

MEDICARE ADVANTAGE NEWS

News and Analysis of Medicare Advantage, Medicare Part D and Managed Medicaid

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MA Bid Outlook for '11: Fewer Service-Area And Product Expansions, More Cost Sharing

With less than a week to go until the June 7 deadline for submission of 2011 Medicare Advantage and Part D bids to CMS, several industry actuaries and consultants say they expect to see fewer bids for new service areas and products than in recent years. They also tell *MAN* they're seeing generally small increases in planned cost sharing and slight declines in benefits for next year to compensate for payment cuts and rising costs.

The big complication that plans are facing in preparing 2011 bids, the observers agree, is specific new CMS policies. They cover such key arenas as discouraging service-area expansions by plans that are under scrutiny for quality deficiencies, ensuring that there are "meaningful differences" in the premiums and features of plans offered by the same sponsor, and enforcing mandatory out-of-pocket (MOOP) limits for beneficiaries (*MAN* 5/13/10, p. 1). Those factors seem to be limiting aggressive decisions by many MA plans, according to observers, but none of them envision major MA plan exits other than those caused by the end of "deeming" for private-fee-for-service products in most counties at the end of this year. And none see an end to zero-premium plans in 2011.

Beyond this, though, there are differences in the bid pictures sketched for *MAN* by two actuaries and two consultants. In general, the actuaries see more signs of belt tightening than do the consultants.

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Plans Should Expect Requests for Records Of Most Complex Members in RADV Audits

Medicare Advantage plans undergoing CMS risk adjustment data validation (RADV) audits should expect the agency to request the records of the sickest and/or most complex members, according to SCAN Health Plan, which recently had first-hand experience with the process. Moreover, both SCAN and another MA plan say that organizations undergoing RADV audits should expect CMS to extrapolate the results of the approximately 200-member sample to the rest of the plan's population.

Long Beach, Calif.-based SCAN, which specializes in MA Special Needs Plans and thus has many very ill members with high and increasing risk scores, was among the initial group of 33 plans selected for RADV audits. It got that notification in October 2008, but it did not receive until November 2009 the list of enrollees for which it had to supply medical records, according to Timothy Schwab, M.D., chief medical and information officer.

SCAN, which has about 120,000 Medicare members, had to furnish the requested information, which was for 2006 dates of service, by Feb. 18, 2010, Schwab told a session of the Medicare Revenue Management Conference sponsored by World Research Group in Arlington, Va., May 25. The RADV audits are designed to ascertain whether MA members in a plan actually have the medical conditions and severity that their risk scores indicate and thus whether the CMS payments to the plan are accurate. CMS has

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the authority to fine plans or even shut them down for RADV violations.

The list of members SCAN received from CMS, according to Schwab, had 201 names for which the plan had to validate 521 Hierarchical Condition Category (HCC) codes. To do that, he said, the plan had to look at about 1,400 physician charts but was allowed, as per the RADV protocol, to submit only the one "best" medical record for each patient in the list to support the claimed medical conditions. He said in response to a question from *MAN* that SCAN has not yet gotten any overall feedback from CMS on its submission other than an acknowledgment that it was received.

The 12 to 13 weeks that SCAN had to come up with the records was complicated by the facts that the dates included the holiday period and that the 2006 records often were not available because the physicians involved had retired or died, physicians had not retained the records, or hospitals went out of business, Schwab noted.

There also were problems, he said, in validating the HCCs because of such factors as lack of physician

training in using those codes in 2006. Schwab added that SCAN used both its own and "outsourced" staff to request medical records from physicians and was willing to take them "in any way they'd supply it."

'Signature Attestations' Aided Process

Some physician groups gave "good cooperation," but SCAN had to get its legal team involved with a few others, especially since half of the "pushback" it got related to false contentions that HIPAA didn't allow the physicians to supply the data, he recalled. The task did get a little easier "late in the game," according to Schwab, when CMS told SCAN it could use "signature attestations" from physicians certifying that a record showed the proper diagnosis for the patient involved. That was especially useful in cases when physicians had moved out of the area.

Once the records came in, SCAN used a team of two of its own certified coders to agree on what was the one best medical record in each case. In the process, it sometimes found HCCs that it hadn't originally submitted, but CMS said it would accept those only if the evidence was on the same record submitted, Schwab said.

