

MA/PDP Enrollment Guidance - Draft Update
Comment Form

Comments due 5:00 p.m. EDT July 2, 2010
Please e-mail all comments to PDPENROLLMENT@cms.hhs.gov

Joint Comments submitted by the following organizations:

- California Health Advocates
- Center for Medicare Advocacy, Inc.
- Community Legal Services, Philadelphia PA
- Medicare Advocacy Project, Greater Boston Legal Services
- Medicare Rights Center
- National Senior Citizens Law Center

Document (Specify MA or PDP)	Section number and Page number	Description of Issue or Question	Suggested Revision/Comment
PDP	Entire Document; PDP Section 10, p. 8	<p>Both the Medicare managed care and prescription drug guidance repeatedly refers to “Authorized Representative.” This term was abandoned for “Representative” by CMS in the final rule released on April 15, 2010.</p> <p>In addition, in the prescription drug guidance, the definition of “authorized representative” is extremely limiting and does not include those that have been appointed to represent a consumer by virtue of Form CMS1696 (Appointment of Representative), which is the form commonly used by consumer advocates, including SHIP counselors, in pursuing enrollment issues on consumer’s behalf.</p>	Please delete the word “authorized” and “legal” in the guidance and the notices. The term “representative” should be included in the definition section and the definition should include those individuals appointed by virtue of Form CMS 1699 (Appointment of Representative).
PDP	Entire Document	The term to describe the new “disenrollment Period” in January and February is inconsistent throughout and between the Medicare Managed Care Manual and the Medicare Prescription Drug Manual. In the Managed Care Manual it is called the “Managed Care	To avoid confusion, the title of the new “disenrollment period” should be consistent throughout all CMS documents and guidance. Previous documents issued by CMS have used the term “Annual Disenrollment Period” (ADP) as used in the draft Part D enrollment guidance.

		Disenrollment Period” and in the Prescription Drug Benefit Manual it is called the “Annual Disenrollment Period.”	We recommend that CMS adopt this language as it is already used in the community and previous releases and will avoid further confusion.
PDP	20.5, p. 15	The passive enrollment process does not allow for input from affected enrollees.	Enrollees should be granted a SEP that allows them to switch plans if they are passively enrolled in another plan.
PDP	§20.5, p. 16	Guidance provides that for CMS-directed passive enrollment, a key factor to be considered in determining whether a new plan offering will be considered comparable or better than the current plan is “New plan premium not significantly higher.” This seems to assume that new plan premium will be higher, which may not necessarily be the case.	Suggested revision : Whether new plan premium is higher and, if so, whether significantly higher.
PDP	§30, p.17	1st sentence, 2 nd paragraph – One SEP, §30.3.8 SEP for Exceptional Condition 11, does not allow the beneficiary to enroll, only disenroll.	Revise 1 st sentence (2 nd paragraph) to read: “During the AEP, individuals may enroll in and disenroll from a PDP plan, or choose another PDP plan. <u>Depending on the SEP, an individual may be limited to enrolling in or disenrolling from a PDP plan.</u> Individuals may enroll in a PDP during the IEP for Part D.”
PDP	§30.2, p. 19	Language about availability of one enrollment/disenrollment choice during AEP which is exhausted once enrollment/disenrollment is effective suggests that the effective date could be different than the end of the AEP and that persons cannot change their mind during the AEP.	Suggested revision : An enrollment/disenrollment choice can not be made after the end of the AEP.
PDP	§30.3, p. 19	The bullet point descriptions of actions available during a SEP are confusing. The first bullet indicates that a member may disenroll from a Part D plan and enroll in Original Medicare. This is confusing because many members are only in a PDP and remain on Original Medicare. This is also true for the second bullet point, as many members will remain in Original Medicare and join a PDP.	Suggested Revision: First Bullet Point: Discontinuing enrollment in a MA plan and enrolling into a Original Medicare with a new Part D plan Second Bullet Point: Joining a Part D plan for the first time. Third Bullet Point: Switching from one Part D plan to another.
PDP	§30.3, p. 19	Third paragraph is imprecise re action triggering the end of an enrollment period. We request more clarity in so that it may not be read to contradict §60.2 and §60.2.1, p.124.	Revise §30.3, p.19 (3 rd paragraph, last 2 sentences) to read: “Once the individual’s <u>enrollment</u> in has enrolled in a new Part D plan <u>becomes effective</u> , the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, the SEP ends when the

