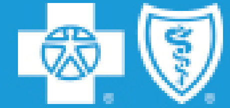
MedicareBlue℠ Solutions

Blue Cross and Blue Shield 2015 Part D Enrollment and Disenrollment Processes

August 11, 2014

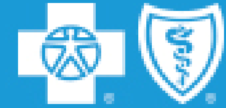
Certification



- The Centers for Medicare & Medicaid Services (CMS) requires Plan Sponsors to provide training and testing on Medicare rules, regulations and compliance-related information on the products they intend to sell
- Specifications for training/testing criteria are provided annually by CMS
- As a sales representative or employee of your local Blue Cross and Blue Shield plan, with responsibility for some aspect of marketing, sales and/or service, you are required to complete certification
- In addition, all selling agents must be qualified, meaning: licensed, appointed according to state laws, and certified on the products they intend to sell
  - Please contact your local plan if you have any question regarding these requirements

For training purposes only. Not approved for public distribution.

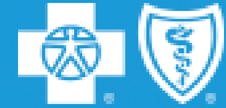
Introduction



- This course provides information about the CMS designated enrollment and disenrollment requirements and processes for Part D Prescription Drug Plans (PDP)
- Due to the limited enrollment timeframes, it’s critical to understand the opportunities available for beneficiaries to enroll, disenroll or make plan changes
- Information in this course is based on Chapter 3 of the Prescription Drug Benefit Manual issued by CMS
  - Refer to this chapter for additional information on eligibility, enrollment and disenrollment
  - To print a copy of the guidance, click on the appropriate document link under “Resources”

For training purposes only. Not approved for public distribution.

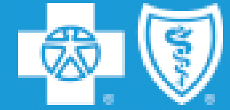
Course Objectives



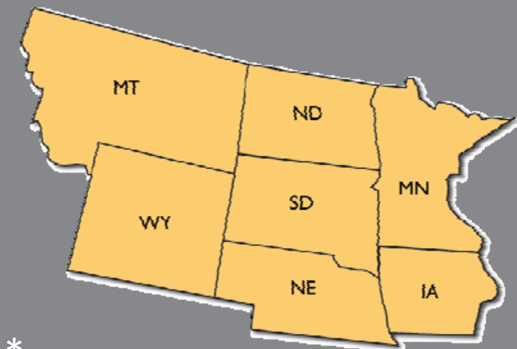
- At the end of this course you should be able to:
  - Understand the importance of determining product suitability
  - Understand the importance of accurate completion and submission of enrollment forms
  - Describe to beneficiaries the sequence of events that will occur after they have submitted an enrollment form
  - Understand the limited instances in which disenrollment requests should be made

For training purposes only. Not approved for public distribution.

MedicareBlue Rx (PDP)
PDP Region 25



- MedicareBlue Rx (PDP) is a stand-alone Part D plan with three options (Value Plus, Standard and Premier) that is available to all eligible Medicare beneficiaries who:
  - Permanently reside in the 7-state region; and
  - Are entitled to Medicare Part A and/or enrolled in Medicare Part B

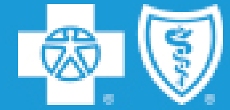


- Wellmark Blue Cross and Blue Shield of Iowa*
- Blue Cross and Blue Shield of Minnesota*
- Blue Cross and Blue Shield of Montana*
- Blue Cross and Blue Shield of Nebraska*
- Blue Cross Blue Shield of North Dakota*
- Wellmark Blue Cross and Blue Shield of South Dakota*
- Blue Cross Blue Shield of Wyoming*

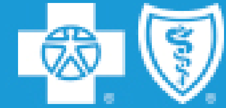
*An independent licensee of the Blue Cross and Blue Shield Association

For training purposes only. Not approved for public distribution.

Product Suitability



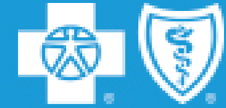
Determining Product Suitability



- When determining product suitability, sales persons must review a beneficiary's current coverage to determine:
  - Suitability of a plan change
  - Current carrier disenrollment requirements (can vary depending upon if Medigap, commercial, Medicare, etc.)
  - The impact a new prescription drug plan may have on the other coverage
  - Whether coordination of other health care benefits needs to be considered
- This is especially important when a beneficiary is enrolled in an employer or union group health plan

For training purposes only. Not approved for public distribution.

