



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE

Sheraton Baltimore City Hotel, April 20-21, 2010

Verbatim Transcript

Tuesday PM Panel

Part 1

THE FIRST QUESTION
RELATES TO

WHAT POLICY OR
GUIDANCE IS THERE

FOR 2011 PART "D"
COVERAGE REGARDING

THE 7% OF GENERIC
DRUGS TO BE COVERED

THROUGH THE GAP,

AND YOU CAN FIND
GUIDANCE TO THIS

IN THE MEMO THAT I MENTIONED
IN MY PRESENTATION

THAT WAS POSTED
ON FRIDAY, APRIL 16.

THIS IS THE 2011 PART "D"
PLAN BENEFIT PACKAGE SUBMISSION REVIEW

INSTRUCTIONS MEMORANDUM.

AND THE SECOND PART
OF THIS QUESTION IS

DOES THIS APPLY TO
GHP PLANS?

YES, IT DOES.

THE SECOND QUESTION RELATES
TO LOW ENROLLMENT,

AND I THINK IT'S ASKING
TO CLARI--SORRY.

I THINK IT'S ASKING TO
CLARIFY WHETHER OR NOT

WE MEAN AT THE PBP LEVEL,

AND, YES, WE WILL USE
OUR AUTHORITY

TO NONRENEW PLANS
AT THE BENEFIT PACKAGE LEVEL

OR THE PBP LEVEL
THAT DO NOT MEET

MINIMUM ENROLLMENT
THRESHOLDS.

THIRD QUESTION IS REGARDING
THE EXPECTATION

FOR TWO ENHANCED
ALTERNATIVE PLANS

IN THE SAME SERVICE AREA,

THAT THEY MUST COVER
AT LEAST SOME BRAND DRUGS

IN THE GAP,

AND THE PERSON IS ASKING
WHETHER OR NOT

CMS WOULD CONSIDER
WAIVING THIS PROVISION

DUE TO THE RELEASE DATE
BECAUSE OF THE CREATION

OF THE FORMULARIES,

WHICH HAD TO BE
SUBMITTED YESTERDAY.

I'M NOT SURE WHAT THE PLAN
WOULD HAVE DONE DIFFERENTLY

ON THE FORMULARY
SUBMISSIONS

AND HOW THAT WOULD AFFECT
THEIR ABILITY

TO COVER BRANDS

IN THE GAP.

SO, UM, PERHAPS
IF THAT INDIVIDUAL

WOULD LIKE TO E-MAIL A QUESTION
TO THE PART "D" MAILBOX

WITH A LITTLE
MORE CLARIFICATION,

THAT WOULD BE HELPFUL.

THERE'S A QUESTION HERE
ABOUT THE 50% BRANDS

COVERED IN THE GAP,

WHICH THERE IS GUIDANCE
FORTHCOMING ON THIS,

BUT THAT'S ABOUT AS MUCH
AS I CAN SAY,

AND AGAIN, IF YOU READ
OUR BENEFITS MEMO,

IT DOES MENTION THAT
GUIDANCE IS FORTHCOMING

REGARDING THIS NEW BENEFIT.

THERE'S A FORMULARY
QUESTION IN HERE

THAT I'M GOING TO HAVE
THE FORMULARY TEAM ANSWER

THROUGH THE PART "D"
FORMULARIES MAILBOX,

AND LASTLY, THERE IS
A QUESTION REGARDING BENZODIAZEPINES

AND WHETHER OR NOT
THEY'RE SUBJECT

TO A COVERAGE
DETERMINATION REQUEST.

IF MEDICAL NECESSITY
IS ESTABLISHED,

IS IT OK TO COVER THEM?

AND THE ANSWER IS
YOU MAY ONLY COVER

EXCLUDED DRUGS THROUGH
A SUPPLEMENTAL BENEFIT

OF ENHANCED ALTERNATIVE PLAN.

THESE DRUGS ARE NOT
CONSIDERED PART "D" DRUGS,

SO THERE WOULD BE
NO FORMULARY EXCEPTIONS

TO BE ABLE TO COVER
THESE DRUGS UNDER PART "D".

