



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE

Sheraton Baltimore City Hotel, April 20-21, 2010

Verbatim Transcript

Medicare Advantage Benefits Policy and Implementation for Contract Year 2011

Part 1

MY NAME IS CHRIS McCLINTICK,
AND I'M A POLICY TEAM LEAD

IN THE MEDICARE ADVANTAGE
GROUP, DIVISION OF POLICY.

AND I'M GOING TO BE
TALKING ABOUT BENEFITS POLICY

AND IMPLEMENTATION WITH
MY COLLEAGUES TODAY--

MARTY ABELN, ALSO IN THE POLICY
DIVISION, AND DALE SUMMERS,

WHO IS IN THE DIVISION OF
FINANCE AND BENEFITS--

AND WE'RE REALLY
LOOKING FORWARD TO THIS.

THERE ARE A COUPLE OF
PROVISIONS, I THINK,

IN THE REGULATION THAT ARE
REALLY EXCITING FOR US

AS POLICY AND
IMPLEMENTATION FOLKS.

AND THE 2 THAT I'M GONNA
TALK ABOUT HAVE TO DO WITH

MEANINGFUL DIFFERENCES
OR DUPLICATIVE BIDS,

WHATEVER YOU WANT TO
CALL IT--BOTH OF THOSE
TERMS HAVE BEEN USED--

AND I'LL GO INTO KIND OF

THE CONTEXT AND BASES

FOR THAT PROVISION, AS WELL AS
ANOTHER ONE HAVING TO DO WITH

LOW ENROLLMENT, WHICH IS
KIND OF SIMILAR IN THAT,

YOU KNOW, IT WILL ULTIMATELY
RESULT IN REDUCING PLANS

AND WILL MAKE IT LESS CONFUSING
FOR BENEFICIARIES

WHILE STILL ENSURING
WHAT WE ALL WANT,

AND THAT IS BENEFICIARY CHOICE.

BUT I WILL TALK
ABOUT THAT, AS WELL,

AND THE BASES AND
CONTEXT FOR THAT.

AND DALE WILL FOLLOW UP
AND TALK ABOUT REALLY

WHERE THE RUBBER MEETS THE ROAD
ON THAT, THE IMPLEMENTATION,

AND THEN MARTY WILL ALSO TALK
ABOUT SOME OTHER POLICY ISSUES

THAT ARE VERY IMPORTANT,
SUCH AS COST-SHARING.

AND, AGAIN, THIS WILL JUST
BE AN OVERVIEW OF THE BASES.

I'M GONNA TALK ABOUT
THE PART "C" PROVISIONS.

THAT'S WHAT I KNOW BEST, AND SO
I'M GONNA GO WITH WHAT I KNOW.

A COUPLE OF FOLKS TODAY
HAVE ALREADY TALKED ABOUT

THE PART "D" PROVISIONS
IN CONNECTION WITH THEIR--

WITH MEANINGFUL DIFFERENCES
IN LOW ENROLLMENT.

AND, ALSO, WE CAN TAKE
QUESTIONS AT THE PANEL

THAT I THINK STARTS
AT 4:15 OR SO,

BUT I WILL BE SPEAKING
PARTICULARLY ON PART "C" HERE.

SO TO GO TO THE ACTUAL
REGULATORY PROVISIONS,

WITH RESPECT TO MEANINGFUL
DIFFERENCES, THIS AFFECTS

BOTH THE BID SUBMISSION
AND THE BID REVIEW REQUIREMENTS

IN THE MA PROGRAM REGULATIONS.

AND THE BID REVIEW REGULATORY
LANGUAGE ACTUALLY STATES THAT

CMS WILL APPROVE A BID ONLY
IF IT FINDS THAT THE BENEFIT

PACKAGE AND PLAN COST
REPRESENTED BY THAT BID

ARE SUBSTANTIALLY DIFFERENT
FROM THE MA ORGANIZATION'S

OTHER BID SUBMISSIONS.

IN ORDER TO BE CONSIDERED
SUBSTANTIALLY DIFFERENT,

EACH BID MUST BE SIGNIFICANTLY
DIFFERENT FROM OTHER PLANS

OF ITS PLAN TYPE
WITH RESPECT TO PREMIUMS,

BENEFITS, OR
COST-SHARING STRUCTURE.

THAT IS, OF COURSE,
THE GENERAL REGULATORY LANGUAGE,

AND, AGAIN, WHERE THE RUBBER
REALLY MEETS THE ROAD ON THIS

WILL BE IN THE GUIDANCE.

SOME OF THAT IS IN THE
REGULATION, OTHER INFORMATION

IS IN THE BENEFITS MEMO
THAT WAS RECENTLY RELEASED

ON THE 16th, I BELIEVE,
AND, AGAIN, DALE WILL TALK
PRIMARILY TO THAT.

AND I'M NOT GONNA GET
INTO IT OTHER THAN TO SAY

FAIRLY GENERALLY THAT, YOU KNOW,
WE'RE TALKING ABOUT

COST-SHARING, STRUCTURE,
AND BENEFITS.

BY THAT, WE HAVE LEFT
OPEN THE POSSIBILITY OF
LOOKING AT PREMIUMS.

I DON'T THINK WE
DO THAT AT THIS TIME.

DALE CAN CORRECT ME IF I'M WRONG
WHEN HE GIVES HIS PRESENTATION.

BUT WE DO HAVE SOME LEEWAY
AND SOME FLEXIBILITY

IN HOW WE'RE GOING TO IMPLEMENT
THESE, AND AS A RESULT,

GUIDANCE, TOO, WILL BE CHANGING
ANNUALLY, AND WE ALL KNOW

IT'S VERY IMPORTANT TO GET THAT
OUT BEFORE THE BID INFORMATION.

WE WILL TALK ABOUT THAT.

I THINK ONE OF THE THINGS WE ALL
HOPE TO DO--YOU WANT TO DO IT,

WE WANT TO DO IT, AS WELL--IS
TO AVOID THESE BIDS BEFORE THEY

ACTUALLY COME TO FRUITION,
AND WE'LL DO THAT BY, YOU KNOW,

PART THROUGH THE OUTREACH

AND BY TALKING TO YOU.

AND I THINK THE GUIDANCE WILL BE
PRETTY CLEAR ON WHAT IT IS

THAT WE'RE LOOKING FOR AND WHAT
WE CONSIDER TO BE DUPLICATIVE

WITH RESPECT TO COST-SHARING.

AS IT IS NOW, YOU KNOW, IT
REALLY IS AN ACTUARIAL NUMBER,

AND, AGAIN, DALE
WILL TAKE A LOOK AT THAT.

IT'LL BE THE VALUE OF ONE
MAO'S PLAN IN A SERVICE AREA

VERSUS ANOTHER PLAN, AND THAT
IS GONNA BE A PRIMARY THING
THAT WE'RE LOOKING AT.

BUT AGAIN, I THINK WE'RE BEING
RATHER CONSERVATIVE IN THE WAY

THAT WE ARE APPLYING IT--
AT LEAST, FOR NOW.

I ALSO JUST WANT TO SAY THAT
WE HAVE A 2-YEAR TRANSITION

PERIOD IN CASES OF
ACQUISITIONS AND MERGERS.

AND--IN OTHER WORDS, IT
WOULD BE A 2-YEAR PERIOD,

IN SUCH A CASE, FOR A PLAN
TO THEN BECOME COMPLIANT

WITH RESPECT TO OFFERING PLANS

IN THE SAME SERVICE AREA
WITH MEANINGFUL DIFFERENCES.

AND THE WAY THAT WOULD REALLY
WORK IS THAT, SAY, IF THERE WAS

A MERGER IN 2010, IT WOULD
REALLY BE IN 2013 THAT THE PLAN

WOULD NOT BE ABLE TO OFFER--
THE MAO WOULD NOT BE ABLE

TO OFFER THE PLAN.

SO YOU REALLY WOULD HAVE
2 YEARS AFTER THE YEAR

OF THE MERGER TO COME
INTO COMPLIANCE WITH THAT.

SO THE GOALS--I THINK I'VE KIND
OF SPOKEN ABOUT THEM ALREADY,

BUT IT'S TO ENSURE THAT
THE COST AND BENEFITS

FOR AN MAO'S PLANS IN A
SERVICE AREA ARE TRANSPARENT,

TO USE A WORD THAT
WE'RE USING A LOT NOW.

SO, IN OTHER WORDS,
THE BENEFICIARIES

REALLY KNOW WHAT THE DIFFERENT
COSTS AND BENEFITS ARE.

THIS ISN'T ALWAYS THE CASE.
IT'S BEEN ALL OF OUR EXPERIENCE,

I THINK, THAT AMIDST ALL THIS
WONDERFUL CHOICE,

THERE ARE LOTS OF TIMES
THAT FOLKS, BENEFICIARIES,

JUST DON'T REALLY KNOW THE
DIFFERENCES BETWEEN THE PLANS.

AND WE'VE LOOKED AT A LOT
OF LITERATURE, AS WELL,

THAT WE'VE CITED IN THE
REGULATIONS, BOTH THE PROPOSED

AND THE FINAL REGULATION,
THAT BEAR THAT OUT, AS WELL,

THAT FOLKS WILL OFTEN
CHOOSE PLANS THAT COST MORE

AND DON'T OFFER
THE SAME BENEFITS.

NOT ALWAYS THE CASE,

BUT THAT'S ONE OF THE THINGS

WHEN YOU HAVE SO MANY
DIFFERENT KINDS OF PLANS,

AND OUR JOB IS TO TRY
TO FIND, ALONG WITH YOU,

A HAPPY MEDIUM IN MAKING SURE
THAT WE HAVE BOTH CHOICE

AS WELL AS TRANSPARENCY.

THE BASIS THAT WE USE
FOR OUR REGULATION--

AND WE CITED IT AND YOU
CAN LOOK AT IT, AS WELL--

IS SECTION 1857(e)(1) OF
THE SOCIAL SECURITY ACT,
TITLE 18, AND THAT

BASICALLY PERMITS THE SECRETARY
TO ESTABLISH ADDITIONAL

CONTRACT TERMS THAT SHE FINDS
NECESSARY AND APPROPRIATE.

AND WE WENT INTO THAT FURTHER,
INTO THE REGULATION,

AND I WOULD--IF YOU'RE
MORE INTERESTED IN THAT,

IN OUR BASES, I WOULD URGE YOU
TO TAKE A LOOK AT THAT.

I JUST WANT TO ALSO MENTION
JUST A BRIEF NOTE ON PPACA,

THE RECENT LEGISLATION.

IT SPEAKS TO THE BIDDING
PROCESS, AS WELL, AND WE THINK

THAT IT PROBABLY FURTHER
STRENGTHENS OUR AUTHORITY

TO LIMIT THE NUMBER
OF PLAN BIDS.

SECTION 3209, FOR EXAMPLE,
REVISES 1854(a)(5)

OF THE SOCIAL SECURITY ACT
AND CLARIFIES THAT THE SECRETARY

NEED NOT ACCEPT ANY OR EVERY
BID SUBMITTED BY AN M.A.O.,

AND THE SECRETARY MAY DENY
A BID FOR A PLAN IF IT PROPOSES

SIGNIFICANT INCREASES IN
COST-SHARING OR DECREASES

BENEFITS OFFERED UNDER THE PLAN.

I DON'T REALLY WANT TO GET
INTO THAT MORE, BUT IT ALMOST

CERTAINLY MEANS THAT,
ULTIMATELY, THERE WILL BE

ADDITIONAL CHANGES JUST
IN ADDITION TO THE ONES

THAT WE WOULD HAVE AS PART OF
THE ANNUAL UPDATES AND GUIDANCE,

AND WE'RE LOOKING AT THAT,
HOW TO--WE'LL BE CONTINUOUSLY

LOOKING AT THAT ON HOW
TO BEST IMPLEMENT THAT.

JUST A WORD ON THE GUIDANCE.

AGAIN, I'VE KIND OF
SPOKEN ABOUT SOME OF THIS,

BUT, OBVIOUSLY, THE REGULATION
THAT JUST RECENTLY PUBLISHED,

4085-F AND WHICH IS NOW
AVAILABLE THROUGH THE FEDERAL

REGISTER, HAS A LOT OF
THE GENERAL POLICIES AND BASES

THAT I'VE BEEN TALKING ABOUT.

