2016 Enrollment and Disenrollment

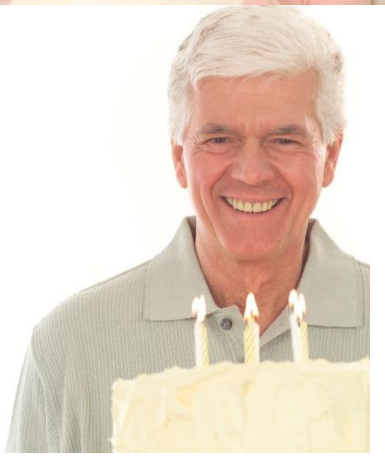
Module 4

UPMC *for Life*

UPMC Health Plan Medicare Program

Medicare Advantage Eligibility

- **An individual must meet the following criteria to join a Medicare Advantage plan:**
  - An individual must be 65 or older or disabled.
  - An individual must be entitled to Medicare Part A and enrolled in Part B.
    - Individual must continue to pay his or her Part B premium to remain enrolled in a MA plan.
  - The individual must reside in the plan's service area.
    - Individuals cannot be incarcerated or live abroad.
  - An individual cannot have End Stage Renal Disease (ESRD).
  - The individual must enroll during a valid enrollment period.



Medicare Advantage Eligibility

End Stage Renal Disease (ESRD) Eligibility Rules

- If an ESRD member is enrolled in a plan's commercial product and becomes eligible for Medicare upon his or her Initial Coverage Election Period; he/she can enroll in a MA plan offered by that same company.
  - The person must have no breaks in coverage from the commercial plan to the Medicare Advantage plan.
- If a person develops ESRD once he/she is enrolled in the Medicare Advantage plan he/she cannot be asked to leave the plan.
  - The individual may switch to other Medicare Advantage plans offered by the same Medicare Advantage plan during a valid enrollment period (e.g., HMO to PPO, or HMO to HMO plan).
- If a plan is discontinued the retiree can make one election to join a new Medicare Advantage plan offered within the same service area.
  - The individual can have no breaks in coverage.

Enrollment Guidelines

❑ Enrollment Procedures

- ❑ A Medicare Advantage Organization must accept enrollment requests received in a face-to-face meeting, by mail, by fax, or through other CMS approved mechanisms, such as CMS on-line enrollment.
- ❑ An individual must complete an enrollment request mechanism to enroll in a Medicare Advantage or Prescription Drug Plan during a valid enrollment period. The individual cannot be enrolled in more than one Medicare Advantage plan at any given time.
- ❑ Upon receiving an enrollment request a Medicare Advantage plan must provide one of the following responses within 10 calendar days:
  - ❑ Acknowledgement notice or notice of denial.
  - ❑ Request for additional/missing information.
  - ❑ Effective date of coverage is normally the 1st of the month after receipt of the request (except for AEP elections)

❑ Medicare Advantage Election Periods:

Medicare Advantage Plans have four enrollment election periods:

- Initial Coverage Election Period and Initial Enrollment for Part D
- Annual Election Period
- Special Election Periods
- Medicare Advantage Disenrollment Period

Enrollment Guidelines

❑ Initial Coverage Election Period (ICEP)

- ❑ The period during which an individual newly eligible for Medicare may make an initial enrollment request to enroll in a Medicare Advantage plan.

- ❑ The Initial Coverage Election Period occurs over a seven month period:
  - ❑ The period begins 3 months prior to meeting the eligibility requirements for Part B. Applications received during this time are effective the 1st day of the month the member becomes eligible for Part B.
  - ❑ The month of an individual's eligibility for Part B. Applications received during this month, are effective the 1st of the following month.
  - ❑ Three months after an individual's eligibility to Medicare Part B. Applications received during this month, are effective the 1st of the following month the application is received by the plan.
  - ❑ Often times this election occurs when an individual turns 65.
  - ❑ Individuals that are eligible for Medicare prior to age 65 (such as for disability) will have a second Initial Coverage Election Period upon attaining age 65.

