CMS, Office of Strategic Operations and Regulatory Affairs Division of Regulations Development – C
Attention: Bonnie L. Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

December 20th, 2007

To whom it may concern:

Per the Paperwork Reduction Act of 1995, we've attached a number of comments back to CMS on our review of the Draft 2009 Plan Benefit Package (PBP tool). Our comments are based on a careful review and testing of the 2009 PBP Beta software, as well as a review of issues arising from Bland & Associates review of our PBPs during the 2008 PBP/BID submission process and a review of issues requiring us to request hard copy changes to our 2008 member materials directly linked to problems with the PBP. I"ve outlined a number of comments directly linked to Medicare Cost plans as well as issues directly linked to MA-PD plans.

Thank you for the opportunity to share our comments with you.

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From: HPMS [mailto:hpms@cms.hhs.gov]
Sent: Saturday, October 27, 2007 1:24 AM
Subject: 2009 Plan Benefit Package (PBP) and Formulary Submission

In accordance with the Paperwork Reduction Act of 1995, the draft 2009 Plan Benefit Package (PBP) and Formulary Submission package has been posted in the Federal Register for a 60 day public comment period. This package includes a list of changes from the CY 2008 to CY 2009 PBP and Formulary files as well as updated PBP screenshots and formulary file layouts. The documents may be downloaded at: http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/list.asp?listpage=1

To be assured consideration, comments and recommendations must be received at the address below no later than 5 p.m. on December 26, 2007:

CMS, Office of Strategic Operations and Regulatory Affairs Division of Regulations Development - C
Attention: Bonnie L. Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Kaiser Permanente
Comments on the
2009 Draft PBP Tool

Medicare Cost Plans:

1. SB report/Part II/Section #28 Renal Dialysis: CMS has modified the PBP tool to no longer display radio buttons for out-of-area dialysis due to the fact that Cost members are not covered for out-of-area dialysis under health plan coverage and has added the additional SB sentence "Cost plan members pay Fee-For-Service cost sharing for out-of-area dialysis." The SB still incorrectly displays a sentence "$XX copay for in and out of area dialysis care," when entering "no" for copayments into section B-12 of the PBP. The SB sentence needs to be modified to reflect In-Area dialysis care only.

2. SB Report/Part One/Introduction: Under heading "What are my protections in this plan?" Language refers to "Medicare Advantage" throughout instead of "Medicare 1876 Cost Plan."

3. SB Report/Part One/Introduction: Some formatting problems need to be corrected in the last section of Part One of the SB i.e, extra spaces between words and before periods.

4. SB Report/Part Two/Section #29/Prescription Drugs: A cost sharing screen for Part D home infusion drugs was added to Section B-15 of the PBP (Medicare Part B RX). However, the SB does not generate any resulting SB sentences related cost sharing for home infusion drugs. Was this intentional? This applies to MA-PD plans as well.

5. SB Report/Part Two/Section #29/Prescription Drugs: When selecting "no deductible" for Part D drugs in the Medicare RX section of the PBP it generates a SB sentence "$0 Deductible." Is it necessary or consistent with other PBP questions when answering "no" to specific questions in the PBP to generate SB sentences that state what doesn't apply.

6. SB Report/Part Two/Section #29/Prescription Drugs: Even though one enters into the PBP generic drug coverage in the gap for out-of-network pharmacies there is no corresponding SB sentence reflecting generic coverage in the gap for Out-of-Network pharmacies in section #29 of the SB. The sentence "The plan covers all formulary generics through the gap" is missing.

7. SB Report/Part Two/"Optional Benefits" section: It appears the sub-heading "Optional Benefits" displays in the SB report regardless of whether or not any optional supplemental benefits are filed in the PBP. We suggest either removing the "Optional Benefits" sub-heading when no optional supplemental benefits are

filed or add a sentence under this heading that states "none are available under this plan."

8. SB Report/Part One/Introduction: The MA only Cost plans (without Part D RX) do not appear to address, in Part One of the SB, what the member's protections are under their plan as they do for plans having Part D coverage. Was this the intent?

9. SB Report/Part Two/Section #28: The SB reads "$XX to $XX copay for Nutrition Therapy for Renal Disease." This is language extrapolated from Section B-14J of the PBP. There should be two sentences, one for renal disease and another for nutrition therapy in section #28 of the SB.

