

# FALL 2012 CMS CONFERENCE



## TRANSCRIPT

### Day 1 08b: EGWP PDE Changes

*Jansak, Abeln, Johnson*

Hi. Thank you very much. So what I'm going to do is Kathryn and I are going to talk about Parts C and D employer contracting, so I'll start off with the Part C part of it. And what I'm going to do is give you kind of an overview of the employer contracting program. Some of this will be pretty familiar to a lot of you, but it'll just kind of go through the highlights. I also am going to talk a little bit about a Part C study that we have been doing that some of you may be aware of. And I'm also going to talk a little bit about updates to Chapter 9 which some of you may have known we've done recently.

Now in terms of the Part C study, what CMS did is we selected, this was a random sample of MAOs, and we asked them to report on specific employer plans that they were serving and we asked for them to provide benefits and cost sharing information at the employer level. And we looked for a broad sample of these. It was meant to be a random sample so we could get a representative idea. It was in no way an audit in the sense of, you know, it was much more a circumstance where because of the way, many of you may know, the Part C. employer program is set up, we don't have the same kind of detail at the employer level that we do for the individual plans. So the purpose of this study is to help CMS understand the value to retirees of the employer plans they enrolled in. And the way we're going to be doing this is we're going to look at the benefits in cost sharing of the selected employer plans and compare these to individual MA plans that are alternatives where they are and that are available. You know, it's a way for us to understand again how well retirees are being served by employer plans. You know, we don't have – I will say that we've had some – how should I put it – some problems with our mailbox, and so some of the data that was submitted, we've had to ask for it to be resubmitted, and we haven't entirely ironed all that out, so some of you may get calls yet to ask for resubmission, but I think we've gotten, at this point, a pretty high submission rate, so we're encouraged by that. And we hope to be able to share with you some results on this in the near future.

Okay. Now the other part of my talk that I want to go over with you a little bit, and I'll do this fairly quickly because I'm going to assume that a lot of you are pretty familiar with employer contracting, and what we're showing here are the Section 185(i) of the Social Security Act and 1860-22(B), which is right here, so these two authorities are what allows – statutory authority so they're very broad – and they've allowed CMS to be able to waive requirements, normal program requirements, in order to create the employer program. For example, the fundamental waiver, as you may know, individual plans have to enroll any Medicare beneficiary that's eligible in the service area, and obviously employer plans, the employer can enroll, open the plan specifically to their retirees, which is the heart of the employer contracting program. So these are the two key authorities for that.

Now another thing I want to mention is recently we did an update to Chapter 9, and this update primarily consisted of just adding in – we haven't done a lot of new waivers in the last couple, three years, but we did update Chapter 9 so that right now it contains all of the waivers that CMS, on the Part C side, has existed. I want to emphasize that the basic requirements of the Part C (inaudible) program haven't changed. I mean the first section of Chapter 9 describes the basic requirements underlying employer group contracting and basically is tying in the two sections of the Social Security Act (inaudible) and lays out the waivers we created to make it possible for employer only plans to exist. And the balance of Chapter 9 is really nothing more than a description of the waivers, a somewhat detailed description of the waivers that have been granted under that authority and describes the conditions in which they're available to eligible plans. And there is – I know Kathryn's working on an update to Chapter 12 that should be out there very soon.

Now in terms of educational pieces, hopefully most of you know this so I'll cover it fairly quickly, in the EGWP, in the Employer Group Waiver Program, there's two basic kinds of claims. There's the so-called 800 series EGWPs, and 800 series just refers to how we track them in our HPMS system, and again these are employer only plans that are offered by MAs and PDs organizations to employer and union groups. And there is also the option for direct contract. That is where an employer, a union, can come to CMS and directly contract with us, although the second option, direct contracting is little used. The great majority of EGWPs we have are ones that are offered through MAOs or PDPs to particular employer or union groups.