AND THEN THE POLICY
BENEFITS MEMO THAT CAME OUT

ON THE 16th, TOO, HAS A LOT OF
REALLY GOOD SPECIFICS IN THERE

ABOUT HOW WE'RE GOING
TO DETERMINE AND ASSESS
MEANINGFUL DIFFERENCES.

BEYOND THAT, WE ARE VERY MUCH--
AS SOMEBODY WHO READ

A LOT OF THE COMMENTS
ON THE PROPOSED REGULATION

FOR THIS PROVISION,
I KNOW VERY WELL THAT ADVOCATES

AND PLANS ALIKE ARE,
LIKE WE ARE, VERY INTERESTED

IN MAKING SURE THAT WHATEVER
THRESHOLDS, ANY CHANGES

THAT ARE MADE, ARE GIVEN WELL
IN ADVANCE OF THE WHOLE

BIDDING PROCESS, AND THAT IS, I
THINK, ONE OF OUR MOST IMPORTANT

TASKS NOW, AND IT WILL BE
FOR THE COST-SHARING, AS WELL.

IT'LL HAVE VARIOUS THRESHOLDS
THAT NEED TO BE SPECIFIED

AND REVISED, AND WE HOPE
TO COMMUNICATE VERY CLEARLY

AND WELL WITH YOU ABOUT THOSE
CHANGES, AND WE'LL PROMISE

TO DO THAT CERTAINLY
IN ADVANCE OF THE BIDDING YEAR.

I'M GONNA GO TO NON-RENEWAL.

THIS IS, AGAIN, ANOTHER VERY
IMPORTANT ASPECT, I THINK,

OF WHAT WE'RE DOING IN ORDER
TO BOTH MAKE SURE THAT PLANS

ARE NOT SO CONFUSING
TO BENEFICIARIES AND--

PERHAPS EVEN MORE IN THIS
REGARD--MAKE SURE THAT

THEY HAVE LONG-TERM VIABILITY,
THAT THEY'RE GOOD, STRONG PLANS.

IT REALLY AFFECTS
ALL MAOs, THOUGH.

YOU'RE GONNA HEAR THROUGH
THE GUIDANCE THAT, YOU KNOW,

WE ARE APPLYING, THAT
THERE ARE EXCEPTIONS

TO THE LOW-ENROLLMENT
REQUIREMENTS--NON-RENEWAL
IS BASED ON THAT.

SNPs, FOR EXAMPLE,
IN SOME INSTANCES.

IT MAKES SENSE THAT THEY
WOULD HAVE LOWER ENROLLMENTS,

PERHAPS EMPLOYER GROUPS,
ET CETERA.

NONETHELESS, THE MOST
IMPORTANT THING IS THAT

THESE REQUIREMENTS
DO APPLY TO ALL PLANS,

AND WE WILL BE MAKING EXCEPTIONS
WITHIN THAT CONTEXT,

AND, AGAIN, DALE
WILL TALK MORE ABOUT THAT.

THE THRESHOLDS WILL VARY
ANNUALLY JUST AS IT DOES
WITH MEANINGFUL DIFFERENCES.

FOR EXAMPLE, WE'RE LOOKING,
I THINK THIS YEAR,

AT PLANS THAT MAOs WITH 500--

500 OR LESS, AND THEN ALSO--
I THINK THERE'S A DIFFERENCE--

THEN SNPs ARE 100 OR LESS,
AND THOSE THINGS COULD CHANGE.

AND, AGAIN, WE NEED

TO MAKE SURE THAT WE

GIVE YOU ALL THE INFORMATION
ABOUT THAT BEFORE THE BIDDING.

IN GENERAL, I THINK WE DO
JUST WANT TO REMAIN FLEXIBLE.

WE DO RECOGNIZE THERE
ARE LEGITIMATE REASONS
FOR LOW ENROLLMENT,

BUT WE ALSO WANT TO ENSURE THAT

THEY REALLY ARE VIABLE
FOR THE LONG TERM.

SOME OF THE EXCEPTIONS
ARE GONNA BE BASED ON
GEOGRAPHICAL LOCATION

AND BENEFICIARY POPULATIONS--
SNPs, I MENTIONED,

IN SOME INSTANCES BECAUSE
THEY DEAL WITH A VERY
TARGETED BENEFICIARY GROUP,

AND, AGAIN, DALE WILL GO
INTO MORE DETAIL ON THAT.

THE REGULATORY LANGUAGE
SAYS THAT THE CONTRACT
MUST BE NON-RENEWED

AS TO AN INDIVIDUAL MA PLAN
IF THAT PLAN DOES NOT HAVE

A SUFFICIENT NUMBER OF
ENROLLEES TO ESTABLISH
THAT IT IS A VIABLE,

INDEPENDENT OPTION, SO THAT'S
WHAT WE'RE GOING FOR.

OK, SO, AGAIN, PART OF
THE GOALS: WE WANT
TO BALANCE THE CHOICE

WHILE REDUCING BENEFICIARY
CONFUSION AND THEN ENSURE

THE PLANS ARE STABLE AND VIABLE.

I THINK WE'VE DISCUSSED THAT
PRETTY MUCH, SO WE WON'T
GO INTO THAT ANY FURTHER.

AND THE GUIDANCE IS
GOING TO BE VERY SIMILAR.

WE KNOW WE HAVE TO DO THIS
BEFORE THE BIDDING,

AND THIS WILL--WE'VE GOT
INFORMATION, OF COURSE,

IN THE BENEFITS MEMO THAT
CAME OUT, AND THEN NEXT YEAR

WE'LL HAVE IT
IN SAME OR SIMILAR GUIDANCE.

AGAIN, THE MATERIAL POINT BEING
THAT WE KNOW WE HAVE TO DO THIS

WELL IN ADVANCE OF
THE UPCOMING YEAR, SO...

Part 2

IT'S A PLEASURE TO BE HERE.

I'VE SPOKEN TO MANY OF YOU OVER
THE YEARS ON PHONES AND STUFF,

AND IT'S KIND OF NICE
TO ACTUALLY BE IN FRONT
AND TALK TO YOU.

WHAT I'M GONNA BE DOING
IS GIVING AN OVERVIEW OF--

I MEAN, I THINK
WE ALL KNOW THERE'S BEEN--

PARTICULARLY KICKING IN 2011,
THERE'S GONNA BE

A LOT OF CHANGES TO THE WAY
THE MEDICARE ADVANTAGE PROGRAM

HAS BEEN OPERATING, AND,
YOU KNOW, MY GOAL HERE IS

TO KIND OF GIVE YOU
AN OVERVIEW OF SOME OF
THE SIGNIFICANT THINGS.

BUT I DID HAVE A QUESTION--
IS, HOW MANY OF YOU
HAVE HAD A CHANCE

TO READ THE REGULATION
THAT WAS JUST PUBLISHED?

THE CROSSWALK GUIDANCE
HAS BEEN PUT OUT THERE,

AND ALONG WITH A MEMO
FROM THE DIVISION
OF FINANCE AND BENEFITS.

I MEAN, HAS EVERYBODY READ THAT
OR HAD A CHANCE TO LOOK AT IT?

OK. WELL, THAT'S GOOD TO KNOW.

SO I GUESS, YOU KNOW,
THE WAY TO PUT THIS IN CONTEXT

IS WE'RE NOT GONNA BE ABLE
TO GO INTO EVERYTHING

THAT'S IN THERE,

BUT WE'RE GONNA TRY TO--
AND I KNOW DALE'S GONNA
GO INTO MORE DETAIL THAN I DO--

BUT JUST TRY TO GIVE YOU
SOME HIGHLIGHTS SO AT LEAST

YOU'LL HAVE SOME KIND OF
A FRAMEWORK TO--

YOU KNOW, WHEN YOU
GO INTO THESE MATERIALS.

AND, YOU KNOW, WE TRIED
TO WRITE THEM TO BE
SOMEWHAT TRANSPARENT,

BUT, YOU KNOW, IT'S
A BUREAUCRACY AND, YOU KNOW...

YOU KNOW, AND YOU CAN CALL US.

DALE AND CHRIS ENJOY
GETTING PHONE CALLS.

[LAUGHTER]

OK, THE ITEMS I'LL BE TALKING
ABOUT, AGAIN, KIND OF BRIEFLY,

ARE THE FACT THAT WE'RE GONNA
HAVE--WHAT'S GONNA BE NEW

IN 2011 IS THAT ALL MA PLANS,
LOCAL MA PLANS--

AND REGIONAL PLANS,
OF COURSE, AS YOU KNOW,
ALREADY HAVE TO DO IT--

BUT THEY'RE GONNA
HAVE TO HAVE A MAXIMUM
OUT-OF-POCKET COST-SHARING.

AND ADDITIONALLY,
ALONG WITH THIS MAXIMUM--

WHICH, BASICALLY,
WHAT THE MAXIMUM IS,
IS WHEN A BENEFICIARY

HITS A CERTAIN LEVEL OF

COST-SHARING, THEN THEIR COSTS

FOR THAT CONTRACT YEAR END
EXCEPT FOR PREMIUM

AND SUPPLEMENTAL BENEFITS.

AND THEN RELATED TO THAT,
THE FACT THAT THERE'S
GONNA BE THIS MOOP.

WE ALSO ARE GONNA--
WE'LL SET LIMITS ON
"A" AND "B" COST-SHARING.

WE'VE BEEN, MORE OR LESS,
DOING THAT THE LAST FEW YEARS.

THIS IS JUST GONNA BE A LITTLE
MORE FORMALIZED PROCESS

WHERE WE SET THESE BANDS
OF HOW MUCH A PARTICULAR
SERVICE CAN COST.

AND THEN AGAIN, THERE'S
GONNA BE THE OVERALL MAXIMUM

OUT-OF-POCKET AMOUNT,
OR THE SO-CALLED MOOP.

I'LL ALSO BE TALKING ABOUT
A COUPLE OTHER MAYBE
LESS SIGNIFICANT

BUT JUST TO BRING THEM
TO YOUR ATTENTION CHANGES

TO THE VISITOR/TRAVELER BENEFIT,

PRIOR NOTIFICATION--USE OF
PRIOR NOTIFICATION RULES,

AND I'LL HAVE A FEW
THINGS TO SAY ABOUT
THE CROSSWALK DOCUMENT.

YOU KNOW, THAT'S THAT DOCUMENT
THAT TELLS YOU WHICH PLANS

FROM 2010 TO 2011 CAN BE
CONSIDERED CONTINUATION PLANS

AND WHICH PLANS CONSTITUTE

TERMINATION PLANS.

TO BEGIN WITH, I'LL
TALK ABOUT THE MOOP LIMITS.

THE REASON WE DID THESE,
BASICALLY--

IN SOME WAYS, THE OVERARCHING
GOAL IS TO PUT

MEDICARE ADVANTAGE ON
A LEVEL PLAYING FIELD

WITH ORIGINAL MEDICARE.

AND AS I'M SURE MOST OF YOU
KNOW, THE GREAT MAJORITY

OF BENEFICIARIES IN ORIGINAL
MEDICARE--THEY WILL PURCHASE

MEDIGAP POLICIES WHICH,
IN MANY INSTANCES,

DO CAP THEIR TOTAL
OUT-OF-NETWORK COST-SHARING.

AND THERE HAS BEEN SOME CONCERN
THAT THOSE BENEFICIARIES

WHO WERE SICKER, WHO HAD SOME
EXPECTATION OF RUNNING INTO

UNUSUALLY HIGH MEDICARE COSTS--
OR, MEDICAL COSTS--

MIGHT BE DETERRED
FROM JOINING AN MA PLAN.

AND ALSO, BY HAVING THESE
MAXIMUM OUT-OF-POCKET AMOUNTS,

IT PUT MA PLANS ON AN EVEN
PLAYING FIELD SO THAT

IF YOU JOINED--A BENEFICIARY
JOINING ONE PLAN

CAN HAVE CONFIDENCE THAT
THERE ARE GONNA BE THESE LIMITS

ON THEIR TOTAL
OUT-OF-POCKET COST-SHARING.

AND AS I SAID, WE THINK
IT CREATES A MORE LEVEL
PLAYING FIELD.