"Our understanding from the beginning was that the audit findings weren't going to apply to just the 201 records requested," he asserted. While he expects extrapolation of the results in some form, Schwab said "the real test is how they're finally going to do the math." He added that the "sample" requested by CMS "didn't look random" but instead seemed perhaps "where they expected the most mistakes to be made."

That fits with the experience of Mital Panara, vice president of Medicare revenue management at Freedom Health Inc. and a May 26 speaker at the conference. The members for which records are requested, he said, tend to be "the sickest members we have" with perhaps three or four chronic conditions each. And any health plan with risk scores higher than those for beneficiaries in Medicare fee-for-service has a higher than average likelihood of being selected for the targeted RADV audits under CMS guidelines, he explained, which are separate from random ones the agency also conducts.

CMS now will extrapolate identified payment adjustments stemming from the RADV audits to the plan's entire patient population, and "that's a huge difference" from how CMS approached medical record reviews previously, he contended.

Both Schwab and Panara also offered specific suggestions for how MA plans can get ready for RADV audits. Schwab said key processes that can be prepared before CMS sends the list of enrollees to check include:

(1) Enrollee list file preparation (have the team ready to generate the "pursuit list");

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(2) Medical record request, receipt — including how to store — and review, including when signature attestations will be pursued; and

(3) Record submission. If the plan uses an outside vendor for submission, he added, it needs tight oversight of the vendor and in any case should have a system that easily can report on which HCCs already were submitted.

The best way to prepare for a CMS RADV audit, said Schwab, is for the plan to do its own audit and use the findings to train and educate its physician network.

Panara agreed with the need for an MA plan to do a “mock RADV audit” itself and offered the following other steps to minimize RADV risks:

◆ **Make at least monthly risk adjustment payment system (RAPS) submissions;**

◆ **Maintain a detailed RAPS submission history log;**

◆ **Keep detailed reports of data “excludes and includes” together with the reasons for exclusion or inclusion.** CMS won’t give plans a “yes or no” answer on what to include, Panara said, adding that “it’s always a gray line.”

◆ **Don’t compensate risk-adjustment consultants based on “success” or “recovery,”** and change quickly any contracts that call for this form of incentive compensation.

In doing a self-audit for RADV, he added, identify potential members likely to be picked by CMS, store all supporting documentations for their HCCs — since CMS’s data-gathering time frames are “very tight” — and prepare deletion reports for CMS containing all diagnosis codes not supported in the records.

Panara noted that plans have 60 days to appeal CMS RADV determinations, but all appeals decisions are final.

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New CMS Reg Raises Enforcement, Financial Risks for MA, Part D Plans

As CMS attempts to rebalance its status as a regulator and a business partner of Medicare Advantage and Part D organizations through new rules, one industry insider says sponsors may confront major financial challenges from this changing regulatory environment.

Under the regulation released in April, sponsors face increased CMS enforcement through audits, mandatory disclosure requirements and denials of certain contracts and bids (*MAN 4/15/10, p. 3*). These provisions could impact benefit design and have significant financial implications, said Michael Adelberg, vice president of public policy and government affairs for Universal American Corp. and former director of Medicare Advantage operations at CMS.

According to Adelberg, speaking at World Research Group’s Medicare Revenue Management Conference in Arlington, Va., May 25, there are 10 provisions in CMS’s technical and policy regulations issued April 6 that “may impact [MA sponsors’] business assumptions.” They are:

(1) **Appealing risk adjustment data validation (RADV) audit findings.** Although Adelberg said the “giant new section on appealing RADV findings is good news,” he contended that the new trend of CMS extrapolating the audit findings and applying them to the entire business at the contract level could have “enormous” financial implications for plans (see story, p. 1). He noted that the president’s budget anticipates \$7 billion in government savings based on future RADV audits.

(2) **Audits of reported data.** Plans now face a “new direct expense,” said Adelberg, with the requirement to have reported data audited by an independent third party. In addition to the financial burden, plans also face increased compliance risks. “Outliers will get flagged,” he warned, and the results “will become grounds to look at contractors’ performance.”