			individual's enrollment in a enrolls in new Part D plan becomes effective or when the SEP time frame ends, whichever comes first, unless specified otherwise for an SEP."
PDP	§30.3.1, p.22	2 nd full paragraph, last sentence. SEP for enrollee who did not notify plan about change in residence. Start of SEP changes from 6 th month to the 12 th month. SEP should run through the end of the 14 th month.	Change the month that ends the SEP, from 8 th to 14 th
PDP	30.3.1, 23	Disenrollment from previous PDP section does not reflect change in time limit for being out of a plan's service area to 12 months	Update text.
PDP	§30.3.1, p.23	Under "Disenrollment from Previous PDP" – SEP for individual who resides out of the service area: Change from 6 th to 12 th month on previous page should be applied here.	Change "six months" (3 rd line) to "twelve months" and "sixth month" (last line) to "twelfth month."
PDP	§30.3.2, p. 23	This section should state explicitly that there is no numerical limit in a year for the amount of times a member can change PDPs if dual-eligibles.	Suggested Revision: "This SEP begins the month the individual becomes dually-eligible. There is no numerical limit on SEPs for Medicaid recipients. As long as the individual remains eligible for Medicaid, the individual may change plans any month in which he/she chooses."
PDP	§30.3.3, p. 24	Although this section includes language about an SEP for individuals where a PDP sponsor or agent materially misrepresented the PDP when marketing it, there should be a provision for an SEP when the member was enrolled in a PDP as a result of a marketing violation. For instance, if the individual was enrolled after an unsolicited visit to the home, or approached at a physician's office.	Suggested revision: Additional bullet point: -the member was enrolled in a PDP as a result of an action on the behalf of the PDP sponsor (or its agent) that violated Medicare marketing regulations.
PDP	§30.3.4, p.25 and §40, p.39	§40 – Special rule for AEP (p.39) needs to be reconciled with §30.3.4 (pg.25) SEPs for non-renewals or terminations	According to § 30.4.3, enrollees in terminating/non-renewing plans have a SEP that runs from October 1 – January 31, with enrollment becoming effective on January 1 for those who make enrollments from October 1 – December 31. §40, Special Rule for the AEP, says that MA organizations may not solicit submission of paper enrollment forms or accept telephone or on-line enrollment requests prior to the beginning of the AEP.

			§40, Special Rule for the AEP should refer to §30.4.3 and make provisions for beneficiaries who are exercising their SEP before the beginning of the AEP.
PDP	§30.3.8.8.D, pp. 30-31	Second sentence is imprecise and doesn't take into account the possibility of canceling an enrollment before the effective date. We request more clarity so that it may not be read to contradict §60.2 and §60.2.1, p.124.	Change to "This SEP permits one enrollment and ends when the individual's enrollment in the PDP becomes effective."
PDP	§30.3.8.8.D, pp.30-31	The MA guidance at 30.3.8.8(D) is more explicit in highlighting the fact that that individuals in MA-only plans who disenroll in the MA Disenrollment period have the right to enroll in a PDP. Because this is a significant change from the former OEP options, we recommend using the more explicit statement.	Suggest tracking the MA guidance by changing the first sentence as follows: "Regardless of whether the MA plan included Part D drug coverage, MA enrollees using the MA Annual Disenrollment period (ADP) to disenroll . . ."
PDP	§30.3.8.8.F, p. 31	Disenrollment from chronic care SNP	We ask CMS to expand the SEP for individuals enrolled in a chronic care SNP to permit disenrollment at any time with rights to enroll in another Part D plan. Several factors argue for such an expansion. First, like individuals who are enrolled in PACE programs, beneficiaries in chronic care SNPs, by definition, have high needs. Like PACE participants, they should have the right to leave a plan if, despite its claim to meet their specialized needs, the plan cannot serve them adequately. Similarly, individuals enrolled in D-SNPs and I-SNPs have continuous enrollment periods. C-SNP enrollees should have parallel rights. Also, the Affordable Care Act created the Annual MA Disenrollment Period, a recognition by Congress of the need for individuals enrolled in MA plans to have an opportunity to give their plan a trial run and disenroll if the plan does not meet their needs. The ADP only applies after the AEP. But many persons with chronic conditions enroll outside the AEP because their condition is newly developed or because they are marketed to outside the AEP. Their need for a trial run is at least as acute—actually more so—as the need of those who enroll in the AEP. Expanding the current

