the form of premium payment requested by the individual.

- A notice of acknowledgement and other required information must be provided to the individual as described in §40.4 of this guidance.
- Telephonic enrollment requests into a plan offered by the same parent organization may be based on the model short enrollment form (Exhibit 1b) or the model plan selection form (Exhibit 1c) instead of the comprehensive individual enrollment form.

The PDP sponsor must ensure that all Part D eligibility and enrollment requirements provided in this guidance are met.

Scripts for completing an enrollment request in this manner must be developed by the PDP sponsor and submitted to CMS for review and approval. The scripts must contain the required elements for completing an enrollment request as described in Appendix 2 of this guidance, and must obtain CMS approval in accordance with applicable Medicare regulations prior to use.

40.1.4 – Auto- and Facilitated Enrollment

42 CFR 423.34
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

CMS auto-enrolls and facilitates enrollment of certain LIS beneficiaries into PDPs. "Auto-Enrollment" is the process that refers to full-benefit dual*ly* eligible individuals. "Facilitated Enrollment" is the process that refers to other LIS beneficiaries. The primary differences between the two are the populations and the enrollment effective date.

LI NET

CMS implemented the Limited Income Newly Eligible Transition (LI NET) demonstration *from January 1, 2010 to December 31, 2023, then as a permanent program starting January 1, 2024. LI NET provides immediate and retroactive Part D coverage for eligible low-income beneficiaries who do not yet have prescription drug coverage. Individuals who are LIS-eligible but do not yet have Part D coverage, and those individuals who have selected a Part D plan but whose enrollment has not taken effect, are enrolled by CMS into LI NET unless the beneficiary has affirmatively declined enrollment in Part D. Beneficiaries may be enrolled in LI NET through the auto- or facilitated enrollment processes, and may be automatically enrolled using the same processes into a Part D plan once LI NET coverage ends.*

NOTE: Beneficiaries may also enroll in LI NET through point of sale, application form, or direct reimbursement request. For more information, visit *https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET*.

LI NET enrollment begins on the first day of the month an individual is identified as LIS-eligible and ends after two months (or, for certain individuals with retroactive coverage, 36 months prior to the date such individual enrolls in (or opts out of) Part D coverage, whichever is later).

An individual's enrollment in the LI NET program, which provides transitional coverage, ends when:

- The individual is auto-enrolled into a standalone Part D plan and that coverage has taken effect.
- The individual elects another Part D plan and that coverage has taken effect.
- The individual voluntarily disenrolls from the LI NET program.
- The individual is involuntarily disenrolled from Part D coverage.
- LIS-eligibility for an individual in LI NET due to an immediate need cannot be confirmed within the period of LI NET coverage.

A. Populations

1. <u>Auto-Enrollment</u>

Full-benefit dual*ly* eligible individuals who have not elected a Part D plan will be auto-enrolled into one by CMS. Full-benefit dual*ly* eligible individuals are defined as those eligible for comprehensive Title XIX Medicaid benefits as well as eligible for Medicare Part D. This includes those who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare Part B premiums and/or cost-sharing (sometimes known as QMB-plus or SLMB-plus). CMS will use data provided by State Medicaid Agencies to identify full-benefit dual*ly* eligible individuals. Please note that full-benefit dual*ly* eligible individuals do not include those eligible *only* for Medicaid payment of Medicare cost-sharing (i.e. QMB-only, SLMB-only, or QI).

Full-benefit dual*ly* eligible individuals who will be auto-enrolled into a PDP pursuant to this section include those enrolled in:

- Original Medicare;
- A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit;
- An 1876 cost plan that does not offer a Part D optional supplemental benefit;
- Medical Savings Account; or
- An 1833 Health Care Prepayment Plan (HC-PP); and
- Who do not meet any of the conditions listed below.

This excludes full-benefit dual*ly* eligible individuals who:

- Live in any of the five U.S. territories
- Live in another country
- Are incarcerated, as defined in §10
- Are not lawfully present in the U.S.
- Have opted out of auto-enrollment into a Part D plan
- Are already enrolled in a Part D plan
  Note: Beneficiaries enrolled in a Program of All Inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their PACE organization, so they do not need to be auto-enrolled

- Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan, other than an MA-PFFS plan that does not offer Part D or an MSA plan. CMS will instead direct Medicare Advantage organizations to facilitate the enrollment of these individuals into an MA-PD plan or PDP offered by the same MA organization; please see Section 40.1.5 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2).
- Are enrolled in a section 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be auto-enrolled instead into the cost plan's Part D optional supplemental benefit, as is described in Chapter 17, Subpart D, of the Medicare Managed Care Manual).

For modified auto-enrollment procedures for full-benefit dual*ly* eligible individuals for whom employers claim a retiree drug subsidy, please see section 40.1.4.H.

2. <u>Facilitated Enrollment</u>

Other LIS eligible individuals are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e. only eligible for Medicaid payment of Medicare premiums and/or cost-sharing); SSI-only (Medicare and Supplemental Security Income [SSI], but no Medicaid); or those who apply for LIS at the Social Security Administration (SSA) or a State Medicaid Agency and are determined eligible for LIS. This includes those who apply and are determined eligible for *the* subsidy. CMS will use data submitted by SSA to identify SSI-only and those who apply for LIS and are determined eligible by SSA. CMS will use data from State Medicaid Agencies to identify those who are QMB-only, SLMB-only, QI, or who apply for LIS and are determined eligible by the State.

Other LIS eligible individuals that will be enrolled into PDPs pursuant to this section include those enrolled in:

- Original Medicare;
- A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit;
- An 1876 cost plan that does not offer a Part D optional supplemental benefit;
- A Medical Savings Account (MSA); or
- An 1833 HCPP; and
- Who do not meet any of the conditions listed below.

This excludes other LIS eligible individuals who:

- Live in any of the five U.S. territories
- Live in another country
- Are individuals for whom the employer is claiming the retiree drug subsidy
- Are incarcerated, as defined in §10
- Are not lawfully present in the U.S.
- Have opted out of facilitated enrollment into a Part D plan
- Are already enrolled in a Part D plan
  Note: Beneficiaries enrolled in a Program of All Inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their

PACE organization, so they do not need to be auto-enrolled

- Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan other than an MA-PFFS plan that does not offer Part D or an MSA plan. CMS will instead direct Medicare Advantage organizations to facilitate the enrollment of these individuals into an MA-PD plan or PDP offered by the same MA organization; please see Section 40.1.2 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2)
- Are enrolled in an 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be facilitated enrolled instead into the cost plan's Part D optional supplemental benefit, as is described in Chapter 17, Subpart D, of the Medicare Managed Care Manual).

B. Qualifying PDPs

A PDP qualifies to receive auto/facilitated enrollments in a given region if it meets all the following criteria:

- offers basic prescription drug coverage
- has a premium at or below the low-income premium subsidy amount in the PDP region
- meets the "Requirements Critical for Ensuring Effective Enrollment of Dual Eligible individuals" issued August 31, 2006.

PDPs that qualify to receive auto/facilitated enrollments may not decline to accept such enrollments. Qualifying PDPs must accept all individuals assigned by CMS who had been previously involuntarily disenrolled by the plan for non-payment of premiums.

Only PDPs with defined standard, actuarially equivalent standard, or basic alternative benefit packages will be included. CMS will not auto/facilitate enroll beneficiaries into PDPs with enhanced alternative benefit packages, even if their premium is at or below the low-income premium subsidy amount for the region. In addition, CMS will not auto/facilitate enroll beneficiaries into an employer-sponsored PDP. Finally, CMS will not auto/facilitate enroll beneficiaries into PDPs that volunteer to waive the "de minimis" amount over the regional LIS benchmark.

Plans that qualify to receive auto/facilitated enrollments in the current year, but will not in the following year will no longer receive new auto- or facilitated enrollments starting in October of the current year. This avoids the need to immediately reassign these beneficiaries to a different plan.

PDPs that do not qualify in the current year, but do qualify in the following year, will start receiving PDP Notification Files and TRRs with auto/facilitated enrollments starting November of the current year (with effective dates no earlier than January 1 of the following year).

The LI NET *sponsor solely* qualif*ies* to receive auto/facilitated enrollments for *limited* periods of time*, typically two months*.

C. Auto/Facilitated Enrollment Process

CMS performs the auto/facilitated enrollment process each day it receives a source file from a State Medicaid Agency or Social Security Administration. The procedures for auto- and facilitated enrollment into PDPs are identical, and work as follows:

1. CMS will identify full-benefit dual*ly* eligible individuals to be auto-enrolled and other LIS eligible individuals to be facilitated enrolled. CMS uses LIS deemed reason code, which indicates the person was a full-benefit dual*ly* eligible sometime during the past year, to define those being auto-enrolled. LIS deemed code and LIS applicant data are used to identify those who need to be facilitated enrolled.

