(e) *Maintenance of enrollment.* An individual who is

enrolled in a PDP remains enrolled in that PDP until one of the following occurs:

(i) The individual successfully enrolls in another PDP or MA-PD plan;

(ii) The individual voluntarily disenrolls from the PDP;

(iii) The individual is involuntary disenrolled from the PDP in accordance with § 423.44(b)(2);

(iv) The PDP is discontinued within the area in which the individual resides; or

(iv) The individual is enrolled after the initial enrollment, in accordance with § 423.34(c).

(f) *Enrollees of cost-based HMOs or CMPs and PACE.* Individuals enrolled in a cost-based HMO or CMP plan (as defined in part 417 of this chapter) or PACE (as defined in § 460.6 of this chapter) that offers prescription drug coverage under this part as of December 31, 2005, remain enrolled in that plan as of January 1, 2006, and receive Part D benefits offered by that plan until one of the conditions in § 423.32(e) are met.

(g) *Passive enrollment by CMS.* In situations involving either immediate terminations as provided in § 423.509(a)(5) or § 422.510(a)(5) of this chapter, or other situations in which CMS determines that remaining enrolled in a plan poses potential harm to plan members, CMS may implement passive enrollment procedures.

(1) *Passive enrollment procedures.* Individuals will be considered to have enrolled in the plan selected by CMS unless individuals—

(i) Decline the plan selected by CMS, in a form and manner determined by CMS; or

(ii) Request enrollment in another plan.

(2) *Beneficiary notification.* The organization that receives the enrollment must provide notification that describes the costs and benefits of the new plan and the process for accessing care under the plan and the beneficiary's ability to decline the enrollment or choose another plan. Such notification must be provided to all potential enrollees prior to the enrollment effective date (or as soon as possible after the effective date if prior notice is not practical), in a form and manner determined by CMS.

(3) *Special election period.* All individuals will be provided with a special enrollment period, as described in § 423.38(c)(8)(ii).

[70 FR 4525, Jan. 28, 2005, as amended at 74 FR 1543, Jan. 12, 2009]

§ 423.34 Enrollment of low-income subsidy eligible individuals.

(a) *General rule.* CMS must ensure the enrollment into Part D plans of low-income subsidy eligible individuals who fail to enroll in a Part D plan.

(b) *Definitions—Full-benefit dual-eligible individual.* For purposes of this section, a full-benefit dual eligible individual means an individual who is—

(1) Determined eligible by the State for—

(i) Medical assistance for full-benefits under Title XIX of the Act for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act; or

(ii) Medical assistance under section 1902(a)(10(C) of the Act (medically needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

(2) Eligible for Part D in accordance with § 423.30(a) of this subpart.

Low-income subsidy-eligible individual. For purposes of this section, a low-income subsidy eligible individual means an individual who meets the definition of full subsidy eligible (including full benefit dual eligible individuals as set forth in this section) or other subsidy eligible in § 423.772 of this part.

(c) *Reassigning low income subsidy eligible individuals*—(1) *General rule.* Notwithstanding § 423.32(e) of this subpart, during the annual coordinated election period, CMS may reassign certain low income subsidy eligible individuals in another PDP if CMS determines that the further enrollment is warranted, except as specified in paragraph (c)(2) of this section.

(2) *Part D prescription drug plans that waive a de minimis premium amount.* If a Part D plan offering basic prescription drug coverage in the area where the

beneficiary resides has a monthly beneficiary premium amount that exceeds the low-income subsidy amount by a de minimis amount, and the Part D plan volunteers to waive that de minimis amount in accordance with §423.780, then CMS does not reassign low income subsidy individuals who would otherwise be enrolled under paragraph (d)(1) of this section on the basis that the monthly beneficiary premium exceeds the low-income subsidy by a de minimis amount. A Part D plan that volunteers to waive such a de minimis amount agrees to do so for each month during the contract year for which a beneficiary qualifies for 100 percent low-income premium subsidy as provided in §423.780(f).

(d) *Automatic enrollment rules*—(1) *General rule.* Except for low income subsidy eligible individuals who are qualifying covered retirees with a group health plan sponsor, as specified in paragraph (d)(3) of this section, CMS enrolls those individuals who fail to enroll in a Part D plan into a PDP offering basic prescription drug coverage in the area where the beneficiary resides that has a monthly beneficiary premium amount that does not exceed the low income subsidy amount (as defined in §423.780(b) of this part). In the event that there is more than one PDP in an area with a monthly beneficiary premium at or below the low income premium subsidy amount, individuals are enrolled in such PDPs on a random basis.

(2) *Individuals enrolled in an MSA plan or one of the following that does not offer a Part D benefit.* Low-income subsidy eligible individuals enrolled in an MA private fee-for-service plan or cost-based HMO or CMP that does not offer qualified prescription drug coverage or an MSA plan and who fail to enroll in a Part D plan must be enrolled into a PDP plan as described in paragraph (d)(1) of this section.