HOWEVER, IN SETTING
THESE AMOUNTS, CMS HAS BEEN

VERY MINDFUL THAT
A LOT OF PEOPLE WHO JOIN

MEDICARE ADVANTAGE PLANS
ARE LOW-INCOME PEOPLE,

AND ONE OF THE REASONS
THEY JOIN THEM IS THEY
CAN'T AFFORD MEDIGAP.

SO WE'VE TRIED, AND AS--
PART OF THE REASON THESE MAXIMUM

OUT-OF-POCKETS AND THE "A" AND
"B" COST-SHARING ARE GONNA BE

ANNUAL PROCESSES IS WE'VE
GOT TO STRIKE A BALANCE BETWEEN

PROVIDING PROTECTION
FOR THOSE PEOPLE WHO EXPERIENCE

INORDINATELY HIGH MEDICAL COSTS,
BUT NOT SETTING THESE LIMITS

SO LOW IS--THEY EITHER CAUSE
THE PREMIUMS OF THE PLANS

TO GO WAY UP OR EVEN
CAUSE PLANS TO DROP OUT.

THE GOAL IS THAT PEOPLE
HAVE CHOICES

ALL AROUND THE COUNTRY, AND SO
WE'RE VERY MINDFUL OF THAT.

AND THAT'S--BUT WE THINK
THAT HAVING A MOOP

AND THE COST-SHARING IN THE
LONG RUN WILL MAKE THESE PLANS

MORE BROADLY ATTRACTIVE,
ACTUALLY.

THE MOOP WILL ONLY APPLY
TO PARTS "A" AND "B" SERVICES,

AND AS I MENTIONED, IT
DOES NOT INCLUDE THE PREMIUM

AND SUPPLEMENTAL BENEFITS.

AND ADDITIONALLY, AS MANY
OF YOU KNOW, SOME PLANS,

A SIGNIFICANT NUMBER OF
PLANS, HAVE ADOPTED

THE LOWER VOLUNTARY MOOP--
WHICH I BELIEVE

WAS AROUND 3,400, 3,500--
AS A MAXIMUM.

A NUMBER OF PLANS, ON THEIR OWN
INITIATIVE, DECIDED TO ADOPT IT.

WE'LL BE SETTING THE MANDATORY
MOOP AT A HIGHER LEVEL,

AND, AGAIN--AT A FAIRLY
SIGNIFICANTLY HIGHER LEVEL.

AND, AGAIN, THE REASON IS
WE WANT TO MAKE IT EASIER

FOR THOSE PLANS--AND SINCE
IT'S GONNA BE A REQUIREMENT

FOR HMOs, LOCAL PPOs--TO HAVE--

AND PRIVATE FEE FOR SERVICE
PLANS--TO HAVE A MOOP.

SO WE WANT TO MAKE SURE
THAT THE MANDATORY MOOP
IS RELATIVELY HIGH,

STILL OFFERS PROTECTION,
BUT ISN'T SO--

IT ISN'T AT SUCH A LEVEL THAT IT
WOULD, AGAIN, DRIVE UP PREMIUM

INORDINATELY OR EVEN
CAUSE PLANS TO DROP OUT.

BUT NONETHELESS, WE ARE STILL

GONNA CONTINUE HAVING

THE VOLUNTARY MOOP IN PLACE
FOR THOSE ORGANIZATIONS

THAT WANT TO CONTINUE
USING THAT.

AND WE WILL ALSO BE LINKING
"A" AND "B" COST-SHARING BANDS

ASSOCIATED WITH WHETHER
YOU ADOPT THE MANDATORY MOOP

OR WHETHER YOU ADOPT
THE LOWER VOLUNTARY MOOP.

PARTS IN THE "A" AND "B"
COST-SHARING THRESHOLDS:

CMS WILL ANNUALLY
ESTABLISH THRESHOLDS,

AGAIN, TIED TO THE MANDATORY
AND VOLUNTARY MOOP.

RPOs ARE NOT SPECIFICALLY--
WELL, THEY HAVE TO HAVE A MOOP,

AND THEY ARE SUBJECT TO
COST-SHARING-LIMITS REVIEWS.

THEY AREN'T SUBJECT
TO THE MANDATORY MOOP IN 2011,

ALTHOUGH WE MAY CONSIDER
RULEMAKING TO CHANGE THAT.

BUT RIGHT NOW, REGIONAL PPOs
HAVE DISCRETION

TO SET THOSE LEVELS
AT WHATEVER THEY WANT.

HOWEVER, WE'RE GONNA STRONGLY
ENCOURAGE REGIONAL PPOs

TO ADOPT AT LEAST
THE MANDATORY MOOP.

WE THINK THAT WOULD BE
OVERALL BETTER AND CREATE
MORE OF A COMPETITIVE

ENVIRONMENT THAT WOULD
ADVANTAGE BENEFICIARIES.

OK? ONE THING I WANTED
TO MENTION, TOO,

IS IN THE PATIENT PROTECTION ACT
THAT WAS RECENTLY PASSED,

THE CONGRESS INSERTED 3 SERVICES
THAT CANNOT HAVE COST-SHARING

THAT WOULD EXCEED ORIGINAL
MEDICARE, AND THOSE BEING

CHEMOTHERAPY, DIALYSIS,
AND SKILLED NURSING CARE.

IN ADDITION, THE CONGRESS
GAVE CMS THE AUTHORITY

TO SET SIMILAR LIMITS,
AND WHAT THEY'RE DOING HERE

IS SETTING THOSE LIMITS
AT THE ORIGINAL MEDICARE AMOUNT,

TO SET THOSE LIMITS FOR OTHER
SERVICES THAT WE DETERMINE

NEED A, AS IT'S FRAMED
IN THE LEGISLATION,

A HIGH LEVEL OF PREDICTABILITY
AND TRANSPARENCY.

HOWEVER, THAT DOESN'T MEAN
THAT YOU COULDN'T SET

THOSE COST-SHARING LIMITS BELOW
THE ORIGINAL MEDICARE AMOUNT,

JUST THAT THE CONGRESS DECIDED,
FOR THOSE 3 SERVICES,

TO SET A CAP SO THAT THOSE
3 SERVICES COULD NEVER EXCEED

WHAT ORIGINAL MEDICARE
COST-SHARING IS.

Part 3

I'M GONNA TALK A LITTLE BIT

ABOUT THE VISITOR/TRAVELER
BENEFIT, AND THE CONTEXT OF

THE VISITOR/TRAVELER BENEFIT
IS THAT, SOME OF YOU MAY KNOW,

IT'S BEEN ON THE BOOKS
FOR A NUMBER OF YEARS.

AND, BASICALLY, IF YOU OFFER
A VISITOR/TRAVELER BENEFIT,

YOU'RE ABLE TO RETAIN SOMEBODY

UP TO 12 MONTHS
OUT OF THE SERVICE AREA.

ABSENT A VISITOR/TRAVELER
BENEFIT, YOU WOULD HAVE TO

DISENROLL SOMEBODY, TO THE
EXTENT YOU ARE AWARE OF IT,

WHO IS CONTINUOUSLY OUT OF THE
SERVICE AREA FOR UP TO 6 MONTHS.

I SHOULD MENTION, TOO, THAT
THAT'S WITHIN THE UNITED STATES.

OUTSIDE OF THE UNITED STATES,
IF THEY'RE OUTSIDE

MORE THAN 6 MONTHS, YOU WOULD
HAVE TO DISENROLL THEM.

AND, OF COURSE, IF
THEY'RE PERMANENTLY OUTSIDE

THE UNITED STATES,
THEY'RE NOT ELIGIBLE TO JOIN.

SO, PREVIOUSLY,
THE VISITOR/TRAVELER BENEFIT

WAS REALLY ILL-DEFINED IN TERMS
OF WHAT WAS REQUIRED TO RETAIN

AN ENROLLEE FOR UP TO 12 MONTHS
OUT OF YOUR SERVICE AREA.

AND IN THIS NEW REGULATION
WE DEFINED THE VISITOR/TRAVELER

BENEFIT IS--BASICALLY,
WHAT YOU WOULD DO IS LET'S SAY

YOU WANTED TO HAVE
A VISITOR/TRAVELER IN FLORIDA.

YOU WOULD HAVE TO TELL
YOUR ENROLLEES WHO WERE GONNA BE

DOWN IN FLORIDA FOR
UP TO 12 MONTHS THAT YOU WOULD

HAVE THIS BENEFIT THAT
WOULD COVER AT IN-NETWORK

COST-SHARING THE COMPLETE
BENEFIT PACKAGE.

AND THE RATIONALE FOR THAT
IS THAT THE PLANS ARE BEING PAID

A FULL CAPITATION PAYMENT,
AND IT SEEMED VERY APPROPRIATE

TO US THAT IF A PLAN WAS GONNA
RETAIN THESE PEOPLE

FOR 12 MONTHS, THEN THEY SHOULD
BE PREPARED TO FURNISH

THE COMPLETE BENEFIT PACKAGE.

SO THAT'S ONE CHANGE.

THESE ARE THE RULES
I BASICALLY JUST TOUCHED ON,

WHERE THE VISITOR/TRAVELER
BENEFIT CAN BE DEFINED
BY GEOGRAPHIC AREAS.

YOU COULD TELL IF YOU'RE
A PLAN IN MINNESOTA OR

ONE OF THE NORTHERN TIER PLACES,
YOU COULD SAY IF YOU GO

TO ARIZONA OR FLORIDA, WE HAVE
A VISITOR/TRAVELER BENEFIT,

AND YOU CAN RETAIN

YOUR ENROLLEES THERE

FOR UP TO 12 MONTHS WHEN
THEY'RE OUT OF THE AREA.

ANOTHER VERY INTERESTING TOPIC

IS PRIOR NOTIFICATION, AND THIS
HAS BEEN A SOURCE OF CONFUSION

BECAUSE WE HAVE
ALLOWED SOME PLANS--

YOU KNOW, IT WASN'T THAT THE
PLANS WERE DOING ANYTHING WRONG.

IT WAS JUST THAT THERE
WAS A PERIOD WHERE CMS WAS

MAYBE BEING A LITTLE
TOO FLEXIBLE WITH SOME OF
OUR RULES IN RETROSPECT.

BUT WHAT PRIOR NOTIFICATION WAS
IS--LET'S SAY YOU'RE IN A PPO

AND YOU GO OUT OF NETWORK,
AND AS I THINK YOU ALL KNOW,

WHEN SOMEBODY'S IN A PPO
AND THEY GO OUT OF NETWORK,

THE PLAN HAS TO COVER
ALL IN-NETWORK SERVICES,

AND THEY CAN'T IMPOSE A PRIOR
AUTHORIZATION REQUIREMENT.

SO IF I'M IN A PPO
AND I GO OUT OF NETWORK,

AS LONG AS THE SERVICE I OBTAIN
IS MEDICALLY NECESSARY

AND PLAN-COVERED,
THE PLAN HAS TO PAY FOR IT.

WHAT SOME PLANS, PPOs, DID--

AND PRIVATE FEE-FOR-SERVICE
PLANS WERE DOING THIS, TOO--

THEY WOULD SAY, "HOWEVER,
IF YOU WILL PRIOR-NOTIFY US--"

THAT IS, IF YOU WILL WHEN
YOU'RE GONNA GET THAT HIP
REPLACEMENT OR WHATEVER IT IS,

"IF YOU OR YOUR PHYSICIAN
WILL CONTACT US IN ADVANCE,
WE WILL GIVE YOU A DISCOUNT."

AND IN THEORY, IT SOUNDS LIKE
NOT A BAD PROGRAM.

BUT WHAT ENDED UP HAPPENING IS

I THINK A LOT OF IT CAME DOWN
TO TERMINOLOGY CONFUSION.

BECAUSE THERE IS SUCH
A THING AS PRIOR AUTHORIZATION,

AND THAT'S PARTICULARLY
USED IN HMOs AND MORE

MANAGED CARE CIRCUMSTANCES
WHERE THE PLAN WILL SAY

"WE WILL COVER THIS IF YOU
GET IT PRIOR-AUTHORIZED.