AND THAT'S IT FOR ME.

AND I'LL RUN THROUGH
A FEW HERE, TOO.

THE FIRST QUESTION IS, UH...

THE ISSUE OF WHETHER
IN 2010 THE NONRENEWAL

OF SNPs BASED
ON LOW ENROLLMENT

WILL APPLY,
OR IS IT SOMETHING

THAT WILL KICK IN
IN 2011,

AND THE ANSWER THERE IS
IT WILL BE A 2011 REQUIREMENT.

OK. AND ANOTHER QUESTION
IS "WILL THERE BE

"STANDARDIZED LANGUAGE
IN THE SB REGARDING

THE MAXIMUM
OUT-OF-POCKET MAXIMUM?"

AND THE ANSWER TO THAT
IS, YES, IT WILL BE THE SAME LANGUAGE

AS FOR THE VOLUNTARY MOOP
FOR 2010,

SO IN OTHER WORDS,
THERE WILL BE THE CHOICE

OF HAVING THE MANDATORY
OR THE VOLUNTARY MOOP,

BUT THE LANGUAGE
WILL BE THERE.

OK. THEN ANOTHER QUESTION HERE
IS, "CAN PLANS OFFER

"A VISITOR/TRAVELER BENEFIT
WHICH IS LIMITED TO 6 MONTHS,

OR MUST IT COVER
7-12 MONTHS?"

WELL, THE ANSWER IS
YOU CERTAINLY COULD OFFER

A VISITOR/TRAVELER BENEFIT
THAT COVERED--

AVAILABLE TO SOMEONE
WHEN THEY'RE OUT

OF THE SERVICE AREA
FOR 6 MONTHS,

BUT IF YOUR INTENT
IS TO RETAIN PEOPLE

WHO ARE OUT
UP TO 12 MONTHS,

THEN YOU WOULD HAVE TO
HAVE A VISITOR/TRAVELER BENEFIT

AVAILABLE IN THAT AREA
SO THAT THEY COULD GET

THE FULL BENEFIT PACKAGE
FOR THAT 12-MONTH PERIOD.

OK. AND ANOTHER GOOD QUESTION
IS "EXEMPLIN WHY REGIONAL PPOs

"ARE EXEMPTED FROM
THE MANDATORY MOOP

"AND OUR PPOs ARE SUBJECT
TO THE MOOP

"AND CATASTROPHIC REQUIREMENTS

ALREADY UNDER 422.101
AND SO FORTH."

WELL, THE REGIONAL PPOs,
THAT CAME BACK WHEN--

SOME YEARS AGO
WHEN WE PASSED MIPPA,

THE CONGRESS PUT IN PLACE
THAT REGIONAL PPOs

HAD TO HAVE
AN IN-NETWORK CAP

WITH PREFERRED PROVIDERS

AND THEN AN OVERALL
CATASTROPHIC CAP

THAT WAS INCLUSIVE
OF IN-NETWORK PROVIDERS

AND OUT-OF-NETWORK
PROVIDERS.

THE DIFFERENCE WAS
WHEN THEY DRAFTED THAT LEGISLATION

THEY ALLOWED THE REGIONAL
PPOs THE DISCRETION

TO SET THOSE AMOUNTS,

YOU KNOW, BOTH
THE CATASTROPHIC

AND THE IN-NETWORK MOOP,

AND AS I EXPLAINED EARLIER,
IT'S OUR INTENTION

TO STRONGLY ENCOURAGE
REGIONAL PPOs

FOR COMPETITIVE REASONS
AND LEVEL PLAYING FIELD REASONS

TO ADOPT THE MANDATORY
MOOP THAT WILL APPLY TO LOCAL PPOs.

AND IT'S ALSO POSSIBLE
THAT WE'LL ENGAGE

IN RULE-MAKING
TO REQUIRE THAT,

BUT RIGHT NOW,
I THINK WE'RE GONNA SEE--

WELL, WE DEFINITELY
WILL SEE WHAT WILL HAPPEN IN 2011

BASED ON DECISIONS
OF THE INDUSTRY.

