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CENTER FOR MEDICARE

TO: Office of Management and Budget

FROM: Lori Robinson, Director
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DATE: December 8, 2014

SUBJECT: Response to CMS-R-262 60-Day PRA comments

CMS appreciates the comments provided on the Paperwork Reduction Act (PRA) package CMS-R-262, *Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)*. Our responses to the comments submitted are below.

Plan Benefit Package (PBP) and Summary of Benefits (SB) Comments

1. PBP Section D – Optional Supplemental Benefits

The Medicare-covered comprehensive dental cost-sharing fields are active. However, we are unable to exit (validate) if data is entered.

If this field should not be utilized, we suggest it be grayed out and made unselectable in the PBP.

CMS RESPONSE: CMS has reviewed this comment and will consider this enhancement for the next contract year.

2. PBP Section C – OON Groups

The current limit on the number of Out-of-Network (OON_ groups in Section C has restricted the way some of our plan benefits appear in the SB. We are concerned the limit is impacting the filing in a way that will potentially cause reader confusion. Increase the limit so that the plan benefits can be more accurately captured. For example, under 11c, we cover supplies at $0 and therapeutic shoes and inserts at 20%. The SB is pulling in two separate cost shares (one for a $0 copayment and the other a 20% coinsurance). If we did not have a limit to the number of groups, we would be able to file this benefit under one group as a range of 0-20%.

CMS RESPONSE: CMS allows up to 15 OON groupings. A user is allowed to create an OON group and provide a minimum and a maximum range. The PBP software can already accommodate what this user is requesting.

3. PBP Section C – OON Groups

Some of the benefit selections in Section C (such as 11b and 11c) contain multiple benefits with different cost-shares. Break sub-categories 11b and 11c selections out into their own individual benefit representations (as they are in Section B) so that the cost-sharing can be captured more accurately. For example, under 11c, we cover supplies at $0 and therapeutic shoes and inserts at 20%. If these benefits were split into separate selections, we would be able to file supplies at $0 and therapeutic shoes at 20%.

CMS RESPONSE: CMS allows up to 15 OON groupings. A user is allowed to create an OON group and provide a minimum and a maximum range to account for all of the services in the given benefit category. CMS will consider this request for a future release.

4. SB – General

Out-of-Network authorization and referral requirements are not appearing in the SB for benefits that had requirements entered in the PBP. Add the superscript numbers (1,2) to the benefit headers when it's required for either In-Network or Out-of-Network.

CMS RESPONSE: CMS will consider this as a future enhancement. The superscript numbers are displaying if there is any authorization or referral requirements for in-network benefits. Authorization and referral data entry currently does not exist for out-of-network benefits. For HMOPOS plans, they can indicate authorization and referral requirements, but there has not previously been a requirement to display this data.

5. SB – Inpatient Services

We are experiencing an issue in the Inpatient Hospital section of the SB for plans with $0 cost-sharing OON. For services "(1a) Inpatient Hospital - Acute" in the screen "SECTION C: POS - INPATIENT - BASE 4", we have entered a copayment amount of $0 with Zero (No copayment per day) day intervals. With these entries, the SB is generating a blank Out-of-Network sentence with no cost-sharing.

Display a sentence similar to "You pay nothing" (which populates for In-Network with a similar entry).

CMS RESPONSE: CMS will be addressing this bug with the contract year 2016 release of the PBP/SB software.

6. SB - Transportation
The SB no longer displays the number of trips. To minimize reader confusion, we would suggest adding the number of trips to the description.

CMS RESPONSE: CMS has further reviewed this requirement and has decided not to implement this level of detail for the CY2016 SB.   Adding this level of detail created a level of beneficiary confusion during beneficiary SB testing.

7. SB – Hospice

Hospice category listed in SB. To minimize reader confusion, we would like to suggest removal of the Hospice category altogether, as this is not currently an MA benefit.

CMS RESPONSE: Hospice is a benefit covered for all Medicare beneficiaries, and CMS believes it would be misleading to remove this benefit. If this benefit was removed from the MA SB benefit display, users may interpret it to mean they do not have any hospice coverage if they are enrolled in a MA plan.

