



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

Real Time Caption Transcript

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Enrollment Policy/Operations/Part D IRMAA James Canavan, CPC/MEAG/DEEP Lynn Orlosky, CMS/CPC

James Canavan

Good morning. Thank you all for coming. I guess I will jump right in with our enrollment policy discussion. Let's see here. Our first slide, as you can see, is a discussion about today, the recent guidance update, the policy on unsolicited applications -- which is a big question every year, and what we will do going forward into 2011.

Two of the big deals in our guidance update were the verification process and changing we made to address certain issues of the affordable care act. The OEV, you can see we removed it from the guidance document. We received it so many comments about it that we decided that it wasn't ready to go in this document yet. It needed rethinking. So it came out. We'll talk more about that in a moment. Refer to 70.6 and the memo from August 17, those are the two places to find the most recent information on the OEV process. One item that you will hear about later today is our new cancellation transaction that won't be using the OEV process. The reason I bring that up is because there is still some confusion out there. I can tell you there's a lot of people say there's a conflict there. No, they're two processes that run side by side. If you want to discuss that more we can talk about that. There are two processes, they're separate, no conflict between them.

When we removed the OEV process the feedback we got on it was very bad. The feedback that we got on it caused us to rethink the way it was -- the way we presented it. And we are exploring other options for it. We may come back to it in the future. It may go another way entirely. We have no idea at this point. It's still in review, as I said.

The affordable care act. First of all, the OEP, open enrollment period, gone. The OEP was the period from January 1 to March 31 that beneficiaries were able to make one election, they couldn't drop or add drug coverage. It was the period that begins the month of entitlements A and B, and ended the last day of third month, or December 31, whichever was earlier. We're calling it the Medicare Advantage [Indiscernible]. A beneficiary already in a Medicare Advantage plan is able to go back to original Medicare. They can then make one choice to pick up Part D coverage. That's separate [Indiscernible] that can you find in our guidance. It works to coordinate with the Medicare care -- enRollie can then choose to pick up Part D.

Next year for effective dates of January 1, 2012 you will see that it's October 15 through December 7. The weeks there should give organizations time to get all of those elections processed for January 1, 2012. Other changes this year, we expanded the incarceration policy to all Medicare Advantage products. So now if a beneficiary is incarcerated they are considered to be living outside of the senior area of their plan. The outside of area process should be applied appropriately. Another update in the guidance that was released on August 17 is the new exhibit 6D. This is a new exhibit, like the other exhibit 6s. This was for MA only plans. It



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removes the Part D specific language.

Finally, we also have a model notice for requesting information for incomplete disenrollment, 11A. When a beneficiary sends in a disenrollment request that is missing information you can send this particular exhibit out to the beneficiary. Okay.

Unsolicited applications, this is a big topic. We get a lot of questions on it every year. What is this process? This is the process where by when a plan receives an application when a beneficiary that was not -- not solicited, a broker, an agent, a sales rep didn't ask for the application. This is something that an beneficiary sends in an application, it has to be received on or after October 1, before November 15. Just because a broker didn't ask for it doesn't mean they can take it. That's something I want to stress. I know we've heard stories of brokers taking applications from beneficiaries and hoarding them until the 15th and then turning them in. That's against our policies. At that point they're causing your organization to be out of compliance, of course, you don't want that. The OEV cost of this, when does it start with these applications? We good question. Does it start when the plan receives it in the mail? Or on the 15th? The right answer is it starts when you receive it. You should immediately hang on it and make the application date the 15th, transmit it, you still need to make that call within the timeframes of when you received it in the mail.

The application date for any of these applications is November 15th. Next year it will be October 15th.. Looking forward, one of the things to keep in mind is the annual enrollment period for next year, as I discussed previously. We at CMS are aware this is not just a change in dates, this is a change in schedule. A lot of things are affected by the AEP. We're working hard to make sure that all of our internal processes are going to be in line. That effects a lot of things. You will be seeing communications from us and other agencies at CMS that will explain how the calendar will change for next year.

Another thing I want to talk about just briefly is the audits for next year. Not going to go too deep into this, because it will come up later in the conference, we've been going over a lot of audit data. Recent data as well as since January 1st. To be Frank, we have a lot of concerns. The biggest trend we've been seeing is that organizations are not meeting the requirements in our guidance. So I can't stress enough to read our guidance documents, they're posted online. Read them, understand them. Have your employees read them. I'm hoping that your enrollment processers are also familiar with. I used to be an enrollment processer myself. I would take these documents with me, read them at lunch, even took them home, read them at night, go through them in front of the TV. Understand them. Not just read them, but also make them part of your mental architecture for how you do your work. Frankly, we've been seeing a lot of problems with timeframes, meeting requirements. I can't stress enough the documents are there for you to use. We don't just put them out there because it keeps us busy, please -- read them.

