

FACT SHEET

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Final 2012 payment policies for Medicare drug and health plans would maintain beneficiary choice, improve quality, and lower Part D cost-sharing
Combined Rate Announcement and Call Letter now available

The Centers for Medicare & Medicaid Services (CMS) today issued changes to Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans for 2012. These changes will help hold insurance companies accountable, improve the quality of care, and ensure Medicare Advantage and Part D plans remains affordable.

This year's updates, detailed in what is known as the Rate Announcement and Call Letter, also include several important changes to strengthen and improve Medicare Advantage and Medicare Part D, including:

- **Higher quality care:** A strong Quality Bonus Payment demonstration will give financial incentives to Medicare Advantage Organizations to improve quality of care for people with Medicare.
- **Beneficiary Protection:** CMS will review all MA bids to ensure beneficiaries are protected from excessive increases in cost sharing or decreases in benefits that account for significant changes to individual Medicare Advantage Organization payment rates. CMS will use authority provided by the Affordable Care Act to ensure Medicare Advantage Organizations do not pass on unreasonable premium increases to people on Medicare.
- **Lower drug costs:** The Medicare prescription drug benefit will be improved by taking further steps to close the Part D coverage gap, or "donut hole." In 2012, seniors in the donut hole will continue to receive a 50 percent discount on their brand-name drugs and coverage of generic drugs in the gap will increase from 7 to 14 percent.

These new tools add to others in the Affordable Care Act that contributed to a 6 percent decrease in Medicare Advantage premiums, 6 percent increase in Medicare Advantage enrollment, and an increase in benefits, on average, in 2011.

Program updates highlighted in today's Rate Announcement and Call Letter include:

- The final estimate of negative 0.16 percent change in the National Per Capita Medicare Advantage Growth Percentage ("Growth Percentage"). This metric measures the estimated growth in per capita expenditures for Medicare beneficiaries and will help determine the benchmarks for Medicare Advantage Organizations.
- A revision of the Quality Bonus Demonstration to create stronger incentives for Medicare Advantage Organizations to improve the quality of care being provided to members. The final quality bonus percentages are unchanged from the Advance Notice. We will apply the plan's quality

bonus percentage to both the applicable amount and the specified amount when calculating the blended benchmark, and will not cap the blended rate at the level of the pre-Affordable Care Act rate for plans with 3 to 5 stars.

- Implementation of the clinically updated CMS-HCC model initially proposed in the 2011 Advance Notice for PACE organizations for 2012
- Use of the minimum frailty score among PACE organizations with at least 100 respondents to the HOS-M as the threshold, in order to determine which FIDE SNPs have levels of frailty similar to PACE, and would therefore receive frailty adjusted payments in 2012
- New guidance on a special enrollment period in 2012 to enable beneficiaries to switch to a Medicare Advantage plan or a prescription drug plan with a 5-star-quality rating at any time during the year
- New cost-sharing thresholds for Medicare Advantage and Prescription Drug plan benefit packages that help CMS to ensure plan benefit designs do not discriminate against beneficiaries in poor health
- An adjustment of 3.41% that would apply to all plans' Part C risk scores to account for differences in coding patterns between Medicare Advantage plans and Medicare Part A and Part B providers
- Changes in calendar items and annual renewal marketing material due dates as a result of the earlier Annual Enrollment Period (AEP)
- Statutory updates to the annual benefit parameters for the defined standard Part D prescription drug benefit
- New guidance regarding how Part D sponsors handle prescriber identifiers on Part D claims and PDE records

Part D Benefit Parameters	2011	2012
Defined Standard Benefit		
Deductible	\$310	\$320
Initial Coverage Limit (Total drug costs after deductible before hitting coverage gap)	\$2,840	\$2,930
Out-of-Pocket Threshold (Total amount beneficiary pays before hitting catastrophic phase)	\$4,550	\$4,700
Minimum Cost-sharing for Generic/Preferred Multi-Source Drugs in the Catastrophic Phase	\$2.50	\$2.60
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	\$6.30	\$6.50
Retiree Drug Subsidy		
Cost Threshold (Amount the RDS sponsor must spend before they can claim the RDS subsidy.)	\$310	\$320
Cost Limit (Amount after which the RDS sponsor can claim no RDS subsidy.)	\$6,300	\$6,500

(Note: The changes from 2011 to 2012 are rounded to the closest appropriate level.)

The Rate Announcement and Call Letter may be viewed using the following link:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>