So here's a little terminology just because sometimes people get confused with this. When we're talking about Employer Group Waiver Plans, what we're really talking about is 800 series plans and direct contractor plans, and we say that because it was the 1857(i) and the 1860-D authority that allowed us – gave CMS the authority to create these plans that would be only available to retirees of a particular employer group. There is another category called Employer Group Health Plans. This has been around for a long time, and basically what that is is that an employer can essentially wrap around, they can take their retirees and they can negotiate with an individual in a plan and they can wrap around extra benefits. The waivers are limited for these plans. They don't have access to the same array of waivers that the 800 series or direct contracting does, but the waivers that are available identify them in Section 20 of Chapter 9.

An area that we've updated recently is there was some confusion about whether associations could participate in the Employer Group contracting program, and the answer is that being a member of an association is not sufficient. You know, basically the issue is it has to be an employment-based relationship with the association, it can't be just membership. So what we've done is we've described, clarified, the eligibility requirements for employer participation, and these are described in Section 30.1 of Chapter 9. And we also updated the regulation to reflect the importance of, again, if it's, you know, it could be –it's employer-based, employee-based participation with an employer or a member of a union which would qualify, and this is described in that CFR 422 106D(5).

This is fairly straightforward. Eligibility to join an employer group plan is the same as it is for individual Part C and D organizations or plans. For example, they have to reside in the service area of the plan. We haven't waived anything along those lines. The two exceptions for Part C are there's a waiver that allows for the enrollment of ESRD beneficiaries which is described in Section

30.3 of Chapter 9. And there's also a waiver to allow for the enrollment of Part B only beneficiaries described in Section 30.4 of Chapter 9.

Now an area where we do get a lot of questions is the fact that one of the unique features of employer group plans is that they have access to the group enrollment mechanism where they can enroll an entire group into an employer plan. And then the policies and procedures, which are important to pay attention to, are described for Parts C and D in Chapters 2 and 3, Section 40.61. So this is an important area for you to look at because it's an option that a lot of – it's a key option, really, to employer contracting.

And the last point I want to emphasize is when you, again, Chapter 9 describes sort of what we did to make the employer program exist and using their waivers, then it's a list a waivers, but other than those waivers, all the rules apply to employer plans as they do to individual MA plans, and in particular we won't waive, and I don't believe have waived, anything that would really represent a beneficiary protection or important right. For example, we had requests to waive both the maximum out-of-pocket amount in the cost sharing limits that apply to individual MA plans right now, and we wouldn't waive that because we think the reason we put those in place is they're important beneficiary protections and we saw no reason they shouldn't be available to retirees in employer plans. So to the extent you're not sure something applies, you really need to be able to put your finger on a specific waiver, and if it's not clear to you whether that's a waiver that you understand or whether it implies, it's incumbent on you to come to us and ask because, again, you really should be following the basic rules unless there's a specific, concise waiver and that you are permitted to use.

So with that overview, I'd like to turn it over to Kathryn for an overview of some Part D themes. Thank you.

Thanks, Marty.

I'm going to cover Part D and a few other issues, enrollment, slides, just some basic areas of information, but I'd like to start off with a Reg that we published on April 12, 2012, Part C and D final rule, with just the sections that affected EGWPs. And in this Reg we revised the definition of Part D Supplemental Benefits, which is found in 42 CFR 423.100, to specifically exclude – excuse me – to specifically exclude any coverage offered through EGWPs other than the basic Part D coverage. In tandem with this, we other defined other health or prescription drug coverage to include coverage offered through EGWPs other than basic Part D prescription drug coverage. These changes together mean, for the coverage gap discount program, that the manufacturer discount will be calculated before applying any other EGWP wraparound benefits aside from the basic Part D coverage.