Here we go. Here's the links of where they've located. they're located. When you go on to those pages you are going to see under the download sections a bunch of documents listed. The documents listed August 19, 2009 is the guidance for in year, 2010. The document listed with August 17, 2010, is the guidance for next year. The reason I point that is out because another question we get a lot is: All of the models in the new guidance have the dates for next year in them. Yes, that's correct. Because those documents you will use for this year you want to use



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your models from this year's guidance, the one from August 19, 2009. Those documents -- models for next year for anything January 1 or later you want to use the guidance from August 17, 2010.

One more thing, we did not update the cost guidance this time around. You want to continue use the guidance from last year on August 19, 2009.

There are lots of places you can go with your questions outside of conferences like this. There are contacts at CMS, we're more than happy to answer your questions. However, we have processes in place to track questions that we get. And the purpose is so that we can see trends. Organizations are not getting this, we need to strengthen that somehow. We ask that you go through the other processes. Starting with you reading the memos, we release those -- there's not really a schedule to them, go to your CMS account manager. I know they're busy, but they will forward their questions on to us if they can't answer your question immediately. We will be able to see where we have places to strengthen things, or where we need to do a little intervention. Of course, the user group calls. I'm sure that many of you are aware of those and dial into them. There's opportunity to ask questions on the calls as well. Most of the subject matter experts are going to be on those calls, or at least a representative from their expert group will be there. We ask that you go through the account managers as a first step to get questions answered. If that doesn't work then if you have personal contacts, none of you are going to stop you, do what you need to do. We ask that you go through your account managers. Above all, before you even contact us -- read the guidance. That's the best way to get your answer.

Okay. Thank you very much, everybody. [Applause]

Lynn Orlosky

Good morning, everyone. It's good to be here on a sunny Tuesday following Labor Day, it was a brilliant weekend. Hopefully everybody got to enjoy the weekend, even though you had to be here at the crack of dawn to work with us regulators. My name is Lynn Orlosky. I'm a technical advisor. I'm going to talk today about the new what we're calling Part D IRMAA. This is a new provision that was in the healthcare reform legislation. And essentially what the requirement is to require higher income individuals to pay more for their Part D premium. This becomes effective January 1, 2011. This is a very similar provision. Most of you are -- everyone would probably be familiar with the same requirement that is applied for Medicare Part B. So similarly, what we've tried to do as we've taken this legislation is really look to how we've laid out Part D. And where we can, follow suit with Part B. Now the specific amount, um, is based upon the national base premium that CMS establishes every year. We take that amount and we're utilizing -- working very closely with the Social Security Administration, there are incomes that individuals report to the IRS are the amounts that we use to then determine the Part D income-related amount.

Essentially, I will note that the one column that is missing from this table is the joint -- married individuals who file separately. But essentially what the requirement does is basically establish four tiers, similar to Part B. Such that individuals who make more than \$85,000, or married couples who make more than \$170,000, are then subject to this requirement. So there are four status amounts, associated are percentages as established in the statute. What we then do is we take the national base beneficiary premium, multiply it using a calculation and come up with



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four amounts that individuals are then -- that comes up with their specific amount that they would be required to pay.

Now I think the key piece, I think what the interest here, is what your role as health plans is, and with regard to paying this amount. The Part D IRMAA, the amount that each individual is going to be charged, is going to be -- if they have enough in their monthly benefit check, [Indiscernible] will be deducted from that check. Regardless of whether they're in premium withhold status, or if they're paying you through check or EFT, this amount is deducted from their benefit. The only exception to that is if the benefit is insufficient or they don't get a benefit check. Then CMS will initiate a direct-bill process with that individual directly. Again, this is very similar to the way that we handle Part B.

So I think the key message here is the Part D IRMAA amount is in no way shape or form going to be collected at the health plan.

Now we've gotten individuals that events in their life may change, their income could decrease, there's a process that individuals can go and present evidence to show what in their life has changed to appeal the Part D IRMAA being applied to them. So individuals will be able to utilize a form that is being revised to also include this Part D IRMAA provision. Individuals will be basically need to just provide that with the necessary evidence in order to have the additional amount removed.