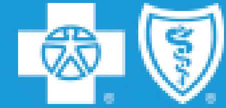
Considerations Related to Other Coverage



- Medicare beneficiaries may be enrolled in only one Medicare Advantage (MA) plan and only one Part D plan at a time
  - Beneficiary may not be simultaneously enrolled in a PDP and an MA plan except for an MA Private-Fee-For-Service plan that does not offer the Part D benefit, a Medical Savings Account (MSA), or unless otherwise provided under CMS waiver authority
- Medicare health plans include:
  - MA or MA-PD plans
  - PDP plans
  - Cost plans (with or without Part D)
- Generally, enrollment into a new PDP will result in disenrollment from other Medicare health plan coverage which includes Part D (PDP, MA-PD, or Cost-PD)
  - Beneficiaries currently enrolled in a non-Medicare prescription drug or health plan (e.g. Medigap) must contact their current carrier to:
    - Determine the impact of enrollment in new coverage on their current coverage (e.g., inability to re-enroll, duplication of benefits, etc.); and
    - Get information on the required steps to disenroll from all or part of the current coverage

For training purposes only. Not approved for public distribution.

Part D Enrollment and Disenrollment Periods

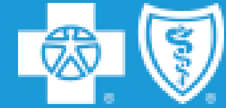


- In order for a Plan Sponsor to accept a request for enrollment or disenrollment, it must be made during a valid enrollment period

- There are 3 periods in which an individual may enroll in and/or disenroll from a PDP:
  - Initial Enrollment Period for Part D (IEP for Part D)
  - Annual Election Period (AEP)
  - Special Enrollment Periods (SEP)

For training purposes only. Not approved for public distribution.

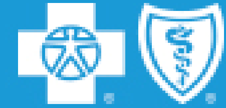
Part D Enrollment and Disenrollment Periods



- Refer to Chapter 3 of CMS' Prescription Drug Benefit Manual for information on all eligibility, enrollment and disenrollment periods, and effective dates
- The last enrollment or disenrollment choice made during an enrollment period, determined by the date a request was received by the plan, will be the choice that becomes effective
- Note that newly-eligible beneficiaries have two enrollment periods that sometimes coincide, IEP and AEP
  - In this situation, it is important to understand which election period and effective date the beneficiary wants, and to check the appropriate enrollment period on the enrollment application

For training purposes only. Not approved for public distribution.

Enrollment Requirements for Part D Products

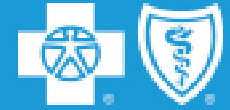


- Once the suitability of a new plan is determined, and the beneficiary's eligibility and election period determination are verified, the enrollment process can begin

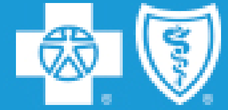
- Before we cover the various enrollment steps and describe the enrollment options available, let's review CMS requirements and guidelines related to the beneficiary's election of a plan option

For training purposes only. Not approved for public distribution.

Federal Guidance



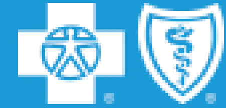
Enrollment Statements and Notices



- Beneficiary is responsible for reviewing statements and notices on the enrollment form
- Sales person must answer all beneficiary questions about these statements (and the plan) before requesting a signature or submitting an enrollment form
- An "authorized representative" is someone with a legal designation to act on behalf of the beneficiary such as power of attorney or legal guardianship
  - Sales persons are not considered "authorized representatives" and may not complete this part of an enrollment form

For training purposes only. Not approved for public distribution.

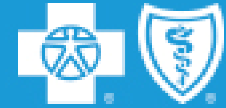
Beneficiary Signature



- A beneficiary's electronic or written signature on an enrollment form is verifying:
  - His or her intent to enroll
  - The personal information provided is accurate and truthful
  - A plan option is elected
  - A billing option is selected
  - Understanding and acceptance of all statements and notices on the enrollment form
- Sales persons must NOT sign and date an enrollment form until the enrollment form is complete, the enrollee signs, and the sales person is ready to submit the application
  - Doing so could adversely affect the enrollment process
  - May enter agent name, number and agency number (if applicable) on the application form prior to enrollee signature

For training purposes only. Not approved for public distribution.

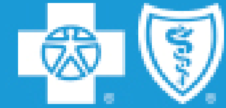
Timely Application Submission



- CMS gives Plan Sponsors very short timeframes for processing enrollment applications and considers receipt of an application by an agent to be the plan receipt date, therefore:
  - Applications should be submitted immediately following receipt
  - Applications received 5 or more calendar days after the agent signature date will be considered untimely and will result in corrective action

For training purposes only. Not approved for public distribution.