2. CMS will identify PDPs that qualify to receive auto/facilitated enrollments.

3. CMS will assign beneficiaries to a plan in a two-step process. The first level of assignment is at the PDP sponsoring organization (PDP Sponsor) level. The second level of assignment is to an individual PDP offered by the PDP Sponsor. This will result in approximately the same proportion of auto-enrollees at the PDP Sponsor level.

   At the first level of assignment, CMS will identify PDP sponsors that offer at least one qualifying PDP in the region. If more than one PDP sponsor in a region meets this criteria, CMS will auto/facilitate enroll on a random basis among available PDP sponsors. Please note that if two or more PDP sponsors are owned by the same parent organization, they are treated as a single organization for purposes of this first step of auto/facilitated enrollment.

   At the second level of assignment, CMS will identify the qualifying PDPs offered by each sponsor in the region. If a given PDP sponsor only has one such PDP in the region, all the beneficiaries assigned to the PDP sponsor will be assigned to that one PDP. If the PDP sponsor offers more than one such PDP in the region beneficiaries will be randomly assigned first among the contracts within the sponsoring organization (if there are more than one with a qualifying PDP), and then among the qualifying PDPs a contract offers.

   This method of random enrollment will result in full-benefit dual*ly* eligible individuals and other LIS beneficiaries being assigned in approximately equal proportions among available PDP sponsors, not PDPs. Since PDP sponsors may offer different numbers of PDPs that meet the auto/facilitated enrollment criteria, auto/facilitated enrollment proportions may vary at the PDP level.

   EXAMPLE:

   There are 4 PDP-sponsoring organizations in a region that offer one or more plans with premiums at or below the low income premium subsidy amount. The numbers of PDPs with an appropriate premium are as follows:

Organization A—1 PDP
Organization B—1 PDP
Organization C—2 PDPs
Organization D—3 PDPs

Step 1: The auto/facilitated enrollment population would first be divided equally and randomly among the four PDP sponsors. Thus, each PDP sponsor would be assigned 25 percent of the available population.

Step 2: Within each PDP sponsor, the population would again be divided equally and randomly. Thus, all of Organization A's enrollees would be assigned to its one appropriate PDP; the same would be true for Organization B; 50 percent of the population assigned to Organization C would be assigned randomly to each of its two plans; and 33.3 percent of the population assigned to Organization D would be assigned randomly to each of its three plans.

PDPs with premiums below the low-income subsidy amount will not be treated more favorably than those with premiums equal to the low-income premium subsidy amount. A PDP's other beneficiary charges – copayment levels, deductibles, etc. – will not be a factor in determining whether it qualifies for auto/facilitated enrollment provided the PDP offers basic prescription drug coverage.

4. CMS will calculate the effective date as the first day of the second month after the current month (see section 40.1.4.D below for details), create a code 61 enrollment transaction for each auto and facilitated enrollment, and submit it to the MARx system.

5. Immediately after auto/facilitated enrollment occurs, the PDP will receive the preliminary "PDP notification file" identifying those assigned, including addresses and full names. CMS does not maintain phone number data on beneficiaries, so this information cannot be transmitted to PDP sponsors. This file ensures PDPs are notified of new auto/facilitated enrollees prior to beneficiaries receiving CMS' auto/facilitated enrollment notice. Since auto/facilitated enrollment can occur daily, these files may be transmitted as frequently as daily.

6. The PDP will then be notified via TRR of the auto/facilitated enrollment confirmed processed by MARx, including the effective date.

For technical specifications and file formats, please see sections *4.3* of the Plan Communications User Guide, on the CMS website at *https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/mapdhelpdesk/plan_communications_user_guide.*

D. Effective Date

Starting January 1, 2010, all auto/facilitated enrollments generated by CMS into qualifying PDPs will have prospective effective dates. Specifically, the effective date will be the first

day of the second month after CMS identifies the person.

> **Example**: Throughout 2010, an individual is eligible for Part D. On July 14, 2010, the State sends data to CMS identifying the person as a full- or partial-*benefit* dual*ly eligible*, or SSA sends data to CMS identifying the person as a new SSI-only or LIS applicant, retroactive to March 1, 2010. CMS randomly auto/facilitate enrolls the person into a qualifying PDP effective September 1, 2010. (If the person was a full dual or SSI-only, CMS creates a second auto/facilitated enrollment transaction *providing retroactive coverage through* the LI NET *program* for March 1 – August 31, 2010).

CMS will calculate the auto/facilitated enrollment effective date, which will be conveyed to plans in the PDP Notification File and the TRR. CMS will ensure that any beneficiary choice will "trump" facilitated enrollment by creating an artificially early application receipt date for systems processing purposes.

Note: For retroactive periods, CMS will auto/facilitate enroll full-benefit dual*ly* eligible individuals and SSI-only beneficiaries into LI NET. Please see below for details on when retroactive periods of coverage are necessary and how they are calculated.

1. Retroactive Auto/Facilitated Enrollments for Full Duals and SSI-Only

Full-benefit dual*ly* eligible individuals and SSI-only beneficiaries may qualify to be retroactively auto/facilitated enrolled by CMS into the LI NET program. Partial-*benefit* dual*ly* eligible individuals and LIS applicants do not qualify for retroactive assignments.

For full-benefit dual*ly* eligible individuals who are Medicaid eligible first and then subsequently become Medicare eligible, the effective date of auto-enrollment will be the first day of Part D eligibility. This effective date ensures there is no coverage gap between the end of Medicaid prescription drug coverage and the start of Medicare prescription drug coverage. CMS will make every effort to identify these individuals prior to the start of their Part D eligibility, so that we can notify beneficiaries and plans prospectively of auto-enrollment. However, in cases where we cannot do so, the enrollment may be retroactive. Please note that Part D eligibility always falls on the first day of the relevant month.

> **Example:** An individual has Medicaid coverage throughout 2010. On March 15, 2010, the State sends data identifying the person as a prospective full dual, who will become Medicare Part D eligible in May, 2010. That night, CMS randomly auto-enrolls the person into a qualifying PDP effective May 1, 2010. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2010.

Retroactive eligibility for Medicare Parts A and/or B will not result in retroactive effective dates for auto-enrollment. This is because Medicare Part D eligibility cannot be retroactive. If eligibility for Part A and/or B is retroactive, Part D eligibility is effective the first day of the month in which the beneficiary received notification of retroactive Medicare Part A/B entitlement (see §10). *Retroactive LI NET coverage begins on the first day of the month an*

individual is identified as eligible for a low-income subsidy as a full-benefit dually eligible or an SSI benefit recipient, or 36 months prior to the date such individual enrolls in (or opts out of) Part D coverage, whichever is later. The retroactive effective date in LI NET cannot be prior to the individual's Part D eligibility date.

> **Example:** An individual has Medicaid coverage throughout 2010. In May 2010, the individual is notified that *they are* entitled to Medicare Part A and/or B retroactive to November, 2009. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2010; the first day of Part D eligibility is May 1, 2010. The person is included on a state MMA file on May 20; CMS auto-enrolls the beneficiary into LI NET for May 1 through June 30, 2010; and randomly auto-enrolls *them* into a qualifying PDP effective July 1, 2010.

For those who are Medicare eligible first, and then subsequently become Medicaid eligible, auto- enrollment will be effective the first day of the month the person became Medicaid eligible (i.e. achieved full-benefit dual status), or January 1, 2006, whichever is later. For this population, there are no data that can be used to identify them prospectively, so the effective date will likely always be retroactive. Please note that auto-enrollment will only occur if the beneficiary is not already enrolled in a Part D plan; if the person is already in a Part D plan, the only impact of becoming newly eligible for Medicaid is that the individual will be deemed eligible for the full low-income subsidy.

> **Example**: An individual is Medicare Part D eligible through 2010. The person applies for Medicaid in August 2010, is determined in October, 2010 to be Medicaid-eligible back to August 1, 2010, and is included on a state MMA file in October. Because the person has Medicare, *they are* not eligible for Medicaid prescription drug coverage (note *they* remain eligible for other Medicaid benefits). CMS auto-enrolls the beneficiary into LI NET retroactive to August 1, 2010, and randomly into a qualifying PDP effective December 1, 2010.

> **Example**: An individual becomes Medicare Part D eligible in May 2010. That same month, the individual applies for Medicaid. In August 2010, the State Medicaid Agency awards Medicaid eligibility effective February 1, 2010 (Medicaid eligibility may be retroactive to three months before the month of application), and includes the person on a state MMA file in August. In this scenario, Medicaid prescription drug coverage is effective February 1 – April 30, 2010. CMS auto-enrolls the beneficiary into LI NET retroactive to May 1, 2010, and randomly auto-enrolls the person into a qualifying PDP effective October 1, 2010.

