



**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.

RPPOS 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.

OBTAINING 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.