"HOWEVER, IF YOU DO NOT
GET IT PRIOR-AUTHORIZED,

"EVEN IF IT'S MEDICALLY
NECESSARY OR COVERED,

WE'RE NOT GONNA PAY FOR IT."

AND, ALSO, INDIVIDUALS BEGAN
TO THINK PRIOR NOTIFICATION

WAS A REQUIREMENT,
WHICH IT REALLY ISN'T.

SO THE WAY--I GUESS PPOs ARE
A GOOD ILLUSTRATIVE EXAMPLE.

THE WAY IT SHOULD BE WORKING
GOING FORWARD IS PEOPLE

WHO GO OUT OF NETWORK IN A PPO
TO OBTAIN SERVICES,

THEY ARE AT RISK OF
OBTAINING A SERVICE

THAT'S NOT MEDICARE COVERED,
OBTAINING A SERVICE

THAT'S SUBSEQUENTLY DETERMINED
TO NOT BE MEDICALLY NECESSARY.

IN THOSE INSTANCES, A PLAN
WOULDN'T HAVE TO PAY FOR IT.

THE PROTECTION
FOR THESE BENEFICIARIES

AND THE EDUCATIONAL BURDEN
ON PLANS IS TO MAKE SURE

PEOPLE ARE AWARE
THAT THEY'RE ENTITLED,
THEY OR THEIR PHYSICIAN,

TO AN ADVANCED
DETERMINATION OF COVERAGE.

SO IF YOU'RE GONNA GO GET A
SERVICE FROM A NON-CONTRACTED--

NON-PREFERRED PROVIDER,
BEFORE YOU GET THAT SERVICE,

THE PROVIDER OR YOURSELF
CAN CONTACT THE PLAN,

AND YOU CAN GET A WRITTEN
BINDING DECISION THAT OBLIGATES

THE PLAN TO COVER THIS SERVICE
BEFORE YOU RECEIVE IT.

SO THAT'S THE IMPORTANT
PROTECTION THAT'S IN PLACE

FOR BENEFICIARIES, BOTH
IN PPOs AND IN PRIVATE
FEE-FOR-SERVICE PLANS.

BUT, OF COURSE, IT'S A MATTER
OF THE BENEFICIARY BEING AWARE

THAT THAT'S A PROTECTION
AND THE PLANS BEING ABLE

TO PROVIDE IT ON A TIMELY BASIS.

OK?

BUT I GUESS THE PUNCH
LINE ON THIS, OR THE
NOT-SO-GOOD PUNCH LINE,

IS PRIOR NOTIFICATION IS NO
LONGER PERMITTED GOING FORWARD.

AND THEN I'M GONNA TALK
A LITTLE BIT, TO CLOSE OFF,

ABOUT THE ANNUAL TRANSITION,
WHICH HAS BEEN

KIND OF COMPLICATED
IN PAST YEARS.

AND WHAT I MEAN BY THAT IS
THE CROSSWALK WHERE YOU SAY

ONE PLAN IS A CONTINUATION OF
ANOTHER PLAN FROM 2010 TO 2011,

LET'S SAY, AND AS LONG AS
THEY'RE CONTINUATION PLANS,

YOU CAN RETAIN THE ENROLLEES.

YOU DON'T HAVE TO GIVE THEM
A DISENROLLMENT NOTICE,

AND THEN THEY HAVE
TO MAKE A POSITIVE ELECTION.

THE PRINCIPLE WE'RE OPERATING
UNDER, WHICH WE THINK IS,

AGAIN, MORE ON SETTING UP
A LEVEL PLAYING FIELD,

IS THAT IN MOST CASES WE EXPECT
THAT WHEN THE STANDARD

TRANSITION RULES ARE NOT MET--
I MEAN, IF A PLAN IS CHANGING

FROM A PPO TO AN HMO,
THERE'S OTHER CIRCUMSTANCES--

THEN THOSE ENROLLEES
WILL HAVE TO BE TERMINATED

AND THEN BE GIVEN INFORMATION ON

"GEE, WE HAVE A PLAN
THAT'LL BE AVAILABLE.

"IF YOU LIKED OUR PREVIOUS PLAN,
YOU MIGHT WANT TO JOIN IT,

BUT THERE'S OTHER PLANS."

WE THINK IT'S IMPORTANT THAT
BENEFICIARIES HAVE THE OPTION

OF MAKING A POSITIVE ELECTION
WHEN THEIR PLAN--WHEN THEIR PLAN

HAS GONE UNDER CHANGES
THAT WE WOULD CLASSIFY IT

AS BASICALLY A NEW PLAN
IN THE NEXT CONTRACT YEAR.

TO TRY TO MINIMIZE CONFUSION
AND UNCERTAINTY,

WHEN YOU LOOK AT THE CROSSWALK,
THERE'S A CROSSWALK,

AND THEN THERE'S A SUMMARY
DOCUMENT WITH IT, WHICH IS
ABSOLUTELY TRANSPARENT.

AFTER YOU READ IT YOU PROBABLY
WON'T HAVE ANY QUESTIONS.

BUT NONETHELESS, WE DID
WORK ON IT PRETTY ASSIDUOUSLY

AND ATTEMPTED TO INCLUDE

ALL POSSIBLE SCENARIOS THAT
COULD COME UP IN THE CROSSWALK.

NEVERTHELESS, WE'RE NOT SAYING

THAT YOU CAN'T MAKE A REQUEST
FOR AN EXCEPTION.

AND THE ONLY THING I WOULD
SAY ABOUT THAT IS FOR US,

THE GOVERNING CONSIDERATION
WOULD BE IF IT'S IN THE
INTEREST OF BENEFICIARIES.

IF THERE'S SOME REASON,

SOME COMPELLING REASON,

WHY IT WOULD BE BETTER
THAT THEY, YOU KNOW,

NOT GET THE OPPORTUNITY
TO MAKE A POSITIVE ELECTION

BUT ARE CONTINUED IN THIS PLAN
INTO THE NEXT YEAR--

AND POTENTIALLY
WITH MEDIGAP RIGHTS.

BUT, AGAIN, THESE ARE
GONNA BE FAR AND FEW BETWEEN,

AND WE WOULD NEED A COMPELLING
REASON WHY WE THOUGHT

IT WAS IN THE INTEREST
OF BENEFICIARIES.

THERE'S A FEW THINGS I WANT
TO BRING TO YOUR ATTENTION
THAT ARE NEW IN THE CROSSWALK.

IN THE PAST WHEN AN ORGANIZATION
HAS DONE A SERVICE--

YOU KNOW, IT'S A 4-COUNTY
SERVICE AREA,

THEY DECIDE TO PULL OUT OF
ONE OF THE COUNTIES.

IN SOME CASES WE'VE
ALLOWED--IF THE PLAN WAS--

THE ORGANIZATION WAS GONNA OFFER
ANOTHER PLAN IN THE COUNTY,

HAD IT WITHDRAWN FOR--WE DID
ALLOW SO-CALLED PASSIVE ELECTION

OF THOSE ENROLLEES INTO THE
NEW PLAN THAT WAS INTRODUCED.

WE'RE NOT GONNA DO THAT ANYMORE.

IF YOU DO A SERVICE
AREA REDUCTION,

IN THOSE AREAS

YOU'VE PULLED OUT OF,

THOSE BENEFICIARIES
WILL GET A TERMINATION NOTICE.

AND EVEN IF YOU'RE OFFERING
ANOTHER PLAN IN THERE,

YOU CAN CERTAINLY TELL THEM
ABOUT THE PLAN AND EMPHASIZE

THAT IF YOU LIKED OUR
PREVIOUS COVERAGE, YOU
WANT TO ELECT THIS PLAN.

BUT WE'RE NOT GONNA ALLOW
THE MEMBERS TO BE SORT OF

CONTROLLED IN A SENSE OF
DIRECTED TO THE SUCCESSOR PLAN.

AND WE DO HAVE, AS I'M SURE
YOU ALSO KNOW, IN 2011,

MOST--WELL, ALL EMPLOYER PRIVATE
FEE-FOR-SERVICE PLANS

AND A SIGNIFICANT NUMBER OF

INDIVIDUAL PRIVATE
FEE-FOR-SERVICE PLANS

WILL BE REQUIRED TO OPERATE
IN THESE CERTAIN AREAS

OF THE COUNTRY
AS NETWORK MODELS.

AND IN OTHER AREAS
OF THE COUNTRY, THEY'LL
STILL BE ABLE TO OFFER

PRIVATE FEE-FOR-SERVICE PLANS AS
NON-NETWORK AND PARTIAL-NETWORK.

WE ARE--BECAUSE RECOGNIZING THE
LARGE CHANGES THAT ARE GOING ON,

WE WILL ALLOW TRANSITIONS
BETWEEN, LET'S SAY,

A NON-NETWORK PRIVATE
FEE-FOR-SERVICE PLAN

MOVING PEOPLE INTO
A PARTIAL--A SUCCESSOR--

PARTIAL- OR FULL-NETWORK PLAN,
AGAIN, GIVEN THE FACT

THAT WE EXPECT THERE IS
A LOT OF CHANGE, AND WE DO

WANT TO MINIMIZE UNNECESSARY
DISLOCATION FOR BENEFICIARIES.

AND FINALLY, I WILL MENTION
THAT SPECIAL NEEDS PLAN--

WE HAVE A NEW RULE
THAT YOU MAY BE AWARE OF,

AND THE "DISPROPORTIONATE
SHARE" MODEL OF SNP PLANS

WON'T BE AVAILABLE IN 2011.

SO FOLKS--AND "DISPROPORTIONATE
SHARE" WAS THERE WAS A POLICY

WHERE YOU COULD HAVE
A SPECIAL NEEDS PLAN TARGETED

TO A PARTICULAR GROUP OF PEOPLE
WITH, YOU KNOW, DUAL ELIGIBLES

OR CHRONIC-CARE CONDITIONS,
AND YOU COULD ENROLL

SOME LEVEL OF PEOPLE WHO
DIDN'T HAVE THAT CONDITION.

WELL, WE'RE NO LONGER
GOING TO ALLOW THAT IN 2011.

SO, YOU KNOW, IN THE
TRANSITION FROM 2010 TO 2011,

YOU WOULD HAVE TO DISENROLL
THOSE INDIVIDUALS WHO

NO LONGER QUALIFIED FOR THE SNP.

AND THERE IS A SLIDE ON THERE
THAT GIVES MY NAME,

CHRIS' NAME, AND DALE'S--WELL,
DALE, YOU HAVE IT SOMEWHERE--

AND AS I SAY, WE
ENJOY CONVERSATIONS
ALL HOURS OF THE NIGHT.

SO WITH THAT,
I'LL TURN IT OVER TO DALE.

Part 4

GOOD AFTERNOON.
MY NAME'S DALE SUMMERS.

I'M FROM THE DIVISION
OF FINANCE AND BENEFITS.

I THINK FOR THOSE OF YOU
WHO WERE HERE THIS MORNING

AND LISTENED TO
KADY AND SARA'S PRESENTATION

AND THEN MARTY
AND CHRIS' PRESENTATION,

I THINK THAT SERVES
AS A PREAMBLE TO

THE INFORMATION I'LL
BE SHARING WITH YOU.

SO IN SOME CASES,
I MAY ONLY SPEND

VERY LITTLE TIME ON A FEW SLIDES

BUT SPEND MORE TIME
ON SOME OTHER SLIDES,

BECAUSE I THINK THE INTERESTING
THING TO YOU

WILL BE THE DETAILS BEHIND IT.

SO AT ANY RATE,
JUST TO GET THINGS ROLLING,

I THINK THE--ESSENTIALLY,
WE'LL BE TALKING ABOUT

MAXIMUM OUT-OF-POCKET COSTS.

WE'LL BE TALKING

ABOUT COST-SHARING.

WE'LL BE TALKING ABOUT
MEANINGFUL DIFFERENCE

AND LOW ENROLLMENT.

WE'LL BE TALKING ABOUT
QUALITY BID SUBMISSIONS,

BECAUSE THAT'S SOMETHING
THAT'S ALWAYS IMPORTANT TO US,

AND I THINK IN EVERYONE'S
BEST INTEREST.

