Medicare Advantage Medical Savings Account (MSA) Plan Application Addendum for Demonstration Applicants

All applicants that wish to offer the MSA demonstration product must complete this addendum as a part of their MSA application.

The demonstration would modify the MA MSA plan design to allow entities to offer competitive products that more closely resemble high-deductible health plans (HDHPs) that are used with health savings accounts (HSAs). In addition, there are certain refinements to improve the product for Medicare beneficiaries. Please answer the questions below.

1. HSA-like Plan Design and Flexibilities for the Demonstration

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM. The demonstration product would have a cost sharing structure in which there is a deductible and a separate limit on out-of-pocket expenditures. The minimum deductible for future years will be announced by CMS in the *Announcement of Calendar Year Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies*, released on the first Monday in April.

A. Has your organization determined the deductible and separate out-of-pocket (OOP) limit it would offer under the demonstration? If so, please provide this information. If your organization has not yet determined these amounts, please provide a time frame in which this information will be determined.

B. Will your organization offer more than one plan under the demonstration? If so, indicate whether or not the deductible and OOP will be uniform across plans or if they will vary.

C. Provide a description on any cost-sharing before and after the deductible. Cost-sharing before the deductible is limit to coverage of preventive services. If you will offer non-Medicare covered preventive services through an optional supplemental benefit provide a description of associated cost-sharing.

LEVEL OF DEPOSIT IN RELATION TO THE DEDUCTIBLE. The deductible must exceed, by at least $500, the yearly deposit into the enrollee's savings account.

COST SHARING FOR NETWORK PLANS. HDHPs that are network plans would be allowed to have different cost sharing for in-network versus out-of-network services, including the option of a separate out-of-pocket cap for in-network in addition to a total out-of-pocket cap.

A. Will your organization offer a network or a non-network product? If your organization intends to offer a network product, please describe any differential in cost-sharing for in-network and out-of-network services.

B. Describe any supplemental benefits that will be offered under the demo. Describe

any differential in cost-sharing for supplemental benefits from the standard Medicare A/B benefits and for in-network and out-of-network services.

FULL COVERAGE OF CERTAIN SERVICES BEFORE THE DEDUCTIBLE IS MET. Before the deductible is met, there could be coverage of preventive services up to the IRS limits. Other services that promote improved health and cost-effective care could also be covered before the deductible is met.

A. Please provide a description of the preventive services that will have full or partial coverage before the deductible is met. If you will offer coverage of non-Medicare covered preventive services, provide a description of these services and whether or not any cost-sharing for these services will apply to the plan deductible. If you will not offer coverage of preventive services before the deductible, please provide an explanation.

TRANSPARENCY. In line with the best practices of HSA/HDHP plans, demonstration sponsors would be required to provide information to enrollees on the cost and quality of individual practitioners and providers, and offer a program to assist enrollees in the use of that information.

A. Describe how your organization will provide cost and quality information to enrollees, including screenshots for any web-based tools used to meet this requirement.

B. If your organization will use a web-based product to meet this requirement, explain how you will provide this information to enrollees that do not have access to the Internet.

C. Describe how your organization will obtain information regarding cost and quality in the requested service area. Will this information be personalized to the member? If no, then explain how enrollees will be able to use this information to make personal medical decisions.

D. Provide a description on how your organization will track enrollee usage of information provided on the cost and quality of providers. Be sure to include how you intend to track use of health services between those enrollees who utilize transparency information with those who do not. How will you share this information with CMS?

2. Service Area and Uniform Benefit Package Requirement

The service area of the demonstration product must consist of at least an entire State or territory. The benefit package or packages offered by an organization must be uniform throughout the State and available in the entire State. (In the case of the District of Columbia, an organization must also include in its service area at least one contiguous State.)

A. Please list the States in the proposed service area.

B. Will there be more than one benefit option in each service area? If so, describe the differences.

C. Will benefits differ among different states? If so, describe the differences.

D. Has your organization done any modeling on projected enrollment for the requested service area? If so, please provide figures on projected enrollment and the characteristics of beneficiaries who are most likely to enroll into your plans (for example, what type of Medicare coverage do they currently have?). If you have figures beyond the first year, please provide that information as well.