CMS will auto-enroll full-benefit dual*ly* eligible individuals who have disenrolled, either voluntarily or involuntarily, from a Part D plan and failed to enroll in a new plan (unless they affirmatively declined or opted-out of auto-enrollment). The effective date will be retroactive to the month after the disenrollment effective date of the previous Part D plan enrollment.

> **Example**: A full-benefit dual*ly* eligible or SSI-only eligible disenrolls from a Part D plan (either voluntarily or involuntarily), effective March 31, 2010. In the April auto/facilitated

enrollment run, CMS auto/facilitate enrolls the person into LI NET effective April 1, and randomly into a qualifying PDP effective June 1, 2010.

In limited instances, a full-benefit dual*ly* eligible voluntarily enrolls in a Part D plan in the month(s) before the individual would otherwise have been auto-enrolled, or CMS auto/facilitates enrollment of a beneficiary with a given effective date, but subsequently data become available that shows the effective date should have been earlier. Individuals with active elections in a Part D plan are not included in CMS' auto-enrollment process, so the auto-enrollment process does not create an enrollment for the uncovered month(s). In these instances, the beneficiary contacts LI NET to request coverage for the uncovered month(s) in the past. The current PDP must refer beneficiaries with uncovered months in the past to LI NET to request coverage.

The PDP must move up the effective date of a facilitated enrollment by a month if the LIS beneficiary requests this in a timely fashion, i.e. before the start of the earlier month. The PDP must accept these requests verbally and in writing; it cannot limit such request to written requests. The beneficiary can contact the plan by telephone or in writing to make this request. The SEP under § 30.3.8 #7 should be used.

Example: CMS facilitates enrollment of an Other LIS eligible in May, 2010, effective July 1, 2010. The beneficiary receives the facilitated enrollment notice in May, and by May 31 requests the PDP makes the facilitated enrollment effective June 1. The PDP submits an enrollment transaction to do so.

E. CMS Notice Provided to Auto/Facilitated Enrolled Beneficiaries:

CMS will notify the beneficiary that *they* will be auto/facilitated enrolled in a given PDP on the auto/facilitated enrollment effective date unless *they* choose another Part D plan (either another PDP, or an MA-PD plan, a PACE organization, or an 1876 cost plan that offers a Part D optional supplemental benefit), or opts out of auto/facilitated enrollment into a Part D plan altogether. For beneficiaries who have a retroactive period of auto/facilitated enrollment, the notice will provide information on obtaining coverage for those periods through LI NET. Auto-enrollment notices will be on yellow paper; facilitated notices will be on green paper. If the beneficiary does not take either action, the person's silence will be deemed consent with the auto/facilitated enrollment, and it will take effect on the effective date. Additionally, all LIS and dual*ly* eligible individuals have a Special Enrollment Period (SEP) that permits them to change Part D plans outside of the AEP, even after the auto/facilitated enrollment takes effect (refer to §§ 30.3.2 and 30.3.8, #*7* of this guidance).

CMS has created an exception to the auto-enrollment procedures for full-benefit dual*ly* eligible individuals who CMS knows to be enrolled in a qualifying employer group plan and for whom CMS has approved the group health plan sponsor to receive the Retiree Drug Subsidy (RDS) (see section 40.1.4.H). CMS will provide notice to such individuals of their choices and advise them to discuss the potential impact of Medicare Part D coverage on their group health plan coverage.

This notice informs such individuals that they will be deemed to have declined to enroll in Part D unless they affirmatively enroll in a Part D plan or contact CMS and confirm that they wish to be auto-enrolled in a PDP. Individuals, who elect not to be auto-enrolled, may enroll in Medicare Part D at a later time if they choose to do so.

F. PDP Notice and Information Provided to Auto/Facilitated Enrolled Beneficiaries:

PDPs must send a notice confirming the auto-enrollment (see Exhibit 24) or facilitated notice (see Exhibit 25) within 10 calendar days after receiving CMS confirmation of the enrollment from the TRR or the PDP Notification File with addresses of auto/facilitated enrollees, whichever is later.

PDPs must also send a modified version of the pre- and post-enrollment materials that must be provided to those who voluntarily enroll in a PDP. If the address indicates the beneficiary is outside the PDP region, please follow procedures in section 50.2.1.4.

Prior to the effective date, the PDP must send each individual who has been auto/facilitated enrolled:

- Proof of health insurance coverage so that *they* may begin using the plan services as of the effective date;

  NOTE: This is not the same as the Evidence of Coverage document described in CMS' marketing guidelines. This evidence may be in the form of member cards, the enrollment form, and/or a notice to the member. If the PDP sponsor does not provide the member card prior to the effective date, it must provide it as soon as possible after the effective date.

- The charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts (including general information about the low income subsidy);

- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the PDP sponsor has not yet provided the ID card); AND

- A Summary of Benefits or Evidence of Coverage. Those who are auto/facilitated enrolled still need to make a decision whether to stay with the plan into which they have been auto- enrolled or change to another one that better meets their needs. Providing the Summary of Benefits or Evidence of Coverage, which is generally considered pre-enrollment marketing material, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.

The requirement in §40.4.2 (see also Exhibits 4 and 7) to inform the beneficiary of whether the enrollment was accepted or rejected does not apply to auto/facilitated enrollments, since CMS generates these transactions and they are already confirmed at the point when the sponsor is notified via the TRR.

There may be certain times during the month death information is updated in CMS records after the auto-assignment/enrollment process has occurred, resulting in auto-enrollment of individuals with a deceased code. In cases where the PDP sponsor receives an auto-enrollment with a deceased code, the PDP sponsor must send a notice to the estate of the member (see Exhibit 13a).

PDPs do not need to send the 30-day Coordination of Benefits survey for new enrollees whether they are auto or facilitated enrolled; they only need to conduct the annual survey.

G. Opt Out:

Full-benefit dual*ly* eligible and other LIS eligible individuals may opt out of (affirmatively decline) auto/facilitated enrollment into a Part D plan. The primary means for doing so is by calling 1-800- MEDICARE. However, the beneficiary may also call the PDP into which *they have* been auto/facilitated enrolled. The PDP may accept the request verbally; a written request is not required. The entity contacted by the beneficiary must inform the individual of the implications of *their* request. In addition, a follow-up notice must be provided that confirms the request to opt- out, and explains the consequences (see Exhibit 26). The entity then sends a Code 51 disenrollment transaction and sets the Part D Opt-Out Flag (field *17*) to Y (opt-out of auto- enrollment).

The beneficiary may opt-out either prior to the auto/facilitated enrollment effective date, or once enrolled in a Part D plan (whether voluntarily or auto/facilitated enrolled into it). If the beneficiary makes the request prior to the effective date of auto/facilitated enrollment, then the entity receiving the opt-out request will submit a disenrollment transaction (with specific coding indicating that the transaction is an opt-out). This will cancel the auto/facilitated enrollment, and the person will never be enrolled. The PDP sponsor should then send the model notice in Exhibit
26. If the beneficiary makes the request after the effective date of enrollment in the plan, then the request results in a disenrollment effective the last day of the month in which the request was made, and the model notice in Exhibit 26a should be used.

Please note that an individual who opts-out does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto/facilitated enrollment processes.

If the beneficiary decides *they* want to obtain the Part D benefit in the future, *they* do so simply by enrolling in a new plan. LIS eligible individuals have a Special Enrollment Period, so they are not limited to the AEP.

The enrollment request will be effective the first of the month following the month in which the Part D plan receives the enrollment request.

H. Special Procedures for Full-Benefit Dual*ly* Eligible individuals with Retiree Drug Subsidy:

CMS has created an exception to the auto-enrollment process for full-benefit dual*ly* eligible individuals who are qualifying covered retirees and for whom CMS has approved the group health plan sponsor to receive the Retiree Drug Subsidy (RDS). The exception process includes:

- CMS identifies the full-benefit dual*ly* eligible individuals with RDS and excludes them from automatic enrollment in a Part D plan; and
- CMS sends a notice (see section 40.1.4.E) to these individuals
    - Informing them of their choices and that they need to proactively enroll in a Part D plan, if they wish to do so:
    - Suggesting that these individuals discuss the potential impact of their decision, on both drug and medical retiree benefits for themselves and their families, with the appropriate staff of the qualified retiree prescription drug plan; and
    - Indicating that they will be deemed to decline enrollment in Part D unless they affirmatively enroll in a Part D plan or contact CMS and confirm they wish to be auto-enrolled into a Part D plan.

40.1.5 – Re-Assignment of Certain LIS Beneficiaries

CMS has the discretion to re-assign LIS beneficiaries, including situations in which their current plan will have a premium above the low-income premium subsidy amount (i.e., benchmark) in the following year, unless the plan volunteers to waive the de minimis amount of the premium above the benchmark. CMS will conduct the reassignment in the fall of each year, and ensure all affected LIS beneficiaries are notified. Affected PDPs are not responsible for initiating any enrollment or disenrollment transactions for reassigned beneficiaries, except for re-enrollment of beneficiaries who opt to remain in their current plan, as described below. Affected PDPs are only responsible for responding to the CMS enrollment transaction promptly when they receive it and for providing appropriate beneficiary notices and materials, also as described below.