Enrollment Process

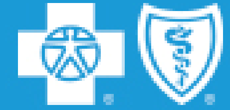


- Once suitability and enrollment eligibility has been determined, the steps in the enrollment process include:
    1. Completion of enrollment form
    2. Receipt of enrollment form by Plan Sponsor
    3. Submission to CMS for approval (accretion)
    4. CMS accretion
    5. Member materials issued by Plan Sponsor upon notification of enrollment approval by CMS

- The enrollment process is explained in more detail in the next several slides

For training purposes only. Not approved for public distribution.

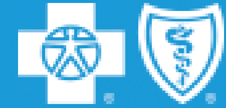
Enrollment Step #1



- Enrollment options:
  - Online via **YourMedicareSolutions.com**
  - Online via **Medicare.gov**
  - Paper application
  - Telephonic enrollment by a beneficiary

For training purposes only. Not approved for public distribution.

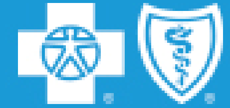
Online Enrollment



- Online enrollment can occur in the following ways:
  - Sales person completes online enrollment via **YourMedicareSolutions.com** with beneficiary present
  - Beneficiary completes online enrollment on his/her own, with or without sales person present
  - Sales person submits paper application via **YourMedicareSolutions.com** without the beneficiary present
    - Beneficiary grants sales person permission for online submission via checkbox on paper enrollment form
    - Paper enrollment forms and confirmation sheets must be kept by sales person for current year plus 10 years (11 years total) and must be provided to Plan Sponsor or CMS upon request

For training purposes only. Not approved for public distribution.

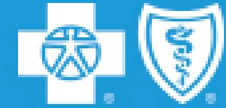
Online Enrollment



- Benefits of online enrollment:
  - Reduces errors and delays due to missing or incomplete information
  - Immediate receipt of enrollment requests without delays
  - Immediate confirmation of submission
  - Allows sales person and plan to meet CMS timelines for acknowledgement letters and outbound enrollment and verification (OEV) letters

For training purposes only. Not approved for public distribution.

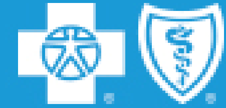
Paper Enrollment Forms



- Paper enrollment forms should be submitted online
  - Upon receipt of a paper enrollment form and permission from the beneficiary (via checkbox on enrollment form), sales persons should immediately enter and submit the paper enrollment information online
- Alternatives to online only if unable to submit online
  - Mail paper applications via overnight mail
  - Fax paper applications (along with fax submission cover page)
    - Overnight addresses and fax numbers can be found in the Agent Administrative Guide
- Premium payments should NOT be included with the enrollment form
  - Premiums will be collected via the billing method the member selected, after CMS approval and the plan becomes effective
    - Inform beneficiary that Electronic Funds Transfer (EFT) and Social Security/Railroad Retirement Board check deduction methods may take two months or more to begin; therefore a paper bill will be sent in the interim
    - Inform beneficiary that this is separate from other EFT transactions (such as EFT for a Medigap plan)

For training purposes only. Not approved for public distribution.

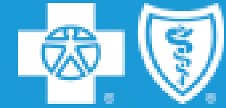
Telephonic Enrollment by a Beneficiary



- Plan Sponsors may accept enrollment requests via an incoming telephone call from a beneficiary to complete an enrollment
  - Telephonic enrollment request must be entirely effectuated by the beneficiary or his/her authorized representative
  - Sales persons must not be physically present or present on the phone at the time of this call
  - Sales persons may be on the call with the pre-enrollment call center and the member to give agent identifier information, but then must disconnect from the call prior to the enrollment of the member
- The beneficiary must have received and reviewed the enrollment materials
- Telephonic enrollments must be recorded and completed through contracted vendor using a CMS-compliant script to ensure that beneficiaries:
  - Understand they are being recorded
  - Are attesting to the accuracy of required elements
  - Understand they are completing an enrollment
  - Are attesting to their intent to enroll
- Collection of financial information is prohibited at any time during the call

For training purposes only. Not approved for public distribution.