❑ Initial Enrollment Period (IEP for Part D)

- ❑ The period during which an individual is first eligible to enroll in a Part D plan, it typically coincides with the individual's Part B eligibility.

Enrollment Guidelines

- **2016 Annual Election Period (AEP)**
  - **In 2015, this Annual Election Period will take place from October 15 to December 7.**
    - The enrollee's plan coverage will begin on January 1, 2016.
    - An individual can make an election during this time. If he/she signs up for multiple plans the last application date submitted is considered to be their final election.
    - Except in very limited circumstances (e.g., qualified special election periods) individuals cannot make plan enrollment changes outside of the annual election period.
    - Individuals can make any type of election during this timeframe. Example: Original Medicare to MA, MA to MAPD, MAPD to MA, etc.
  - **Plans cannot solicit applications from an enrollee prior to October 15.**
    - Brokers/agents should remind beneficiaries that they cannot submit enrollment requests prior to the start of the Annual Election Period. Brokers may not hold applications for members until the AEP begins.

Enrollment Guidelines

- **2016 Annual Election Period (AEP) *(continued)***
  - If a Medicare Advantage plan receives unsolicited paper applications prior to the start of the Annual Election Period it must retain and process the application:
    - Written notice that acknowledges receipt of the application must be sent to the enrollee.
    - The plan must submit the enrollment request to CMS on the first day of Annual Election Period, October 15th with an “application date” of the same date.

Enrollment Guidelines

❑ Special Election Periods (SEPs)

- ❑ Special Election Periods are election periods outside of the usual Medicare Advantage enrollment timeframes, when an individual may elect a plan or change his or her current election. Once an individual elects a new plan the Special Election Period ends even if the timeframe for the Special Election Period has not expired.
  - ❑ There are very limited circumstances when a beneficiary can make mid-year changes.
- ❑ It is the responsibility of the Medicare Advantage Organization to determine if a Special Election Period applies to the enrollee.
- ❑ Examples of Special Election Periods include (but are not limited to):
  - ❑ Significant Change in Provider Network – established by CMS on a case by case basis if it determines a network change to be significant.
  - ❑ Changes in residence outside the plan's service area; including if an individual is out of the service area for over six months.
  - ❑ If a plan has a CMS contract violation, or terminates their contract with CMS.
  - ❑ The member recently moved into a nursing home.
  - ❑ Enrollees in an employer group health plan is retiring.
  - ❑ If an individual loses dual eligibility status, low income subsidy, or special needs status.
  - ❑ If an individual becomes eligible or loses eligibility in a state pharmaceutical assistance program (SPAP), such as PACE/PACENET.
  - ❑ **NOTE**: SPAP SEP cannot be used to enroll in a Medicare Advantage No Rx Plan if coming from Original Medicare/PDP.

Enrollment Guidelines

- **Special Election Period to Enroll in a 5-Star Plan**
  - **An eligible individual may use this Special Election Period to enroll in a 5-Star plan during the year that the plan has a 5-Star rating.**
    - The 5-Star rating will apply to a plan for a calendar year (January to December).
      - Star Ratings are released by CMS in October of each year. If a plan was assigned a 5-Star Rating this Special Election period would apply to the upcoming year.
    - Individuals can switch from an MA plan, a PDP, a cost plan or Original Medicare to an MA-only plan, an MA-PD plan, a PDP or a cost plan that has a 5-star overall rating.
      - NOTE: If an individual would leave a plan with Part D coverage to enroll in a 5-Star MA plan (no-Rx), he or she would lose their Part D prescription drug coverage and would NOT be able to enroll in another Part D plan until a qualified subsequent election period (e.g., Annual Election Period). Late enrollment penalties might also apply.
  - **The enrollment effective date when enrolling into a 5-Star plan is the first of the month following the month in which the 5-Star Plan receives the enrollment request.**
    - An individual may use this SEP only one time from December 8 (prior year) through November 30 of the year in which the organization has been granted a 5-star overall rating.