(3) **Mandatory maximum out-of-pocket (MOOP) limit.** The new regulation (*MAN 5/13/10, p. 1*) establishes a mandatory MOOP limit for all MA plans on overall cost sharing for Parts A and B services. It also continues to offer MA organizations the option of adopting a lower voluntary MOOP limit with greater flexibility in Parts A and B cost sharing than what is available for MA plans that design their benefit packages consistent with the higher, mandatory limit. “I don’t know who could argue that this is not good policy,” said Adelberg. However, the question is “does it become so expensive as to hinder benefit design?”

(4) **Network adequacy requirements for MA plans.** The rule establishes prepopulated values for each county in the United States. Therefore, sponsors now are going to know ahead of time, for example, how many skilled nursing facilities it will need in a particular service area.

This requirement does not apply to incumbent plans, Adelberg noted. So “new plans coming into a county with no existing members will have stricter requirements,” he said.

(5) **Disclosure of compliance problems.** MA and Part D plan sponsors and their contractors are now required to notify the public of compliance problems. Plans now must “divulge to its membership in writing that the organization is in trouble,” noted Adelberg.

In addition to the direct costs of mailing letters and calling enrollees, plans also will face “significant indirect costs,” he said. If a plan fails to satisfy this requirement and is sanctioned by CMS, it will face negative media coverage, potential loss of members and nervousness of investors, explained Adelberg. He pointed out that CMS

also has the right to create special election periods for members in such situations.

(6) Terminating contracts on specific grounds. The new regulation sets out 13 specific grounds for CMS to terminate plan contracts. These include failures to provide accurate required data, meet service-access requirements and meet marketing requirements. If a plan's data are "always consistently in the outlier category, this opens up grounds for eventual termination."

(7) Denying contract applications. The regulation specifically states that CMS can deny a contract application for a plan's past performance. For instance, Adelberg said, if a plan had problems in one area last year, CMS may say that it is not the right time for the plan to expand its service area and that it needs a year of "being clean."

The new regulation "doesn't take away appeal rights," but it explicitly states that the burden is on the applicant/appellant, he maintained. "CMS will deny more applications," Adelberg predicted.

(8) Imposing and lifting sanctions. Under the regulation, CMS can impose sanctions on plans based on the same 13 specific grounds it can use to deny contract applications.

(9) Denying bids that are not "significantly different." Under the regulation, organizations submitting contracts to market plans must submit bids and benefit packages with "substantial differences." For Part D plans, explained Adelberg, this means one standard plan and two enhanced plans.

(10) Applying recovery audit contractors (RACs) to MA and Part D plans. The new regulation allows RACs, which got started in Medicare fee-for-service, to turn their attention to Part C and Part D.

There is a silver lining to all of this rebalancing, said Adelberg. "A smaller group of high performing contractors may result in better program outcomes," he suggested. It now is hard to say that a beneficiary is better off in an MA plan than in an FFS plan, according to Adelberg. "As the landscape slims and data become more robust, it may become easier to prove" the value of MA plans, he contended.

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Texas Awards STAR+PLUS Pacts For ABD Enrollees to Five Plans

A big season for Medicaid managed care contract awards kicked off last month with five plans being selected for the expansion of the STAR+PLUS program in Texas (*MAN 3/25/10, p. 4*). Indiana was expected to make its contract renewal award shortly after *MAN* press time, with Illinois' selection for a five-county mandatory Medicaid managed care pilot program (*MAN 3/11/10, p. 5*) to follow very soon thereafter.

The Texas Health and Human Services Commission's STAR+PLUS program, which now serves the aged, blind and disabled (ABD) population with integrated

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acute and long-term care services in 29 Texas counties, on May 11 picked Centene Corp., Molina Healthcare, Inc. and locally based Parkland Community Health Plan to serve the seven-county Dallas area. The commission selected AMERIGROUP Corp. and Bravo Health Inc. for the six-county Tarrant service area in north Texas. Contracts in both areas are slated to start in February 2011 if the pacts are finalized this summer as anticipated.