			chronic care SEP to allow disenrollment would be consistent with Congressional intent as expressed in the establishment of the ADP.
PDP	§30.4, p. 33	There is an error in Example A. Under explanation, it states that the request was received on August 18, 2007. The example states August 18, 2010.	Suggested Revision: Explanation: Since the date the request was received is August 18, 2010, this not an AEP request.
PDP	§30.4, p. 34	Guidance provides that Mr. Doe, when using the SEP EGHP, can only choose an effective date of up to three months after the month in which the request is made. Mr. Doe could, however, continue his EGHP—and creditable coverage—for up to eight months after work cessation and request enrollment when retiring with an eight month later start date.	Comment: The guidance should state that the effective date that Mr. Doe can choose depends on when during his SEP EGHP Mr. Doe requests enrollment.
PDP	§30.4, p. 35	There is an error in the example under Initial Enrollment Period for Part D. The example states Mrs. Jones is eligible for Medicare on July 1, 2010, and her IEP for Part B is April 1, 2010 through October 31, 2010. It then states that her IEP for Part D is July 1, 2010 through October 31, 2010. This is incorrect. Her IEP for Part D should mirror her IEP for Part B and be from April 2010 through October 31, 2010.	Suggested Revision: Therefore her IEP for Part D is April 1, 2010 through October 31, 2010.
PDP	§40, p.40	1 st full paragraph – Since this guidance is for CY 2011, the AEP would start Nov 15, 2010. Dates are confusing.	Change dates applicable for AEP in 2010 for CY 2011.
PDP	§40, p. 38-39	The section describing the requirement for outbound educational calls should require that the PDP determine how the individual was contacted and enrolled by the broker or agent. This will ensure that individuals were not enrolled as a result of a marketing violation. This should be documented by the PDP. This also provides an opportunity to further screen for marketing violations, abusive agent practices, and improper enrollment based on misinformation. In instances where individuals were enrolled as a result of a marketing violation (door to door solicitation, unsolicited phone calls, etc.), the PDP should be required to report this to CMS. Calls to LEP beneficiaries also need to be conducted in the beneficiary’s preferred language, which is	Suggested Revisions: Addition to language on second paragraph on p. 39: “The purpose of performing outbound enrollment verification calls is to ensure applicants have an understanding of the product type and plan into which they are enrolling, and that the applicant is not enrolling as a result of a marketing violation or a material misrepresentation of the PDP by an agent or broker. The sponsor must keep statistics on disenrollment requests resulting from verification calls and document how the applicant came into contact with the agent or broker, and how s/he applied to enroll in the plan. If the sponsor determines that the applicant has applied for enrollment potentially as a result of a marketing violation, it must