3. <u>Payment Levels</u>

The total payment on behalf of each enrollee will be the same as under the current MA MSA provisions. That is, the beneficiary-level monthly capitation payment (the deposit plus plan payment) will equal the plan benchmark adjusted by the individual enrollee's risk score. (The uniform MA MSA deposit reflects the plan-level projected risk profile and is the difference between the plan A/B benchmark and the plan A/B "bid" for the HDHP.)

4. <u>Options for Beneficiary Deposits</u>

PERIODIC DEPOSITS. Generally there would be a yearly deposit paid in one sum in advance. Plans may propose variations on this approach, such as semi-annual deposits; such proposals should address cases in which health care costs are incurred early in the year that exceed amounts deposited, but not the amount that would be deposited at the beginning of the year under a regular MSA plan.

A. If your organization proposes periodic deposits into the beneficiary accounts, provide a description, including the frequency of the deposits. Explain how you would address cases where the enrollee incurs high health costs early in the year.

B. If you propose to make periodic deposits, explain why your organization believes this is more beneficial than an annual, lump-sum deposit to enrollees.

VARIABLE DEPOSITS. While one option is to have a uniform deposit for each enrollee, CMS is soliciting proposals for ways in which deposits to beneficiary accounts can be greater for beneficiaries with higher expected health care costs. For example, an organization could propose the creation of annual tiers of deposits (where "higher risk" tiers are assigned higher deposits), and identification of a method for assigning enrollees to a tier. CMS also is examining whether there might be other options that could result in increased deposits for individual beneficiaries.

A. If your organization proposes variable deposits for different enrollees in the same plan, please provide a description. Describe the methodology used to determine the

amount received by each enrollee, such as the creation of annual tiers of deposits.

B. Provide a description on how you will educate enrollees on how their deposit amount is determined, and why different members have different deposit amounts.

DISTRIBUTION OF DEPOSITS. CMS would make necessary changes to ensure effective administration of the new product. For example, if there are variable deposit levels, CMS could send the entire payment to the plan, and the plan would be responsible for distributing the appropriate portion into each enrollee's MSA. CMS would develop reporting requirements for the deposits.

RECOVERY OF DEPOSIT. CMS will work with plans in the demonstration to ensure a timely and effective recoupment process.

A. Description how you intend to recover current-year deposit amounts for members who are disenrolled from the plan before the end of the calendar year.

5. Other Issues

EMPLOYER-ONLY PRODUCTS. Under this demonstration (and also for regular MSA plans), MA organizations will be allowed to offer MSA plans in the employer group market only. CMS will not apply its usual policy of requiring an MA organization to offer an MA plan to non-employer group members in order to provide a plan that is limited to employer group members.

- Will your organization offer an employer/union group waiver plan? If so, follow the instructions at http://www.cms.hhs.gov/EmpGrpWaivers/01_Overview.asp for completing the 2008 Application for MA Organizations to Offer New Employer/Union-Only Group Waiver Plans (EGWPs). To complete the application, please access the following link in HPMS:

  Contract Management > Contract Management > Select Contract Number > Online Applications/EGWP Attestation

- Please note that employer/union group waiver plans only have to be licensed in one State in order to have a national service area.

- MA organizations offering employer/union group waiver plans also can vary the cost-sharing amounts and supplemental benefits for each employer/union group in its MSA plan.

RELATIONSHIP TO PART D DRUG COVERAGE. MSA plans may not include Part D benefits. However, plans may design a stand-alone PDP product that would be attractive to enrollees in the demonstration product while being offered to the general Medicare population. For employer-group only plans, the stand-alone PDP may be an employer-group only product.
LOCK-IN. As with the MA MSA, enrollees would be locked in for the entire calendar

year, unless they move out of the plan's service area for more than six months.