

DEPARTMENT OF HEALTH & HUMAN
SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

Office of Communications

CMS NEWS

For Immediate Release

Friday, February 17, 2011

Contact:

CMS Office of Public Affairs
202-690-6145

CMS PROPOSES 2013 PAYMENT & POLICY UPDATES FOR MEDICARE DRUG & HEALTH PLANS TO ENSURE CHOICE AND IMPROVE QUALITY

Public comments now open for 2013 combined Advance Notice and Draft Call Letter

The Centers for Medicare & Medicaid Services (CMS) today announced proposed payment and policy guidance for Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans for 2013 that will help continue the trend of lower premiums and stable or improved benefits that beneficiaries in these programs have experienced over the last two years. The preliminary trend factors included in the proposed guidance reflect an estimated annual growth rate of 2.47

percent, which will sustain a strong Medicare Advantage landscape for 2013. Earlier this month, CMS announced that Medicare Advantage premiums had dropped 7 percent over the past year while enrollments increased by about 10 percent. The guidance announced today is a proposed draft and CMS is accepting public comment.

The 2013 Advance Notice and the draft Call Letter, released today, will maintain access to Medicare Advantage (MA) plans as an affordable option for people with Medicare and ensure drug and health plan sponsors are accountable to America's senior and disabled beneficiaries for improved quality of care and stable cost-sharing for the coming year.

"CMS is proposing policies that will help keep costs low and make Medicare stronger," said Jonathan Blum, CMS Deputy Administrator and Director of the Center for Medicare.

For the 2013 benefit year, as in 2012, CMS has combined the Advance Notice and the draft Call Letter into one single guidance document that contains provisions of the Affordable Care Act, revisions to payment methodologies, and other policy and operational process updates for Part C organizations and Part D sponsors.

Proposed guidance for 2013 includes:

- **Controlling Beneficiary Costs and Premium Increases:** CMS will again exercise its authority under the Affordable Care Act (ACA) to deny bids, if it determines that the bid proposes too significant an increase in cost sharing or decrease in benefits from one year to the next.
- **Lower drug costs:** CMS will address improvements in the Medicare prescription drug benefit, specifically those provisions that close the Part D coverage gap, or "donut hole." As a result of the Affordable Care Act, in 2013 eligible drug plan enrollees with liability in the donut hole will continue to receive a 50 percent discount on covered brand name drugs and in addition, will see a further 2.5 percent reduction in cost sharing on such drugs. For generic drugs in the gap, cost sharing shrinks to 79 percent, from 86% in 2012. People enrolled in Medicare Part D, who are not otherwise subsidized and enter the coverage gap, will pay less each year until 2020, at which time they will pay only 25% for covered brand-name and generic

drugs. This is the same percentage paid in the initial coverage phase after the deductible is met.

- **Stronger Part D & MA plan quality:** In 2013, CMS will alert plan members if their drug or health plan has failed for three straight years to achieve at least a three star quality rating and offer a special enrollment period, if desired, that will allow the member to move to a higher quality plan. For MA plans, the three-year Quality Bonus Payment demonstration will continue to provide financial incentives to improve quality of care for people with Medicare.
- **Reducing inappropriate over-use of prescription drugs:** For Part D plans, CMS will propose drug utilization management improvements to address overprescribing and overutilization of opiates and other medications to ensure beneficiary safety and prevent fraud.
- **Supplemental Benefits:** CMS is clarifying its definition of certain supplemental benefits in an effort to ensure transparency and consistency across all MA plans that choose to offer such benefits.

Program proposals highlighted in today's Advance Notice and draft Call Letter for 2013 include:

- Preliminary estimates of the MA Growth Percentage and the FFS Growth Percentage which are trend factors applied to the county rates. The combined effect of these growth percentages is estimated to be 2.47 percent. This metric measures the estimated growth in per capita expenditures for Medicare beneficiaries and will help determine the benchmarks for Medicare Advantage plans. This positive growth trend will help ensure that beneficiaries maintain a choice of plans without significant increases in premiums or decreases in benefits.
- Notice of changes under the Affordable Care Act that move the MA benchmarks closer to Medicare fee-for-service costs and base part of the MA payment on plan quality. CMS discusses the transition to fee-for-service based rates and the quality bonus payments. Final benchmarks will be announced in the 2013 Rate Announcement published on April 2, 2012.
- The Medicare-Medicaid Coordination Office (MMCO) has issued guidance for organizations interested in offering demonstration plans in 2013 under the Capitated Financial Alignment Demonstration. CMS is seeking comments on

the requirements that were detailed in a MMCO memorandum issued in January 2012.

- Continuing with a coding pattern adjustment of 3.41% that is applied to all MA plans to account for differences between Medicare Advantage plans and Medicare Part A and Part B providers, and to improve plan payment accuracy.
- Statutory updates to the annual benefit parameters for the defined standard Part D prescription drug benefit. They include:

Part D Benefit Parameters	2012	2013
Defined Standard Benefit		
Deductible	\$320	\$325
Initial Coverage Limit (Total drug costs after deductible before hitting coverage gap)	\$2,930	\$2,970
Out-of-Pocket Threshold (Total amount beneficiary pays before hitting catastrophic phase)	\$4,700	\$4,750
Minimum Cost-sharing for Generic/Preferred Multi-Source Drugs in the Catastrophic Phase	\$2.60	\$2.65
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	\$6.50	\$6.60
Retiree Drug Subsidy		
Cost Threshold (Amount RDS sponsor must spend before claiming the RDS subsidy.)	\$320	\$325
Cost Limit (Amount after which RDS sponsor claims no RDS subsidy.)	\$6,500	\$6,600

(Note: The changes from 2012 to 2013 are rounded to the closest appropriate level.)

The Advance Notice and draft Call Letter may be viewed using the following link:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/> then click on Announcements and Documents for access the 2013 files.

Comments on the proposed Advance Notice and draft Call Letter are invited from the industry and other stakeholders and must be submitted by close of business/6 p.m. Eastern Standard Time on March 2, 2012. Comments may be submitted by e-mail to

AdvanceNotice2013@cms.hhs.gov.

The final 2013 Rate Announcement and Call Letter will publish April 2, 2012.

###