		<p>particularly important since many of the worse marketing abuses have occurred with LEP beneficiaries.</p>	<p>document all incidents of enrollments based on misconduct by agents, brokers, or plan representatives, such as misrepresentation of plan benefits, marketing abuses, or improper contacts, and report such incidents to CMS. In addition, please require plans to encourage individuals to call their local SHIP. Historically 1-800-Medicare has not been helpful or reliable in exploring enrollment options.</p> <p>In addition, if possible, as part of the fundamental information plans sponsors must share on OEV calls, sponsors should state star ratings.</p> <p>This section should expressly reference and provide the link to the Medicare Marketing Guidelines.</p> <p>If a beneficiary has indicated a language preference on the application, the OEV call should be made in the beneficiary's preferred language. Plan representative scripts also should emphasize that reps should make the offer of interpreter services if an individual appears to have limited proficiency in English.</p>
PDP	<p>§40, p. 38-39 and Exhibit 36, p. 185</p>	<p>No timeframe is provided for the plan sponsor, after three unsuccessful telephone attempts to contact the applicant, to send the applicant an enrollment verification letter (Exhibit 36). Moreover, cancellations are only permitted up to the end of the AEP or, for other enrollments, the last day of the month in which the enrollment was received. Exhibit 36 states "The deadline for canceling your enrollment is the day before your enrollment effective date. If you call us on or after your enrollment effective date, we can't cancel your enrollment." This guidance is inadequate to protect beneficiaries. If an outbound verification call/letter reaches a beneficiary near to or after the end of the individual's AEP or SEP and if such verification reveals that the individual did not understand the plan rules, the individual does not get the benefit of the OEV.</p>	<p>For individuals who enroll at least 15 days prior to the effective date of their enrollment, plans should be required to send the enrollment verification letter enough in advance of the enrollment effective date so that applicant has at least ten days in which to call the plan. For individuals who apply in the last half of the month or in the last 15 days of the AEP, we believe it would be fairest and most simple administratively to give an automatic two month SEP to all individuals who wish to disenroll based on OEV contacts that were made later than 10 days prior to the effective date of the enrollment. Many of these individuals would qualify for the SEP for contract violation at 30.3.3 but are unlikely to know of their right to ask for that SEP. At the very least, these individuals should be informed of their right to ask for an SEP and be told the procedures for making such a request.</p>

			In light of the importance of verification, we also urge CMS to provide plans with model language for both verification scripts and verification letters.
PDP	§40, p. 39,	Special Rule for the Annual Coordinated Election Period (AEP) - The dates included in this section are inconsistent and at times do not specify if the guidance refers to the AEP in 2010, which begins November 15 or the AEP in 2011, which begins October 15.	Please include years in the guidance. For example, the second bullet that begins “For AEP enrollment requests received prior to October 15 plans must submit . . .” but for 2010, the date should be November 15, October 15 applies in 2011. In addition, the bullet, as the rest of the section, should refer to the AEP in both 2010 and 2011. Again, this section seems to refer to 2010 in some places and 2011 in others.
PDP	40.1, p. 41	Not requiring sponsors to include the plan premium on their enrollment mechanisms is a missed opportunity to provide important information. Including this information would not be detrimental to plans or potential enrollees.	All sponsors should be required to provide the plan premium on their enrollment mechanisms.
PDP	§40.1.4.D.1 p. 50, last paragraph	In situations where the auto-enrollment process results in a coverage gap, and the individual must rely on the demonstration contractor, the current PDP should be required to provide the demonstration contractor’s contact information to the member.	Suggested Revision: In these instances, the current PDP must give the contact information of the demonstration contractor to the member, in order for the member to request coverage for the uncovered month(s) in the past.
PDP	§40.1.5, p.54	De minimis is not explained or defined.	Explain, per the de minimis guidance released June 29, 2010, that the de minimis amount will be set annually by CMS and announced when the benchmarks are released.
PDP	§40.1.5B, p.55	Cross-walking versus reassignment. For CY 2010, beneficiaries cross-walked to consolidated plans were not notified. This created a particular problem for beneficiaries who did not qualify for LIS. Example: Sponsor X had Plan A and Plan B in 2009, and got approval from CMS to consolidate the 2 plans into one, Plan A, in 2010. Plan A in 2009 was quite different than Plan A in 2010 – the premium is much higher in 2010. Enrollees in Plan B were “cross-walked” into Plan A for 2010. Sponsor X is required to send only an Annual Notice of Change to all enrollees. Enrollees in Plan B did not receive any other notice that Plan B is now Plan A,	CMS should provide additional protections for individuals who are cross-walked. CMS and/or sponsor should send a special notice to beneficiaries who are cross-walked, in addition to the ANOC. The special notice should inform beneficiaries that they are being cross-walked; and about the plan to which they are cross-walked, esp. any differences in premium, cost-sharing and benefits compared to the plan from which they are cross-walked. The special notice should be sent before the ANOC, encourage beneficiaries to read the ANOC for details about the new plan, and emphasize that they may choose a different

