



**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.