Assuming enrollment is equally split in each area among the winning plans, Carl McDonald, a securities analyst at Oppenheimer & Co., predicts each of the plans in the Dallas area will generate about \$90 million in annual revenue, while each in the Tarrant area will garner about \$75 million. The revenue is relatively large because payments to plans are much higher than the overall Medicaid average in light of the services required for this difficult population.

But there are things not to like about this contract, says McDonald in a May 17 research note. First, he points out, the state is requiring plans to cut inpatient utilization by at least 22% compared with levels in the current fee-for-service Medicaid program — which will continue to pay for inpatient hospital costs — or incur substantial penalties. Second, Texas is asking for value-added services to promote healthy lifestyles and improved health outcomes, and the services need to be furnished for at least 12 months and at no cost to the state, he adds.

Brian Wright, a securities analyst at Collins Stewart LLC, estimates in a May 14 research note that Centene and Molina each will get about 50,000 members in the new contract in 2011. The estimated earnings per share the pact will generate in 2011 are 12 cents for Centene and 21 cents for Molina, according to Wright.

Privately held Bravo Health is a newcomer to Medicaid. But it serves Medicare Advantage beneficiaries, including via Special Needs Plans, in the Dallas-Fort Worth area, where it now has more than 20,000 members.

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MA Bids Will Show Less Expansion

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Stephen Wood, senior vice president at Ingenix Consulting, for instance, says he expects to see “reasonably aggressive pricing.” Plans are doing as much as they can to hold down premiums, he says, so again in 2011 they’ll be paring back benefits. One complication, though, for next year, Wood continues, is the new CMS requirement for at least a \$20 per month price difference among MA products from the same sponsor and at least \$22 for stand-alone Prescription Drug Plans. Wood adds that while he hasn’t heard of plans exiting products because

of this requirement, he does know of plans not entering products they had considered.

Another dampening effect comes from CMS’s new “clamping down” on MA service-area expansions, he says. Aside from the impact of its “quite high” provider access requirements, Wood explains, agency officials said at a recent conference that it is dissuading plans with quality problems from following through on intentions to enter new service areas. The combined effect, he theorizes, is that for every three service-area expansions applied for, only one will wind up being granted. He notes that plans will withdraw expansion applications if there are questions rather than running the risk of having their entire contract turned down.

There are other complications related to the end of PFFS deeming in most counties this year. To the extent that PFFS plans have been unsuccessful in network contracting, there may be a lot of PFFS members looking for new plans for 2011, Wood says. Since these members seem likely to be price shopping and appear willing to give up some access, MA HMOs rather than PPOs may be the big gainers, he predicts.

Zero-Premium Products Will Stay in 2011

In terms of specific bid strategies, “our experience is plans will do everything but drop the zero premium — it’s the holy grail,” he asserts. Moreover, he says, keeping that feature in 2011, when base payment rates for MA are at least steady, is not as tough as it will be in future years. However, plans still have to offset rising costs, and “non-medical benefits are the first to go,” but plans also need to keep some differentiating “sizzle” in their offerings.

So Wood envisions small boosts in copays as prevalent for 2011, especially since \$1 to \$3 increases in office-visit copays can save large plans a lot of money and not run afoul of CMS anti-discrimination rules. Other things he reports seeing are intentions to boost copays for durable medical equipment, raise outpatient deductibles and copays, and separate out lab-test copays — “but that causes administrative problems.” Inpatient deductibles, Wood adds, can’t go up much more without violating CMS’s new MOOP limits.

The copay and premium strategies in MA plans’ bids for 2011 will depend on the product, Jeff Fox, president of Gorman Health Group, LLC, tells MAN. On MA HMOs in low-income markets, he predicts, plans will raise cost sharing rather than premiums. Increases, he says, may occur more in ancillary services than in primary care office visits, and some dental and vision benefits may go away. In the PPO market, plans might boost monthly premiums substantially, perhaps from about \$100 now up to \$125, which would still leave them competitive with Medicare supplement products, he adds. *continued*

Fox notes that the supplements themselves will be tougher competitors in 2011 because of the new M and N products, which feature low premiums but more cost sharing than other Med supp products. He reports seeing some MA plan sponsors changing their benefits because of these new products — or even starting those products themselves. But in general, he predicts, MA plans will try to make few or no changes in benefits and premiums where they must compete with M and N supp products.

