DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR BENEFICIARY CHOICES

DATE: November 3, 2006

TO: Medicare Advantage (MA) Organizations offering an MSA plan in 2007

FROM: Abby L. Block /s/
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SUBJECT: Additional Information on Enrollment in MSA Plans

The Centers for Medicare & Medicaid Services (CMS) is providing additional information for MA organizations that will offer a Medicare Medical Savings Account (MSA) plan in 2007, including a model enrollment form (see attachment A). This information supplements the policy contained in Chapter 2 of the Medicare Managed Care Manual, which is available on the CMS web site at the following link:
http://www.cms.hhs.gov/HealthPlansGenInfo/06_MedicareHealthPlanEnrollmentandDisenrollment.asp#TopOfPage

MSA Enrollment Requests:

All MA plans, including MSA plans, must have a paper enrollment form available for eligible individuals to request enrollment. Attachment A of this memo provides a model MSA plan enrollment form. Organizations may use this form as it appears, or may customize their enrollment forms based on this model, if they follow usual Medicare marketing material approval practices and ensure all the required MSA specific elements are included.

In addition to a paper enrollment form, MA organizations offering an MSA plan may also utilize the following additional, optional enrollment request vehicles described in Chapter 2, section 20 of the Medicare Managed Care Manual:

- 20.4.1 – Alternate Employer Group Enrollment Mechanism
- 20.4.3 – Enrollment Via the Internet (not including the Online Enrollment Center on Medicare.gov)
- 20.4.4 – Enrollment Via Telephone
- 20.4.8 – Group Enrollment for Employer or Union Sponsored Plans (for MSA Employer/Union plans).

All information necessary to successfully enroll the individual in the MSA plan must be provided to consider the enrollment request compete, including the answers to questions 1 – 4 on the

model MSA enrollment form. Additionally, the plan must obtain the necessary banking and account information before the enrollment can be considered complete. The MA organization must ensure its materials describing the MSA plan explain the details of having the MSA account and what options the individual will have regarding the account.

Election Periods and MSA Plan Enrollment Processing:

Per sections 30.7 and 50.8 of Chapter 2 of the Medicare Managed Care Manual, individuals may request enrollment into an MSA plan during the Annual Coordinated Election Period (AEP) and their Initial Coverage Election Period (ICEP). Individuals may not request enrollment during the 2007 MA Open Enrollment Period (OEP). To facilitate the offering of employer/union sponsored MSA plans, CMS will also permit individuals to request enrollment into an employer/union sponsored MSA plan using the Employer Group Health Plan Special Enrollment Period (EGHP SEP).

Voluntary disenrollment from an MSA plan may be requested by the individual only during the AEP or during any applicable SEP by submitting a request in writing to the MSA plan organization; MSA enrollees may not request disenrollment by calling 1-800-Medicare. An individual who has never before elected an MSA plan who wishes to cancel an enrollment request submitted during November of the AEP may do so until December 15, 2006.

All MSA enrollment requests effective January 1, 2007 must be received by the MA organization on or before 12/31/2006 and submitted by the plan to MARx before the payment cut-off date in January. (This date will be provided by CMS in the future, but should be on or around January 10, 2007). If this submission date is missed, the MA organization will follow the usual Medicare processes to submit manual "retro" corrections where applicable. (Note that any enrollments processed by MARx after the mid- December payment cut-off date will not be reflected until the capitation payment for February 2007.)

An MSA plan, like any other Part C plan, must provide all the necessary information to each individual about being a member of the plan prior to the effective date of enrollment (please refer to MA plan requirements in Chapter 2 of the Medicare Managed Care Manual). Plan benefits must be available on the effective date of enrollment regardless of whether or not a transaction has been processed or accepted by CMS systems (i.e. MARx).

Establishing the MSA Banking Account during the Enrollment Process

Medicare beneficiaries interested in enrolling in a MSA plan will need to establish an MSA bank account to accept MSA deposits in accordance with the MSA plan's procedures. The MSA Organization must have documentation that a beneficiary has opened the MSA account before submitting an enrollment transaction to MARx for that beneficiary. CMS will make the annual deposit payment to the plan on the same schedule as the monthly capitation payment. Per Section 1853(e)(2) of the Act, payment of an MSA deposit cannot be made until the beneficiary account has been established.