UM, THEN A QUESTION ABOUT
THE VISITOR/TRAVELER PROGRAM.

"FOR 2010, PLANS WERE
ALLOWED TO OFFER A VT PROGRAM

"BUT ONLY AS AN OPTIONAL
SUPPLEMENTAL BENEFIT.

"WITH THE 2011 CHANGES,
ARE PLANS NOW ABLE

"TO OFFER
A VISITOR/TRAVEL BENEFIT

AS A MANDATORY SUPPLEMENTAL?"

AND I THINK OUR ANSWER
TO THAT IS WE THINK

THE VISITOR/TRAVELER BENEFIT
SHOULD BE

AN OPTIONAL
SUPPLEMENTAL BENEFIT,

AND THE REASONING
FOR THAT IS THAT--

TO GO BACK TO MY
EARLIER EXAMPLE,

IF YOU'RE A PLAN BASED
IN, SAY, IN MINNESOTA

OR NORTH DAKOTA
OR SUCH SOME PLACE

AND YOU WANT TO OFFER

SNOWBIRDS A CHANCE

TO STAY IN YOUR PLAN
WHEN THEY'RE GONE

FOR AN EXTENDED AREA,
I MEAN, WE CERTAINLY

THINK THAT'S FINE,
BUT WE THINK IT WOULD BE

DISCRIMINATORY AGAINST
THOSE INDIVIDUALS

WHO ARE EITHER LOWER INCOME
OR THEIR HEALTH STATUS

MADE IT DIFFICULT
FOR THEM TO TRAVEL.

SO AT THIS POINT,
OUR VIEW IS

THAT IF YOU OFFER
VISITOR/TRAVELER

IT SHOULD BE AN OPTIONAL
SUPPLEMENTAL BENEFIT.

OK. AND, UM...

OH. A QUESTION ABOUT
WHETHER THE MOOP

APPLIES FOR EMPLOYER PLANS,
SO-CALLED 800-SERIES PLANS,

800--EMPLOYER-ONLY PLANS,

AND IF PLANS REQUEST
A WAIVER,

IS IT POSSIBLE THAT
THERE WOULD BE A WAIVER FOR EMPLOYER PLANS?

AND THE ANSWER IS
WITH EMPLOYER PLANS

AND 800-SERIES PLANS,
THEY ARE SUBJECT

TO ALL THE REQUIREMENTS
THAT APPLY TO ANY

INDIVIDUAL PLAN.

OUR UNDERGIRDING PRINCIPLE
THERE IS THAT THESE RETIREES

WHO WORK FOR AN EMPLOYER
ARE MEDICARE BENEFICIARIES,

AND THE MAO IS RECEIVING
A FULL CAPITATION PAYMENT

FOR THESE PEOPLE JUST
AS THOUGH THEY WERE IN AN INDIVIDUAL PLAN,

SO IT'S OF CONCERN TO US
THAT THEY RECEIVE

ALL OF THE NOTIFICATIONS.

THERE ARE SOME WAIVERS
THAT ALLOW NOTIFICATIONS

TO BE OFF CALENDAR YEAR
AND TO BE MODIFIED,

BUT WE BELIEVE THEY
SHOULD RECEIVE

ALL NOTIFICATIONS
AND HAVE THE SAME SORT

OF PROTECTIONS THAT ARE
AVAILABLE TO INDIVIDUALS

IN NONEMPLOYER PLANS.

SO THE ANSWER WOULD BE
THAT THE 800--

THE WAIVER--THE REQUIREMENT
TO OFFER A MOOP

DOES NOT APPLY
TO 800-SERIES PLANS.

HOWEVER, AS ALWAYS,
A WAIVER CAN BE REQUESTED,

AND WE WOULD LOOK
AT THESE WAIVERS

BASICALLY TO THE EXTENT
THAT THEY'RE IN THE INTEREST

OF THE BENEFICIARIES
AND THAT THEY DON'T

DETRACT FROM AN IMPORTANT
BENEFICIARY PROTECTION

THAT SOMEONE IN AN INDIVIDUAL,
NONEMPLOYER PLAN WOULD HAVE.