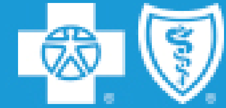
Application Do's for Sales Persons



- Do make sure to understand marketing rules, including what Scope of Appointment (SOA) is, when a SOA form is required, and how to properly complete the form
  - Refer to section 70.9.3 of the Medicare Marketing Guidelines for more information
- Do put your Agent number on all enrollment forms mailed or left with enrollee to ensure receipt of commissions
- Do submit applications online via **YourMedicareSolutions.com**
- Do submit applications immediately upon receipt in order to remain compliant and avoid corrective action
- Do keep original applications, SOA forms and a copy of all confirmation sheets (fax, online, overnight) for the current year plus 10 years (11 years total) for verification

For training purposes only. Not approved for public distribution.

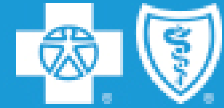
Application Do's for Sales Persons



- Do include beneficiary's best telephone number on application so Plan Sponsor can contact beneficiary if there is missing or incomplete information
- Do provide a description of the enrollment verification process and inform enrollees they will receive an OEV letter from the Plan Sponsor within 15 calendar days of application receipt date (date sales person signed application when applicable)
  - Plan Sponsors are required to conduct OEV for enrollments to ensure individual understands the plan rules
  - Note the OEV process will not delay processing of the enrollment application

For training purposes only. Not approved for public distribution.

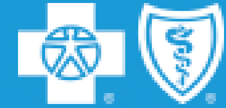
Application Don’ts for Sales Persons



- Do not mail paper enrollment forms via the United States Postal Service (USPS) regular mail
  - Can only be entered and submitted online with beneficiary’s permission, faxed or sent via overnight mail
- Do not sign and date the enrollment form BEFORE the enrollee
- Do not hold an enrollment form for a future effective date
  - Form must be submitted immediately upon receipt from the enrollee
- Do not hold and batch enrollment forms
  - Form must be submitted immediately upon receipt from the enrollee
- Do not submit an enrollment form to your brokerage or agency to batch and submit
  - Form must be submitted immediately upon receipt from the enrollee

For training purposes only. Not approved for public distribution.

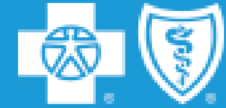
Enrollment Step #2



- Acknowledgment of receipt of enrollment form
  - The Plan Sponsor is required to mail an acknowledgement of receipt to the beneficiary within 10 calendar days of the application receipt date
    - The date of receipt is the sales person's signature date, if applicable
- Keep confirmation of enrollment submission
  - Online: print the confirmation of the enrollment submission; e-mail confirmation may also be requested
  - Fax: keep the fax transmission receipt
  - Overnight mail: keep all receipts and tracking information
  - Telephonic: Pre-enrollment call center provides confirmation number to beneficiary or his/her authorized representative

For training purposes only. Not approved for public distribution.

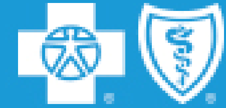
Enrollment Form Application Date



- CMS defines the enrollment form "application date" as the date that the enrollment form is received by the Plan Sponsor
  - Receipt by the sales person is considered receipt by the Plan Sponsor
- Receipt of the application by the plan is considered to be:
  - The date the sales person signs and dates the enrollment form;
  - The **earlier** of the date stamp and/or signature date of the sales person or the agency; or
  - If there is no sales person signature on enrollment form, the Plan Sponsor's mailroom receipt date
- Online enrollments are electronically date-stamped to identify the application date
- Paper enrollment forms mailed by a beneficiary directly to the processing centers are date stamped the day they are received
  - If sales person's signature date is present, it is used as application receipt date
  - Note: Agents should not pre-sign applications distributed to beneficiaries, but they can add Agent ID to receive commissions

For training purposes only. Not approved for public distribution.

What Happens Upon Receipt of Enrollment Form?

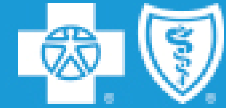


- Within 10 calendar days of the application receipt date the beneficiary will:
  - Be mailed an acknowledgment letter verifying receipt of a complete enrollment form (this may be used as proof of coverage until member materials arrive) OR
  - Be mailed a letter requesting missing or additional information OR
  - Be mailed a written notice of denial based on a determination by the Plan Sponsor that the beneficiary is ineligible

- Within 15 calendar days of the application receipt date, an OEV letter will be mailed to the beneficiary to verify he or she understands the plan rules

For training purposes only. Not approved for public distribution.