Acceptable documentation that an MSA account has been established includes a written/electronic notice from the bank that the beneficiary has opened an MSA account, or a written/electronic communication from the beneficiary that the MSA account has been opened, with the bank routing number and account number reported on the communication. The MSA organization must retain this documentation.

Described below are several procedures that the MSA Organization could implement to facilitate the establishment of these MSA accounts:

1. The organization provides the beneficiary with specific banking enrollment materials to begin the process necessary for establishment of the MSA banking account. The specified bank supplies the beneficiary with the required signature card and items needed for establishing the account. The beneficiary completes and returns the required documents to the specified bank. The bank provides the information to the MSA plan to complete the enrollment transaction.

2. For an employer-based MSA plan, the plan's designated bank deals directly with the employer allowing the employer to facilitate the establishment of an account on behalf of the Medicare beneficiaries enrolling in the MSA plan.

Finally, these procedures must accommodate the following guidance:

- MSA organizations must educate beneficiaries that the enrollment is not complete until the MSA account is set up.

- The organization must have documentation that the account has been established prior to submitting the enrollment transaction to CMS.

- Once the enrollee's initial deposit has been received in the MSA account the enrollee may then transfer the funds to his or her own banking institution.

Model MA MSA Plan Enrollment Form ("Election" may also be used)

To Enroll in <plan>, Please Provide the Following Information:

[Optional Field] **Please check which plan you want to enroll in:**

___ Product ABC $XX per month ___ Product XYZ $XX per month

LAST name:	FIRST Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Social Security Number: *(providing this information is optional)*	Home Phone Number: ( )

Permanent Residence Street Address:

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

Emergency contact: [Optional field] _____

Phone Number: [Optional field]_____**Relationship to You** [Optional field]_____

[optional field] **E-mail Address:**

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? □ Yes □ No

Generally, if you answered "yes" you are not eligible to enroll in <MSA plan>. However, if you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. To enroll in <MSA plan>, you may not have other health coverage as described below. Please answer each of the following questions:

A. Are you enrolled in your State Medicaid program? □ Yes □ No

B. Are you receiving Medicare Hospice benefits? □ Yes □ No

C. Some individuals may have other health coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or other health benefits that cover all or part of the annual Medicare MSA deductible. If you have any other such coverage, you are not eligible to enroll in <MSA plan>

Will you have other health coverage in addition to <MSA plan>? □ Yes □ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage so we can help you decide if you are eligible to enroll in <MSA plan>:

Name of other coverage:	ID # for this coverage:	Group # for this coverage
_____	_____	_____

3. Will you reside in the United States for at least 183 days during each year you are enrolled in <MSA plan>?

□ Yes □ No

4. Do you or your spouse work? □ Yes □ No

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

___ Language A (e.g., Spanish)

___ Language B (e.g., Chinese)

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

<Name> is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any health coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan ("disenroll") during the Annual Coordinated Enrollment Period that is November 15th through December 31st of every year (disenrollment is effective the following January 1st) or under certain limited special circumstances, by sending a request in writing to <MSA plan>. If I choose a Medicare MSA plan and have not ever before elected an MSA

plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan is not complete until the bank account is established. I understand that I am enrolling in a plan that does not pay for Medicare covered services until a high deductible is satisfied, but allows me to use funds in my MSA account to pay for health services after the deductible is met the plan pays 100% of Medicare covered services.

If I am enrolling in a MSA demonstration plan, I may be responsible for cost sharing for certain preventive services, as described by the plan, before the deductible is met. After the deductible is met, I may be responsible for cost-sharing until my expenses for covered services reach the out-of-pocket maximum after which the MSA demonstration plan pays 100% of Medicare covered services.

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact the plan at <MSA plan contact number>.

<MSA plan> serves a specific service area. If I move out of the area that <Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <MSA plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from [name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <MA Plan> or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must provide the following information:

Name : _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____