OK. THANK YOU.

Part 2

I HAVE A FEW QUESTIONS
HERE, AS WELL.

FIRST QUESTION IS CAN
THERE BE A MOOP AMOUNT

BETWEEN THE MANDATORY
AND VOLUNTARY AMOUNT?

AND THE ANSWER TO THAT
WOULD BE YES.

HOWEVER, IN THAT SITUATION,
THE COST-SHARING STANDARDS

FOR THE MANDATORY MOOP
WOULD APPLY.

THEORETICALLY, THERE
COULD BE A SITUATION

WHERE THERE IS ZERO-DOLLAR
MAXIMUM OUT-OF-POCKET,

AND IT COULD BE ANYWHERE
FROM \$0.00 TO \$3,400,

AND THE \$3,400 COST-SHARING
STANDARDS WOULD APPLY

IN THAT SITUATION.

IF THE MOOP AMOUNT
IS BETWEEN \$3,401 AND \$6,699--

OR \$6,700 I SHOULD SAY,

THAT'S WHEN THE MANDATORY
MOOP AMOUNTS WOULD APPLY--

MANDATORY COST-SHARING
THRESHOLDS WOULD APPLY

TO THOSE MOOP AMOUNTS.

WILL A PART "C" OTC BENEFIT
CONTINUE TO BE ALLOWED FOR 2011?

THE ANSWER TO THAT IS YES.

I THINK THERE'S MORE GUIDANCE
TO THAT, ALSO,

IN CHAPTER 4
OF THE "MANAGED CARE MANUAL."

WE HAVE A QUESTION
ABOUT SUBMITTING QUESTIONS

TO THE MA BENEFITS MAILBOX,

AND I HAD MENTIONED BEFORE
THAT WE DO WANT TO MAKE SURE

THAT WE PROVIDE
CONSISTENT ANSWERS

AND COMPLETE
AND ACCURATE ANSWERS.

WE HAVE A QUESTION
ABOUT WHETHER OR NOT

IT'S POSSIBLE TO,
AT SOME POINT,

PUT SOME FREQUENTLY
ASKED QUESTIONS AND ANSWERS

UP ON A WEB SITE OR MAKE
THOSE AVAILABLE TO PLANS?

I WILL SAY
TO THE EXTENT POSSIBLE,

THE ANSWER TO THAT IS YES.

SO WE'LL LOOK INTO THAT
AND SEE IF WE CAN WORK THROUGH THAT.

SOMETIMES, THERE'S
A LOT OF MOVING PARTS,

AND WE WOULD NEED TO GO

THROUGH CLEARANCE CERTAINLY,

BUT WE'LL CERTAINLY
LOOK INTO THAT.

THERE'S A QUESTION
ABOUT THE OUTPATIENT PSYCHIATRIC CO-PAYMENT

OR CO-INSURANCE.

ACTUALLY, A COUPLE
OF QUESTIONS ON THIS ISSUE.

IN THE COST-SHARING STANDARDS,
IT STATES THAT IT NEEDS

TO BE NO GREATER
THAN ORIGINAL MEDICARE,

AND IF YOU LOOK
ON PAGE 16 OF THE BENEFITS

AND OPERATIONAL GUIDANCE
THAT WENT OUT THIS PAST FRIDAY,

THERE'S ACTUALLY
A FEW PARAGRAPHS OR LANGUAGE

ANSWERING THIS QUESTION.

FOR 2011, I BELIEVE
THE ORIGINAL MEDICARE COINSURANCE IS 45%,

BUT AS WE WENT THROUGH
IN THE PRESENTATION,

THERE'S ALSO THE OPPORTUNITY
TO USE A \$40 CO-PAYMENT

OR SOMETHING LESS THAN THAT

TO MEET THAT
COST-SHARING STANDARD.

WE HAD SEVERAL QUESTIONS
ABOUT WHETHER OR NOT

THE MOOP APPLIES
TO ADDITIONAL BENEFITS

OR SUPPLEMENTAL BENEFITS.