The next other change that affected EGWPs in the Reg, Marty's already sort of touched on, but we wanted to underscore this that unless it is explicitly waived, EGWPs must follow the rules. And I guess some of the waivers, for instance not submitting plan benefit packages, sometimes if people aren't familiar with the rules they might think they could get other things waived, or even everything waived, but that's not the case. We do grant waivers. As Marty's noted we haven't done that in a while. And if we do grant a waiver, generally it applies to all EGWPs. And as Marty

suggested, we do have a list of granted waivers in the respective manuals, Prescription Drug Benefit Manual, Chapter 12, and the Medicare Managed Care Manual, Chapter 9, and just so you know there's going to be URL links to these citations. Also, on an ongoing basis we announce approved waivers through HPMS, so you might check there. And we are certainly aware of the unique operational and other issues that EGWPs are facing and we do accept waiver requests on an ongoing basis. And, again, both manuals have a list of the issues that we would like to see discussed when you're making your waiver request, and it includes, for instance, we'd like to see the cites, statutes, regs, guidance that are sort of informing your decision. And just as a couple of wrinkles, one of the things is we'd like to emphasize and understand what it is about the EGWPs because, again, this will apply to all EGWPs, that is different from other plans or, you know, health insurance setups that would merit different treatment. And the other thing we're interested in hearing is about the beneficiary protections, positive cost benefit analysis. You know, don't be coy if you think that there might be an effect that's perhaps not positive, but having said that, I would like to point out that we have appreciated the concerns that EGWPs have been voicing about transitioning from one plan to another, namely retiree drug subsidy plans being converted to EGWPs. We've seen some more of this planning in the future, which is perhaps not a surprise given the elimination of the RDS subsidy deduction which will be effective January 2013. And, again, in the future we do anticipate more RDS conversion to EGWPs.

Now we're going to talk about the past a little bit, just very briefly. The following series of slides cover enrollment numbers. And what you can see here is first this is for MA employers. You'll see that the about 20% of people in MA enrollment are in employer-related enrollment. For PDPs the chunk is a little bit smaller, 10% are in employer versus non-employer enrollment. And then here we have a couple of enrollment trends, and this slide, basically a trend is that they vary somewhat for Part C as opposed to Part D. And we can see for the total number of plans in the chart on the left has moved downward slightly to a current plateau for 2012. And the enrollment numbers for MA employer issues have rose slightly and then they dropped in 2012. In contrast, there has been a steady increase in the employer PDP enrollment. Who knows what the future holds.

Next I'd like to just cover – we have a slide here for the resources. Again we understand that a lot of you people do definitely understand what the current rules are, but for the people who are jumping into the EGWP waters for the first time, we would appreciate if you could check out the CMS guidance first. Again, we do welcome your inquiries, but, again, it's good to check out what we've got here before you contact us if you're not familiar with it so that you can sort of understand what some of the parameters are.

That slide had the MA resources. Here are the MA resources for the Part D section. And here are – here's email address for Marty Abeln and myself, and we welcome your inquiries and we thank you for your interest.

Next, before we move on to our next presenter, Amanda Johnson, who will be covering PD changes, I'd like to introduce Craig Meyer, the Deputy Director of the Part D Policy Division, and he has an announcement to make about the regulatory definition of Part D supplemental benefits.

Good afternoon, everyone. I feel like, you know, I should open up by saying that we interrupt your regularly scheduled planning for this important message. As Kathryn mentioned, in the final rule we published in April, we changed the definition of Part D supplemental benefits to explicitly

exclude supplemental benefits offered through EGWPs. And since publication of that time, we've received a number of questions and people have raised concerns that frankly we wish happened during rule making and not really sure why it didn't. But nonetheless, we've gotten a lot more questions since publication of that final rule. I'd say they fall into two buckets. One would be regulatory status. There's a lot of questions around, well, wait a second, if they're not Medicare benefits, how does ERISA apply to these benefits or does it? How does HIPAA apply? What about state laws and state requirements for filing? What about state insurance laws? So we've gotten those questions. I would say with respect to the questions around other federal laws, we are currently working on an FAQ with Socio to address – hopefully address – some of those questions. I really can't, you know, provide exactly what that's going to say, but with respect to kind of how these benefits would be treated under other federal laws, that is something we're actively working on an FAQ that hopefully would clarify some of that.