Enrollment Guidelines

❑ Open Enrollment Period for Institutionalized Individuals (OEPI)

- ❑ The Open Enrollment Period for Institutionalized Individuals is continuous for eligible institutionalized individuals.
  - ❑ For purposes of the Open Enrollment Period for Institutionalized Individuals to apply, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution.
  - ❑ Most plans will not have a huge volume of this type of enrollment.
- ❑ The Open Enrollment Period for Institutionalized Individuals ends two months after the month the individual moves out of the institution.
- ❑ A Medicare Advantage eligible individual can make an unlimited number of enrollment requests during the Open Enrollment Period for Institutionalized Individuals.
  - ❑ A Medicare Advantage plan is not required to accept requests to enroll into its plan during the Open Enrollment Period for Institutionalized Individuals, but if it is open for these enrollment requests, it must accept all requests for this type of enrollment.

Enrollment Guidelines

❑ Medicare Advantage Disenrollment Period (MADP)

- ❑ Enrollees that join a Medicare Advantage plan and wish to disenroll can do so during the Medicare Advantage Disenrollment Period period and return to Original Medicare.
  - ❑ Individuals CANNOT switch to another Medicare Advantage plan during this period.
- ❑ The Medicare Advantage Disenrollment Period is from January 1 through February 14 each year.
- ❑ The effective date of a disenrollment request made using the Medicare Advantage Disenrollment Period will be the first of the following month.
  - ❑ Example: If an enrollee would submit a request to disenroll on February 8, the effective date would be March 1, 2016.

Enrollment Guidelines

- **Types of Disenrollment**
  - **Two types of disenrollment – Voluntary and Involuntary**
    - There are times when an enrollee will request to disenroll from a plan and there are instances when a plan is required to disenroll a member.
  - **Voluntary disenrollment by the member**
    - A member may request disenrollment from a Medicare Advantage plan during an election period. The member may disenroll by:
      - Enrolling in another plan (during a valid enrollment period).
      - Giving or faxing a written notice to the Medicare Advantage plan.
      - Submitting a request via the internet to the Medicare Advantage plan.
      - Calling 1-800-MEDICARE.
    - The disenrollment request must be signed and dated.
    - The Medicare Advantage plan must provide the member with a notice of disenrollment within ten calendar days after receipt.

Enrollment Guidelines

Types of Disenrollment *(continued)*

Involuntary Disenrollment

- An organization must disenroll a member under the following circumstances:
  - A change in residence that makes the individual ineligible to remain enrolled in the plan (e.g., moves outside of the plan's service area)
  - The member is away from the service area for more than 6 months
  - The member loses entitlement to Medicare Part A or Part B.
  - A Special Needs Plan enrollee that loses his or her special needs status.
  - Depending on the plan's policy, failure of the member to pay the plan premium.
  - Falsifying or withholding information from the plan (e.g., allows someone else to use their ID card)
  - The Medicare Advantage plan contract is terminated or the service area of the plan is reduced.
  - The member dies.
  - Incarceration
  - Failure to pay Part D IRMAA

Enrollee rights

- Medicare Advantage enrollees have the right to make a complaint if the plan ends his or her membership.
- When the plan ends a member's enrollment it must explain the disenrollment reason in writing and explain how the enrollee may file a complaint (e.g., failure to pay premium).

Enrollment Guidelines

❑ Enrollment Application Requirements *(paper, phone or online)*

- ❑ The following information **MUST** be reviewed and acknowledged **by the enrollee***:
  - ❑ Understanding of the requirement to continue to keep Medicare Part A and B.
  - ❑ Agreement to abide by the Medicare Advantage plan's membership rules, as outlined in member materials (e.g., Evidence of Coverage).
  - ❑ Consent to the disclosure and exchange of information necessary for the operation of the Medicare Advantage program.
  - ❑ Understanding that he or she can be enrolled in only one Medicare health plan and that enrollment in the Medicare Advantage plan automatically disenrolls him or her from any other Medicare health plan and/or prescription drug plan.
  - ❑ Understanding of the rights to appeal services and payment denials made by the Medicare Advantage plan.
  - ❑ Understanding of the plan benefits, plan premiums (if applicable) and plan star ratings information.

*Most of this information is included in the enrollment application in the "Rights and Responsibilities Section."