A. Population to be Re-Assigned

CMS will reassign beneficiaries enrolled in "Losing" PDPs who meet all of the following criteria:

For PDPs that offered a basic benefit and premium below the regional LIS benchmark in the current year, but will lose to reassign because they will have a premium in the following year that will be above the benchmark amount (unless they volunteer to waive the de minimis amount above the benchmark):

- They will continue to be eligible for 100% premium subsidy LIS in the following year. Individuals may qualify for 100% premium subsidy because they were deemed eligible for LIS (i.e., because they were a full-benefit dual*ly* eligible, Medicare Savings Program participant, or Supplemental Security Income (SSI) recipient), OR because they applied and were found eligible for the 100% LIS premium subsidy).
- They were originally enrolled by CMS into their current PDP, i.e. through auto/facilitated enrollment, or reassignment.

- They do not live in a U.S. territory.

For PDPs that are non-renewing (terminating):

- All current LIS enrollees who will continue to have LIS in the following year, regardless of premium subsidy amount, and regardless of whether the individual was assigned to or voluntarily enrolled in a plan.

The actual reassignment process is typically run on a single day in early October. CMS will only reassign beneficiaries who meet the above criteria as of the day of the reassignment run. CMS does not subsequently "sweep" for individuals who may meet the criteria at later points in time.

B. "Losing" PDPs

A PDP will lose LIS beneficiaries to re-assignment if it meets any of the following criteria:

- The PDP has beneficiaries originally auto/facilitated enrolled or reassigned by CMS and there will be a new premium liability in the following year for those eligible for 100% premium subsidy under LIS. The premium increase would be due to the premium going above the LIS benchmark.

  Per 1860D-14(a)(5) of the Social Security Act, the PDP will not lose beneficiaries if:
  - The plan's premium is within a "de minimis" amount of the LIS benchmark, and
  - The plan voluntarily agrees not to collect the de minis premium amount over the benchmark (see section 40.1.5.B.1 below for additional details.

- The PDP is terminating for the following year.

As part of determining whether a terminating PDP should be included in reassignment, CMS determines whether it is truly non-renewing (i.e. all beneficiaries will be disenrolled with no automated enrollment into another PDP), or whether beneficiaries are actually being cross-walked to a different PDP. If the latter, CMS will perform the following additional steps:

- Determine if the PDP had a premium below the LIS regional benchmark and a basic benefit in the current year.
  - If it does not, then the PDP will be carved out of reassignment (i.e. not considered "terminating" for purposes of reassignment), and all beneficiaries will be cross- walked.
  - If it does, CMS will determine whether the PDP to which beneficiaries are cross- walked qualify as a "Gaining" PDP per section 40.1.5.G.
    - If so, the beneficiaries will not be included in reassignment, and all beneficiaries will be cross-walked, since the plan to which they are being cross-walked will have no premium for those with 100% premium liability.
    - If not, beneficiaries who meet the criteria for reassignment due to premium increase in section 40.1.5.A above will be reassigned (to ensure they have no new premium liability the following year); the

remaining beneficiaries will be cross-walked.

CMS account managers will contact losing plans in September to confirm the plan is aware it will lose beneficiaries due to reassignment. Plans that are uncertain about whether they will lose to reassignment should contact their CMS account manager to confirm.

Volunteering for "De Minimis"

As noted above, per section 1860D-14(a)(5) of the Social Security Act, a PDP or Medicare Advantage with Prescription Drug (MA-PD) plan may volunteer to waive the portion of the monthly adjusted basic beneficiary premium that is up to a de minimis amount above the LIS benchmark for a subsidy eligible individual. The de minimis amount may not be waived from the enhanced portion of a Part D premium applicable to the enhanced benefit.

CMS will announce the de minimis amount in August, when the benchmarks are released. We will determine the de minimis amount taking into consideration the goal of minimizing reassignments without undue cost to the Medicare Trust Fund.

CMS will not reassign LIS members from plans that volunteer to waive the de minimis amount. However, for continuing Part D plans, we only reassign beneficiaries originally assigned to a zero- premium PDP that will have a new premium liability in the following year. We do not reassign beneficiaries from continuing MA plans, regardless of the level of the Part D premium. As a result, while any Part D plan that qualifies may volunteer to waive the de minimis premium, we anticipate that the only Part D plans that are likely to volunteer are those continuing PDPs that would otherwise lose beneficiaries to reassignment.

A Part D sponsor will volunteer to waive de minimis premium amount on a plan by plan basis. The Sponsor may opt to volunteer for one plan benefit package that qualifies and not another. For each plan benefit package for which a Sponsor volunteers, the Sponsor agrees to waive the de minimis premium amount for all LIS beneficiaries with 100% premium subsidy in that plan benefit package. This includes any member for any month in the contract year for which the individual is 100% premium subsidy eligible. The Part D sponsor will be responsible for identifying these members based on existing data already transmitted by CMS, and ensuring no premium is charged to them.

Plans with de minimis premiums must inform CMS of their intent to participate in the voluntary de minimis program within five business days after the de minimis amount is released. Specific dates will be provided when the de minimis amount is announced. Plans will inform CMS of their intention to participate through HPMS. A de minimis link will be available from the left navigation bar in HPMS under Plan Bids/Bid Submission/CY2011/Manage Plans. All organization users with the bid download/upload access type associated with a contract number will have access to the de minimis page for qualifying plans under the contract number. The default value will be unchecked (i.e., "No") so a plan must select the checkbox to indicate that it wants to volunteer to participate.

C. Re-assignment Process

CMS will attempt to reassign beneficiaries within the same organization wherever possible.

First, CMS will identify other qualified plans in the same region offered under the same contract number, or if that is not available, under a different contract number sponsored by the same parent organization. If the organization has more than one such plan in that region, CMS will randomly reassign beneficiaries among those plans. CMS will first attempt to identify a benchmark PDP within the same organization; only if none are available will it assign to a PDP within the same organization that volunteers to waive the de minimis amount above the benchmark.

If the organization does NOT offer another qualifying PDP, CMS will randomly reassign affected beneficiaries to other PDP sponsors that have at least one qualifying PDP in that region. CMS will follow the two-step process used under auto/facilitated enrollment, i.e. random distribution first at the sponsor level, then randomly among qualifying plans within the sponsor (see section 40.1.4.C). CMS will not randomly reassign to de minimis plans.

Reassignment usually takes place in early October. CMS will send a preliminary file of reassignees to "gaining" and "losing" plans in mid-October. This file shall be used by plans for purposes of identifying beneficiaries who will be receiving CMS' blue reassignment letters; for "gaining" plans to obtain full name and address data; and for "losing" plans to identify the appropriate ANOC per section 40.1.5.E. The final confirmation will be received via TRR in late November.

Please note: beneficiaries are not always assigned to a "gaining" PDP that serves the same region as the "losing" PDP. CMS will use the beneficiary's state of residence to determine where the beneficiary needs to be reassigned. CMS determines state of residence first by checking if a state submitted the person on a recent state MMA file; if the person was not included on a recent state MMA file, CMS then uses the beneficiary address on its system. It is possible that, since originally assigned to a plan, a beneficiary's address had changed, so *they* must be reassigned to a new region. As a result, when reassignment is to another plan within the same organization, sponsors may not see all beneficiaries from the "losing" plan moved to the "gaining" plan. In addition, PDPs in regions with no "losing" plans may gain a few beneficiaries from reassignment. Finally, "gaining" plans may receive reassignees that appear to reside outside the region (based on beneficiary address), but who are not. For these individuals, sponsors should follow the procedures in section 50.2.1.4.

CMS may conduct a second reassignment for LIS beneficiaries in non-renewing Medicare Advantage plans (see section 40.1.8 of Chapter 2 of the Medicare Advantage Manual). In this second reassignment, "gaining" PDP's will receive a second round of reassignees.

D. CMS Notification to Beneficiaries

CMS will ensure that all beneficiaries being re-assigned are notified. These notices will be on blue paper, and will instruct beneficiaries who are being reassigned because of a premium increase to contact their current plan if they wish to remain with the plan for the following year. Per section 1860D-14(c), CMS will also provide reassigned beneficiaries with information on formulary differences between the individual's former plan and new plan (with respect to the individual's drug regimen), as well as a description of the right to

coverage determination, exception, reconsideration, appeal, or grievance. The model CMS notice will be available on the following web page in the fall of each year: www.cms.gov/LimitedIncomeandResources/LISNoticesMailings/list.asp#TopOfPage

E. Plan Communication to Affected Beneficiaries

"Losing" PDPs are responsible for sending an appropriate ANOC, as follows:

- If individuals are being reassigned within the same organization, the ANOC should be for the following year's plan, and include the Evidence of Coverage and LIS Rider.
- If the PDP is losing beneficiaries to a different PDP sponsoring organization, it may, at its discretion, use the alternate ANOC in Exhibit 30; it need not send the Evidence of Coverage or LIS Rider.
    - If it chooses to use the standard ANOC, it should use the version applicable to the plan in which the beneficiary is currently enrolled, and shall include the Evidence of Coverage and LIS Rider.