With respect to state requirements, obviously we can't speak to the state requirements and those questions about whether there's filing requirements and we don't have enough time to find out all the ins and outs of these requirements. So we understand that, and I can't really say, you know, the plans are going to have to figure out, if you will, what state requirements apply and what don't. One thing I did want to point out though because it was kind of in this line of state or other requirements was that there's concern with dual regulation and there's going to be all these conflicts. But actually we do think at a claims basis, not talking about, you know, whether you have to file benefits under state insurance laws that aren't Medicare benefits at all, but at a claims level, you know, now with the coverage gap being filled in next year at 2-1/2%, you know, there's no true donut hole or whatever, you know, we think almost all, if not all, claims really are going to be Part D claims, and we believe that therefore the Part D rules would apply, you know, with respect to appeals and grievances and things like that. That's at a claims level, though. Again, I'm not talking about whether, you know, somehow state filing requirements don't apply. Those folks' questions still need to be answered.

So with that said, we've gotten to this point where we, you know, there's still some unanswered policy questions around these regulatory things while we're working on guidance, and there's also these other issues that what we're going to do is delay implementation of this change to the definition of Part D supplemental benefits until 2014. What this means, again, is the definition, the new definition, that was issued in the final rule, explicitly excluded EGWP supplemental benefits. So what we're saying is that kind of we're going to delay that therefore the status quo remains. That means that EGWP benefits can be structured as enhanced alternative Medicare benefits, and those enhanced alternative Medicare benefits apply. That's how a lot of EGWPs are doing it today. Which also means the discount is calculated after those benefits are applied, not before. Or in the case where some plans have already restructured so that they're actually going to be providing supplemental benefits that are non-Medicare benefits, and they've already apparently figured out, you know, in the areas they work in, which, you know, they're advice and that about which laws apply and how they apply. They can go ahead and do that in 2013 as well, and in that case the discount gets calculated first and the benefits wrap around. I just want to make it clear, it's not like we've heard some people saying, that you can treat it like an EA plan for all reasons, except for the discount, then treat it as if you can calculate the discount beforehand and get the full discount ahead of wrapping around. So it's one or the other, but for 2013 the delay means that they can still be considered Medicare supplemental benefits.

The other thing I just want to say, there are a lot of technical questions that we heard during this process, too, that also factors into it. I think when these benefits are going to be considered other health insurance, OHI, you know, originally our OHI rules and some of our PD add everything rules designed around the fact that OHI was truly a separate payor, an unrelated payor, so that Part D paid, and then it goes over to OHI and those get recorded a certain way on PDs. This idea that, you know, the EGWPs really would be co-administering two separate benefits, really kind of – some questions have been raised whether those OHI rules should remain the same under those scenarios or apply the same way as they do when they're two totally separate unrelated payors. So those questions remain, and I think you'll look for the 2014 rate notice for us to kind of put those issues out there again so that we can get answers well ahead of 2014 implementation date. So I do want to make sure people understand we're not going to change the policy, we're going to, in a sense, change the applicable date of this change in definition from 1-1-13 to 1-1-14, but we are confirming the policy that, you know, beginning 1-1-14 all these supplemental benefits will be considered non-Medicare benefits.

I would just end by saying yes, we are working on written guidance to put this in guidance as quick as we can get it cleared, but I can't give you an exact timeframe when that will be.

So with that I'll turn it over to Amanda Johnson to go into some PDE discussions.

Thank you, Craig. As Craig mentioned, my name is Amanda Johnson. I'm representing the Division of Payment Reconciliation, which is in the Medicare Plan Payment Group. And within my division, our division functions as the business owner for the Drug Data Processing System and the Payment Reconciliation System. And we also produce the invoices for the Coverage Gap Discount Program and we'll be doing the reconciliation for that program as well. So Marty and Kathryn gave you more of a policy overview, whereas my talk is going to focus more on operations.

