April 3, 2020

Delivered to: OIRA_submission@omb.eop.gov

Thank you for the opportunity to submit comments on the *Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request Form (CMS-10718)*. UCare provides the following comments for consideration.

- Remove the questions regarding the effective date of Hospital (Part A) and Medical (Part B) coverage. Health plans use the Medicare Beneficiary Identifier (MBI) to verify the effective dates in CMS systems. We do not use the dates entered on the enrollment form.

- Remove the question "Do you have End-Stage Renal Disease (ESRD)?" Health plans will not use this question in 2021.

- Reword the question "Are you a resident in a long-term care facility, such as a nursing home" or provide more information about what is considered a long-term care facility and what is not (e.g. assisted living facilities). As written, many people who live in assisted living facilities answer this question "yes."

- The enrollment form does not include questions needed to identify some Special Enrollment Periods (SEPs) (for example, *SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively*). Could CMS add additional questions to help identify this and other SEPs?

- Do not bold or capitalize the following sentence in the disclaimer, "Without authorization, neither Medicare nor <Plan Name> will pay for the services." This information is no more important than the other text. Also, many people read the statement to mean that all services need prior authorization, which is not the case.

Sincerely,

Tracy Hoisington

Tracy Hoisington
Federal Government Relations Specialist
UCare

Anthony Mader
Vice President, Public Policy
Anthem, Inc.
1121 L Street
Sacramento, CA 95814
(916) 403-0522

Submitted via email: OIRA_submission@omb.eop.gov

April 6, 2020

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development, Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Model Medicare Advantage (MA) and Medicare Prescription Drug Plan (PDP) Individual Enrollment Request Form (Form Number: CMS–10718/OMB Control Number 0938-New)

Dear CMS Desk Officer:

Anthem, Inc. (Anthem) appreciates the opportunity to provide comments on the proposed model MA and PDP Individual Enrollment Request Form (Form)(Form Number: CMS–10718/OMB Control Number 0938-New), as outlined by the *Federal Register* notice dated March 6, 2020.

Anthem shares the Centers for Medicare & Medicaid Services' (CMS') commitment to preserve and strengthen the MA and Part D programs. We deliver high-quality services to improve beneficiaries' health and well-being by working with CMS to offer affordable and patient-centered coverage options. To that end, our comments focus on recommendations that will improve transparency, making the Form easier for beneficiaries to understand and complete.

Specify Mandatory and Optional Sections

Issue: The proposed cover page of the Form states, "Note: You must complete all items on page 1. The items on page 2 are optional — you can't be denied coverage because you don't fill them out." Depending on the amount information each plan includes, the mandatory information intended to be included on page 1 could extend into page 2. The optional questions envisioned to be on page 2 could then extend to page 3. For example, page 1 contains a section titled, "Answer these important questions," where Special Needs Plans (SNPs) will insert questions regarding beneficiary special needs criteria. Given page 1 of the proposed Form utilizes a full page, even before plan information is included, it is likely that the mandatory information requests will extend past the current page 1.

Recommendation: To ensure the form is user-friendly, we request CMS include language that references the *sections* that are required, rather than the *pages.* For example, CMS should include the following language: "You must complete all items in section 1. The items in section 2 are optional." We also recommend that conforming changes be made throughout the Form to ensure beneficiaries understand which sections are mandatory and optional.

Request for Clarification on Capturing Premium Payment Selections

Issue: The reminders section of the proposed cover page states, "Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit." However, the proposed Form does not request bank account information.

Recommendation: We encourage CMS to clarify how health plans will obtain each beneficiary's premium payment option. The Form does not capture the premium payment selection or banking information. If CMS does not intend to collect this information on the Form, we request clarification on how this information will be collected.

In addition, we request the addition of language to accommodate $0-premium plans. We recommend CMS include the following language on the cover page, "Your plan will send you a bill for the plan's premium, *if applicable.*"

We also support the addition of explanatory language to educate applicants about automatic premium deductions from Social Security and Railroad Retirement Payments. CMS should consider adding user-friendly information that is similar to the Social Security Handbook, which reads "Medicare Part B premiums must be deducted from Social Security benefits if the monthly benefit covers the deduction. If the monthly benefit does not cover the full deduction, the beneficiary is billed."