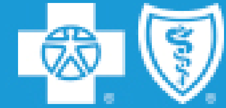
Missing or Incomplete Information on Enrollment Forms



- Enrollment forms with missing or incomplete information cannot be sent to CMS for approval
  - The beneficiary will be contacted via telephone or in writing within 10 calendar days of the application receipt date to request missing information or clarifying documentation
  - If the missing information is received within the allowable timeframe, and the election is deemed "complete," the plan will forward the election to CMS
  - If the missing information is not received within the allowable timeframe, the enrollment request will be denied
- Note: the OEV process is not delayed due to missing or incomplete information

For training purposes only. Not approved for public distribution.

Missing or Incomplete Information on Enrollment Forms

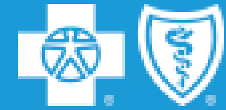


- For Annual Enrollment Period (AEP) enrollment requests, additional documentation must be received by December 7, or within 21 calendar days of the request for additional information (whichever is later)

- For all other enrollment periods, additional documentation 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 training purposes only. Not approved for public distribution.

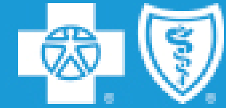
Common Errors on Enrollment Forms



- Common errors that delay processing and may impact effective dates include
  - Not using beneficiary's legal name as identified by Social Security Administration
  - Missing or incorrect date of birth
  - Missing, incorrect or incomplete Medicare health insurance card (HIC) number
    - Must include all letters and numbers
  - No plan option selected
  - Missing beneficiary signature (or signature of authorized legal representative)
  - Election period not identified

For training purposes only. Not approved for public distribution.

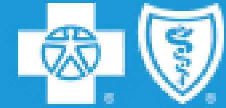
Denial of Beneficiary's Election



- The Plan Sponsor may deny elections based on:
  - Missing or clarifying information not being provided within the required timeframe
  - Determination of ineligibility, including:
    - Beneficiary does not reside in service area
    - Beneficiary does not have a valid election period
    - Beneficiary has outstanding premium balance with Plan Sponsor and fails to become current within the timeframe specified by the Plan Sponsor

For training purposes only. Not approved for public distribution.

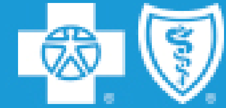
Denial of Beneficiary’s Election



- Under these circumstances, the Plan Sponsor must provide notice of denial to the beneficiary, including the reason for denial, within 10 calendar days of this determination
  - Denial of an enrollment means the enrollment request was not submitted to CMS because the Plan Sponsor identified that the election was not valid

For training purposes only. Not approved for public distribution.

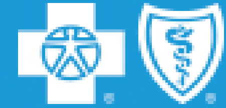
Enrollment Steps #3 & #4



- Submission to CMS for approval
  - Plan Sponsor must submit enrollment data to CMS within seven calendar days from receipt of the completed application for accretion
- CMS Accretion
  - CMS reviews the enrollment requests to verify that the beneficiary meets all CMS eligibility requirements and notifies the Plan Sponsor of approval or rejection

For training purposes only. Not approved for public distribution.

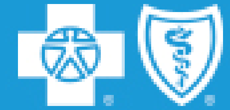
Enrollment Step #5



- Member materials issued upon approval by CMS
  - The Plan Sponsor must mail the beneficiary notification of CMS' response within 10 calendar days
  - A member ID card will arrive and the member may use this card for prescription purchases beginning on the effective date
  - Additional member information will arrive separately which includes important plan information such as the Evidence of Coverage (EOC)
    - EOC can also be accessed at **YourMedicareSolutions.com**

For training purposes only. Not approved for public distribution.

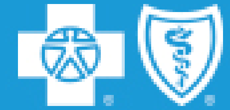
Disenrollment from Part D Plans



- In general, once a plan option has been elected, the member is "locked in" to the chosen plan for the remainder of the plan year (calendar year)
- Generally, enrollment into a Medicare drug plan during a valid enrollment period will automatically disenroll the beneficiary from another Medicare health plan that includes Part D coverage (PDP, MA-PD, or Cost-PD)
  - Submission of a disenrollment request could exhaust the beneficiary's election period and adversely affect enrollment into a new plan
  - Submission of an enrollment into a PDP, when the member is enrolled in a MA-PD or Cost-PD, will result in the enrollee returning to Original Medicare for non-Part D coverage

For training purposes only. Not approved for public distribution.