ONE THING THAT WE WANTED TO DO
IS PROVIDE

A LITTLE BIT OF CONTEXT FOR OUR
CONVERSATION TODAY, THOUGH,

SO IT'S PROBABLY
WORTH ABOUT A MINUTE

JUST TO REVIEW A COUPLE
OF THINGS,

AND THAT IS, IF YOU LOOK
AT THE NON-EMPLOYER PLANS,

IN THE MEDICARE
ADVANTAGE PROGRAM,

WE HAVE ABOUT 2,800
THAT ARE OFFERED FOR 2010.

IN 2009, THERE WAS ABOUT 3,400
OF THOSE PLANS OFFERED.

AND AGAIN, HMOs REPRESENT
THE MAJORITY OF THE PLANS

AS WELL AS
THE MAJORITY ENROLLMENT.

THERE'S NOT A BULLET ON HERE,
BUT ESSENTIALLY

THE LOCAL PPOs AND REGIONAL PPO,

THE NUMBER OF PLANS HASN'T
REALLY CHANGED DRASTICALLY

BUT THE ENROLLMENT
HAS CONTINUED TO GROW.

ONE THING THAT WE'VE NOTICED
IS PRIVATE FEE-FOR-SERVICE PLANS

HAS DECREASED FROM
LAST YEAR TO 2010.

THE ENROLLMENT HAS
DECREASED A BIT AS WELL.

AND ONE THING THAT'S CLEAR
IS THAT IN MOST AREAS,

THERE IS A GOOD BIT OF CHOICE
FOR BENEFICIARIES,

AND THAT'S A GOOD THING.

THE ONE THING THAT'S ALSO
IMPORTANT TO NOTE IS

THAT THERE ARE SOME AREAS
THROUGHOUT THE COUNTRY

WHERE CHOICE IS PRETTY LARGE.

ACTUALLY, WE HAVE A FEW COUNTIES

WHERE THERE'S OVER 100 CHOICES
FOR BENEFICIARIES.

SO OBVIOUSLY, THERE'S
A LITTLE BIT OF A CONCERN

AS FAR AS MAKING SURE THAT
A BENEFICIARY ISN'T OVERWHELMED

OR CONFUSED BY
THE NUMBER OF CHOICES,

AND THAT'S WHAT SOME OF OUR
GUIDANCE IS TRYING TO ADDRESS.

YOU'VE SEEN A SLIDE

SIMILAR TO THIS

PROBABLY IN ABOUT TWO OR 3
OTHER PRESENTATIONS,

SO I WON'T
DWELL ON IT THAT MUCH,

BUT SUFFICE IT TO SAY THAT
JUNE 7 IS WHEN THE BIDS ARE DUE,

AND YOU HAVE THE SOFTWARE
AVAILABLE TO YOU NOW,

AND WE CERTAINLY ENCOURAGE YOU
TO USE IT, TEST IT

TO MAKE SURE THAT ONCE
THE BIDS ARE SUBMITTED

THAT THEY'RE
SUBMITTED ACCURATELY

AND THAT WE CAN BASICALLY
GO ABOUT THE SUMMER

AND WORK THROUGH
THE BID REVIEW PROCESS.

CERTAINLY DURING
AUGUST AND SEPTEMBER,

THERE'S A LOT OF ATTESTATIONS
AND ALSO CONTRACTS.

OCTOBER 1 IS THE LAST DATE
FOR A PLAN CORRECTION REQUEST

TO BE SUBMITTED.

AGAIN, AS KADY INDICATED
THIS MORNING,

WE REALLY WANT TO SEE THAT
AS A RARE CASE,

BUT AT ANY RATE, OCTOBER 1st

IS THE LAST DATE
FOR THOSE REQUESTS.

TOOLS FOR GETTING STARTED.

OBVIOUSLY, WE'VE TALKED ABOUT

THE HEALTH CARE
REFORM LEGISLATION,

THE FINAL REGULATION
THAT'S AVAILABLE.

THE HPMS MEMO THAT
CHRIS AND MARTY REFERRED TO

THAT WENT OUT ON
FRIDAY, AUGUST 16th.

ACTUALLY, THERE ARE
3 MEMOS THAT REALLY PERTAIN TO

WHAT WE'RE TALKING
ABOUT HERE TODAY,

AND THAT WOULD INCLUDE
THE PART D MEMO,

THE CROSSWALK MEMO.

ACTUALLY, I BELIEVE
THAT'S REFERRED TO

AS THE RENEWAL,
NON-RENEWAL GUIDANCE,

AND THEN, OF COURSE,
THE BENEFITS POLICY

AND OPERATIONAL GUIDANCE FOR
THE MEDICARE ADVANTAGE PROGRAM.

SO IF YOU HAVE
THOSE 3 DOCUMENTS,

I THINK THEY WOULD
ALL BE INFORMATIVE

AS FAR AS HELPING UNDERSTAND
WHERE WE'RE TRYING TO GET

AS FAR AS THIS YEAR'S BIDS.

OTHER DOCUMENTS TO KEEP IN MIND
CERTAINLY WOULD BE

THE CHAPTER 4 GUIDANCE
FOR MEDICARE ADVANTAGE.

ALSO PARTICIPATE
IN THE USER GROUP CALLS.

AS FAR AS SUBMITTING QUESTIONS
TO US,

AT THE END THERE'LL BE A SLIDE
THAT HAS MY CONTACT INFORMATION

AS WELL AS CONTACT INFORMATION

FOR OUR MEDICARE ADVANTAGE
BID TEAM,

BUT THERE'S ALSO ANOTHER
RESOURCE FOR YOU,

AND THAT'S
THE MA BENEFITS MAILBOX,

AND IT'S A DIFFERENT ADDRESS
THIS YEAR TO GO TO,

AND WE WOULD LIKE FOR YOU
TO USE THAT AS MUCH AS YOU CAN.

ONE OF THE REASONS
FOR THAT IS THAT

THERE'S A GREAT DEAL OF CHANGE
THIS YEAR, OBVIOUSLY,

AND WHAT IS HELPFUL FOR US

IS TO MAKE SURE THAT
AS WE'RE GETTING THE QUESTIONS

THAT WE'RE GIVING
A COMPLETE ANSWER

AND AN ACCURATE ANSWER
AND A CONSISTENT ANSWER

TO PLANS.

SO FOR THAT REASON
EVEN IF YOU CALL US,

WE'LL TRY TO RESPOND
TO YOU THE BEST WE CAN,

BUT IN SOME CASES,
WE MAY ASK YOU

TO SUBMIT THAT QUESTION
TO THE MAILBOX,

AGAIN, SO THAT WE CAN
GIVE YOU CONSISTENT GUIDANCE

AND ACCURATE
AND COMPLETE GUIDANCE.

IT'S AMAZING HOW MANY TIMES

ONE PERSON CAN ASK
ONE QUESTION ANOTHER--

ASK THE SAME QUESTION ONE WAY

AND ANOTHER PERSON WILL
ASK IT A DIFFERENT WAY,

AND IT REALLY HAS A BEARING ON THE
GUIDANCE THAT'S PROVIDED.

SO AGAIN, WE'RE TRYING TO USE
THAT MAILBOX THIS YEAR

AS A WAY OF
GETTING THE QUESTIONS

AND RESPONDING TO THEM
IN A CONSISTENT MANNER.

AS FAR AS OUR BENEFIT GOALS,

ESSENTIALLY WE'RE
TALKING ABOUT COST SHARING

AND ALSO THE MAXIMUM
OUT-OF-POCKET GUIDANCE,

AND ONE THING THAT I'M
GOING TO SAY RIGHT NOW IS

WE SAY IT'S MAXIMUM
OUT-OF-POCKET GUIDANCE.

WE REFER TO IT AS "MOOP,"

AND YOU WILL SEE THAT

IN THE POLICY MEMOS,

YOU WILL SEE THAT IN SLIDES,

SO I'LL PROBABLY JUST GO AHEAD
AND START USING THE WORD "MOOP."

BUT ESSENTIALLY,
WHAT OUR GOAL IS

WITHIN THE MEDICARE ADVANTAGE
BID TEAM

IS TO BASICALLY REVIEW
THE MEDICARE ADVANTAGE BIDS

TO MAKE SURE THAT
THE BENEFIT DESIGNS

ARE NOT DISCRIMINATORY
IN SOME WAY.

SO THAT'S REALLY OUR FOCUS,
AND WHAT WE'RE TRYING TO DO

IS GIVE YOU THE INFORMATION
AHEAD OF TIME

SO THAT YOU KNOW HOW
TO CONSTRUCT YOUR BIDS

IN SUCH A WAY THAT
THEY'RE NOT DISCRIMINATORY.

ONE THING THAT MARTY AND CHRIS
HAS ALLUDED TO

IS THE FACT THAT THIS YEAR,

WE ARE LOOKING AT
THE NEW MOOP REQUIREMENT.

WE HAVE TWO TYPES OF MOOPS.

AGAIN, THE MANDATORY
AND THE LOWER, VOLUNTARY MOOP,

AS WE HAVE IN THE PAST.

WE'RE ALSO MAKING SURE
THAT IN OUR GUIDANCE

THAT WE'RE ALIGNING OUR
CALL-SHARING STANDARDS

WITH THE NEW
HEALTH CARE LEGISLATION.

AS FAR AS THE CHANGES FOR 2011,

ESSENTIALLY ALL
LOCAL MA PLANS,

EMPLOYERS AS WELL AS
NON-EMPLOYERS,

ARE REQUIRED TO HAVE A MANDATORY

MOOP FOR ALL A/B SERVICES.

AND THIS INCLUDES
ALL THE DIFFERENT PLAN TYPES--

HMOs, HMOs WITH
POINT OF SERVICE,

LOCAL PPOs, AND PRIVATE
FEE-FOR-SERVICE PLANS.

MARTY ALSO DISCUSSED THE ISSUE
ASSOCIATED WITH REGIONAL PPOs

IN TERMS OF THEY CAN DETERMINE
THEIR OWN MAXIMUM OUT-OF-POCKET,

BUT WE'RE ENCOURAGING
THOSE PLANS TO FOLLOW

AT LEAST OUR MANDATORY GUIDANCE.

WE HAVE PRESERVED THE LOWER,
VOLUNTARY MOOP FOR 2011.

THIS IS SOMETHING THAT
COULD BE BENEFICIAL TO YOU

BECAUSE IT ALLOWS YOU
A LITTLE BIT MORE FLEXIBILITY

WITH COST-SHARING.

AND I GUESS ONE OF THE THINGS THAT
IS, FROM OUR PERSPECTIVE,

FOR 2010, WE HAD ABOUT
40% OF THE PLANS,

NON-EMPLOYER PLANS,
HAVE--THE VOLUNTARY MOOP

OF \$3,400 THAT COVERED
ALL A/B SERVICES,

AND THAT REPRESENTED
ABOUT 1/3 OF THE ENROLLEES.

WE HAD ANOTHER 1/3 OF PLANS
WHO ALSO HAD A MOOP.

NOW, GRANTED, THEY DIDN'T COVER
ALL A/B SERVICES,

BUT THERE ARE A NUMBER
OF PLANS OUT THERE

THAT ALREADY HAVE
A MOOP IN PLACE

AND WE'RE HOPING THAT
THIS WILL BE AN EASY TRANSITION.

ONE THING TO POINT OUT
IS THAT LOCAL PPO PLANS

DO HAVE A LITTLE BIT
OF A WRINKLE,

AND THAT IS THAT WE NEED
TO HAVE A MOOP LIMIT

FOR IN-NETWORK SERVICES AS WELL
AS ONE FOR CATASTROPHIC.

CATASTROPHIC LIMIT REALLY
INCLUDES

IN-NETWORK AS WELL AS
OUT-OF-NETWORK SERVICES.

SO WHEN YOU'RE LOOKING AT
THE LOCAL PPO,

IT'S A LITTLE BIT DIFFERENT.

AND THIS IS SORT OF MODELED
AFTER WHAT THE REGIONAL PPO IS.

BUT, AGAIN, THE REGIONAL PPO
HAS A BIT MORE LATITUDE

ABOUT WHAT THOSE AMOUNTS ARE
FOR 2011.