		nor did they have a SEP or guaranteed issue rights. Some thought that Plan A in 2010 would be similar to Plan A in 2009, and were shocked by the higher premium on the invoice they received in January 2010, after the AEP. Without an SEP, they were stuck.	plan. These beneficiaries should also get a SEP.
PDP	§40.1.5.B, p. 55	The second bullet point under the section where a PDP will not lose beneficiaries seems to be incorrect. It currently reads the plan voluntarily agrees NOT to waive the premium... This should read voluntarily agrees to waive the premium amount over the benchmark.	Suggested Revision: The plan voluntarily agrees to waive the premium amount over the benchmark.
PDP	§40.1.5 D., p. 57	There is no model notification letter.	Comment: There should be a model notification letter.
PDP	§40.1.5.F, p.58	The section titled “Requests for ‘Re-Enrollment’ in the “Losing” Plan should include mandatory language that the PDP inform the individual of the likelihood that there are other benchmark PDPs in the plan area that will likely have a similar formulary. Oftentimes, dual-eligibles will stay in a PDP even though it is no longer a benchmark plan, for fear that a new plan will not have a formulary with all the individual’s medications. Requiring losing PDPs to inform duals that there are likely other benchmark plans with similar, if not identical formularies, ensures that LIS eligible individuals do not bear the burden of premium increases unnecessarily.	Suggested Revision: Adding language: The PDP must inform the individual of the likelihood of the existence of benchmark plans in the plan region that will have a similar, if not identical formularies.
PDP	§40.1.5F, p.58	1 st para, 6 th line – Should this be Nov 15 for CY 2011 and Oct 15 for CY 2012?	Verify the month.
	§40.2, p. 61; §50.3.1, p. 85; and Appendix 2, p. 115	The guidance states on page 85 that if someone who has been disenrolled for failure to pay premiums attempts to re-enroll, the plan may require payment of the outstanding balance before considering the enrollment request to be “complete.” Premium balance is not, however, an enrollment request data element.	Comment: Enrollment request which contains all the elements listed in Appendix 2 should be considered complete regardless of whether there is an outstanding premium balance.
PDP	§40.2.2, p.68	2 nd paragraph, 2 nd line – Dec 7 is incorrect for the AEP in 2010.	Correct the date for AEP in 2010 for CY 2011. Please clarify that the guidance applies in both 2010 and 2011. Guidance should refer to 2010 and 2011 AEP dates, and anytime a date is used in reference to an AEP, the guidance should also note the year in order to avoid