"Losing" PDPs should make their best effort to identify individuals who will be lost to reassignment for purposes of providing the appropriate ANOC. Plans may identify potential reassignees by identifying those that meet both of the following conditions:

> Individuals initially assigned by CMS (enrollment source = A [auto-enrollment], C [facilitated enrollment] or H [reassignment]; or TRCs 117, 118, or 212A) and Individual has 100% premium subsidy in following year (per the TRR or monthly LIS history report)

Terminating PDPs should send a termination notice as instructed in the Call Letter.

Additionally, "losing" plans will be required to send a letter confirming disenrollment from the plan due to re-assignment within 10 calendar days from receiving disenrollment confirmation on a TRR (See Exhibit 10(b) for model letter).

"Gaining" PDPs are responsible for providing enrollment confirmation (See Exhibit 29) and enrollment materials to beneficiaries within 10 calendar days of receiving confirmation of reassignment on a DTRR.

"Gaining" PDPs do not need to send the 30-day Coordination of Benefits survey for new enrollees whether they are auto or facilitated enrolled; they only need to conduct the annual survey.

F. Requests for "Re-Enrollment" in the "Losing" Plan

CMS' notices to affected beneficiaries will instruct them to contact their current plan if they wish to remain with the plan for the following year. *In the rare occasion a reassigned beneficiary contacts the plan to indicate that they wish to remain with the plan for the following year, the plan should send the case to the Retroactive Processing Contractor to cancel the enrollment into the new plan and remain in the "losing" plan.*

As part of this enrollment, the plan must confirm and document the beneficiary's understanding of the financial liability *they* will incur by remaining with the plan for the following year. **However, DO NOT transmit these enrollment elections to *the RPC* until a TRR is received confirming the beneficiary's disenrollment from the plan in late November.** If the "re-enrollment" transaction is sent in before disenrollment due to reassignment is confirmed, the transaction will be rejected as "beneficiary already enrolled." For beneficiaries re-enrolling in their current plan, the sponsor need not send a disenrollment confirmation letter, but must send the standard enrollment confirmation letter in section 40.4.

G. "Gaining" PDPs

PDPs that qualify for auto- and facilitated enrollment (see section 40.1.4.B) with effective dates starting January 1 of the following year will also qualify to receive those LIS beneficiaries reassigned as described above. Qualifying PDPs must meet the "Requirements Critical for Ensuring Effective Enrollment of Dual Eligible individuals" issued August 31, 2006. The only time CMS will reassign to a de minimis PDP is when a PDP sponsoring organization does not offer a benchmark PDP in the region, but does offer a de minimis PDP.

40.1.6 – Group Enrollment Mechanism for Employer/Union Sponsored PDPs

CMS will allow a PDP sponsor to accept enrollment requests into an employer or union sponsored PDP using a group enrollment process that includes providing CMS with any information it has on other insurance coverage for the purposes of coordination of benefits, as well as creditable coverage history it has on each beneficiary group enrolled for purposes of assessing the late enrollment penalty.

It is the PDP sponsor's responsibility to ensure the group enrollment process meets all applicable PDP enrollment requirements. PDP sponsors must ensure that any contracts and/or other arrangements and agreements with employers and unions intending to use the group enrollment process make these requirements clear.

The group enrollment process must include notification and materials to each beneficiary as follows:

- Beneficiaries participate in the group enrollment mechanism by receiving advance notice that the employer/union intends to enroll them for a prospective date in a PDP that the employer/union is offering; and
- That the beneficiary may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to employer/union benefits opting out would bring; and
- This notice must be provided by the PDP sponsor, or the employer or union acting on its behalf, not less than 21 calendar days prior to the effective date of the beneficiary's enrollment in the group sponsored PDP.
- Additionally, the information provided to each beneficiary must include a Summary of Benefits offered under the employer/union sponsored PDP, an explanation of how to get more information about the PDP, and an explanation on how to contact Medicare for information on other Part D options that might be available to the

beneficiary.

- Each individual must also receive in the group enrollment notice materials the information contained in Exhibit 1 under the heading "Please Read & Sign Below."

The PDP sponsor must ensure all of the above requirements are met prior to submission of the enrollment transactions to CMS. For enrollments processed using the SEP EGHP, the application date is the first day of the month prior to the effective date of the group enrollment for all mechanisms at all times. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems. For the purposes of providing notices and meeting other timeframe requirements, PDP sponsors will use the date the organization receives the request. For example, if a valid group enrollment mechanism file is received by the organization on January 24th for enrollments effective February 1st, the receipt date for the provision of required notices is January 24th and the application date submitted on the enrollment transactions is January 1st.

The employer or union must provide in the group enrollment file(s) all the information required for the PDP sponsor to submit a complete enrollment request transaction to CMS, including permanent residence information (refer to Appendix 2 for a complete list of the elements required for an enrollment transaction to be considered complete). Records must be maintained as outlined in §60.8 of this chapter.

40.1.7 – Enrollment for Beneficiaries in Qualified State Pharmaceutical Assistance Programs (SPAPs)

CMS will allow sponsors to accept enrollment requests in an agreed-upon electronic file format from qualified SPAPs, provided the SPAP has met the following requirements:

- The SPAP must attest, as required by section 40.2.1 of this guidance that it has the authority under state law to enroll on behalf of its members.
- The SPAP must coordinate with the sponsor to provide the required data elements for the sponsor to process and submit an enrollment request to CMS.
- The SPAP must provide a notice to its members in advance of submitting the requests for a prospective date that explains that the SPAP is enrolling on their behalf, how the enrollment works with the SPAP and how individuals can decline such enrollment.

In return, PDPs that agree to accept enrollment requests from SPAPs in this format are required to process them like any other enrollment and in accordance with notification timeframes.
Additionally, the sponsor must ensure the SPAP has met the above requirements prior to submission of the enrollment transaction to CMS. It is important for the PDP sponsor to work with the contact at the SPAP in the event that the plan encounters any problems processing the
enrollment request in the format provided. Because the SPAP is the authorized representative of the beneficiary, the sponsor is responsible for following up with the SPAP if the enrollment is incomplete in any way (to obtain missing information) or if the enrollment is conditionally rejected due to the existence of the employer/union drug coverage (to confirm

that the individual understands the implications of enrolling in a Part D plan).

Special note for SPAP enrollment requests during the AEP - For enrollment processing purposes for the AEP, the application date must be set to October 15th. This will ensure that subsequent beneficiary-generated enrollment requests made during the AEP will supersede the SPAP enrollment in CMS systems.

40.2 – Processing the Enrollment Request

42 CFR 423.32
(Rev. 2, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

If an individual completes an enrollment request during a face-to-face interview, the PDP sponsor may ask to see the individual's Medicare card to verify the spelling of the name, and to confirm the correct recording of Medicare Number, and entitlement dates for Medicare Part A and Part B. The individual does not have to show or provide the Medicare card or other evidence when submitting the request. The other forms of evidence as listed in item "B" are only requested when the enrollment request doesn't include the Medicare Number and the plan is unable to locate the individual in CMS systems. For processing all enrollment requests, the PDP sponsor must verify Medicare entitlement as described in item "B" below in this section.

Appendix 2 lists all the elements that must be provided in order to consider the enrollment request complete. If the PDP sponsor receives an enrollment request that contains the required elements, the PDP sponsor must consider the enrollment request complete even if the optional data elements on the enrollment request are not provided. If a PDP sponsor has received CMS approval for an enrollment request mechanism that contains data elements in addition to those on the model paper enrollment form included in this guidance, the enrollment request must be considered complete even if those additional elements are not provided.

If a PDP sponsor receives an enrollment request that does not have all necessary elements required in order to consider it complete, it must not immediately deny the enrollment. The PDP sponsor must check available CMS systems (e.g. either the BEQ or MARx online query) for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the "sex" field on the enrollment request and the PDP sponsor has access to this information via available systems, the sponsor must not request the information from the beneficiary. If the required but missing information is not available via CMS systems, the enrollment request is considered incomplete and the PDP sponsor must follow the procedures outlined in §40.2.2 in order to complete the enrollment request.

The following should also be considered when completing an enrollment:

A. **Permanent Residence Information -** The PDP sponsor must obtain the individual's permanent residence address to determine that *they* reside within the PDP plan's service area. If an individual puts a Post Office Box as his or her place of residence on

the enrollment request, the PDP sponsor must consider the enrollment election incomplete and must contact the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the PDP sponsor should consult the State law in which the PDP sponsor operates and determine whether the enrollee is considered a resident of the State.