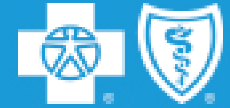
Disenrollment from Part D Plans



- While most disenrollments occur as the result of enrollment into another Medicare health plan, there are limited instances where a beneficiary may request to disenroll:
  - Electing to disenroll during the Annual Enrollment Period (AEP) without electing another Medicare health plan option
  - Newly eligible for Veteran's Administration (VA) prescription drug benefits
  - Newly eligible for group or union health benefits
  - Determination of dual-eligibility or loss of dual-eligibility
  - Permanent residence change out of service area or into an institution (e.g., long-term care facility)
- Refer to Chapter 3 of the Prescription Drug Benefit Manual for more information

For training purposes only. Not approved for public distribution.

Disenrollment from Part D Plans

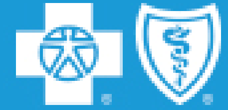


- Members who would like information on how to disenroll from a Part D plan may:
  - Call the Customer Service phone number listed on the back of the ID card or the number listed in the EOC
  - Find information in the Medicare & You handbook
  - Contact Medicare at 1-800-MEDICARE

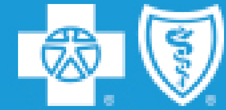
- When there is no associated enrollment into a new Medicare health plan, all disenrollment requests must be submitted in writing and signed

For training purposes only. Not approved for public distribution.

Course Summary



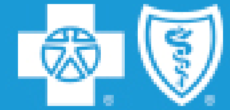
Course Summary: Medicare Part D Enrollment and Disenrollment



- Sales persons assisting beneficiaries with submission of an enrollment form must:
  - Determine if the beneficiary is enrolled in other medical or prescription drug coverage AND
  - Determine the impact on the current plan by enrollment in a Part D plan
- Product advantages and limitations should also be discussed to assist beneficiaries with selecting the product that best suits their needs

For training purposes only. Not approved for public distribution.

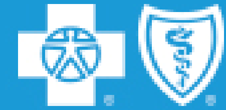
Course Summary: Medicare Part D Enrollment and Disenrollment



- Once suitability and enrollment eligibility has been determined, the steps in the enrollment process include:
  1. Completion of Enrollment Form
  2. Receipt of Enrollment Form
  3. Submission to CMS for approval (accretion)
  4. CMS Accretion
  5. Member materials issued upon approval by CMS

For training purposes only. Not approved for public distribution.

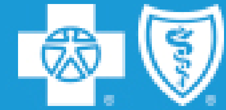
Course Summary: Medicare Part D Enrollment and Disenrollment



- Sales persons assisting beneficiaries with enrollment need to utilize one of the following options to expedite receipt of a complete enrollment request and reduce errors:
  - Online enrollment via **YourMedicareSolutions.com** with beneficiary present
  - Paper to online enrollment with beneficiary's permission for sales person to enter and submit application online without beneficiary present
  - Paper via overnight mail or fax
- Applications must be submitted immediately upon receipt
  - Do not mail paper enrollment forms via USPS regular mail

For training purposes only. Not approved for public distribution.

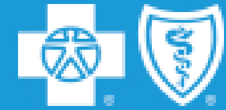
Course Summary: Medicare Part D Enrollment and Disenrollment



- Beneficiaries are notified in writing when Plan Sponsor first receives the enrollment form, and again when the enrollment has been approved or rejected by CMS
- Acknowledgement of receipt of an enrollment form is required within 10 calendar days of the application date and includes one of the following:
  - Acknowledgement Letter
  - Request for missing information
  - Notice of plan denial due to an invalid election/lack of eligibility
- Beneficiaries are notified in writing within 10 calendar days of CMS accretion; CMS approval generates a member ID card and other important member materials
- OEV letter will be mailed to the beneficiary within 15 calendar days of the application receipt date to verify he or she understands the plan rules

For training purposes only. Not approved for public distribution.

Course Summary: Medicare Part D Enrollment and Disenrollment



- Generally, disenrollment from one Medicare health plan that includes Part D occurs as the result of a valid enrollment into another Medicare health plan with Part D, so a disenrollment request should not be submitted
- Opportunities to submit a request to disenroll, without enrolling in another plan are limited, but may include:
  - Electing to disenroll during the Annual Enrollment Period without electing another Medicare health plan option
  - Newly eligible for Veterans Administration (VA) prescription drug benefits
  - Newly eligible for group or union health benefits
  - Determination of dual-eligibility or loss of dual-eligibility
  - Permanent residence change out of service area or into an institution (e.g., long-term care facility)
- When there is no associated enrollment into a new Medicare health plan, all disenrollment requests must be submitted in writing and must be signed

For training purposes only. Not approved for public distribution.