

Default enrollment factsheet

Default enrollment is a process that allows eligible health insurers to move newly Medicare-eligible Medicaid Managed Care (MMC) enrollees into a qualifying Medicare Dual-eligible Special Needs Plan (D-SNP).

States, in conjunction with the Centers for Medicare & Medicaid Services (CMS), may approve the use of default enrollment by certain MMC insurers that also offer a D-SNP.

60-day notice

Insurers that are eligible to use default enrollment are required to send a notice to enrollees they identify for default enrollment no fewer than 60 days before the start date for their D-SNP coverage. This start date is the same as the beneficiary's Medicare effective date.

Medicaid Managed Care (MMC): private plan that provides Medicaid benefits. Enrollees usually must use in-network providers or receive prior authorization from their plan before getting certain kinds of care. MMC plans may offer care coordination.

Dual-eligible Special Needs Plan (D-SNP): type of Medicare Advantage Plan for individuals enrolled in Medicare and Medicaid (dually eligible individuals). Like other Medicare Advantage Plans, D-SNPs typically require enrollees to use in-network providers for Medicare services.

Notices should provide clear information comparing the beneficiary's new D-SNP and current MMC, including:

- Differences in benefits, premium costs, and cost-sharing
- Instructions for those interested in declining the default enrollment as to how they can instead choose Original Medicare or a different Medicare Advantage Plan

Troubleshooting issues with default enrollment

Individuals can opt out of default enrollment up until the calendar day prior to their enrollment effective date, which is also the individual's Medicare effective date.

Beneficiaries also have the option to change their coverage if they missed the opportunity to opt out. Dually eligible individuals have access to a Special Enrollment Period (SEP) once per calendar quarter during the first nine months of the year. This SEP can be used to switch to a new Medicare Advantage Plan or to Original Medicare and a separate Part D plan. Beneficiaries also have access to a three-month SEP to change coverage after a gain, loss, or change to their Medicaid or Extra Help

eligibility. People who are default enrolled in the last three months of the year can use this SEP instead of the one for all dually eligible individuals.

Disenrolling from the D-SNP may also mean losing access to certain Medicaid-covered services (such as long-term services and supports (LTSS)) that the person accesses through the plan. Individuals receiving LTSS should consider their other coverage options to avoid interruptions in needed care.

Note: In some states, such as Tennessee and New York, beneficiaries who are default enrolled are entitled to continuity of care rights. This allows them to continue receiving services from providers that they have been seeing, even if those providers are not in their new D-SNP's network for a set amount of time.

Case example: Ms. P is 64 years old and has an MMC plan from Health Plan A, which also covers her LTSS. She turns 65 on August 15 and her Medicare will be effective August 1.

By around June 1, Ms. P should receive a notice from Health Plan A explaining that she will be automatically enrolled in a D-SNP starting on August 1 unless she declines it. This D-SNP will also cover her LTSS. The notice should explain how her D-SNP coverage will differ from her current MMC plan's coverage and provide instructions for choosing alternative coverage. On August 1, if Ms. P makes no changes, she should be enrolled into a Health Plan A D-SNP. If Ms. P decides to find alternative coverage, she may lose LTSS coverage. She should find out if there are other alternatives for LTSS coverage in her area before making a change.

Individuals who have questions about default enrollment or need help navigating their coverage options should contact their State Health Insurance Assistance Program (SHIP) by visiting www.shiphelp.org or calling 877-839-2675. It may also be helpful to contact the State Department of Health.

Additional resources for professionals

- Integrated Care Resource Center Default Enrollment FAQ:
 - [https://www.integratedcareresourcecenter.com/sites/default/files/HPMS%20Level%201%20Memo%20-%20Default Enrollment FAQs 2-25-19.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/HPMS%20Level%201%20Memo%20-%20Default%20Enrollment%20FAQs%202-25-19.pdf)
- Default Enrollment Final Rule (83 FR 16495-16502)
 - <https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf>