

Medicare Advantage Benefits Snapshot

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2010 Division of Finance and Benefits Activities

- Duplicative and Low Enrollment Plans (April – May 2009)
- Bid Review (June – August 2009)
- Plan Corrections (September 2009)

Reducing Low Enrollment and Duplicative Plan Offerings for 2010

- CMS' objective was to reduce the number of multiple and low enrollment plans
- A large number of plan options can make it confusing for beneficiaries to evaluate and choose the best option
- Low Enrollment Plans:
 - ❖ Plans with 100 or fewer enrollees that have been in existence for two or more years
- Duplicative Plan Options:
 - ❖ More than 3 plans of the same type are located within an identical service area

CMS and Plans Worked Together in Reducing Beneficiary Confusion

- About 400 low enrollment and/or duplicative plans (12% of total plans) did not submit bids for 2010
- About 65% of the 400 plans were considered low enrollment
- CMS made allowances to ensure beneficiary access to MA plans (e.g., made exceptions in situations where no other MA plans were available)

CMS Cost Sharing Review for 2010 Plans

- CMS reviewed bids to ensure cost sharing amounts and benefit designs did not discriminate against beneficiaries, or steer them, on the basis of health status
- Communicated benefit design expectations to plans through 2010 Call Letter
- Compared bid cost sharing amounts with Medicare FFS and other MA plans once bids were submitted

CMS Cost Sharing Review for 2010 Plans (continued)

- Established standards for discriminatory cost sharing:
 - Actuarial Equivalence for specific service categories
 - Utilization Scenarios and Medicare FFS levels defined in 2010 Call Letter
- Contacted all plans not meeting standards to explain process for revising bids to conform with requirements

Plans with a Qualifying MOOP Received Greater Flexibility in Cost Sharing Standards

- Qualifying maximum out-of-pocket (MOOP) for CY2010 is $\leq \$3,400$
- Beneficiary access to plans with a MOOP is nearly 100%
- Percent of MA plans with a qualifying MOOP will grow from 29% in 2009 to 39% in 2010
- MA plan enrollees with a qualifying MOOP is projected to grow from 21% in 2009 to 31% in 2010

CMS Cost Sharing Standards for 2010

Category	Non-Qualifying MOOP Standards	Qualifying MOOP Standards
Inpatient Catastrophic (90 Days)	\$9,078.00	N/A
Inpatient Short Stay (10 Days)	\$1,752.00	N/A
Inpatient Mental Health (15 Days)	\$1,954.00	\$2,500.00
SNF (42 Days)	\$2,944.00	\$3,384.00
Home Health (37 Days)	\$ 0.00	\$1,014.00
Physician Mental Health Visit	\$ 43.50	N/A
Renal Dialysis (156 visits)	\$4,180.80	\$4,180.80
Part B Drugs-Chemo	20% / \$100	N/A
Part B Drugs-Radiation	20% / \$100	N/A
Part B Drugs	20% / \$100	20% / \$100
DME-Equipment	20%/\$100	N/A
DME-Prosthetics	20%/\$100	N/A
DME-Supplies	20%/\$20	N/A
DME-Diabetes Test	20%/\$20	N/A

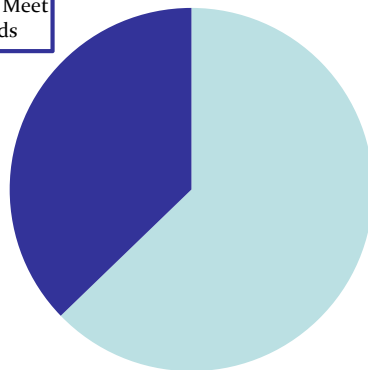
CMS and Plans Worked Together to Meet CY 2010 Cost Sharing Standards

- For 2010, CMS identified 1,092 plans with outlier cost sharing levels above CMS standards based on initial bid submissions; and all plans were required to modify bids to comply with CMS standards
- About 4.3 million enrollees will benefit from the reduction of outlier cost sharing

Medicare Advantage Plans
(2,932 Plans)

Plans Requiring
Changes to Meet
Standards

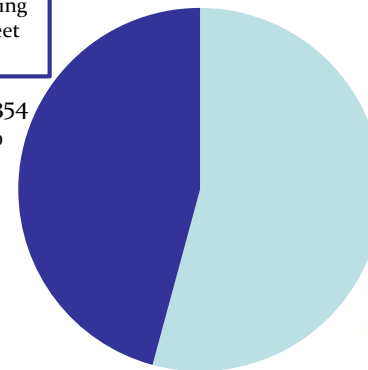
1,092
37%



Medicare Advantage Enrollees
(9,458,288 Enrollees)

Beneficiaries Enrolled
in Plans Requiring
Changes to Meet
Standards

4,331,354
46%



Plan Corrections

- Accurate marketing materials depend on an accurate PBP, therefore it is extremely important that your PBP submission is accurate and complete
- A request for a plan correction:
 - Indicates the presence of inaccuracies and/or the incompleteness of the bid
 - Calls into question an organization's ability to submit a correct bid and the validity of the of the info submitted in the bid
- MAOs requesting a plan correction in CY 2010 are receiving corrective action warning letters
- Current number of plan corrections to date are 131, compared with 530 plan corrections for CY 2009 and 1,709 from 2008

Ongoing Efforts to Reduce Beneficiary Confusion in 2011

- Continuing to focus on reducing beneficiary confusion
- Currently analyzing marketplace data regarding:
 - Plans where low enrollment would not be expected
 - Duplicative offerings by geographic area
- Specific populations served, geographic location, and other factors will be considered for low enrollment plans
- Overall value of A/B and supplemental benefits, presence of Part D benefit, and other factors will be considered for duplicative offerings
- CMS will communicate with plans (e.g., Call Letter, outreach calls)

Benefits Policy Considerations for 2011

- Evaluate and consider integration of health status data into cost sharing reviews
- Policy considerations
- Review Chapter 4 Benefits Manual to understand policy issues