10. SB Report/Part Two/Section #29/ Prescription Drugs: The MA only Cost plans disables B-15 (Part B RX) of the PBP. Section #B-20 (outpatient drugs), contains the Medicare Part B benefits but there is nowhere to add information regarding home infusion drugs, as in other PBP plans. Should home infusion drugs be called out in the note section of B-20 or in B-13 Other as instructed by CMS last year?

11. SB Report/Part Two/Section #1/ Premium and other Important Information:: Currently Cost Plans still enter their Part A & B premium amounts in Section D of the PBP. This premium amount is then extrapolated to the SB in Section #1 as well as the MOC. For Cost plans offering Part D, it appears the total combined Part A/B/D premium is not reflected in the SB, Section #1 without a hardcopy request to add in the Part D premium. We would like to see CMS find a better way to reflect the total combined A/B/D premium in Section#1 of the SB.

12. SB Report/Part Two/SB sentences: The SB sentences generated for plans with no coinsurance or copayments display differently from sentences generated for plans having coinsurance or copayments in the following benefit sections of the SB; #3, #4, #11, #12, #16, #21, #26, #32, and #33. For example, Inpatient Hospital Care having a $0 copay will read "$0 copay" versus a plan with a $250 copay will read "$250 for each Medicare covered hospital stay." This may cause confusion for members comparing multiple plans bound together within one SB. We recommend CMS look more carefully at how sentences may vary between the many SB versions (Cost vs. MA-PD) as well as how sentences may differ between the Original Medicare column and the health plan column e.g., chiropractic care (Section #9 of the SB).

13. SB Report/Part Two/Section #1/Premium and other Important Information: For Cost plans offering a $0 premium for Part A and B services, there is no premium sentence in Section #1 of the SB. We would like to see a premium sentence added for plans that charge a $0 premium for Part A and B benefits to avoid requesting a hard copy change through CMS Central Office.

MA-PD Plans:

1. SB Report: When attempting to generate an SB report off the PBP tool for all benefits including optional supplemental benefits, we receive error messages. The error messages eventually go away after clicking "yes" numerous times but displays only the mandatory benefits and not the optional supplemental benefits e.g, dental and hearing.

2. SB Report/Part Two/Section #5/SNF Care: The cost sharing is displayed for "non-Medicare-covered" SNF stays but not for "Medicare-covered SNF stays."

3. The PBP is asking for home infusion drug cost sharing in Section B-15 (Part B drugs) but doesn't display any cost sharing language in Section #29 of the SB (Prescription Drugs). We would like to know if this was intended or not.

4. PBP Data entry/B-17A Eyewear: For plans that charge a coinsurance for Post-cataract eyewear they must indicate "yes" to the question "is there an enrollee coinsurance." Once they indicate "yes" they then must indicate the coinsurance amount to the question "Indicate coinsurance percentage for Medicare covered benefits." Having to indicate "yes" to the coinsurance question also requires they indicate the amount of coinsurance for non-Medicare covered eyewear. For example, if a plan charges 20% for post-cataract eyewear, they indicate so in #17B-Base 4 but also have to indicate 100% for non-Medicare covered eyewear if they don't charge a coinsurance for non-Medicare covered eyewear. This generates an SB sentence "100% of the cost for glasses, limited to one pair of glasses every two years." Somewhat misleading if a plan offers either a copay or maximum coverage amount for non-Medicare covered eyewear. This same problem comes up for plans that provide a Maximum Plan benefit coverage amount for post-cataract eyewear rather than a coinsurance or copayment for Medicare covered eyewear. The SB, in this scenario generates a sentence that reads "$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery as well as up to 1 pair (s) of glasses every two years." Again, the resulting SB sentence appears to be somewhat misleading for plans that offer a Maximum Plan benefit coverage amount in lieu of coinsurance or copays. I think this could be resolved by separating out the post-cataract (medicare covered) cost sharing questions in the PBP from other non-covered eyewear cost sharing. If a plan offers a Maximum Plan coverage amount for Medicare or non-Medicare covered eyewear, the copayment/coinsurance sentences in the SB should be suppressed. This same issue applies to Section #18B, hearing aides as well.

5. PBP Data Entry/Section B-9A/Outpatient Hospital Services: This section of the PBP generates a lot of questions in terms of what types of services (cost sharing) should be reflected in this section For instance, the definition could be any medical services received as an outpatient in a hospital setting, which could include; specialist visits, cardio rehab, radiation therapy, MRIs, CATSCANS, lab work, outpatient surgeries etc. If this is the case you would be inclined to reflect a range of cost sharing encompassing the cost sharing for these various services. Having said this, there is some concern these same services are also called out in other sections of the PBP e.g, B-8, B-9, B-9B, B-7 etc. We would like to see more definitive guidance on what services should be called out under B-9A in the BID Submissions manual.