			confusion.
PDP	§40.2.2, p.68-69	Optional Exception for LIS Eligibles – Exception to §50.3.1 (p.85), allowing a sponsor to consider an enrollment request complete even though the applicant owes premiums to the sponsor. The section does not address what notice the applicant must receive if premiums are owed and whether those premiums will be waived.	Require sponsor to notify applicant of the amount owed from the previous enrollment and the premium applicant would be responsible for going forward. Further, plans should not be permitted to consider unpaid premiums or to attempt to collect them unless they have timely billed the beneficiary. CMS policy should be laid out in the guidance. See also comment re 50.3.1.
PDP	§40.2.3, p. 69	The first paragraph of this section is quite misleading. It states that a PDP must deny an enrollment within 10 days of receiving an enrollment request based on ... (2) an individual not providing information to complete the enrollment request within the times frame described in 40.2.2. The timeframes in 40.2.2 require that a PDP give an applicant 21 days to submit additional information after the request for additional information. A PDP cannot deny an enrollment within 10 calendar days of receiving an enrollment request for failure to provide information, and at the same time comply with 40.2.2 This language should be revised for clarity.	Suggested Revision: A PDP sponsor must deny an enrollment within 10 calendar days of receiving an enrollment request based on its own determination of the ineligibility of the individual to elect the PDP plan (e.g. individual no have a valid enrollment period to elect a plan). A PDP must deny an enrollment request if an individual fails to provide information to complete the enrollment request within the time frames described in 40.2.2
PDP	§50.2.1.4, p. 80	The language in the final paragraph should be changed from should to must.	Suggested Revision: If the sponsor is unable to contact the auto/facilitated enrolled beneficiary, or receives no response, the PDP sponsor must not disenroll the beneficiary.
PDP	§50.2.1.6(2, p. 81	Language is too weak.	Suggested revision: Rather than “Sponsors are encouraged to,” sentence should say “Sponsors should....”
PDP	§50.3.1, pp. 83-85	Notice requirement for collection actions, not just for disenrollment, should be added.	Although this guidance is focused on disenrollment for non-payment, it does mention the right of a plan to seek to collect payment even if the plan does not disenroll the individual. We think it therefore is appropriate that this section also include clear directions to plans about their

			responsibility to bill promptly and lay out the prohibitions on collection if billing does not meet CMS timeliness requirements. CMS's recent action to suspend a plan for billing abuses as well as the many instances that advocates have seen of untimely billing coupled with aggressive collection suggest the need to emphasize CMS's billing expectations and requirements in this guidance.
PDP	§50.3.2, p. 89	This section should include language that states PDPs cannot disenroll members for exercising appeal/grievance rights within the plan system itself, or with CMS. Although obvious, there are other examples listed, and this should be included.	Suggested Revision: The PDP sponsor may not disenroll a member because he/she exercises appeal or grievance rights, either within the PDP grievance system itself, or with CMS.
PDP	§50.3.2, p. 91	The advance notice should be required to include specific behaviors that the PDP considers to be disruptive. Additionally, the PDP should be required to explain to the individual how the allegedly disruptive behavior "substantially impairs the PDP sponsor's ability to arrange for or provide services to either that particular member or other members of the PDP".	Suggested Revision: The notice must inform the individual specifically of the behavior it finds disruptive, and explain to the individual how the behavior substantially impairs the PDP sponsor's ability to arrange for or provide services to either that particular member or other members of the PDP.
PDP	§60.2.2, p.100	1 st paragraph, 4 th line – Reference to §50.2.2 for exception – do you mean §60.1.1?	Check and correct reference.
PDP	Appendices	Translation of model materials	We were pleased to see that, in its May 19, 2010 memo to plans, CMS issued specific guidance about the data that must be used to determine whether a plan is required to translate documents into languages other than English. To further facilitate improved service to LEP beneficiaries and since most plan translation responsibilities will be for Spanish translations, we urge CMS to consider creating Spanish translations of the model documents and requiring plans that are serving areas that meet the threshold for Spanish to use the model translations. Creating a single set of translated documents would serve several purposes. It would bring administrative simplification and avoid duplication of effort both by CMS and by plans. CMS would not be reviewing different translations by dozens of plans. A