8. SB – Dental

Plans with a periodicity entered as "Other, describe" are generating a sentence of "for up to 1" in the SB. To minimize reader confusion, we would suggest removing the periodicity for entries with "Other, describe" and revise to a general statement such as "See your EOC for details".

CMS RESPONSE: When the periodicity of “other, describe” is selected, CMS does not know the periodicity because it is described by the plan in the notes field. In these instances, the plan user should use the SB section III free-form text to describe the periodicity requirements.

9. SB – Urgent Care

The SB is displaying the text "depending on the service" following a range of cost-shares entered into the PBP. We enter a range to account for services provided at contracted vs. non-contracted care centers. Revise this statement to read "depending on the location" to accurately capture the intent of the range.

CMS RESPONSE: If the user requests a change to the display of the SB sentence, the user should request an SB hard copy change. This is standardized language that displays for all contracts.

10. SB – MOOP display

The maximum out-of-pocket statement in the SB does not clarify that it applies only to Medicare-covered services. Please revise to state that this limit only applies to Medicare-covered services.

CMS Response: Throughout the SB, the use of “Medicare” vs. “Non-Medicare” has been removed. This was outlined in multiple CMS communications to plan users during the SB redesign. It has been determined that it is more important to communicate the plan-covered benefits and not differentiate between what is covered under Original Medicare or is a supplemental plan benefit. CMS will not consider this change for the future.

11. SB – Coverage Limit Display

This statement appears in the SB for plans that have coverage limits: "Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply". We believe this statement may cause confusion for readers because there are also coverage limits on out-of-network benefits as well. Please revise and remove the specification of "in-network".

CMS RESPONSE: The CMS SB already accounts for an out-of-network sentence if benefits out-of-network are included in the coverage limit. The sentence that generates is as follows: “Our plan has a coverage limit every year for certain ***out-of-network*** benefits. Contact us for the services that apply.”

12. SB – Comprehensive Dental

The following statement was added to the 2015 SB: "Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth". We believe this sentence is confusing and would suggest removing it from the SB for plans that do not offer additional dental coverage. For plans that offer supplemental benefits, we would suggest adding a description of the comprehensive benefits included.

CMS RESPONSE: CMS will consider this as a future enhancement. CMS believes it is important, however, to notify beneficiaries that the dental benefit covered under Original Medicare is small.

13. SB – Outpatient Therapies

The outpatient group and individual therapy visits are not broken out between the different 7e and 7h cost-shares in the SB. Please add cost-sharing sentences to highlight the differences between these benefits.

CMS RESPONSE: CMS will consider this as a future enhancement. Organizations should use SB Section III (the free-form text) to highlight any benefit differences that should be highlighted.

14. PBP – Section B-14

The additional annual physical exam is not appearing in the SB for plans that offer coverage (as entered in 14b of the PBP). Add the respective description for plans that cover this benefit.

CMS RESPONSE: CMS will consider this as a future enhancement. Organizations should use SB Section III (the free-form text) to highlight any benefits that do not automatically generate in the SB display.

15. PBP – Rx Section

Plans that offer gap coverage display the following statement: Under this plan, you may pay even less for the brand and generic drugs on the formulary. The plan offers additional coverage for [___ formulary generics and ___ formulary brands]. <The overall gap coverage description (i.e., few, some, many, all) for formulary drugs will be populated from the approved Medicare and You Handbook data.> Due to the timing of the Medicare and You release, we would suggest revising this to read as a general statement that wouldn't be held up by the release. If possible, we would suggest "The plan offers additional coverage in the gap".

CMS RESPONSE: Starting in CY2015, CMS no longer used gap coverage labels and instead displays the gap coverage cost sharing amount. This has been found to be more helpful to beneficiaries. Since CMS no longer displays gap coverage labels, we will not consider this for a future release. The following language is currently displayed: “Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.”