Include Optional Supplemental Benefits Packages

Issue: Many plans offer optional supplemental benefits packages. However, the proposed Form does not include a section that would allow beneficiaries to make benefits package selections. Providing clear information to beneficiaries will help aide decision-making, while also ensuring the plan receives the correct information in a timely manner.

Recommendation: To aide transparency, we recommend CMS include a section allowing beneficiaries to select an optional supplemental benefits package. The benefit packages listed should include monthly premiums, so beneficiaries can select the plan and the benefits package that best meets their individual needs.

Include Primary Care Physician (PCP) Identification Numbers and Current Patient Status

Issue: The proposed Form includes a section titled, "List your Primary Care Physician (PCP), clinic, or health center." However, the section does not request the PCP identification number. The section also does not ask if the beneficiary is a current patient.

Recommendation: We recommend that CMS add two questions to this section that request a PCP identification number and whether the beneficiary is a current patient. These are common informational questions posed to beneficiaries by plans upon enrollment and will help streamline the process and avoid beneficiary confusion.

***

We value the partnership that we have developed with CMS and welcome the opportunity to discuss our recommendations to ensure the delivery of robust benefits and quality care via the MA and Part D programs. Should you have any questions or wish to discuss our comments further, please contact Danielle Horne at (818) 298-7830, or Danielle.Horne@Anthem.com.

Sincerely,

Anthony Mader
Vice President, Public Policy

Anthem is a leading health benefits company dedicated to improving lives and communities, and making healthcare simpler. Through its affiliated companies, Anthem serves more than 79 million people, including 41 million within its family of health plans and over 2.5 million Medicare consumers. We aim to be the most innovative, valuable and inclusive partner. For more information, please visit www.antheminc.com or follow @AnthemInc on Twitter.

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Sincerely,

Anthony Mader
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APPLICATION FOR ENROLLMENT IN MEDICARE PART C (MEDICARE ADVANTAGE PLAN) or PART D (MEDICARE PRESCRIPTION DRUG PLAN)

WHO CAN USE THIS APPLICATION?

- **(For MA eligibility)** Individuals entitled to Medicare Part A and enrolled in Part B
- **(For Part D eligibility)** Individuals entitled to Medicare Part A and/or enrolled in Part B

Spell out "Medicare Advantage" instead of MA

In addition, individuals must:

- Live in the MA or Part D plan's service area
- Be U.S. Citizens or be lawfully present individuals in the United States

WHEN DO YOU USE THIS APPLICATION?

Use this form:

If you are newly eligible for Medicare or otherwise have a valid election period to enroll in either a Medicare Advantage plan OR Prescription Drug Plan.

NOTE: Your Initial Coverage Election Period (ICEP) lasts for 7 months. It begins 3 months before the month you are newly eligible for Medicare (generally, your 65th birthday or 25th month of disability) and ends 3 months after the month you are newly eligible for Medicare

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS APPLICATION?

You will need:

- Your Medicare Number
- Your current address and phone number

This is confusing. Is this necessary information ?

WHAT'S INCLUDED WITH THE ENROLLMENT FORM?

We have mandatory addenda (to be part of the application), which are optional for the beneficiary to complete; and optional addenda which are optional for the plan to include and the beneficiary to complete.

THINGS TO REMEMBER?

- If you're signing up during open enrollment you can send your form anytime from October 15 but no later than December 7.
- You (or your authorized representative) must fill out a separate form for each person enrolling in the plan.
- Your plan will bill you. You can choose to sign up to have your premium payments deducted from your bank account.

WHAT HAPPENS NEXT?

Send your completed and signed application to the Medicare Advantage or Prescription Drug plan. If you have questions, call MEDICARE at **1-800-633-4227**. **TTY users should call 1-877-486-2048. You may call 24 hours a day 7 days per week.**

HOW DO YOU GET HELP WITH THIS APPLICATION?

Phone: Call MEDICARE at **1-800-633-4227**. **TTY users should call 1-877-486-2048.**

En español: Llame a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y unrepresentante estará disponible para asistirle.