YOU'LL NOTICE ON SOME OF OUR
SLIDES

AND THEN ALSO IN THAT POLICY
MEMO THAT WENT OUT ON FRIDAY

THE HMO POINT OF SERVICE PLANS

DO NOT HAVE A CATASTROPHIC MOOP
REQUIREMENT,

AND THIS IS BECAUSE
THE POINT OF SERVICE IS

ESSENTIALLY A SUPPLEMENTAL
BENEFIT.

ONE THING OF NOTE IS THAT
IN LOOKING AT THE MOOP,

OR THE MAXIMUM OUT-OF-POCKET
CALCULATION,

IT DOES INCLUDE ALL
COST-SHARING--

DEDUCTIBLES, COINSURANCE, AND
CO-PAYMENTS FOR A/B SERVICES.

THE NEXT SLIDE GOES INTO WHAT
THE ACTUAL AMOUNTS ARE.

AND ESSENTIALLY, AGAIN, THIS IS
IN THE POLICY MEMO.

IT'S A CHART, SO, HOPEFULLY, YOU
CAN SEE THE NUMBERS OK,

BUT IF NOT--SIMILAR
OR SAME CHART IS ACTUALLY

IN THE POLICY MEMO.

AND, AGAIN, THIS OUTLINES
WHAT THE MOOP AMOUNTS ARE

FOR 2011. ESSENTIALLY,
THE FAR-RIGHT COLUMN OF IT

WOULD BE THE MANDATORY MOOP
AMOUNT, WHICH IS \$6,700,

AND THE VOLUNTARY MOOP IS
\$3,400.

THE \$6,700 IS BASED ON THE 95th
PERCENTILE OF BENEFICIARIES

WHO USE ORIGINAL MEDICARE.

BASICALLY, THAT MEANS

THAT 5% OF PROJECTED--ORIGINAL
MEDICARE BENEFICIARIES

WILL SPEND MORE THAN \$6,700
FOR 2011.

SO THAT'S WHERE THE MANDATORY
MOOP AMOUNT WAS SET AT.

THE VOLUNTARY MOOP, YOU'LL
RECOGNIZE THIS NUMBER

BECAUSE IT'S THE SAME NUMBER
FOR 2010.

AND THAT'S \$3,400. ROUGHLY,
THAT'S THE 85th PERCENTILE

OF ORIGINAL MEDICARE
BENEFICIARY SPENDING.

SO THAT'S SORT OF THE LOGIC
THAT WAS USED IN COMING

TO THOSE NUMBERS.

WITH THE LOCAL PPO, YOU'LL
NOTICE THAT THERE IS

THE CATASTROPHIC AMOUNT,

AND ALSO FOR THE VOLUNTARY
AND THE MANDATORY.

ESSENTIALLY THAT CATASTROPHIC
AMOUNT WAS ESTABLISHED

BY 1.5 TIMES WHATEVER THE BASE
MOOP WAS.

SO ESSENTIALLY THAT'S HOW THE
CATASTROPHIC AMOUNT WAS SET UP.

ONE OTHER THING THAT YOU'LL
NOTICE ON THE SLIDE IS

THE FACT THAT PRIVATE
FEE-FOR-SERVICE HAS

A COUPLE OF DIFFERENT VARIETIES.

YOU HAVE THE FULL NETWORK,
PARTIAL NETWORK,

OR NON-NETWORK.

IN ALL 3 CASES, IT'S THE SAME
MOOP AMOUNT,

AND IT'S JUST
THE ONE MOOP AMOUNT.

SO THAT'S SOMETHING OF
PARTICULAR NOTE.

Part 5

THE NEXT SLIDE GOES INTO HOW TO
EXECUTE THIS IN THE PBP.

OBVIOUSLY THIS HAS BEEN A YEAR
OF CHANGE AND A GREAT DEAL

OF CHANGE.

AND THE GUIDANCE AROUND MAXIMUM
OUT-OF-POCKET WAS FINALIZED

AFTER THE PBP WAS ESSENTIALLY
FULLY BAKED.

AND, ACTUALLY, IT WAS
DISTRIBUTED ON APRIL 9th.

AND OUR POLICY MEMO CAME OUT
ON APRIL 16th.

SO TERMINOLOGY DOESN'T
NECESSARILY ALIGN

BETWEEN THE REGULATION
AND WHAT'S IN THE PBP.

SO THIS TABLE IS ALSO
IN THE POLICY MEMO.

AND IT'S ESSENTIALLY A ROADMAP
FOR YOU AS FAR AS NAVIGATING

THE PBP AS FAR AS
THE TERMINOLOGY.

JUST TO HIT ON A COUPLE OF
POINTS.

ESSENTIALLY IN THE PBP THE WORD
"IN NETWORK"

AND IN THE REGULATION
THE WORD "IN NETWORK"

ARE ACTUALLY THE SAME.

THEY'RE SYNONYMOUS.

WHEN IT COMES TO THE TERM
"CATASTROPHIC," THOUGH,

IN THE PBP, THAT'S SYNONYMOUS
WITH COMBINED.

SO WHEN YOU'RE LOOKING AT
A LOCAL PPO

OR A REGIONAL PPO,
IN ORDER TO PLACE

YOUR CATASTROPHIC MOOP AMOUNT
IN THE PROPER PLACE,

YOU REALLY HAVE TO GO
TO THE LOCATION OR THE LABEL

THAT IS COMBINED.

IN THE CASE OF PRIVATE
FEE-FOR-SERVICE, WE DO HAVE

ONE SITUATION WITH

THE PRIVATE FEE-FOR-SERVICE
NON-NETWORK PLANS, WHERE

THE TERM IS REALLY GENERAL.

SO WHEN YOU GO IN THERE TO LOOK
FOR WHERE TO PLACE

THE MOOP AMOUNT, YOU REALLY
ONLY HAVE ONE LOCATION,

AND THAT'S REFERRED TO AS
"GENERAL."

THERE'S ALSO WITHIN THE PBP
THE OPPORTUNITY TO HAVE

AN OUT-OF-NETWORK AMOUNT.

AND AS THIS CHART ILLUSTRATES,
WHAT WE'RE INSTRUCTING IS

THAT WHEN YOU GO INTO THE
OUT-OF-NETWORK, THAT BASICALLY

THAT NEEDS TO BE A NO.

ESSENTIALLY CLICK ON "NO"

IN THAT CATEGORY.

SO, AGAIN, THIS CHART
IS IN THE POLICY MEMO.

THERE'S LANGUAGE AROUND THE CHART
SO THAT IT WILL HELP YOU

NAVIGATE AS FAR AS WHERE TO
PLACE THE MOOP AMOUNTS

FOR THIS COMING YEAR.

MOVING ON TO
THE COST-SHARING REVIEW.

AND AGAIN THE MOOP REALLY DOES
SORT OF FOLLOW ALONG

WITH COST-SHARING BECAUSE
IF YOU ADOPT

THE LOWER VOLUNTARY MOOP AMOUNT,

YOU GET A LITTLE BIT MORE
FLEXIBILITY.

AND WHAT OUR APPROACH IS THIS YEAR
IS TO--IN THE PAST,

WE'VE GOTTEN THE BIDS.

WE'VE CONDUCTED SOME OUTLIER
ANALYSIS.

AND THEN WE'VE GONE BACK
TO THE PLAN.

WE'VE GOTTEN SOME FEEDBACK AND
SAID, "HEY, WHY CAN'T YOU GUYS

JUST GIVE US THE STANDARDS UP
FRONT AND WE'LL GO FROM THERE?"

SO FOR THIS, FOR 2011,
THE POLICY MEMO THAT WENT OUT

ON FRIDAY FOR THE MEDICARE
ADVANTAGE PLANS DOES INCLUDE

THESE COST-SHARING STANDARDS
FOR MEDICARE ADVANTAGE PLANS.

AND, ACTUALLY, THERE'S TWO TYPES
OF TESTS.

ONE IS THE ACTUARIAL EQUIVALENCE
STANDARDS.

AND THEN THERE'S ANOTHER
CATEGORY OF STANDARDS

WHICH WILL BE SERVICE CATEGORY
STANDARDS.

AND I'LL GET INTO THOSE IN
A LITTLE BIT MORE DETAIL

IN JUST A MINUTE OR TWO.

BUT WHAT WE'RE EXPECTING IS THAT
WE'VE GIVEN YOU THE STANDARDS

THROUGH THE POLICY MEMO.

SO IT'S OUR EXPECTATION THAT
YOU'LL BE ABLE TO BAKE THAT

INTO THE BIDS THAT ARE SUBMITTED
JUNE 7th.

AND ONCE THE BIDS ARE SUBMITTED,
WE CAN BASICALLY GO BACK

AND REVIEW TO MAKE SURE THAT
THE BIDS DO CONFORM

WITH THOSE STANDARDS.

ONE THING THAT WE ARE RESERVING
THE ABILITY TO DO--AND THAT IS

ONCE THE BIDS ARE SUBMITTED,
WE ARE GOING TO BE CONDUCTING

OTHER CHECKS, OTHER ANALYSIS
JUST TO MAKE SURE THAT THERE'S

NOT SOME OTHER FORM OF
DISCRIMINATION GOING ON.

BUT OUR HOPE IS THAT BY GIVING
YOU THESE STANDARDS

AHEAD OF TIME, IT WILL MAKE LIFE
A LITTLE BIT EASIER.

ONE THING THAT YOU'LL NOTICE
IN THE STANDARDS--

AND ACTUALLY MARTY TALKED ABOUT
IT, AND CHRIS AS WELL,

IS THAT IN THE HEALTH CARE
REFORM LEGISLATION, WE HAD

3 THINGS CALLED OUT.

ONE WAS RENAL DIALYSIS THAT
NEEDED TO BE 100%

FEE-FOR-SERVICE, OR IN
THE POLICY MEMO, YOU'LL SEE IT

REFERRED TO AS "NO GREATER
THAN ORIGINAL MEDICARE."

IT'S BASICALLY SYNONYMOUS.

BUT ESSENTIALLY RENAL DIALYSIS
CAN'T BE ANY GREATER

THAN ORIGINAL MEDICARE.

IT ALSO SAID

PART "B" CHEMOTHERAPY
ADMINISTRATION SERVICES

CAN'T BE ANY GREATER THAN
ORIGINAL MEDICARE.

WELL, IN THE POLICY MEMO,
WE'VE BASICALLY INCLUDED IN THAT

PART "B" DRUGS AS WELL.

SO YOU'LL SEE THAT IN
THE COST-SHARING GUIDANCE.

SKILLED NURSING FACILITY WAS
INCLUDED IN THE LEGISLATION.

AND ESSENTIALLY OUR VIEW OF THAT IS
THAT ON AN OVERALL BASIS,

THE COST-SHARING NEEDS
TO BE LESS THAN

OR ACTUARIALLY EQUIVALENT

TO FEE-FOR-SERVICE.

ONE THING THAT YOU'LL NOTICE
ONCE WE GET INTO THE NEXT SLIDES

AND YOU MAY HAVE ALREADY
SEEN THIS IN THE POLICY MEMO,

BUT THERE IS SOME LATITUDE TO
HAVE COST-SHARING

DURING THE FIRST 20 DAYS
FOR A MEDICARE ADVANTAGE PLAN.

BUT FOR THE DAYS AFTER
THE 20th DAY,

THE COST-SHARING CAN'T BE ANY
GREATER THAN ORIGINAL MEDICARE.

BUT, AGAIN, KEEP IN MIND THAT ON
AN OVERALL BASIS,

IT STILL NEEDS TO BE LESS THAN
OR ACTUARIALLY EQUIVALENT

TO FEE-FOR-SERVICE.

SO WE'RE GOING TO BACK TO--IF
YOU RECALL

ON THE PREVIOUS SLIDE, WE SAID
THERE'S SORT OF TWO FORMS

OF TESTS. ONE IS ACTUARIAL
EQUIVALENCE,

AND THEN THE OTHER IS
THE SERVICE CATEGORY.

THIS SLIDE'S ATTEMPTING
TO GO INTO--

SHOW YOU A LITTLE BIT MORE

ABOUT WHAT THE ACTUARIAL
EQUIVALENCE TEST IS.

ESSENTIALLY ALL MA PLANS CAN'T
EXCEED COST-SHARING

IN THE AGGREGATE OF MEDICARE
FEE-FOR-SERVICE.