THE ANSWER TO THAT IS YES,

OR IT CAN APPLY
TO THOSE BENEFITS.

THERE WERE SEVERAL QUESTIONS,
AND SOME OF THEM GOT

INTO SOME DETAILS
ABOUT HOW TO MAKE THAT

HAPPEN IN THE PBP.

I GUESS WHAT I WOULD
RECOMMEND IS

AS FAR AS HOW TO
EXECUTE THAT IN THE PBP

IT MIGHT BE GOOD
TO SUBMIT THOSE QUESTIONS

TO THE MAILBOX

SO THAT WE CAN MAKE SURE
WE GIVE YOU THE GUIDANCE

THAT'S ON TARGET
FOR YOUR SITUATION.

THERE'S ALSO A QUESTION
ABOUT PREVENTIVE SERVICES.

CAN A PLAN CHARGE
\$0.00 CO-PAY FOR OFFICE

AND SORT
OF OUTPATIENT SETTINGS

BUT IN AN INPATIENT BASIS?

HOW'S THAT DEALT WITH?

ESSENTIALLY, IN SITUATIONS
WHERE SOMETHING IS CONDUCTED

ON AN INPATIENT BASIS,
IT'S COVERED

BY THE INPATIENT BENEFIT.

AND ONE THING THAT I'D LIKE
TO MAKE A COMMENT ABOUT, TOO,

AS FAR AS THE MA MAILBOX.

WHEN YOU'RE SUBMITTING
QUESTIONS ABOUT PART "C,"

PLEASE DO SEND THAT
TO THE MA BENEFITS MAILBOX,

BUT ALSO BE AWARE THAT
IF YOU HAVE A QUESTION

DEALING DIRECTLY
WITH A PART "D" BENEFIT,

AS IN THE DRUG BENEFIT,
I BELIEVE PART "D"

ALSO HAS A MAILBOX THAT YOU
COULD SEND THOSE QUESTIONS TO.

I REALIZE THAT CAN BE--
IT WOULD BE NICE

IF YOU COULD GO
TO ONE MAILBOX,

BUT WE'RE IN A SITUATION
WHERE IN ORDER TO RESPOND

TO YOU ACCURATELY,
THE PART "C" FOLKS

WILL BE DEALING
WITH THE MEDICAL BENEFITS

ASPECT OF IT,
AND THE PART "D" FOLKS

WILL ADDRESS YOUR
PART "D" QUESTIONS.

THANKS.

OK. UM, AND FOR
THE QUESTIONS I RECEIVED,

THE ONES THAT, I GUESS,
MAKE THE MOST SENSE

TO DISCUSS
IN A LARGER AUDIENCE.

I THINK SOME CLARIFICATION
IS NEEDED REGARDING THE SNPs

AND WHAT AND WHAT YOU

CANNOT OFFER FOR 2011.

WHEN I INDICATED THAT
YOU COULD NOT CREATE NEW

ALL-DUAL, FULL-DUAL,
OR ZERO-DOLLAR COST SHARE,

THAT IS STILL TRUE,
BUT YOU CAN CREATE

NEW MEDICAID SUBSET SNPs,

AND I SUSPECT SOME OF YOU
HAVE APPLIED FOR THOSE

FOR THIS UPCOMING YEAR.

SO THERE ARE TWO TYPES
OF MEDICAID SUBSET SNPs,

AND THAT'S MEDICAID
SUBSET ZERO-DOLLAR COST SHARE

AND MEDICAID SUBSET
NON-ZERO-DOLLAR COST SHARE,

AND THOSE TWO SNP TYPES--

DUAL-ELIGIBLE SNP TYPES
I SHOULD SAY--

ARE STILL ALLOWED
TO BE CREATED

AS A NEW PLAN FOR 2011,

BUT THE GUIDANCE
STILL HOLDS TRUE

THAT THE ALL-DUAL,
FULL-DUAL, AND ZERO-DOLLAR

COST SHARE DUAL-ELIGIBLE SNPs
YOU WILL NOT BE ABLE

TO CREATE NEW PLANS
IN 2011 FOR THOSE.