)	First day of the month after the month the MA organization receives an enrollment request.
Special Election Period	Generally, the first day of the month after the month the MA organization receives an enrollment request. However, exceptions apply for certain SEPs.

54. Post-Enrollment: When does coverage begin?

- If a Plan Sponsor receives an enrollment request and determines the applicant is eligible for more than one election period, it must allow the individual to choose the enrollment effective date.
    - To determine the beneficiary's choice of election period and effective date, the MA organization must attempt to contact the beneficiary and must document its attempts.
    - If the MA organization is unable to obtain the beneficiary's desired enrollment effective date, the MA organization must assign an election period using the ranking of election periods set forth in the regulations.

- Individuals eligible for the employer group health plan (EGHP) SEP and one or more other election periods who make an election via the employer or union election process will be assigned an effective date according to the EGHP SEP unless the individual requests a different, allowable, effective date.
- If one of the election periods for which the individual is eligible is the ICEP, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and Part B.

55. Title Page – Disenrollment

56. Disenrollment from MA, Part D, or Cost Plans

There are two types of disenrollment:

  - Voluntary disenrollment:
    - An enrollee chooses to disenroll from a plan because they no longer want to be enrolled.
  - Involuntary disenrollment:
    - In certain situations, the plan may be required or may have the option to end an enrollee's membership. The disenrollment is not the enrollee's choice.
- Plans or their marketing representatives may **not** either orally or in writing or by any action or inaction request or encourage any enrollee to disenroll from the plan except in specific situations authorized by CMS.
- Plans may contact enrollees to determine the reason for a voluntary disenrollment but must not discourage an enrollee from disenrolling after they indicate a desire to do so and may not market to the disenrolled individual during the call.

57. Voluntary Disenrollment from MA or Part D Plans

During a valid election period, an enrollee may request disenrollment from an MA or prescription drug plan by:

- enrolling in another plan.
- sending or faxing a signed written notice to the plan sponsor (or employer/union group, if applicable).
- submitting a request via the Internet to the plan sponsor (if the plan offers this option).
- calling 1-800-MEDICARE or for TTY users call 1-877-486-2048.

Enrollees making verbal requests must be instructed to request one of the above methods.

Exceptions:
- Employer or union sponsored plans may have other disenrollment mechanisms.
- To disenroll from an MSA plan enrollees must write to the plan. The enrollee cannot disenroll via 1-800-MEDICARE.

- To ensure disenrollment from a PDP, enrollees should submit a written request or call Medicare in the following situations:
    - Joining an MA PFFS plan without drug coverage
    - Joining an MSA plan
    - When NOT joining any other health or prescription drug plan

58. Voluntary Disenrollment from Cost Plans

- Medicare Cost plan enrollees may end their membership at any time during the year and enroll in Original Medicare.
    - The enrollee must submit a written request and cannot disenroll by calling Medicare.
- A beneficiary who disenrolls from a Cost plan may join a MA plan or a PDP during the Annual Election Period or other MA or Part D election period.

59. Required Involuntary Disenrollment from MA or Part D Plans

Plan sponsors must disenroll an enrollee from the plan in the following situations:

- A permanent change in residence (including incarceration) makes the enrollee ineligible to remain enrolled in the plan.
- The enrollee does not stay enrolled in Part A and Part B for MA and MA/PD plans or does not stay enrolled in either Part A or Part B for PDP plans.
- A SNP enrollee loses special needs status (e.g., an enrollee of a dual eligible SNP loses Medicaid eligibility) and does not reestablish special needs plan (SNP) eligibility prior to the expiration of the period of deemed eligibility.
- An MSA enrollee no longer meets the criteria to enroll in an MSA.

60. Required Involuntary Disenrollment from MA or Part D Plans

Plan sponsors must disenroll an enrollee from the plan in the following situations:

- The enrollee dies.
- The plan sponsor's contract is terminated, withdrawn, or the service area is reduced and excludes the enrollee.
- The member fails to pay their Part D-IRMAA to the government and CMS notifies the plan to effectuate the disenrollment.
    - Note that CMS has established a 3-month initial grace period before individuals in an MA-PD or PDP will be disenrolled for failure to pay their Part D IRMAA.
- The member is not lawfully present in the United States.
- A PDP must also involuntarily disenroll an individual who materially misrepresents information to the PDP sponsor regarding reimbursement for third-party coverage.