BUT FOR OUR COST-SHARING
STANDARDS FOR 2011, WE'RE

CALLING OUT 5 SEPARATE
CATEGORIES AS WELL, WHERE

THE COST-SHARING CANNOT
BE GREATER

THAN MEDICARE FEE-FOR-SERVICE.

AND IN THE POLICY MEMO, IF YOU'VE
READ THIS, THERE'S ONE

OF THE MOST COMPLICATED TABLES
THAT I'VE SEEN, BUT I'VE BEEN

ASSURED BY OUR ACTUARIES
THAT, YES, ACTUARIES AT PLANS

WILL UNDERSTAND THIS AND IT'S
HELPFUL TO THEM.

BUT IT TELLS YOU IN PAINFUL
DETAIL HOW THAT TEST IS

CONDUCTED SO THAT YOU CAN
MEET THIS STANDARD.

AND THE CATEGORIES
INCLUDE IN-PATIENT,

SKILLED NURSING FACILITY,

HOME HEALTH, DURABLE MEDICAL
EQUIPMENT, AND PART "B" DRUGS.

GOING INTO THE NEXT TEST,
THE SECOND TEST--AND THIS

INCLUDES SERVICE CATEGORY TESTS--
-ESSENTIALLY WHAT WE'VE

DONE IS LISTED OUT

SOME UTILIZATION SCENARIOS,

IF YOU WILL.

FOR INSTANCE, THE SECOND ONE
ON THE CHART HERE IS

IN-PATIENT ACUTE, 10 DAYS.

AND IF YOU LOOK UNDER
THE VOLUNTARY MOOP COLUMN,

IT HAS A NUMBER OF 2,231.

SO WHAT THAT MEANS IS
IF YOU ADOPT

THE LOWER VOLUNTARY MOOP AMOUNT
THAT WE WILL GO INTO THE PBP

AND LOOK AT YOUR COST-SHARING
TO SEE IF YOUR COST-SHARING IS

LESS THAN OR EQUAL TO 2,231
FOR A 10-DAY STAY.

SO WHY DID WE CHOOSE A 10-DAY
STAY?

WHY DID WE CHOOSE A 60-DAY
STAY OR A 6-DAY STAY?

ESSENTIALLY WHAT WE WERE LOOKING
FOR WAS SOME TESTS THAT WERE

BETWEEN AN AVERAGE LENGTH OF STAY
AND A LONGER LENGTH OF STAY

OR A NUMBER OF VISITS

SO THAT WE COULD SORT OF CAPTURE
THE AVERAGE VISIT

VERSUS SOMEONE WHO'S SICKER

SO THAT WE COULD TRY TO IDENTIFY
AND ELIMINATE DISCRIMINATION.

SO THAT'S HOW WE CHOSE
THE TESTS.

AND IF YOU'RE LOOKING AT
THE 10-DAY STAY

AND YOU HAVE THE LOWER
VOLUNTARY MOOP,

YOU HAVE 2,231, BUT IF YOU
HAVE A MANDATORY MOOP AMOUNT,

YOU HAVE A LOWER NUMBER.

SO HERE AGAIN, THAT'S SHOWING

A LITTLE BIT MORE FLEXIBILITY

FOR THOSE FOLKS FOR THOSE PLANS
THAT ADOPT

THE LOWER VOLUNTARY
MOOP AMOUNT.

THE ONE RIGHT ABOVE THAT,
WHICH IS THE FIRST ONE--

THE IN-PATIENT ACUTE 60-DAY STAY--WE
HAVE THE LETTERS N/A

THERE. REALLY, THAT'S
NOT APPLICABLE BECAUSE IT'S

ANOTHER FORM OF FLEXIBILITY IF
YOU ADOPT

THE VOLUNTARY MOOP AMOUNT.

GOING DOWN THROUGH THE LIST,
I THINK THE FIRST, PROBABLY 5

ARE SORT OF SELF-EXPLANATORY.

BUT A FEW SLIDES AGO, WE TALKED
ABOUT THE SITUATION

WITH SKILLED NURSING FACILITIES.

AND AGAIN ON THE ACTUARIAL
EQUIVALENCE TEST,

WE'RE LOOKING ON AN OVERALL
BASIS, IS THIS PLAN

LESS THAN OR ACTUARIALLY
EQUIVALENT TO ORIGINAL MEDICARE?

BUT IN THE COST-SHARING
STANDARDS WITHIN THE PBP,

WE'RE GOING TO BE LOOKING FOR
CERTAIN THINGS.

AND, AGAIN, WE SAID THAT AN MA PLAN
CAN HAVE SOME COST-SHARING

FOR THE FIRST 20 DAYS.

THIS CHART SAYS WHAT
THE LIMITS ARE.

SO IF YOU HAVE A VOLUNTARY MOOP,

THAT'S \$100 A DAY.

IF IT'S A MANDATORY MOOP,
IT'S \$50 A DAY.

SO, AGAIN, SHOWING A LITTLE BIT
OF FLEXIBILITY.

FOR THE SNF DAYS
21 THROUGH 100,

NO GREATER THAN FEE-FOR-SERVICE
ON A PER-DAY BASIS.

SO HOPEFULLY THIS WILL HELP
PROVIDE SOME GUIDANCE

ON HOW TO MEET THIS SKILLED
NURSING FACILITY TEST.

BUT THE LAST TEST ON THE SLIDE
IS HOME HEALTH, WHICH IS

37 VISITS, WHICH IS ACTUALLY
SORT OF LIKE THE AVERAGE NUMBER

OF VISITS FOR A MEDICARE
RECIPIENT.

IF YOU ADOPT A VOLUNTARY MOOP,
YOU DO HAVE SOME LEEWAY

OR THE ABILITY TO HAVE SOME
COST-SHARING ON HOME HEALTH,

WHEREAS ON THE MANDATORY MOOP,
IT HAS TO BE ZERO.

AND, AGAIN FOR THIS SERVICE
CATEGORY TEST, WE'RE GOING IN

TO THE PBP AND LOOKING FOR IT.

ON THE ACTUARIAL
EQUIVALENCE TEST,

WHICH WAS ON THE PREVIOUS SLIDE,
WE WERE GOING

INTO THE BID PRICING TOOL,
OR THE BPT,

TO LOOK FOR THAT INFORMATION.

MOVING TO THE NEXT SLIDE,

THIS IS A CONTINUATION

OF THE SERVICE CATEGORY
COST-SHARING STANDARDS.

AND THE FIRST ONE TALKS ABOUT
PHYSICIAN MENTAL HEALTH VISIT.

AGAIN, JUST AS A REMINDER,
WE SAY 100% OF FEE-FOR-SERVICE.

WE DON'T HAVE A WHOLE LOT OF
REAL ESTATE

ON THESE POWERPOINT SLIDES, BUT
IN THE POLICY MEMO, YOU'LL SEE

THAT IT'S "NO GREATER THAN
ORIGINAL MEDICARE."

IT'S SYNONYMOUS.
IT'S THE SAME THING.

SO IN ESSENCE FOR A PHYSICIAN
MENTAL HEALTH VISIT,

WE'RE SAYING THAT IT NEEDS TO BE

NO GREATER THAN ORIGINAL
MEDICARE

OR YOU CAN HAVE UP TO
A \$40 CO-PAYMENT.

YOU'LL SEE THE OTHER SERVICES LISTED
HERE: RENAL DIALYSIS,

PART "B" DRUGS, AND--WELL,
THE VARIOUS PART "B" DRUGS.

AND IT'S 100% OF
FEE-FOR-SERVICE.

AGAIN, WHICH, IF YOU LOOK
AT FEE-FOR-SERVICE

OR ORIGINAL MEDICARE, MANY OF
THESE ARE EXPRESSED ON

A COINSURANCE BASIS.

IF WE HAVE A STANDARD THAT'S
BASED ON COINSURANCE,

THERE IS LATITUDE TO HAVE
A CO-PAYMENT, BUT YOU NEED

THE GUIDANCE THAT'S IN
THE POLICY MEMO.

THERE IS A SUBSECTION THAT DEALS
WITH COINSURANCE AND CO-PAYMENTS

IN THE POLICY MEMO.

SO IF YOU'RE A PLAN
AND YOU NEED TO MEET

THESE COINSURANCE
REQUIREMENTS,

YOU CAN MEET THE COINSURANCE
REQUIREMENTS BY HAVING

A CO-PAYMENT, BUT YOU HAVE TO GO
BACK AND LOOK IN THE POLICY MEMO

TO SEE HOW YOU DO THAT.

SO THERE IS SOME LATITUDE
TO ACCOMPLISH THAT.

BUT THE LAST SERVICES ON
THIS SLIDE ARE DME.

AND, AGAIN, IF YOU HAVE
A MANDATORY MOOP,

IT'S NO GREATER THAN
ORIGINAL MEDICARE.

IF YOU HAVE CHOSEN THE LOWER
VOLUNTARY MOOP, YOU DO HAVE

SOME LATITUDE ON WHAT
THE COST-SHARING IS.

ONE THING THAT I'LL REMIND YOU
OF, THOUGH, IS THAT IF YOU

THINK BACK TO THAT ACTUARIAL
EQUIVALENCE, OVERALL

THE DME CATEGORY STILL HAS
TO BE ACTUARIALLY EQUIVALENT

WITH ORIGINAL MEDICARE,
THOUGH.

SO YOU HAVE SOME LATITUDE THERE.

BUT WE SORT OF HAVE A CHECK THERE
JUST SO THE FLEXIBILITY

DOESN'T GO TOO FAR.

SO AGAIN, JUST TO SORT OF
TOUCH ON THINGS.

WE HAVE TWO TYPES OF TESTS.
ONE'S THE ACTUARIAL EQUIVALENCE.

AND THEN WE HAVE THE SERVICE
CATEGORY TESTS.

AND THAT'S WHAT WERE ON
THESE LAST TWO SLIDES.

THE SERVICE CATEGORY TESTS
COME FROM THE PBP.

AND THE ACTUARIAL EQUIVALENCE
TESTS COME FROM THE BPT,

OR THE BID PRICING TOOL.

Part 6

Dale: PREVENTIVE SERVICES.

ESSENTIALLY, WITH THE NEW
LEGISLATION, THERE IS A FOCUS

ON THE PREVENTIVE SERVICES,
AND THIS IS A VERY IMPORTANT

ISSUE TO US BECAUSE WE
FEEL THAT IT'S IMPORTANT

FOR BENEFICIARIES TO HAVE
ACCESS TO THESE PREVENTIVE

SERVICES WITHOUT COST SHARING.

FOR 2011, CMS IS STRONGLY
ENCOURAGING PLANS TO COVER ALL

THESE PREVENTIVE SERVICES
WITH A ZERO COST SHARING.

AND THERE'S A LIST OF--I
BELIEVE IT'S 18 SERVICES

IN THE POLICY MEMO THAT
WAS SENT OUT ON FRIDAY.

AS A WAY OF ENCOURAGING THAT
FOR 2011, ON THE MEDICARE

OPTIONS TO COMPARE, WE WILL
IDENTIFY PLANS WHO HAVE

COVERED ALL THESE TESTS
WITH ZERO COST SHARING.

AND WE'LL ALSO IDENTIFY
THOSE PLANS WHO HAVE NOT,

ON THE CONVERSE.

BUT IT IS IMPORTANT FROM OUR
PERSPECTIVE THAT PLANS COVER

THESE PREVENTIVE SERVICES
AT ZERO COST SHARE.

ONE THING THAT WE NEED TO
MENTION IS THE FACT THAT WE

ARE--WE INTEND TO ISSUE

RULEMAKING TO ESTABLISH THIS

AS A REQUIREMENT FOR 2012,
AND ALSO TO INTEGRATE IT INTO

THE MEASUREMENT OF BENEFITS
AND--THE MEASUREMENT OF THESE

BENEFITS INTO OUR
PERFORMANCE RATING.

I GUESS MOVING ON TO CHOICE,
OR MEANINGFUL DIFFERENCE

AND LOW ENROLLMENT--CHRIS
TOUCHED ON THIS EARLIER,

AND THAT IS THAT WE ARE
PLANNING ON CONTACTING

MEDICARE ADVANTAGE
ORGANIZATIONS HERE IN THE NEXT

COUPLE OF WEEKS TO ELIMINATE
LOW ENROLLMENT PLANS PRIOR TO

BID SUBMISSION.