Service-area expansions in MA for 2011 are a complicated story, Fox suggests. While there was a lot of interest (although less from newcomers than in the past), some sponsors withdrew plans for certain counties, according to Fox, since CMS early in the process was “pretty aggressive” in tightening standards for network adequacy, and sponsors didn’t want to risk antagonizing the agency. Later on, CMS backed off on that, but by then it was too late for the plans to submit applications for those counties before the February deadline, he says.

This doesn’t mean, though, that there won’t be tough competition for PFFS enrollees coming up for grabs in areas where deeming is ending. Fox reports seeing some plan sponsors planning to push PPOs for those members, while others are preparing a “hybrid” that meets PFFS standards of the same cost sharing in and out of network.

Actuary Brian Weible, principal in Wakely Consulting Group, agrees that the push for PFFS members will go in both directions. In “fringe” areas, he tells *MAN*, there will be new “network PFFS plans” in 2011. Sponsors prefer to offer PPOs, he explains, but providers don’t like that acronym, so some sponsors are calling it by a different name and simply asking providers to sign a contract to keep the PFFS product going. The majority of PFFS enrollment in non-rural areas, though, will go the PPO route rather than network PFFS, Weible asserts.

While the competition for PFFS members will be keen, he says, overall there’s a definite decline in intentions by MA sponsors to offer new service areas and products in 2011 because of flat revenues and rising costs. In working with plans on bids, “we’re seeing generally slight increases in cost sharing and slight declines in benefits,” especially on dental, vision, over-the-counter drugs and Part B premium buydowns, Weible reports.

“They’re serving a many-headed master,” he contends, referring to CMS. Aside from no increase in payment rates for 2011, the agency’s new rules limiting MA cost sharing to the actuarial equivalent of FFS in some aspects, along with the new minimum-price-differential guidance, are combining to increase the need but limit the feasible extent for boosting copays, suggests Weible.

Medicare Advantage Enrollment by Plan, as of April 9, 2010

								Year to Date	
	12/1/2008	12/1/2009	1/1/2010	2/1/2010	3/1/2010	4/1/2010	5/1/2010	Change	% Change
Aetna	365,085	433,363	413,574	437,097	440,439	440,602	442,521	9,158	2.1%
AMERIGROUP	9,049	15,000	15,119	15,557	16,302	16,772	17,162	2,162	14.4%
Centene	NA	1,064	1,189	1,667	1,829	1,968	2,068	1,004	94.4%
CIGNA	34,762	51,896	101,885	136,697	144,191	144,191	145,986	94,090	181.3%
Coventry	379,568	516,151	173,811	186,199	187,909	189,942	190,942	(325,209)	-63.0%
Health Net	293,721	287,190	265,279	270,993	272,879	274,725	276,796	(10,394)	-3.6%
HealthSpring	161,459	188,770	188,218	193,322	194,316	195,535	197,320	8,550	4.5%
Humana	1,436,467	1,510,248	1,713,660	1,729,852	1,735,632	1,747,719	1,760,316	250,068	16.6%
Molina	7,843	11,596	11,020	14,525	16,019	17,159	18,419	6,823	58.8%
Triple-S	63,354	58,020	58,737	58,444	57,241	56,608	55,804	(2,216)	-3.8%
UnitedHealth	1,538,699	1,847,077	1,913,276	1,988,470	2,002,397	2,023,507	2,039,747	192,670	10.4%
Universal American	242,038	239,426	262,754	275,825	279,595	286,222	293,487	54,061	22.6%
Universal Health Care	51,587	56,736	50,889	45,844	44,574	43,206	42,479	(14,257)	-25.1%
WellCare	245,076	226,758	123,881	120,573	119,425	117,964	116,695	(110,063)	-48.5%
WellPoint	469,448	420,866	434,197	461,752	466,714	470,021	475,745	54,879	13.0%
Total publicly traded	5,246,569	5,807,425	5,676,600	5,890,973	5,934,888	5,982,935	6,033,008	225,583	3.9%
Total MA enrollment*	10,256,432	11,292,824	10,971,628	11,374,120	11,459,308	11,551,574	11,648,392	355,568	3.1%

*Excluding disease management demo

NA=not applicable

SOURCE: CMS data and Oppenheimer & Co. analysis, May 24, 2010

Weible agrees that plans with zero-premium products will go “to any limits they can” to preserve it, but says plans that have premiums now might go up by perhaps \$10 per member per month for 2011. It still is a “very competitive market,” he says, but, partly since first-quarter 2010 MA results seemed good and enrollment continues to be strong (see table, p. 6), he doesn’t foresee many plan exits for 2011.