61. Involuntary Disenrollment When an Enrollee Moves from the Service Area

- MA Organizations:
    - must disenroll enrollees who have been out of the service area for more than 6 months (PFFS plans can allow continued enrollment for up to 12 months) if the individual is not in a continuation area offered by the MAO or the MAO does not offer an extended visitor/traveler (V/T) benefit.
    - may offer an extended V/T benefit of up to 12 months. Under this benefit, enrollees may remain temporarily out of the service area for up to 12 months without being disenrolled.

- Part D Plan Sponsors:
    - must disenroll an enrollee 12 months after identifying that the individual has moved outside of the service area if the plan has been unable to confirm the move with the enrollee.
    - exceptions may apply to enrollees who have a low-income subsidy.

62. Required Involuntary Disenrollment from Cost and MSA Plans

- MSA Plans must additionally disenroll an enrollee who no longer meets MSA eligibility requirements except the MSA Plan may not disenroll beneficiaries who elect the Medicare hospice benefit while enrolled in the MSA Plan.
- Medicare cost plans must disenroll an enrollee:
    - who does not stay continuously enrolled in Part B.
    - who has a permanent change in residence (including incarceration) out of the plan's geographic service area.
    - who has a temporary absence from the service area for more than 90 consecutive days (up to 12 months for plans with an extended absence option).
    - who is deceased.
    - when the cost contract is terminated or non-renewed.
    - when the member is not lawfully present in the United States.
- Cost plans that offer an optional supplemental Part D benefit must disenroll individuals who fail to pay their Part D IRMAA from that optional benefit only (the three-month initial grace period applies).

63. Optional Involuntary Disenrollment from MA, Part D or Cost Plans

- Plan sponsors <u>may</u> involuntarily disenroll an enrollee from the plan (but are not required to do so) if the enrollee:
    - does not pay premiums on a timely basis.
    - engages in disruptive behavior (CMS must approve the disenrollment after reviewing the evidence presented by the plan).
    - provides fraudulent information on an enrollment request.
    - allows another individual to use their enrollment card.
- Plan sponsors must take action consistently among all enrollees of each plan.

64. Optional Involuntary Disenrollment from MA, Part D or Cost Plans – Failure to Pay Premium

- If a member fails to pay the plan premium, a Plan Sponsor may choose to:
  - do nothing.
  - disenroll the member after a grace period and notice.
- In addition, if an MA member fails to pay the premium for optional supplemental benefits but pays the premium for basic and mandatory supplemental benefits, the MAO may reduce the member's coverage ("downgrade" coverage).
- Plans sponsors must apply the policy they choose uniformly for all plan members. However:
  - MA-PD plans have the option to retain dually eligible members and individuals who qualify for the low-income subsidy (LIS) who fail to pay premiums even if the MA organization has the policy to disenroll members for non-payment of premiums.
  - MA-only plans may retain individuals who are dually eligible for both Medicare and Medicaid (i.e., individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program.
  - PDPs have the option to retain individuals who qualify for the low-income subsidy who fail to pay premiums.

65. Optional Involuntary Disenrollment from MA, Part D or Cost Plans – Failure to Pay Premium, Enrollee Rights

Enrollee's Rights:

- For failure to pay plan premiums the plan sponsor must:
  - notify the enrollee in writing.
  - provide enrollees with a grace period of not less than 2 months.
- Under certain circumstances, individuals may be reinstated for good cause if the beneficiary pays the overdue premiums within 3 calendar months of disenrollment and other criteria are met.
- Enrollees have the right to make a complaint if the plan ends their membership.

66. Additional information

- Guidance for Eligibility, Enrollment, and Disenrollment procedures for Medicare Advantage (MA) plans, including MA-PD plans, PDPs and for Cost plans is found on the following page: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/