Individuals for whom the Batch Eligibility Query (BEQ) or MARx online query (M232 screen) reflects an incarcerated status, that beneficiary is considered to reside outside of the service area and are, therefore, not eligible to enroll.

B. Entitlement Information and Medicare Number –
42 CFR 423.50(a)(1)(i.)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Following the procedures outlined in the CMS Plan Communications User Guide, PDP sponsors must verify Part D eligibility/Medicare entitlement by either the Batch Eligibility Query (BEQ) process or the MARx online query (M232 screen) or its equivalent for all enrollment requests except enrollment requests from a current enrollee of a PDP who is requesting enrollment into another PDP offered by the same parent organization with no break in coverage (i.e. "switching plans").

Individuals are not required to provide evidence of entitlement to Medicare Part A and/or enrollment in Part B with their enrollment request. If the systems (BEQ or MARx on-line query) indicate that the individual is entitled to Medicare Part A and/or enrolled in Part B, then no further documentation of Medicare entitlement from the individual is needed. CMS systems are updated within two business days of SSA processing new or changed Part A or Part B entitlement for a Medicare beneficiary. The CMS systems are the most up-to-date data regarding Medicare entitlement for the beneficiary.

At the time CMS first receives entitlement information for a new beneficiary, the Medicare Number will also be assigned for that individual. In the event that the enrollment request doesn't include the Medicare Number and the plan is unable to locate the individual in the BEQ or MARx online query, the sponsor should consider the enrollment request incomplete and follow § 40.2.2.

The individual may provide the Medicare Number to the sponsor verbally or in writing. Examples of possible documents the beneficiary may send to the plan which outline the Medicare Number (and entitlement information) include:

- Medicare card;
- Medicare Award notice from SSA (shows Medicare entitlement dates only);
- Benefit Verification notice from SSA (includes Medicare Number and entitlement start dates);
- Medicare card information from the individual's MyMedicare.gov account; and
- A notice from CMS regarding change in Medicare Number.

NOTE: If the beneficiary provides any of the notices listed above, the date on the letter should be no more than two months before the enrollment request was received by the PDP sponsor. If there is a discrepancy between the entitlement information in a document and the information in CMS' systems, use the data in CMS systems to determine eligibility for enrollment.

C. **Effective Date of Coverage –** The PDP sponsor must determine the effective date of enrollment as described in §30.4 for all enrollment requests. If the individual fills out an enrollment request in a face-to-face interview or through telephone enrollment, then the PDP sponsor representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the PDP sponsor to confirm the actual effective date of enrollment. The PDP sponsor must notify the member of the effective date of enrollment prior to the effective date (refer to §40.4 for more information and a description of exceptions to this rule).

   If an individual submits an enrollment request with an unallowable effective date, or if the PDP sponsor allowed the individual to select an unallowable effective date, the PDP sponsor must notify the individual in a timely manner and explain that the enrollment must be processed with a different (allowable) effective date of enrollment. The organization should resolve the issue with the individual as to the correct effective date, and the notification must be documented. If the individual refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the enrollment according to the procedures outlined in §60.1.

   PDP sponsors must ensure enrollees have access to plan benefits as of the effective date of enrollment the PDP sponsor has determined and may not delay provision of plan benefits in anticipation of the submission to or reply from CMS systems.

   For auto/facilitated enrollments, refer to section §40.1.4 of this guidance for more information.

D. **Health Related Information –** PDP sponsors may not ask health screening questions during the enrollment process.

E. **Statement of Understanding and Release of Information –** The PDP sponsor must include the information contained in **Exhibit 1** on page *2* under the heading "Please read and sign below" in all of its enrollment request vehicles.

F. **Signature and Date on Paper Enrollment Forms –** When a paper enrollment form is used, the individual must sign the enrollment form. If the individual is unable to sign the form, a legal representative must sign the enrollment form (refer to §40.2.1 for more information). If a legal representative signs the form for the individual, then *they* must attest on the form that *they have* the authority under State law to effect the

enrollment request on behalf of the individual and that a copy of the proof of other authorization 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. Acceptable documentation includes items such as court-appointed legal guardianship or durable power of attorney.

The individual and/or legal representative should also write the date *they* signed the enrollment request; however, if *they* inadvertently fail to include the date on a paper enrollment form, or if an alternate enrollment mechanism is used, then the date of receipt that the PDP sponsor notes on the enrollment request will serve as the "signature date" of the request.

If a paper enrollment form is submitted and the signature is not included, the PDP sponsor may verify with the individual with a phone call and document the contact, rather than return the paper enrollment form as incomplete. The documentation of this contact will complete the enrollment request (assuming all other required elements are complete).

When an enrollment request mechanism other than paper is used, the individual or his or her legal representative must complete the enrollment mechanism process, including the attestation of legal representative status as described above. A pen-and-ink signature is not required. For a telephone request the signature element is satisfied with a verbal attestation of intent to enroll and for an electronic request it is satisfied with an electronic signature or a clear and distinct step that requires the applicant to activate an "Enroll Now," or "I Agree," type of button or tool.

Electronic signatures have the same legal effect and validity as pen-and-ink signatures. A PDP sponsor utilizing electronic signatures in electronic enrollment must, at a minimum, comply with the CMS security policies. For more information on the requirements for legally binding electronic signatures, see the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. §7001, and "Use of Electronic Signatures in Federal Organization Transactions" published by the CIO Council.

G. Other Signatures – If the PDP sponsor representative helps the individual fill out the enrollment request, then the PDP sponsor representative must clearly indicate *their* name on the enrollment form and indicate *their* relationship to the individual. However, the PDP sponsor representative does not have to include *their* name on the form when:

- *They* pre-fill the individual's name and mailing address when the individual has requested that an enrollment form be mailed to *them*,
- *They* fill in the "office use only" block, and/or
- *They* correct information on the enrollment form after verifying information (see "final verification of information" below).

The PDP sponsor representative does have to include *their* name on the form if *they* pre-fill any other information, including the individual's phone number.

H. Old Enrollment Requests – If the PDP sponsor receives an enrollment request that was completed more than 30 calendar days prior to the PDP sponsor's receipt of the request, the PDP sponsor is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

I. Determining the Application Date – The PDP sponsor must date as received all enrollment requests as soon as they are initially received. The application date is the date the enrollment request is initially received by the PDP sponsor, except for requests submitted via the CMS On-line Enrollment Center, requests made into employer or union- sponsored plans, and auto or facilitated enrollments (refer to §10 for definitions of "receipt of enrollment request," "completed enrollment request" and "application date"). If the request received is incomplete, follow the instructions provided in section 40.2.2 below.

Part D plans must use the application date in the appropriate field when submitting enrollment transactions to CMS. Appendix 3 of this guidance provides a summary of application dates for CMS enrollment transactions.

J. Correction of Information – The PDP sponsor may find that it must make corrections to an individual's enrollment request. For example, an individual may have made an error in writing his or her telephone number or may have transposed a digit in his or her date of birth. The PDP sponsor should make this type of correction to the enrollment request (e.g. the enrollment form) when necessary, and the individual making those corrections should place their initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, or an electronic record of a similar nature, may be used by the PDP sponsor (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These types of corrections will not result in the PDP sponsor having to co-sign the enrollment form.

K. Sending the Enrollment to CMS – For all complete enrollment requests, the PDP sponsor must transmit the appropriate enrollment transaction to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §*4*0.4 within the required time frames. Processes for submitting transactions are provided in CMS systems guidance.

L. Premium Payment and Withhold options
(Rev. 1, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

PDP sponsors may include on all enrollment request mechanisms the option for individuals to: 1) pay plan premiums by being billed directly by the plan or 2) have the premiums withheld from their SSA/RRB benefit check. The plan may also choose to

offer other payment methods, such as automatic deduction from the individual's bank or other financial institution or from a credit card.

The enrollment mechanism can advise the individual that if *they* do not select a premium payment option, the default action will be direct bill.

Railroad Retirement Board (RRB) enrollees may also submit requests to have their premiums withheld from their RRB retirement payments. Sponsors may choose to offer this option on all enrollment mechanisms as well.

On the enrollment mechanism, PDP sponsors may also include in this section a statement that advises those individuals who qualify for extra help that if the extra help does not cover the entire plan premium, the individual is responsible for the amount that Medicare does not cover.

Model language has been provided on Exhibits 1 and 1b to reflect these options.

M. U.S. Citizenship or Lawful Presence Information – PDP sponsors must use the CMS Batch Eligibility Query (BEQ), (individual or batch submission) or, via on-line access, the MARx M232 screen, to verify eligibility on the basis of incarceration status or unlawful presence status. An exception to this are enrollment requests from a current enrollee of a PDP who is requesting enrollment into another PDP offered by the same parent organization with no break in coverage (i.e., "switching plans").