The exits envisioned by Pat Dunks, a principal and consulting actuary at Milliman, are basically just in PFFS, where some plans couldn’t get networks together. But Dunks also says new activity reflected in 2011 bids is likely to be “very limited,” and some products will be “falling out” because of the need for the \$20 price differential.

In general, according to Dunks, plans seem to be handling 2011 on a “pretty fiscally sound basis,” cutting benefits and raising premiums in addition to making operational improvements. Plans with premiums are looking at premium hikes of no higher than \$15 or \$20 PMPM and will use benefit cuts (generally higher copays in such areas as office visits) to make up for the remaining revenue shortfall, he says. Some plans, he notes, also are dropping enhanced pharmaceutical coverage. Overall, while for 2010 half of the financial shortfall that plans suffered made its way to members, for 2011 it may be 75% to 80%, he forecasts.

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‘It’s All in the Timing’ for Impact of New Requirements on 2011 Bids

The impact of the new health reform law and regulations associated with it on the upcoming Medicare Advantage and Part D 2011 bids deadline is large and perhaps most clearly visible in the cases of MA Special Needs Plans and stand-alone Prescription Drug Plans, consultants suggest. And a big part of that impact relates to the timing — when the law got enacted and when 2011 applications and bids are due.

On SNPs, for example, the law gave chronic care SNPs a big plus by allowing a change in risk-scoring methodology for their enrollees new to Medicare beginning in 2011, notes actuary Brian Weible, principal in Clearwater, Fla.-based Wakely Consulting Group. The first year an enrollee is in these C-SNPs, Weible explains, is very difficult for the plans because these often very sick members need a lot of medical services. C-SNPs also face new requirements from CMS, which has been concerned that their proliferation was more designed to take advantage of the year-round marketing allowed for SNPs than to sign up individuals who meet the criteria. But the risk-scoring change along with the attractive benefits that C-SNPs offer might spur new entries for 2011, Weible says.

The problem, though, says Stephen Wood, Chicago-based senior vice president at Ingenix Consulting, is that “it’s all in the timing.” The March enactment of the reform law and its favorable rebalancing of risk scores for SNPs came after the February deadline for 2011 product and service-area applications, “so you’re kind of stuck,” Wood points out. Some SNPs got “cold feet,” opting not to file applications for expansions based on what may or may not come out in a reform law that was very much in limbo in February.

While 2011 bids are due June 7, plan sponsors are not allowed to bid for products not included in the February applications.

The upshot is that the rebasing of SNP risk scores, Wood tells *MAN*, will help primarily existing SNPs next year. Knowing they can get higher payments for first-year enrollees may lead to aggressive marketing for 2011 that could result in membership growth, he indicates.

A conversely analogous situation occurs in the case of PDPs. The guidance released by CMS April 16 (*MAN* 4/29/10, p. 1) requires in 2011 at least a \$20 per month price difference in out-of-pocket costs among MA products from the same sponsor and \$22 for PDPs (see story, p. 1).

Particularly in PDPs, according to Wood, this will mean substantial out-of-pocket costs for the “high-end” product to achieve the required differential. He says that makes the “enhanced” product “really expensive” in relation to the basic one, and plan sponsors are concerned that they therefore may need to drop the enhanced product in future years. Since “everybody” starting in 2011 will get the 50% discount on brand drugs in the Part D coverage gap, it may be hard to justify at least a \$22 differential for the enhanced product, he suggests.

The 2011 applications had to be filed well before the guidance came out, so there may be some plans backing off, as is permissible, in the actual bids on their expressed intention to launch new enhanced Part D products next year.