Enrollment Guidelines

- **Enrollment Application Requirements *(paper, phone or online) (continued)***
- **CMS will not accept an application unless the following fields are completed:**

Required Fields	
Enrollee name	Plan name (plan selection)
Enrollee date of birth	Plan premium option *
Enrollee sex	ESRD question response
Enrollee permanent residence address	Enrollee signature and signature date (or Rep)
Enrollee's Medicare number	Authorized representative contact information **

*If premium option is not completed, the enrollee is defaulted to direct bill. This is not a CMS requirement.

** Authorized representative information needs to be completed if he/she signed the application on behalf of the enrollee.

Applications

- An enrollment application must be used to enroll an individual with a Medicare Advantage plan for the first time (this includes electronic or telephonic enrollment).

- If an existing plan member would like to change to a different plan during the annual election period the following rules must be followed:
  - If a member wants to move to a different plan offering of the same plan type (e.g., HMO plan to a different HMO plan), then a plan change form (or short enrollment form) can be completed and signed by the member.
  - If a member wants to move to a different plan offering and different plan type (e.g., PPO plan to an HMO plan); then a new enrollment application must be completed and signed by the member.

Applications

Premium Withholding Language Updated– New for 2016

- The CMS model application language implies that Social Security or the Railroad Retirement Board “will” deduct all premiums due from the members effective date. This is not always the case, and sometimes members are billed for premiums not deducted by Social Security or the RRB. This has been generating complaints from our membership, so the language has been updated.
  - “Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. If Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check **should** include all premiums due from your enrollment effective date up to the point withholding begins**. If the first deduction does not include all premiums due from your enrollment effective date, we will send you a letter letting you know the amount you owe UPMC for Life for any premiums not deducted by Social Security or RRB.** If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)”

Applications

Enrollment Application Dating

- Completed applications must be forwarded to UPMC Health Plan within 48 hours of receipt.
  - Late applications may not be eligible for commission.
- An enrollment application enrollee's signature date must NEVER be altered by a agent/broker.
  - The application enrollee signature date **cannot** be back-dated or changed in any way.
- If an agent/broker leaves an application with a potential enrollee the application **cannot** be dated in the Office Use Only box.
  - Only date an application in the "Office Use Only" box when the enrollee has completed it and you are taking possession of the application.
  - The plan's receipt date is the date the broker receives the signed application from the beneficiary when meeting face to face, in the agency/ office etc.

Applications

❑ Enrollment via Telephone

- ❑ Telephonic enrollment requests may be accepted ONLY during an incoming (or in-bound) telephone call from a beneficiary.
- ❑ The Medicare Advantage plan must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his/her authorized representative.
- ❑ Individuals must be advised that they are completing an enrollment request.
- ❑ Each telephonic enrollment request must be recorded (audio) and include a statement of the enrollee's agreement to be recorded, and a verbal attestation of the intent to enroll.
- ❑ Collection of financial information (e.g. a credit card or bank account number) is prohibited at any time during the application enrollment call.

Applications

Outbound Enrollment and Verification

- All plan sponsors are required to maintain a system to ensure beneficiaries are enrolled into the plan they requested and understand the rules applicable to that plan. This verification includes enrollment applications from agents and brokers.
  - The plan has the option to complete the enrollment verification process by telephone, email (if beneficiary opted-in for email) or direct mail.
  - The beneficiary must be contacted within fifteen (15) calendar days of receipt of the enrollment request.
  - Plans/Part D Sponsors are not expected to delay processing the enrollment request (including, but not limited to, activation of benefits and submission of enrollment request data to CMS) while completing the enrollment verification process.
  - The verification letter must inform beneficiaries that they are expected to notify the Medicare Advantage Organization (MAO) of an intent to cancel the processing of their enrollment within seven calendar days from the date of the letter or phone call or by the day before the enrollment effective date, whichever is later.

- Enrollment verifications must be after the sale has occurred; NOT at the point of sale.
  - Enrollment verifications cannot be conducted by agents or brokers.
  - The agent or broker cannot be present with the enrollee if we are calling or emailing the applicant.