			<p>single model translation also would foster use of uniform Spanish vocabulary around Part D, making it easier for Spanish speakers to understand the program. Finally and perhaps most importantly, having model documents would encourage plans that are not required to translate documents to do so voluntarily because model translations are easily available. We hope CMS could eventually develop translated models in other languages as well, but Spanish would be a good first step.</p> <p>We also reiterate comments we have made repeatedly that the 10 percent threshold for translations, which is set out in CMS’s language access plan, is grossly inadequate to meet the needs of LEP beneficiaries and is entirely disproportional to the HHS and DOJ plans, which set safe harbors at 5 % or 1,000 people, whichever is smaller. Under CMS LEP guidance, a plan can serve tens of thousands of beneficiaries speaking a non-English language and not have any obligation to provide translated materials.</p>
PDP	Appendices	References to extra help	<p>We suggest that, throughout the Model Letters, the term “Extra Help” should appear using initial caps in order to make it clear that the term is specific and refers to the Low Income Subsidy.</p>
PDP	Appendix 2, 115	There is no information on the enrollment mechanisms that gives enrollees an indication of how long they should wait to receive a response to their application.	<p>While the response time will vary based on how long it takes for the sponsor to receive the application, there should be some limit that ensures that enrollees are not left wondering whether their application was received (e.g., “you will receive a response within 15 business days”). This should be added to all enrollment mechanisms.</p>
PDP	Exhibit 1, p. 122	Reference to availability of counseling	<p>We appreciate including a reference to counseling services in the application but suggest changing the current language and placement. Instead of being part of the attestations by the applicant, we think the reference would be better placed in a box prominently at the bottom of the page with text as follows: “Free counseling services are available in your state to provide advice</p>

			concerning Medicare Advantage and Prescription Drug Plan options, Medicare supplement insurance, medical assistance through the state Medicaid program, and the Medicare Savings Program. For assistance, call [insert SHIP number].”
PDP	Exhibit 1a, p. 124	Sixth box: re long term care	Change “for example” portion to: “for example, a nursing home or skilled nursing facility”
PDP	Exhibit 1A, p. 124	Seventh box: PACE program should be defined. In PA, PACE is also a name for the state pharmacy assistance program. This could be confusing to individuals.	Suggested Revision: I recently left a Program of All-Inclusive Care for the Elderly (PACE).
PDP	Exhibit 4, p. 137	Reference to late enrollment penalty	The second paragraph under “Will I pay a late enrollment penalty” is for MA-PD plans, which appears to be an error since this is PDP guidance. Also there should be a note that this paragraph should not be included for persons with the Low Income Subsidy.
PDP	Exhibit 22, p. 163	“IMPORTANT” paragraph is unclear and requires several readings to understand what it is trying to say.	Suggested revision: Paragraph should be rewritten to say something simpler, like: “If you had prescription drug coverage with another plan before enrolling with us and want to keep that coverage, you should get in touch with that plan and tell them. They may request a copy of this letter for their records. If your former plan sent you a disenrollment letter, you must get in touch with them no later than 30 days from the date they sent that letter.”
PDP	Exhibit 24 and 25 pp. 165-67	Inform beneficiary who is eligible for the LIS and also other prescription drug coverage that if he/she chooses to enroll in other prescription drug coverage, h/she may not benefit from the LIS.	Add under “What are my costs in this plan?” – “Extra help is available only with a Medicare prescription drug plan.” Add in last paragraph, 1 st page – “If you choose other types of prescription drug coverage, extra help may not be applied to lower your prescription drug costs.” Add in 2 nd paragraph, 2 nd page – “Please note that extra help is not available without Medicare prescription drug coverage.”
PDP	Exhibit 29, p. 173	Last paragraph (before Thank you) – Inform beneficiary that enrolling in another Medicare prescription drug plan will automatically disenroll him/her from this PDP.	Add “Enrolling in a different Medicare prescription drug plan will automatically disenroll you from <PDP name>.”
PDP	Exhibit 30, p. 174	Bullets are unclear. Also no reference to SHIP availability.	Change to –What your monthly premiums would be if you stayed in our plan for [following calendar year]

			<p>-Your benefits and costs if you stayed with us for [following calendar year]</p> <p>-what you can do if your drug in [following calendar year] is no longer on our drug list or is more expensive. The letter should also include a box at the bottom saying: If you want help in deciding what to do, contact your local SHIP program, which can provide counseling on your choices. Call [SHIP number] for assistance.”</p>
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