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NEWS BRIEFS

◆ **CMS on May 17 notified Quality Health Plans, Inc. (QHP), which operates Medicare Advantage and stand-alone Prescription Drug Plans, that it would impose sanctions and a civil monetary penalty (CMP) of \$586,000.** In addition to the CMP, CMS said, the Tampa, Fla.-based insurer must immediately suspend all marketing and enrollment of new members for its MA plans and PDPs. Following an on-site audit, the agency said it found that “the plan had failed to fully meet obligations to Medicare beneficiaries by not providing them with timely monthly premium invoices, denying their coverage of approved Part D prescription drugs and [by] the plan’s contradictory and inappropriate payments for medications that are specifically excluded on CMS’s drug formulary.” The agency said it discovered that QHP had not billed beneficiaries for their premiums since January 2008. And QHP recently sent enrollees a lump-sum bill for the entire amount, in some cases up to \$1,000, with no payment options, according to CMS. The agency added that QHP’s PDP enrollees are largely low-income subsidy beneficiaries and that the complaints were brought to CMS’s attention mostly from those members. The insurer has 17,000 enrollees in Florida and New York. Requests for comment made to Angela Hart, director of compliance at QHP, did not result in a response by *MAN* press time. Visit www.cms.gov or www.qualityhealthplans.com.

◆ **Some MA plans may have deceived seniors by attracting healthier enrollees into low-premium plans and then slapping them with high and unexpected out-of-pocket expenses,** according to a new Government Accountability Office (GAO) report. The June 1 report on the relationship between benefit package design and an MA plan’s average enrollee health status was requested by Democrats on the House Ways and Means and the Energy and Commerce committees. The report found that healthier seniors who are enrolled in low-premium plans paid around \$100 more for a typical inpatient stay than did those plans that had beneficiaries in poorer health. These healthier seniors also paid about \$150 more for a typical inpatient mental health stay, around \$500 more for a typical skilled nursing facility stay and above \$300 more for a year of renal dialysis, GAO said. “Recent reports have found that seniors in Medicare Advantage spend fewer days in a hospital, are subject to fewer hospital readmissions, and are less likely to have ‘potentially avoidable’

admissions, for common conditions ranging from uncontrolled diabetes to dehydration, compared to fee-for-service Medicare,” responded Robert Zirkelbach, spokesman for America’s Health Insurance Plans, in a prepared statement. To view the report, visit www.gao.gov/new.items/d10403.pdf.

◆ **Since beginning its controversial Medicaid managed care program for 42,000 aged, blind and disabled (ABD) beneficiaries in February 2009, Hawaii’s QExA program is finally seeing improved services and “beefed up” provider networks,** *Honolulu Advertiser* reported on May 24. In 2007, Hawaii decided to shift the ABD population from fee-for-service Medicaid into managed care plans to achieve cost savings, but the program was delayed several times over concerns about network adequacy for both UnitedHealth Group’s Evercare subsidiary and WellCare Health Plans, Inc.’s Ohana Health Plan (*MAN* 2/6/09, p. 6). According to the newspaper, new statistics on QExA show that both Ohana and Evercare have decreased the average processing time for claims from a high of 22 days to about 10, and increased the number of participating specialists. Complaints from medical providers about both plans have also dropped, with Evercare receiving one in April and Ohana getting two, according to the publication. For the second quarter of 2009, Evercare got 122 complaints and Ohana had 19, the *Advertiser* reported. Visit www.qexa.org.

◆ **MA and PDP operator HealthSpring, Inc. said that last month its board of directors approved the repurchase of up to \$100 million in stock through June 30, 2011.** HealthSpring’s last stock repurchase was in 2008, when it bought \$47 million. At the end of the first quarter of 2010, the insurer had about \$76 million in cash to use for the stock repurchases, according to Carl McDonald, a securities analyst at Openheimer & Co. Inc. Visit www.healthspring.com.

◆ **PEOPLE ON THE MOVE:** HealthSpring named **Sharad Mansukani, M.D.**, to a new board position to help deal with major changes to Medicare resulting from the health reform law. Mansukani will become vice chairman-strategic planning of the board and will cease to be an executive officer of HealthSpring. He was executive vice president-chief strategy officer. The insurer also said that **Mark A. Tulloch**, executive vice president-enterprise operations, added the title of chief operating officer.

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