Again, just to reiterate, the role of the plan, the role of you in this process is not to calculate this amount, it's not to collect this amount, it's not to bill this amount. That is solely the role for CMS to handle. Again, in concert with SFA. We've gotten many questions, I believe on the user group calls, they've been filtered through your various account managers. I can assure you that we will be providing you with some FAQs. We want to help you as far as where to direct the questions. You will essentially be a liaison to help the individual if they have questions. Let's say they say my income has gone down. We will be releasing a memo which will clarify your roles and help you to answer their questions and give you some model FAQs. We want to assist you in answering the questions for individuals. Not that we want to tell you what to tell folks, but we think that we're directing you to FSA and CMS, we have a script and appropriate training at our call centers, we can alleviate a lot of the confusion. This is obviously a different -- different than Part B where the individual would have all of the amounts. The fact that they may be paying you a premium and have a subsequent bill coming from CMS, we understand that will create some confusion. We want to help you to educate your members. We also to make sure that we can provide you with the best outreach information that we can.

As far as -- there is going to be -- CMS has been working on regulations to implement the provisions that were part of the provider act, and more detail on the Part D IRMAA will be provided in that regulation. I wanted to also note as far as beneficiaries being notified of this amount. As I mentioned, this is similar to Part B, beneficiaries will be notified in November as SSA does their annual benefit announcements. The letter will tell them of their benefits amount of SSA, their Part B premium and their Part D IRMAA premium. That's going to be the first time that they're going to hear about this. So we'll be poised to provide you with information to address any questions that -- at that point in time beneficiaries may say I got this letter that says I pay Part D, but I already pay you. Again, that's where CMS is going to provide you with



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information such that you can answer those questions. With that, at this point in time that is pretty much the key pieces for Part D IRMAA.

While it's obviously something that is required by the legislation, it's also something that we recognize that beneficiaries anything that you add additional amount to their premiums it's a sensitive subject. At this point in time we will have a memo coming out in the near future to clarify your roles. Stay tuned. I think now we're going to entertain some questions for both Jim and myself.

All right. Now just as I mentioned before, this is your lucky chance. Those of you who have questions rise and shine. We have mics in the aisles right here. All we ask is that you please state your name and tell us where you work and feel free to ask your question. If you cannot access a mic we do have wonderful people with wireless mics that they can pass to you, raise your hand. Do I need to remind everyone that the only bad question is the only one that you don't ask? Anyone? Do we have a question? I'm sorry, with the lights I can't see. There we go. Now, if your question should be directed to Jim or Lynn just ask.

My question is for Lynn. You mentioned the regs coming out. How will be notifying beneficiaries? Will they know about the increase premium? Or will it just hit them in January?

The notification for this specific amount is going to be released in the notice from SSA, this is -- it comes around the Thanksgiving holiday. That's something that is done every year, when beneficiaries get this specific -- I have heard SSA refer to it as a "turkey letter." It's issued around the end of November to let folks know about their benefit amounts for January. It's very detailed. It tells them if they have the Part B amount it goes into how much is going to be deducted. In that same letter that's where we will tell them they will be subject to this new Part D premium amount. As I mentioned, the income -- we use the income that individuals report to the IRS. There is a very close data exchange. For the enrollments that we have in our systems going into the first of the year we will use that information and data exchanges with SSA, they feed it back. It's basically just a huge coordination of data that we've been working on for several, several months to ensure that folks are going to have their enrollment and this amount correctly reflected.

All right.

Hi. With regards to the Part D IRMAA, is there going to be any thought with the communication that goes out to individuals that might be part of an employer group. The retiree may be paying a portion, or none at all.

Regardless of whether or not they're part of a group or they will be subject. This is another key outreach strategy angle that our external affairs folks are working on. SSA too, they have dealt with these questions for a couple of years when Part B IRMAA was implemented. So similarly -- we're almost taking the employer group situation and expanding it to the entire population. That's a good point. Again, that's a point that we'll address in our strategy. Thanks for bringing that up.



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Thank you.

I work for government works incorporated. Plans make their online web portal prior to November 15 for those beneficiaries that have a special election period prior to November 15?

You are asking about beneficiaries with a special election period prior to?

Yes. If a plan had an online enrollment portal, can that be made available prior to November 15? Or is that considered soliciting applications?

If the beneficiary is using the special election period it has nothing to do with the organize OEP. Certainly they should not be seeing any -- well -- short answer is yes, if it's a special election period it should not have anything to do with the OEP.

If it was received online you can treat it as --

I misunderstood. Yes, that should be fine.

Thank you.