Before I jump into my presentation, I just want to reinforce that this presentation is not meant to replace any existing guidance or regulations that we have, and it also would not replace anything that's forthcoming. And also I want to make note that this presentation that you see right here supersedes the presentations that you might have seen previously posted for this conference.

So the purpose of today is to have a discussion with you all about PDE issues for employer group waiver plans. And since we are delaying the implementation of our policy change, we're just going to focus on what the existing instructions are, and it's just going to be a very high-level discussion, as we only have about 15 minutes to wrap this presentation up. And if you want more details about how to implement and report PDEs for EGWPs offering either EA or OHI, you can always refer to our previous regulations and guidance as well as our technical assistance training guides.

So we have two objectives for my part of the presentation, and one is to discuss current PDE reporting for EGWPs that are offering an enhanced alternative benefit. And the other objective is to discuss the current PDE reporting rules for EGWPs that have OHI. And keep in mind that although our topic here is EGWPs, the rules that we have are rules that apply to all plans. So, for example, if you have a non-EGWP plan that offers an enhanced alternative benefit, the same rules that I'm

discussing whenever we're talking about EGWPs in this presentation would apply to those plans as well. And the same with OHI.

So I'm going to jump into PDE reporting for EGWPs that offer the enhanced alternative benefit. And when we're reporting the values on the PDE, we're looking for the NPP field, which is the Non Plan Paid amount field on the PDE. And this field can only be reported whenever we're looking at the covered drugs, only enhanced alternative benefit plans can report in this NPP field. And it's field 39 on our PDE record layout, and if you look at the definition of what that field will contain, it is going to be the plan payment for enhanced alternative benefits. And that field is excluded from the Part D payment reconciliation with one exception, and that would be if an enhanced alternative benefit plan is submitting a plan-to-plan PDE for a low income beneficiary, and there is NPP, that amount does get included in the reconciliation. But just on your general non-plan-to-plan PDEs, NPP is excluded from reconciliation.

We have a calculation for how we report NPP, and this calculation has appeared in our training guide, if you've been to our technical assistance training for PDEs. And that calculation takes the sum of our payment fields, the patient pay amount, CPP, PLRO, other troop, LISC, and reported gap discount, and subtracts that from the gross covered drug cost. And those values for NPP can be positive, negative or zero. And if there's a positive value, that means that the benefit offered by the enhanced alternative plan is greater than the benefit under the defined standard. If the NPP value is zero, that means that the enhanced alternative plan is offering the same value as the defined standard. And if the amount is negative, then the plan would pay less than what is covered under the defined standard benefit.

So this is just a very simple PDE example. As I mentioned, you can always look at our previous guidance or our technical assistance guide where we could have numerous enhanced alternative examples for PDE reporting. In this example here, we have a beneficiary who purchases a \$100.00 drug in the initial coverage phase, and the co-pay for that drug is \$10.00. And in the initial coverage phase we know with the defined standard benefit the beneficiary would pay 25% and the plan would pay 75%. In this case the beneficiary's co-pay is \$10.00, so we would put \$10.00 in the patient pay amount field. We map our CPP to the defined standard, so that would still be 75%, in this case it would be \$75.00, and then to determine our NPP, we would take \$100.00 minus the sum of our \$10.00 and our \$75.00 to come up with our \$15.00 NPP.

Now I want to talk about how you would report the PDE if there is OHI. And there are two types of OHI. There is the troop eligible or non-troop eligible OHI. And for this presentation we're going to focus on OHI in the case where it is not troop eligible. And in that instance, the amount is recorded in the patient liability reduction due to other payor amount field on the PDE, and this is Field 37 on the PDE record layout. And that definition for that field is it is going to be the dollar amount that is paid by entities that reduce the patient liability or cost but do not count as true. And the calculation for this field is to take the original patient pay amount and subtract out the patient pay amount reported by the OHI.

So we have a general approach for how you would report PDEs with OHI. First you want to see what the beneficiary cost sharing and the plan cost sharing would be under the defined standard benefit. Second, then, you would want to determine what the beneficiary would pay under the OHI.