Individuals are not required to provide evidence of U.S. citizenship or lawful presence status with the enrollment request, nor are PDP sponsors permitted to request such information or documentation. The systems (BEQ or MARx online query) will indicate the lawful presence status of a non-U.S. citizen, including the start and, if applicable, the end date of the unlawful presence status of the individual.

CMS eligibility queries will only reflect data for the existence of an unlawful presence status. When neither the BEQ nor the MARx online query shows any indication of unlawful presence in the U.S., the PDP sponsor must treat the lack of information as confirmation of evidence of U.S. citizenship or lawful presence status.

When either the BEQ or the MARx online query shows an indication of unlawful presence in the U.S. and the organization receives documentation of lawful presence from the applicant, the plan cannot use this documentation to establish eligibility. If the PDP sponsor is provided evidence of lawful presence by the applicant in the form of a document from the Department of Homeland Security or SSA and neither the BEQ nor the MARx online query reflects this lawful presence status, the organization should refer the applicant to SSA to request that SSA update its records.

N. ***Beneficiary Ethnicity and Race*** *– These data fields are required to be included on the enrollment form; however, applicant response to these questions is optional. When provided by an applicant, MA and Part D plans will submit these data to CMS as part of the enrollment*

transaction. If a plan receives a rejected transaction reply code (TRC) 394 (Rejected; Invalid Personal Information) or informational TRC 396 (Invalid Personal Information Submitted). The plan must send a subsequent corrected transaction code (TC) 92 (Personal Information Change Record) to rectify. CMS expects plans to submit the beneficiary response to the race and ethnicity field, including confirming if the beneficiary did not provide the optional data. Until all race and ethnicity data are accepted by CMS, including annotating that the beneficiary did not answer the question, the field is not considered complete.

40.2.1 – Who May Complete an Enrollment Request

42 CFR 432.32(b)

A Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in, or disenrollment request from, a PDP. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the State in which the beneficiary resides may allow. CMS will recognize State laws that authorize persons to effect a Part D enrollment or disenrollment request for Medicare beneficiaries. Persons authorized under State law may include court-appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request or complete an enrollment request mechanism due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, PDP sponsors should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

When someone other than the Medicare beneficiary completes an enrollment or disenrollment request, *they* must:

1) Attest that *they have* the authority under State law to do so;
2) Attest that proof of authorization, if any, required by State law that empowers the individual to effectuate an enrollment or disenrollment request on behalf of the individual is available upon request by CMS. Part D sponsors cannot require such documentation as a condition of enrollment or disenrollment; and
3) Provide contact information.

The sponsor must retain the record of this attestation as part of the record of the enrollment or disenrollment request. CMS provide*s* a sample attestation as part of the model enrollment form (Exhibit 1).

If a sponsor has reason to believe that an individual making an election on behalf of a beneficiary may not be authorized under State law to do so, the sponsor should contact its

CMS account manager with all applicable documentation regarding State Law and the case in question. The account manager may request supporting documentation from the individual making the election.

When an authorized representative completes an enrollment request on behalf of a beneficiary, the PDP sponsor should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e. sending mail to the beneficiary directly or to the representative, or both) and make reasonable accommodations to satisfy these wishes.

Representative payee status, as designated by SSA, is not necessarily sufficient to enroll or disenroll a Medicare beneficiary. Where PDP sponsors are aware that an individual has a representative payee designated by SSA to handle the individual's finances, PDP sponsors should contact the representative payee to determine *their* legal relationship to the individual, and to ascertain whether *they are* the appropriate person, under State law, to execute the enrollment or disenrollment request.

40.2.2 – When the Enrollment Request Is Incomplete

42 CFR 423.32(a) and 423.32(b)(1)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

When the enrollment request is incomplete, the PDP sponsor must document its efforts to obtain the missing information or documentation needed to complete the enrollment request. The sponsor must make this determination and notify the individual within 10 calendar days of the receipt of the request that additional documentation is needed for the enrollment request, unless the required but missing information can be obtained via CMS systems.

Note: An enrollment request is considered complete even if the only information missing is the eligibility for the election period. In such circumstances, the plan must contact the individual to assure they have a valid election period before processing the enrollment. (See Section 30 for more information regarding eligibility for election periods and Section 40 for enrollment processing requirements.)

If the request is missing the Medicare Number, see §40.2.B for more information.

If a paper enrollment form is missing a signature, see §40.2F for more information.

For incomplete IEP enrollment requests received prior to the month of entitlement to Part A or enrollment in Part B, additional documentation to make the request complete must be received during the first three months of the IEP, or within 21 calendar days of the request for additional information (whichever is later). For incomplete IEP enrollment requests received during the month of entitlement to Part A or enrollment in Part B or later, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

For incomplete AEP elections, additional documentation to make the request complete must

be received by December 7, or within 21 calendar days of the request for additional information (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

EXAMPLES

- Ms. Stears' 65th birthday is April 20, 2011. She is eligible for Medicare Part A and Part B beginning April 1, 2011 and has decided to enroll in Part B beginning on April 1. Her IEP for Part D begins on January 1, 2011 and ends on July 31, 2011. She submits an incomplete IEP enrollment request on January 15, 2011, and the sponsor requests the required but missing information on January 20, 2011. The enrollment request must be denied if the required information is not received by March 31, 2011.

- Ms. Mohan's 65th birthday is June 10, 2011. She is eligible for Medicare Part A and Part B beginning June 1, 2011 and has decided to enroll in Part B beginning on June 1. Her IEP for Part D begins on March 1, 2011 and ends on September 30, 2011. She submits an incomplete ICEP enrollment request on July 5, 2011, and the sponsor requests the required but missing information on July 7, 2011. The enrollment request must be denied if the required information is not received by July 31, 2011.

When an incomplete enrollment request is received near the end of a month or an enrollment period, the use of the full 21 calendar day period to complete the request may extend beyond CMS systems plan submission "cut-off" date (these dates are provided in the CMS Plan Communications User Guide). PDP sponsors may utilize a code 61 enrollment transaction to directly submit the request to CMS as provided in the CMS Plan Communications User Guide.

If additional documentation needed to make the request complete is not received within the timeframe above, the organization must deny the enrollment request using the procedures outlined in §40.2.3.

Requesting Information from the Applicant – To obtain information to complete the enrollment, the PDP sponsor must contact the individual to obtain the information within 10 calendar days of receipt of the enrollment request (see Exhibit 3). If the contact is made orally (by phone), the PDP sponsor must document the contact and retain the documentation in its records.

While CMS has provided a model notice, we would encourage plans to obtain information by the most expedient means available. The PDP sponsor must explain to the individual that if the information is not received within the timeframes described above, the enrollment will be denied. If the PDP sponsor denies the enrollment request, the sponsor must provide the individual with a notice of denial of enrollment (see Exhibit 6).

If all documentation is received within allowable time frames and the enrollment request is complete, the PDP sponsor must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must provide the individual with the information described in §40.4

Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low Income Subsidy – For enrollment requests submitted by dually eligible individuals and individuals who qualify for the low income subsidy (LIS), a PDP sponsor may consider an enrollment request complete if there are premium amounts due to the sponsor from a prior enrollment, even if the sponsor has a policy to consider such enrollment requests incomplete.

The PDP sponsor has the discretion to implement this exception to dually eligible individuals and individuals who qualify for LIS within each of its plans. If the sponsor offers this exception in one of its plans, it must apply the policy to all such individuals who request enrollment in that plan.

40.2.3 – PDP Sponsor Denial of Enrollment

For enrollment requests that do not require additional information from the applicant, a PDP sponsor must deny an enrollment within 10 calendar days of receiving the enrollment request based on its own determination of the ineligibility of the individual to elect the PDP plan (e.g. individual not having a valid enrollment period to elect a plan). For incomplete enrollment request that require information from the applicant and for which the applicant fails to provide the information within the required time frame, a PDP sponsor must deny the enrollment within 10 calendar days of the expiration of the time frames described in §40.2.2.

PDP sponsor denials occur **before** the organization has transmitted the enrollment to CMS. For example, it may be obvious that the individual is not eligible to elect the plan due to place of residence. This "up-front" denial determination must be within 10 calendar days from the date of receipt of an enrollment request.

Notice Requirement – The organization must provide a notice of denial to the individual that includes an explanation of the reason for the denial (see Exhibit 6). This notice must be provided within 10 calendar days of either 1) receipt of the enrollment request or 2) expiration of the time frame for receipt of requested additional information, as described in the following examples:

- A PDP sponsor receives an AEP enrollment request from an individual on December 1st and determines on that same day that the individual is ineligible due to place of residence. The organization must provide the notice of denial within 10 calendar days from December 1st.

- A PDP sponsor receives an enrollment request from an individual on January 7 and is unable to determine, through direct contact with the beneficiary or the beneficiary's authorized representative, that the beneficiary has a valid enrollment period available. The sponsor should send a notice of denial within ten calendar days from January 7.

