



SOCIETY OF ACTUARIES

**Health Pricing Boot Camp
August 10- 11, 2009**

Session 3b: Medicare Part C- Bid Process

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Part C, Session 2

2:30 - 3:45

Medicare Part C - Bid process: Dan

Detail overview of the bid process, discussing separately HMO and SNP, local PPO, regional PPO, and Private Fee for Service (PFFS). Explanation of the use of claim experience and risk score experience, manual rating for plans with no experience and plans with semi-credible experience. How to project data from the base period to the contract period - adjusting for trend, benefit change, population change, etc.

For this session, we will discuss putting together an MA BPT. We will look at several hypothetical bids of increasing difficulty and complexity.

KEY CONCEPTS:

1. Base period experience—this includes not only claims, but also the membership and its composition and risk score, for a specific plan of benefits that might not be identical to the future contract year plan of benefits. WKS 1.
2. Projection of Base Period Experience to Contract Year—we need to adjust the 2008 experience to a 2010 level in the bid. WKS 1.
3. Projection Factors—in order to make that adjustment above from 2008 to 2010, we must trend the 2008 experience and adjust for all 2008 vs. 2010 differences for change of plan, population, and service area. Changes in medical management or provider deals can be incorporated into medical trend factors. WKS 1.
4. Credibility of Base Period Experience—the CMS standard for full credibility (100%) for Part C is 24,000 member months in the base period, which is 2,000 average members. If the number of member months in the base period is less than 24,000, the Part C credibility formula is $SQ RT (mem\ mos / 24,000)$. Thus a plan is 50% credible with 6,000 member months (500 average members). WKS 2.
5. Manual Rate—plans that were not in force in 2008 do not have base period experience. They require the use of a manual rate only. Plans with less than full credibility of base period experience also require the use of a manual rate that is then blended in WKS 2 with the projected base experience.
6. Allowed Cost—WKS 1 and 2 handle benefit expense on an Allowed basis. Allowed Cost is “first dollar” cost—it includes the MAO paid liability plus the cost sharing borne by the member or beneficiary.
7. Cost Sharing—this is the portion of first \$ cost that is the responsibility of the member. Prior to the 2010 Contract Year bids, it was that easy to define, but since the concept of DE# was introduced this year, it is more complicated. The part C handouts include a 2009 CY MA BPT s well as the 2010 so that participants can see the difference in the way cost-sharing is now handled. In the case on non DE# members, they generally are financially responsible for their own cost-sharing.. In the case of dual eligible # members (CMS nomenclature), their cost-sharing is paid by Medicaid. WKS 3 and WKS 4.

8. Paid Cost or Net PMPM— $\text{Paid Cost} = \text{Allowed} - \text{Plan Cost Sharing}$. This is the MAO's liability. WKS 4
9. Non-benefit expense—administrative cost. WKS 4

SNPs:

When MA began in 2004, most of the bids were HMO, as they were under Medicare + Choice program, as they were under Medicare Risk in the 90's. Under MA today, there is a sub-category of plans called Special Needs Plans (SNPs). SNP bids present a new set of challenges for the actuary because they are tailored for specific populations, which may have certain chronic conditions, or are Dual eligible, or are institutionalized. SNPs are often designed for frail, elderly populations, or for those under 65 and disabled.

VARIATIONS ON WKS 1:

The claim experience in WKS 1 must be aggregated into the type of service categories provided by CMS. We will discuss how the data from fee for service plans may be different than the data from plans that use partial, full, or global capitation.

MANUAL RATES:

We could spend a full day talking about this topic alone, but time does not permit during this course. We will discuss appropriate data sources for manual rates and the different approaches actuaries use to establish manual rates. We will cover CMS data and the 5% Sample, as well as the use of related plans to establish a manual rate.

THE VALUE Of CHANGES In PLAN Of BENEFITS:

In order to establish the value of cost-sharing, actuaries need to know the effective value of cost-sharing that will apply and either the utilization units that copays will be applied to, or the allowed cost that coinsurance is applied to. The question also arises whether the change in cost-sharing will influence utilization and allowed cost. We will discuss this.