Once you have that information, then you can do your calculation for PLRO. You have your original patient pay, you subtract out your OHI patient pay, and that amount is reported as PLRO. Then you want to update the patient pay amount to reflect the change in cost sharing, and then also you want to determine the troop amount.

So I'm going to walk through two examples, and, again, these are just very basic examples to show you how this works. Again, the drug is going to be a \$100.00 drug. In the initial coverage phase we know that the patient would pay \$25.00 and the plan would pay \$75.00 in the defined standard benefit. In this example, under the OHI the beneficiary would pay \$10.00. So we have \$25.00 as the original patient pay, \$10.00 as the OHI patient pay, which then results in a \$15.00 PLRO. So the patient now pays \$10.00 as opposed to the \$25.00 that they would pay under the defined standard, and the troop amount for this PDE is \$10.00.

And this slide is just showing you a few of the fields on our PDE record layout just to show you how they would be populated for this particular example.

In the next example, we're going to have the same scenario. The \$100.00 drug. The difference here is under the OHI the beneficiary would pay \$30.00. So when we're doing our PLRO calculation, we take our \$25.00, subtract out \$30.00, we come up with negative \$5.00, and the patient would pay \$30.00 and the troop amount for this PDE would be \$30.00.

And again this is just a very brief summary of what the PDE fields would look like for this particular example.

Now the last concept that I want to cover is how to populate the PDEs for the coverage gap. And we released six steps in our July 9, 2010 Guidance where we first released instructions for how to report PDEs for the coverage gap discount. So I'm going to walk through those steps. We also provided you with a four-step approach in the 2013 Advance Notice, and that approach provides you with more detail in how to calculate the manufacturer, the beneficiary, and the plan liabilities for 2013 going forward. So the way I look at that four-step approach is it just expands on our existing six-step approach that we released initially, so I'm going to walk through those steps so you can understand how that four-step approach fits into this approach.

For the first step we want to determine what costs fall within the coverage gap. And the next step is determining what our discount eligible cost is, keeping in mind that any supplemental benefits would apply before determining the discount eligible cost. Our discount eligible cost would exclude the vaccine admin fees as well as the dispensing fees. Our next step, then, is calculating the gap discount, which would be that manufacturer liability that you would be calculating whenever – in step one of our four-step approach.

When we look at our next step, we're determining beneficiary cost sharing. And OHI would apply after the gap discount is applied. And in this case, if we're looking at that four-step approach, steps two and three talk about how to calculate out the beneficiary cost sharing, so our step four is kind of broken out into two different steps to calculate out beneficiary cost sharing.

*FALL 2012 CMS CONFERENCE*

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And keep in mind that the current policy of placing the dispensing fee and the vaccine admin fee outside of the coverage gap when possible will remain in effect in 2013. In our 2013 Final Rate Notice, we announced that we were changing our existing policy with respect to how the dispensing fee is calculated on claims that straddle the coverage gap and for coverage gap claims with reduced cost sharing under EA plans. We are going to revisit this issue in our 2014 Rate Notice to provide the industry with another opportunity to comment on this change.

When you look at step five of our six-step process where we're calculating the covered and the non-covered portion of plan paid cost sharing, this would be that step four that we discussed in our four-step approach in the 2013 Advance Notice.

And our last step is to update the gross covered drug cost accumulator and the troop accumulator in preparation for the next PDE coming in.

And that is just a brief summary of how we report PDEs for EGWPs that offer either the EA plan or OHIs, and it looks like we do have some time for questions, so you can feel free to ask any questions. And I don't have my contact information up here, but I can give that to you in case we run out of time or questions come up later. My email address is amanda, A - M - A - N - D - A, dot johnson, J - O - H - N - S - O - N, at cms dot hhs dot gov. We also monitor a PDE mailbox, and that might be the best place to submit your questions, and that is pdejan, which is J - A - N, 2011 at cms dot hms dot gov.

Thank you.