(3) *Exception for individuals who are qualifying covered retirees.* (i) Full benefit dual eligible individuals who are qualifying covered retirees as defined in §423.882 of this part, and for whom CMS has approved the group health plan sponsor to receive the retirement drug subsidy described in subpart R of this part, also are automatically enrolled in a Part D plan, consistent with this paragraph, unless they elect to decline that enrollment.

(ii) Before effectuating such an enrollment, CMS provides notice to such individuals of their choices and advises them to discuss the potential impact of Medicare Part D coverage on their group health plan coverage. The notice informs 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.

(iii) All other low income subsidy eligible beneficiaries who are qualified covered retirees are not enrolled by CMS into PDPs.

(4) *Enrollment in PDP plans that voluntarily waive a de minimis premium amount.* CMS may include in the process specified in paragraph (d)(1) of this section that PDPs that voluntarily waive a de minimis amount as specified in §423.780, if CMS determines that such inclusion is warranted.

(e) *Declining enrollment and disenrollment.* Nothing in this section prevents a low income subsidy eligible individual from—

(1) Affirmatively declining enrollment in Part D; or

(2) Disenrolling from the Part D plan in which the individual is enrolled and electing to enroll in another Part D plan during the special enrollment period provided under §423.38.

(f) *Effective date of enrollment for full-benefit dual eligible individuals.* Enrollment of full-benefit dual eligible individuals under this section must be effective as follows:

(1) January 1, 2006 for individuals who are full-benefit dual-eligible individuals as of December 31, 2005.

(2) The first day of the month the individual is eligible for Part D under §423.30(a)(1) for individuals who are Medicaid eligible and subsequently become newly eligible for Part D under §423.30(a)(1) on or after January 1, 2006.

(3) For individuals who are eligible for Part D under §423.30(a)(1) of this subpart and subsequently become newly eligible for Medicaid on or after

January 1, 2006, enrollment is effective with the first day of the month when the individuals become eligible for both Medicaid and Part D.

(g) *Effective date of enrollment for non-full-benefit dual-eligible individuals who are low-income subsidy-eligible individuals.* The effective date for non-full-benefit dual-eligible individuals who are low-income subsidy-eligible individuals is no later than the first day of the second month after CMS determines that they meet the criteria for enrollment under this section.

[75 FR 19815, Apr. 15, 2010, as amended at 76 FR 21570, Apr. 15, 2011]

§ 423.36 Disenrollment process.

(a) *General rule.* An individual may disenroll from a PDP during the periods specified in § 423.38 by enrolling in a different PDP plan, submitting a disenrollment request to the PDP in the form and manner prescribed by CMS, or filing the appropriate disenrollment request through other mechanisms as determined by CMS.

(b) *Responsibilities of the PDP sponsor.* The PDP sponsor must—

(1) Submit a disenrollment notice to CMS within timeframes CMS specifies;

(2) Provide the enrollee with a notice of disenrollment as CMS determines and approves; and

(3) File and retain disenrollment requests for the period specified in CMS instructions.

(c) *Retroactive disenrollment.* CMS may grant retroactive disenrollment in the following cases:

(1) There never was a legally valid enrollment; or

(2) A valid request for disenrollment was properly made but not processed or acted upon.

§ 423.38 Enrollment periods.

(a) *Initial enrollment period for Part D—Basic rule.* The initial enrollment period is the period during which an individual is first eligible to enroll in a Part D plan.

(1) *In 2005.* An individual who is first eligible to enroll in a Part D plan on or prior to January 31, 2006, has an initial enrollment period from November 15, 2005 through May 15, 2006.

(2) *February 2006.* An individual who is first eligible to enroll in a Part D plan in February 2006 has an initial enrollment period from November 15, 2005 through May 31, 2006.

(3) *March 2006 and subsequent months.* (i) Except as provided in paragraph (a)(3)(ii) and (a)(3)(iii) of this section, the initial enrollment period for an individual who is first eligible to enroll in a Part D plan on or after March 2006 is the same as the initial enrollment period for Medicare Part B under § 407.14 of this chapter.

(ii) Exception. For those individuals who are not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B, their initial enrollment period under this Part is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D.

(iii) An individual who becomes entitled to Medicare Part A or enrolled in Part B for a retroactive effective date has an initial enrollment period under this Part beginning with the month in which notification of the Medicare determination is received and ending on the last day of the third month following the month in which the notification was received.

(b) *Annual coordinated election period*—(1) *For 2006.* This period begins on November 15, 2005 and ends on May 15, 2006.

(2) *For 2007 through 2010.* The annual coordinated election period for the following calendar year is November 15 through December 31.

(3) *For 2011 and subsequent years.* Beginning with 2011, the annual coordinated election period for the following calendar year is October 15 through December 7.

(c) *Special enrollment periods.* A Part D eligible individual may enroll in a PDP or disenroll from a PDP and enroll in another PDP or MA-PD plan (as provided at § 422.62(b) of this chapter), as applicable, at any time under any of the following circumstances:

(1) The individual involuntarily loses creditable prescription drug coverage or such coverage is involuntarily reduced so that it is no longer creditable coverage as defined under § 423.56(a).