WE'RE ALSO GOING TO BE
COMMUNICATING INFORMATION TO

YOU TO HELP IN MAKING SURE
THAT ALL OF YOUR PLANS ARE

BUILT SO THAT THEY'RE
MEANINGFULLY DIFFERENT, AS WELL.

THE ONE THING THAT I WOULD
ALERT YOU TO--THAT IT IS

IMPORTANT TO READ THAT CROSSWALK
GUIDANCE AS WELL AS THE--

WELL, IT'S ACTUALLY CALLED
"RENEWAL/NON-RENEWAL

GUIDANCE, BUT PEOPLE REFER
TO IT AS CROSSWALK GUIDANCE.

IT'S IMPORTANT TO READ THAT,
BECAUSE IN THIS PROCESS

OF ADDRESSING LOW ENROLMENT
AND MEANINGFUL DIFFERENCE,

THAT MAY BE HELPFUL FOR
YOU AS FAR AS CONSOLIDATING

SOME PLANS.

FOCUSING ON LOW ENROLMENT
PLANS, WE'RE GOING TO BE--

FOR 2011, WE'LL BE LOOKING
AT PLANS WHO HAVE BEEN

IN EXISTENCE FOR
AT LEAST 3 YEARS.

WE'RE GOING TO BE CONTACTING
PARENT ORGANIZATIONS

IN THE NEXT FEW WEEKS TO
POTENTIALLY ELIMINATE PLANS.

CHRIS ALLUDED TO
THESE NUMBERS BEFORE.

FOR NON-SNP PLANS, THAT WOULD
BE FEWER THAN 500 ENROLLEES.

FOR SNP'S, IT WOULD BE PLANS
WITH LESS THAN 100 ENROLLEES.

ONE THING TO KEEP IN MIND,
THOUGH, AND TO THE EXTENT

POSSIBLE BEFORE
WE CONTACT YOU--

WE'RE GOING TO
TRY AND ALLOW

FOR THOSE THINGS THAT
CHRIS IDENTIFIED.

FOR INSTANCE, IN SOME AREAS,
IT MAY BE SERVICING--THE PLAN

MAY BE SERVING A UNIQUE
POPULATION, SO WE'RE GOING TO

TRY TO ALLOW FOR THAT.

WE ALSO WANT TO MAKE SURE
THAT THERE ARE OTHER CHOICES

FOR BENEFICIARIES IN

A PARTICULAR AREA.

SO TO THE EXTENT POSSIBLE ON
THE FRONT END, WE'RE GOING TO

TRY AND ELIMINATE--WELL,
LET ME--POOR CHOICE OF WORDS.

TO THE EXTENT POSSIBLE,
WE'RE GOING TO TRY AND GET

THOSE PLANS OUT OF THE LIST
THAT WE'RE SENDING OUT TO

ORGANIZATIONS SO THAT YOU CAN
LOOK TO ELIMINATE THOSE PLANS.

WE WANT TO GIVE YOU A LIST OF
WHAT WE TRULY BELIEVE ARE LOW

ENROLMENT PLANS THAT REALLY
NEED TO BE ELIMINATED.

NOW, THERE ARE SOME
CASES THAT WE MAY MISS.

IT'S--IT'S SORT OF AN ART
FORM IN IDENTIFYING THOSE,

SO THERE WILL BE AN
OPPORTUNITY FOR YOU WHEN YOU

RECEIVE THIS INFORMATION
TO EITHER SAY, "YES, WE

AGREE WITH YOU.

WE'RE GOING TO ELIMINATE THIS
PLAN FOR 2011" OR "WE DON'T

REALLY AGREE WITH
YOU ON THIS ONE.

WE WANT TO SUBMIT
A BUSINESS CASE."

SO IN THIS INFORMATION THAT
WE'LL BE SENDING TO YOU,

WE'LL BE PROVIDING YOU WITH
INSTRUCTIONS ON HOW YOU CAN

SUBMIT THAT BUSINESS CASE TO
US SO THAT WE CAN HAVE THAT

DIALOGUE AND MAKE
THAT DECISION.

AND THERE WILL BE MORE
INSTRUCTIONS IN THAT.

OUR GOAL IS TO GET THAT
OUT WITHIN THE NEXT

COUPLE OF WEEKS.

ON THE CASE OF MEANINGFUL
DIFFERENCE, ACTUALLY,

KATY ALLUDED TO THIS
THIS MORNING ON PART D.

WE'RE GOING TO BE LOOKING
AT PLANS AT THE COUNTY LEVEL

FOR MEDICARE ADVANTAGE,
AND WE'RE GOING TO BE USING

OUT-OF-POCKET COST DATA,
AND IT'S REFERRED TO BY

THE TERM "OOPC."

AND MANY OF YOU MAY BE
FAMILIAR WITH THIS AS--

THE OOPC DATA IS ACTUALLY USED ON
THE MEDICARE OPTIONS COMPARE

SO THE BENEFICIARIES CAN
GET AN IDEA OF WHAT THEIR

OUT-OF-POCKET COSTS WOULD BE.

SO WE'RE GOING TO BE USING
THAT INFORMATION IN DOING

THE ANALYSIS FOR MEANINGFUL
DIFFERENCE.

ONE THING THAT WE'LL BE LOOK--
I GUESS WE SHOULD GO INTO

A COUPLE THINGS HERE, TOO,
IS THAT IF YOU'RE LOOKING

AT A NON-SNP PLAN, THE
OOPC DATA WILL BE PART

OF THE MEANINGFUL DIFFERENCE,

BUT THERE'S OTHER
PARTS, AS WELL.

AND THAT IS, IF IT'S A--WE'LL
BE SEPARATING PLANS INTO PLAN

TYPES AND THEN WHETHER OR
NOT THEY HAVE PART D OR DON'T

HAVE PART D.

BECAUSE AN HMO IS
DIFFERENT FROM A LOCAL PPO.

A HMO WITH A PART D AND
WITHOUT A PART D IS DIFFERENT.

SO THOSE ARE MEANINGFULLY
DIFFERENT.

BUT WITHIN THOSE PLAN TYPES
AND WITHIN THOSE--WHETHER OR

NOT THE PLAN HAS A PART D
BENEFIT, WE'RE GOING TO BE

LOOKING AT THE OOPC DATA AS A
WAY OF DIFFERENTIATING WHETHER

OR NOT THEY TRULY ARE
MEANINGFULLY DIFFERENT.

WHEN WE'RE LOOKING AT SNP'S,
WE WILL LOOK AT PLAN TYPES,

AND WE'LL ALSO LOOK AT THE
UNIQUE POPULATIONS SERVED.

FOR EXAMPLE, CHRONIC CARE
SNP'S HAVE A NUMBER OF DIFFERENT

POPULATIONS THEY CAN SERVE,
SO OUR GOAL IS NOT TO

ELIMINATE A PLAN THAT IS
SERVING A UNIQUE POPULATION,

SO WE'RE GOING TO BE LOOKING
AT MEANINGFUL DIFFERENCE

BETWEEN THOSE TYPES OF--AT

THAT LEVEL OF DETAIL.

AND AS FAR AS WHAT THE
ACCEPTABLE DIFFERENCE BETWEEN

THE PLAN VALUES WILL
BE FOR 2011, IT'LL BE

\$20 PER MEMBER PER MONTH.

AND THAT'S FOR BOTH PART C
AND D BENEFITS COMBINED.

THE WAY THAT YOU'LL BE ABLE
TO DEAL WITH THAT IS TO--

ESSENTIALLY, IN THE NEXT TWO
WEEKS, WE WILL BE SENDING TO

YOU A WAY TO ACCESS YOUR
OOPC DATA FOR YOUR PLANS.

AND THE OOPC DATA THAT WILL
BE AVAILABLE TO YOU WILL BE

BROKEN OUT BY
SERVICE CATEGORIES.

I BELIEVE IT'S SOMETHING LIKE
30 SOME SERVICE CATEGORIES.

AND IF YOUR ACTUARIES CAN
USE THAT DATA, THEY CAN MOST

LIKELY DO SOME INTERNAL
MODELING SO THAT AS YOU'RE

BUILDING YOUR BIDS TO BE
SUBMITTED FOR JUNE 7, THAT YOU

CAN MAKE INTO YOUR BIDS
A MEANINGFUL DIFFERENCE.

SO WE'LL BE LOOKING TO GET
THAT INTO YOU VERY SHORTLY.

I THINK JUST TO MOVE ON TO A
COUPLE OF KEY POINTS HERE TO

WRAP UP--QUALITY
BID SUBMISSIONS.

IT IS EXTREMELY IMPORTANT THAT
THEY'RE CORRECT, COMPLETE,

AND ACCURATE.

THAT YOU COMPARE THE PBP
INFORMATION TO THE BPT DATA.

THAT YOU GENERATE A SUMMARY
OF BENEFITS TO ENSURE THAT

MARKETING MATERIALS
ARE CORRECT.

AND IT IS IMPORTANT FROM
AN ACTUARIAL

CERTIFICATION STANDPOINT.

THAT DOES MEAN SOMETHING TO
CMS, SO IT'S IMPORTANT THAT

YOU MAKE SURE THAT THE BIDS
THAT YOU SUBMIT ARE COMPLETE

AND ACCURATE.

AND IT'S IMPORTANT THIS
YEAR MORE THAN EVER.

IF YOU'RE A BENEFITS PERSON,
TALK WITH YOUR COMPLIANCE AREA,

TALK TO THE ACTUARIALS--TALK
TO YOUR ACTUARIES.

WORK TOGETHER SO THAT
YOU CAN SUBMIT IT.

AND WE REALIZE AT CMS THAT
WE NEED TO WORK TOGETHER

INTERNALLY, AS WELL, BETWEEN
MEDICARE ADVANTAGE GROUP AS

WELL AS THE PART D GROUP
AND THE OFFICE OF ACTUARY.

AND WE'LL DO THE BEST WE CAN
TO WORK TOGETHER AS WELL AS

WITH OUR CONTRACTORS.

AS FAR AS PLAN CORRECTION
REQUESTS, I'M NOT GOING TO

BEAT ON THIS TOO LONG.

KATY MENTIONED
IT THIS MORNING.

WE REALLY EXPECT THAT TO BE
A RARE SITUATION.

TO THE EXTENT THAT THERE IS
A PLAN CORRECTION SUBMITTED,

THERE WILL BE A
COMPLIANCE LETTER.

IF THERE'S A PLAN CORRECTION
SUBMITTED THIS YEAR AND THERE

WAS ONE SUBMITTED LAST YEAR,
IN ALL LIKELIHOOD, THERE WILL

BE A CORRECTIVE
ACTION PLAN, AS WELL.

AND JUST A QUICK COUPLE
OF SUMMARY POINTS.

JUNE 7 IS CERTAINLY
AN IMPORTANT DATE.

I THINK SARAH'S HIT ON THE
FACT BEFORE AS FAR AS WHO TO

CONTACT IF YOU HAVE
ISSUES WITH HPMS.

HERE IS THE MAILBOX FOR--THE
MA BENEFITS MAILBOX IS

AN IMPORTANT PLACE TO SEND
QUESTIONS OR QUESTIONS THAT

YOU MAY HAVE.

AGAIN, THAT'LL ALLOW US TO
GET YOU CONSISTENT

AND COMPLETE ANSWERS.

AND THE LAST SLIDE HERE IS
DEALING WITH BID TEAM CONTACTS.

THIS INCLUDES MY CONTACT
INFORMATION, AS WELL AS OTHERS

ON THE BID TEAM.

IT ALSO HAS THE REGION
RESPONSIBILITY AT THIS POINT.

ONE THING THAT I WILL
MENTION IS THAT IN SOME CASES,

WE ASSIGN LARGER ORGANIZATIONS
TO AN INDIVIDUAL, SO WE MAY

HAVE TO SORT OF WORK AMONG
OURSELVES TO GET YOU TO

THE RIGHT PERSON.

BUT GENERALLY SPEAKING,
THESE ARE THE PEOPLE WHO ARE

WORKING FOR EACH
OF THE REGIONS.