Include the telephone numbers for the Plan they're signing up with too?
"You can also call our Plan at <xxxxxx>, TTY <xxxxxxx>, <days & hours>. "

Exhibit 1: Model Individual Enrollment Request Form

To Enroll in <plan>, Please Provide the Following Information:			
Name of Plan You are Enrolling In:			
LAST name:	FIRST Name:		
Birth Date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Gender: ☐ M ☐ F	Home Phone Number: ( )	
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field*: **E-mail Address: _____**]			

Please Provide Your Medicare Insurance Information
Medicare Number:

Please read and answer these important questions:
[*MA-PD plans insert:* 1. Will you have other prescription drug coverage in addition to <MA plan>? ☐ Yes ☐ No If "yes", please list your other coverage and your identification (ID) number(s) for this coverage. Name of other coverage: ID # for this coverage: Group # for this coverage _____ _____ _____]
[Special Needs Plans] insert question(s) regarding the required special needs criteria]

IMPORTANT: Read and Sign Below:

- **Release of Information:** By joining this Medicare Advantage Prescription Drug Plan/Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- (Medicare Advantage only) I understand that when my <plan name> coverage begins, I must get all of my medical and prescription drug benefits from <plan name>. Benefits and services authorized by <plan name> and contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor <plan name> will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Address:
Phone Number:	Relationship to Enrollee:

Does this direction to the Plan need to be on the application?

OMB No. 0938-XXXX
Expires:XX/XX

Mandatory Addendum: This is considered part of the enrollment application but optional for the beneficiary.

[*Optional fields*: Can you please tell us a little more about yourself. Answering these questions is voluntary and will not be used to process your enrollment. Information provided will only be used to help understand program participation for the purpose of reducing inequalities in certain groups.]

Ethnicity Data Are you Hispanic, Latino/a, or Spanish origin (One or more categories may be selected):

_____No, not of Hispanic, Latino/a, or Spanish origin
_____Yes, Mexican, Mexican American, Chicano/a
_____Yes, Puerto Rican
_____Yes, Cuban
_____Yes, another Hispanic, Latino, or Spanish origin

☐ I decline to provide this information

Race Data What is your race? (One or more categories may be selected):

_____White
_____Black or African American
_____American Indian or Alaska Native
_____Asian Indian
_____Chinese
_____Filipino
_____Japanese
_____Korean
_____Vietnamese
_____Other Asian
_____Native Hawaiian
_____Samoan
_____ Guamanian or Chamorro
_____Other Pacific Islander

☐ I decline to provide this information

Please provide language or accessible format preference:

Preferred spoken language _____ if needed

Preferred written language _____

Accessible format preference (e.g., Braille, audio tape, or large print) _____

Please contact <plan name> at <phone number> if you need information in an accessible format or language ~~other than what is listed above.~~ Our office hours are <insert days and hours of operation>. TTY users should call <TTY number.>

Optional Addendum: Plans can add value added information here

Does this direction to the Plan need to be on the application?

Do you or your spouse work? ☐ Yes ☐ No

[*Optional field:* **Please choose the name of a Primary Care Physician (PCP), clinic or health center:**]

[*Optional field:* **Paying Your Plan Premiums:**
MA-only, MA-PD plans and Part D plans with premiums insert: **You can pay your monthly plan premium**
[*MA-PD plans with premiums insert:* **(including any late enrollment penalty that you currently have or may owe)] by mail** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.]**

[*MA-PD and PDPs with premiums insert:* **If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

[*Optional field:* **Electronic Delivery of Plan Specific Materials:** ***Choose one***

☐ I opt/choose to receive **all** plan specific materials available electronically

☐ I opt/choose to receive only the following plan related materials electronically: {*plans may list those types or categories of materials that are available for electronic delivery}*

Plans may also include information needed to sign up for portals or other mechanisms to receive materials electronically.]

Comments for Updated Enrollment Form 2021

Optional county field – We do not believe the county should be optional. CMS recently had a system update that is putting members into incorrect counties.