- A PDP sponsor receives an AEP enrollment request on December 1st from an individual, identifies the enrollment request as incomplete, and on December 2 notifies the individual of the need for additional information. The beneficiary does not submit the information by December 23 (as required under §40.2.2), which means the organization must deny the enrollment. The organization should send notice of denial within ten calendar days from December 23.

40.3 – Transmission of Enrollments to CMS

For all enrollment requests effective January 1, 2008, and after that the organization is not denying per the requirements in §40.2.3, the PDP sponsor must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the PDP sponsor within 7 calendar days of receipt of the **completed** enrollment request. CMS system "down" days are included in the calculation of the 7 calendar days (refer to *the MARx monthly calendar at https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/mapdhelpdesk/mapd-marx-calendars-and-schedules*). For the purpose of assessing compliance with this requirement, CMS will count the enrollment request receipt date as "day zero" and the following day as "day one." All enrollment requests must be processed in chronological order by date of receipt of the enrollment request.

PDP sponsors are encouraged to submit transactions on a flow basis and as early as possible to resolve the many data issues that arise from late submissions. However, if the organization misses the cutoff date, it must still submit the transactions within the required 7-day time frame.

NOTE: The 7-day requirement to submit the transaction does not delay the effective date of the individual's enrollment in the PDP, i.e., the effective date must be established according to the procedures outlined in §30.4.

More detail on how PDP sponsors must submit transmissions to CMS are contained in the Medicare Advantage and Prescription Drug Plans Plan Communications User Guide.

40.4 – Information Provided to Member

Much of the enrollment information that a PDP sponsor must provide to the enrolling individual must be provided prior to the effective date of enrollment. However, some information will be provided after the effective date of coverage. A member's coverage begins on the effective date regardless of when the member receives all the information the plan sends.

As discussed previously (section 30), the PDP sponsor must provide required notices in response to information received by CMS on the DTRR that provides the earliest notification. Sponsors may choose to send notifications based on the availability of each Batch Completion Summary Status (BCSS) file if they desire. However, in no case may use

of the BCSS for this purpose extend any timeframe established in this guidance. Sponsors choosing to utilize the BCSS for certain required beneficiary notifications must do so consistently.

The PDP sponsor may provide the required notices described in §§40.4.1 and 40.4.2 in a single ("combination") notice (see Exhibit 2b). The combination notice takes the place of separate acknowledgement and confirmation notices and, as such, requires expedited issuance. To use the combination notice, the sponsor must be able to provide this notice within 7 calendar days of availability of the *D*TRR. Additionally, when following this option to use the combination notice, if the PDP sponsor is unable to ensure that the beneficiary will receive this combination notice prior to the enrollment effective date (or within timeframes for incomplete enrollment requests or enrollments received at the end of the month), the sponsor still must ensure that the beneficiary has the information required in §40.4.1 within these timeframes described therein.

If an individual's enrollment includes a request for SSA or RRB premium withhold and was processed after the monthly cut-off for payment, the sponsor must submit the request for premium withhold separate from the enrollment request. *Plans should resubmit the request for premium withhold timely to assure the individual can have premium withholding at the next possible effective date.* Additionally, the sponsor must inform the individual that:

- If *their* request for premium withholding is approved, it will start in 1-2 months;
- The effective date for premium withholding will not be retroactive;
- The member will be responsible for paying the sponsor directly for all premiums due from the enrollment effective date until the month in which premium withholding begins; and
- For plans implementing §50.3.1, failure to pay premiums for months in which premium withholding is not in effect will result in disenrollment from the plan.

40.4.1 – Prior to the Effective Date of Enrollment

(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Prior to the effective date of enrollment, the PDP sponsor must provide the member with all the necessary information about being a Medicare member of the PDP, including the PDP rules, and the member's rights and responsibilities (an exception to this requirement is described in §40.4.2.). In addition, the PDP sponsor must provide the following to the individual:

- For enrollment requests submitted via electronic enrollment or telephonic enrollment mechanisms, evidence that the enrollment request was received (e.g., a confirmation number). For paper enrollment requests, sponsors are not required to provide evidence of receipt outside of the acknowledgement or combination notice outlined below. Sponsors may choose to provide a confirmation number or other tracking

mechanism indicating receipt of the paper enrollment request. However, sponsors are expected to keep a copy of the paper enrollment form and provide a copy upon request by the beneficiary.

- A notice acknowledging receipt of the enrollment request providing the expected effective date of enrollment (see Exhibit 2). This notice must be sent no later than 10 calendar days after receipt of the completed enrollment request; and

- Proof of health insurance coverage so that *they* may begin using the plan services as of the effective date. This proof must include the 4Rx data necessary to access benefits.

NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in the Medicare Communications and Marketing Guidelines. The proof of coverage provided may be in the form of member ID cards, the enrollment form, and/or a notice to the member (refer to Exhibit 2, which is a model letter with optional language that would allow the member to use the letter as proof of coverage until *they* receive a member card. As of the effective date of enrollment, plan systems should indicate active membership.

Regardless of whether an enrollment request is made in a face-to-face interview, by fax, by mail, or by any other mechanism defined and allowed by CMS, the PDP sponsor must explain:

- The charges for which the prospective member will be liable, e.g., any premiums (this includes any Part D late enrollment penalty), coinsurance, fees or other amounts; (including general information about the low income subsidy).

- The prospective member's consent to the disclosure and exchange of necessary information between the PDP sponsor and CMS.

- The potential for member liability if it is found that the member is not eligible for Part D at the time coverage begins and the member has used PDP services after the effective date.

- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the PDP sponsor has not yet provided the ID card).

Requirements for providing information to individuals enrolled via the auto-enrollment and facilitated enrollment processes are outlined §40.1.4.

40.4.2 – After the Effective Date of Coverage

42 CFR 423.32(d)
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

CMS recognizes that for some enrollment requests, the PDP sponsor will be unable to provide the materials to the individual, including notification of the effective date, prior to the effective date, as generally required in §40.4.1. These cases will usually occur only when an enrollment request is received by the PDP sponsor in the last few days of a month, and the effective date is the first of the upcoming month. In these cases, the PDP sponsor still must provide the individual all materials described above no later than 10 calendar days after receipt of the enrollment request. In these cases, the PDP sponsor is also strongly encouraged to call these new members as soon as possible (such as within 1 - 3 calendar days) to provide the effective date, information to access benefits and explain the PDP rules. The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.

Acceptance/Rejection of Enrollment - Once the PDP sponsor receives a DTRR from CMS indicating whether the individual's enrollment has been accepted or rejected, the PDP sponsor must notify the individual of CMS' acceptance or rejection of the enrollment within 10 calendar days of the availability of the DTRR that contains the earliest notification of the acceptance/rejection (see Exhibits 4 and 7). The enrollment confirmation notice must explain the charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance. For those eligible for the low-income subsidy, the enrollment confirmation notice must specify the limits applicable to the level of subsidy to which the person is entitled.

There are exceptions to this notice requirement for certain types of transaction rejections. These exceptions exist so as not to penalize the individual for a systems issue or delay, such as a plan transmission or keying error. In this case, the PDP sponsor must request a retroactive enrollment correction from CMS (or its designee) within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. If CMS (or its designee) is unable to process the enrollment correction due to its determination that the individual is not eligible for enrollment, the PDP sponsor must reject the enrollment and must notify the individual of the rejection within 10 calendar days after CMS' (or its designee's) determination. Retroactive enrollments are covered in more detail in §60.3.

If a PDP sponsor rejects an enrollment request and later receives additional information from the individual substantiating their eligibility, the PDP sponsor must obtain a new enrollment request from the individual in order to enroll the individual and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §60.3 for more information regarding retroactive enrollments.

40.5 – Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive action may be necessary (refer to §§50.3

and 50.5 for more information). In addition, a reinstatement to the plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from *their* original plan of choice.

An enrollment that is not complete is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if a PDP sponsor or CMS determines at a later date that an incorrect permanent address was provided at the time of enrollment and the actual permanent address is outside the PDP's service area.

There are also instances in which an enrollment that appears to be complete can turn out to be legally invalid. In particular, CMS does not regard an enrollment as actually complete if the individual, or *their* legal representative, did not intend to enroll in the PDP. If there is evidence that the individual did not intend to enroll in the PDP, the PDP sponsor should submit a retroactive disenrollment request to CMS (or the CMS Retroactive Processing Contractor). Evidence of lack of intent to enroll by the individual may include:

- An enrollment request signed by the individual when a legal representative should be signing;
- Request by the individual for cancellation of enrollment before the effective date (refer to §60.1.1 for procedures for processing cancellations).

Payment of the premium does not necessarily indicate an informed decision to enroll. For example, the individual may believe that *they were* purchasing a supplemental health insurance policy, as opposed to enrolling in a PDP.