16. SB – OON Display

For HMOPOS plans, benefits that are not covered out-of-network have been excluded from the SB. To minimize reader confusion, we would like to suggest adding a statement such as "Out-of-Network: Not Covered" to help clarify the plan's coverage.

CMS RESPONSE: CMS will consider this as a future enhancement. CMS only displays plan covered benefits and believes the SB will be unnecessarily lengthened if we also include which services are not covered by the plan.

17. SB – Fitness Benefit

The fitness benefit description was removed from the SB for 2015. Add the fitness benefit description back into the SB since it is a popular and highly utilized benefit.

CMS RESPONSE: CMS will consider this as a future enhancement. Organizations should use SB Section III (the free-form text) to highlight any benefits that do not automatically generate in the SB display.

18. PBP - Optional Supplemental

The deductible for comprehensive dental in the Optional Supplemental screens is not available, so the deductible value must be entered in the notes section.

CMS RESPONSE: For PPO plans, there is a requirement that they cannot enter a deductible at a service category level (all deductibles are at the plan level). PPOs can however enter a deductible at the optional supplemental package level.

19. PBP – Section B:

Currently, only the Inpatient benefit allows for tiered copays in the PBP software. If there are tiered copays for any other benefits, the cost shares must be entered as a range along with an explanation in the notes section. Add a field for each category to note whether or not there is a cost share range due to tiering.

CMS RESPONSE: CMS has updated the PBP to allow for tiered benefits throughout the PBP for CY2016. This will be available for all service categories with the exception of B-4a: Emergency Care, B-4c: Worldwide Emergency/ Urgent Coverage, B-10a: Ambulance Services, B-15: Medicare Part B Rx Drugs, B-20: Prescription Drugs and for MMPs.

20. SB – Comprehensive Dental

There is no description for mandatory supplemental comprehensive dental benefits in the SB. Add a generic comprehensive bullet for plans that offer the dental mandatory supplemental benefit and refer readers to the EOC for details.

CMS RESPONSE: CMS will consider this as a future enhancement. Organizations should use SB Section III (the free-form text) to highlight any benefits that do not automatically generate in the SB display.

21. SB – Monthly Premium Deductible and Limits

Erroneous out-of-pocket sentence generation when no out- of-pockets was entered in the PBP. We offer Cost Plans. Two PBPs indicated in Section D of the PBP software that there was not an out-of-pocket maximum. The Summary of Benefits, Section II, Is there any limit on how much I will pay for my covered services, had the following sentence generate: No. There are no limits on how much our plan will pay. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. The second sentence is in accurate. We recommend the Summary of Benefit sentence generated only state, No. There are no limits on how much our plan will pay, when no out-of-pocket maximum is entered in the PBP.

CMS RESPONSE: CMS will be addressing this bug with the contract year 2016 release of the PBP/SB software.

22. SB - Comprehensive Dental

We use PBP Section 16B to enter our optional supplemental dental benefits. There is a field to enter a deductible if one applies which we did, and this entry aligns with our comment in this section. A sentence generates in the Summary of Benefits Dental benefit section which states, -
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing after you pay your deductible. There is an option on screen 16b Comp Dental Base 1 to indicate if the plan provides Comprehensive Dental
Items as a supplemental benefit under Part C, and we checked, yes. We also entered the comprehensive dental deductible in Section D, Optional Supplemental - Label and Premium #1 screen. We recommend if a plan indicates yes in section 16B they intend to offer comprehensive dental items as a supplemental benefit, that a sentence regarding any deductible not generate in the Dental Section of the SB. This is not the correct section of the SB for this sentence to generate.

CMS RESPONSE: CMS will consider this as a future enhancement. Please note, optional supplemental benefits require a plan enrollee to pay an additional premium for to obtain the benefit (i.e., the beneficiary does not automatically have the benefit by being enrolled in the plan). It does not make sense to group optional supplemental benefits together with Original Medicare and mandatory supplemental benefits (which all beneficiaries in the plan obtain by being enrolled in that plan).

If you have any questions regarding our responses, please contact Sara Walters at sara.walters1@cms.hhs.gov or 410-786-3330.

Thank you.