- This would affect enrollment at the time of application processing. Applicants can either be denied or processed into the wrong region based on the county in MARx. At times we find the county in MARx does not match what is filled out on the application. This in turn could start the Out of Area process and would not be a good member experience.
- We have come across members that we have started the Out of Area process on per the TRR and received responses back from members that they have never moved. The county would not be able to be validated from the application in order to have documentation to request a SCC RPC to update MARx to the correct county.

Optional PCP – We do not believe these should be optional.

- This would cause member disruption and more work for the Plan not to have the PCP at the time of enrollment. The Plan would need to assign a PCP in the members area of residence and send a letter to the member. Most times it is not the correct PCP and the member spends time calling into Customer Care to change their PCP.

Optional Paying your Plan Premium – We do not believe these should be optional.

- This would cause member disruption and more work for the Plan not to have payment option at the time of enrollment. The Plan would automatically process the application for the member to get a bill each month and pay premiums directly to the Plan. This will prolong members being set up on automatic deduction from Social Security. These requests sent to CMS/Social Security are time sensitive and have cut off dates.
- This would also cause member disruption if the EFT fields are not on the application. The member would have to spend time calling into Customer Care, receive an EFT form in the mail, fill it out, mail it back in, and then processed by the Plan.

The Attestation of Eligibility for an Enrollment Period page is not mentioned.

- We believe this is a crucial part of filling out an application so that the Plan knows what the election is for enrollment. There are many election options to choose from that require the member to insert a date in order to be eligible for a Special Election Period, or to advise the effective date for coverage. This would cause member disruption with a phone call. Would we get a hold of the member and receive a response in time? A Request for Information letter cannot be sent for applications received that do not have a clear election period to enroll.

Shannon Schuster
Director, Regulatory Affairs
Government Programs
UnitedHealthcare
3100 AMS Blvd
Green Bay, WI 54313
920-661-6217

To: Centers for Medicare and Medicaid Services
Submitted electronically via: OIRA_submission@omb.eop.gov

From: Shannon Schuster
UnitedHealthcare
UnitedHealth Group

Date: April 6, 2020

Re: *Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request Form*

Attached are comments regarding the Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request Form.

Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request Form

Comments Submitted by
UnitedHealthcare
4/6/2020

UnitedHealthcare (UHC) appreciates this additional opportunity to provide input to the Centers for Medicare and Medicaid Services (CMS) regarding the Model Medicare Advantage ("MA") and Medicare Prescription Drug Plan ("Part D") Individual Enrollment Request Form ("Model Enrollment Form"). Our comments are identified by section in which they appear in the Model Enrollment Form.

All Fields On This Page Are Required (Unless Marked Optional)

UHC recommends that CMS revise the Phone Number section to add fields for both "Landline" and "Mobile Number."

We recommend moving the following field into this section as "Required":

- List your Primary Care Physician (PCP), clinic, or health center:

We also recommend adding the following fields to the PCP section above:

- Phone Number
- Are you seeing this doctor?

Additionally, we recommend that CMS move the following fields into this section as "Optional":

- I want to get the following materials via email. Select one or more...
- Select one if you want us to send you information in a language other than English...
- Select one if you want us to send you information in an accessible format...

Finally, we recommend that CMS add the following new fields into this section:

- Middle Initial
- County (in Mailing Address field)

Your Medicare Information

UHC recommends inserting underscores that correspond to the number of Medicare Beneficiary Identifier (MBI) characters. Additionally, we recommend that the MBI number appear on multiple pages (e.g., in a footnote) in case it is missed or transcribed incorrectly. The following example demonstrates our recommendation:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Further, we recommend that CMS insert the following fields into the "Your Medicare Information" section:

- Name (as it appears on your Medicare card)
- <u>Is Entitled to:</u> <u>Effective Date:</u>
  Hospital (Part A) M M - D D - Y Y Y Y _____
  Medical (Part B) M M - D D - Y Y Y Y _____

Answer these Important Questions

We recommend adding a field for "Date Plan Started" in this section.