6. PBP Data Entry/ B-15: Medicare Part B RX drugs: Would like to see day supply added for Part B drugs in B-15 of the PBP.

7. PBP Data Entry/ B-7C and 7i: physical, speech and occupational therapy; Would like to see B-7C ;physical and speech therapy combined in the PBP with B-7i occupational therapy.

8. PBP Data Entry/ B-14F: Colorectal Screening: Section #B-14F, by definition, includes a number of screenings e.g, flexible sigmoidoscopy as well as a colonoscopy. Would like to see more guidance in the BID Submission Manual/PBP instructions as to what cost sharing should be included in this section in terms of what's considered diagnostic vs. preventive. If this section includes both flexible sigmoidoscopies as well as colonoscopies this could require a ranges of copays or coinsurance for these procedures depending on the procedure. In some cases the cost sharing for an "additional screening" may pertain to only one of the screenings and not to both but the SB sentence generated states "$__ copay up to 1 additional screening without stating whether or not its for a flex sig or a colonoscopy. Would like to see colonoscopies called out separately from flexible sigmoidoscopies in the PBP or the elimination of this "additional screening" sentence.

9. SB Report/Section #32 Vision Services: Under the Original Medicare Column of the SB, we recommend adding the word "each" to the following sentence or remove it from the plan column sentence; "Medicare pays for one pair of eyeglasses or contact lenses after <u>each</u> cataract surgery."

10. SB Report/Section #1 Introduction/ Who is eligible to join": In answering "yes" to the PBP question "is this a Part D Payment Demo, " the following sentence is generated for individual plan SBs; "You cannot enroll in this plan if your current or former employer or union helps pay for your drugs." This sentence seems more appropriate for group plans but somewhat misleading for individual MA-PD or Cost plans.

11. SB Report/Part Two/General; Any place the SB talks about a benefit not being covered it states "service not covered." We recommend it should read "service are not covered." For example, currently it reads under Inpatient Acute: Out-of-Network: "unless otherwise noted, out-of-network services not covered." It should read "unless otherwise noted, out-of-network services are not covered."

12. SB Report/ Section #30 Dental Services: Authorization is checked in the PBP under preventive dental services, yet it does not generate a sentence in the SB that reads "Authorization rules may apply." It seems this is inconsistent with how other benefit categories display this sentence in the SB when checked in the PBP.

13. PBP/HPMS/SB Report/Plan Service Name on HPMS: Would like to see an increase in the variable data space for entering Plan Service Area names. This would prevent plans from having to abbreviate plan service area names involving multiple counties configured into one PBP plan. This abbreviated naming is displayed in the SB.

14. SB Report/Part Two/Section #2 Doctor and Hospital Choice/Visiting member benefit::
15. In 2007, The SB sentence "You are covered for U.S. visitor/travel benefits. Contact plan for details, "was removed. We would recommend adding back in the following sentence "You may be covered for visitor or travel benefits. Contact plan for details." This would allow further elaboration in Part 3 if plans wish to do so and accommodate the variations in visiting/travel coverage plans may have.

COVENTRY
Health Care

December 24, 2007

Bonnie L. Harkless
Centers for Medicare & Medicaid Services (CMS)
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development - C
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7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Harkless:

I would like to thank the Centers for Medicare and Medicaid Services (CMS) for this opportunity to review and submit comments related to 2009 PBP and Formulary Submission package.

We are requesting that CMS consider the following suggestions and incorporate clarifications into the final 2009 PBP and Formulary Submission package. We ask that CMS improve the ability within the PBP to input a Part B premium reduction. Additionally we suggest that for PPO plans the PBP should allow for differentiation of out-of-network benefit limits across things such as routine eye exams, dental or eyewear. In the past, it has been impossible to separate in and out-of-network to allow for different amounts. The amounts for out-of-network had to be totaled and entered into a comments field. This then created a Summary of Benefits in which the different amounts were not delineated for each out-of-network item or service (but rather included one overall amount for all). A change to the PBP would streamline this activity for plans and allow for greater clarity.

Again, thank you for the opportunity to provide input.

Sincerely,

Mary Ninos
Vice President Medicare
Compliance Officer

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