IMPORTANT: Read and sign below

UHC recommends rephrasing the statement below to make it clearer for the beneficiary:

> [MA plans insert: I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services ~~authorized~~ provided by <Plan Name> and contained in my <Plan Name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. ~~Without authorization, n~~ Neither Medicare nor <Plan Name> will pay for benefits or services that are not covered.]

UHC also recommends that all of the "authorized representative" fields are separately listed (e.g., first name, last name, city, state, zip code, etc.)

All Fields on this page are optional

We recommend deleting the header "All Fields On This Page Are Optional" so that beneficiaries will not skip this section. Beneficiaries can check the "I choose not to answer" field if they do not want to provide this information.

We also ask that CMS permit MA plans and Part D sponsors to populate these fields optionally. For example, if the plan does not capture this information in their systems, plans should not be required to print these fields on their enrollment forms.

- Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
- What's your race? Select all that apply.

There are several typos in this section. We ask CMS to please correct them (i.e., "coverage", "Physician") in the final Model Enrollment Form:

- In "You can't be denied coverge because you don't fill them out," "coverge" should be changed to "coverage".
- In "List your Primary Care Phsyician (PCP), clinic, or health center," "Phsyician" should be changed to "Physician".

We ask CMS to move the following section to the "All Fields On This Page Are Required (Unless Marked Optional)"section and make them "optional" fields.

- Select one if you want us to send you information in a language other than English.
- Select one if you want us to send you information in an accessible format.
- I want to get the following materials via email. Select one or more.

Paying your plan premiums

UHC recommends that CMS align this section with the "Paying Your Plan Premiums" section found in the current CMS enrollment application model.

Additionally, from a beneficiary clarity perspective, we recommend that the payment language below be revised as follows:

> We will bill you directly until the Social Security Administration approves the deduction. Once we notify you of the approval, you may stop making your payment. It could take up to 90 days after the approval for the first deduction to occur and it could be for up to three months of premium. If Social Security does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

General Comment (Employer or Union Coverage)

UHC recommends that CMS include a section for employer or union coverage and consider including the following fields:

- Do you have health insurance with an employer or union right now? · Yes · No
- If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining our plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.
- Do you or your spouse work? · Yes · No
- Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, Long Term Disability (LTD) coverage, Workman's Compensation, Auto Liability, or Veterans benefits) · Yes · No
- If yes, please complete the following:
  Name of Health Insurance Company
  Subscriber Name Group Number
  Member Number Effective Dates (if applicable)

General Comment (Include a Medicaid Information Section)

UHC recommends that CMS include a Medicaid section that aligns with the "Are you enrolled in your State Medicaid program?" found in the current CMS enrollment application model.

General Comment (Non-Model Submissions)

UHC recommends that CMS continue to allow MA plans and Part D sponsors to retain the ability to file Non-Model Enrollment Application Forms.

General comment (Enrollment Guidance Release Timeframe)

UHC proposes that on an annual basis, CMS release the final Enrollment Guidance in April. The current timeline does not take into account the technology and process updates necessary to make the changes outlined in the Enrollment Guidance. Additionally, the steady increase in MA membership has led to an

increase in the number of materials that need to be produced, which strains production timelines. We anticipate that growth will continue. UHC recommends earlier release dates to accommodate these concerns, as well as increased communication from CMS on release timelines and status updates if guidance or models will be late.

General comment (CMS Review Timeframe)

In section 100.4 of the Medicare Communications and Marketing Guidelines (MCMGs), CMS describes the enrollment application form as a "Communication" material, which generally does not require CMS review or submission. However, this section further indicates that enrollment application form submissions are required by statute (HPMS submission code 1070 or 1072). Section 1851 of Title XVIII requires that enrollment application forms be submitted to CMS for approval at least 45 days before their intended use. UHC recommends that CMS pursue updates to the statute, and then update the enrollment application form submission guidance to align with other Communication materials that require an 'informational' submission, such as the Evidence of Coverage. We believe this will assist MA plans and Part D sponsors in ensuring that beneficiaries have timely access to required enrollment mechanisms during the AEP.

If you have any questions on these comments, please feel free to contact me at 920-661-6217.

Respectfully,

Shannon S. Schuster

Shannon Schuster
Director, Regulatory Affairs
UnitedHealthcare