# RECORD, Volume 22, No. 2*

Colorado Springs Spring Meeting
June 26–28, 1996


## Session 32TS
## Medicare Risk Contracts


**Track:** Health
**Key words:** Contracts, Health Maintenance Organizations



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*Summary: This is a teaching session on the working Medicare contracts—how they are set up, potential risk/rewards, pricing, etc.*


**Mr. Frank R. Kopenski, Jr.:** My name is Frank Kopenski and my colleague is Ken Leinbach. We are both with the Milwaukee office of Milliman & Robertson. This presentation will provide background on the origin of Medicare risk contracts, discuss the feasibility of a HMO or competitive medical plan (CMP) entering the Medicare risk market, and outline the adjusted community rate (ACR) filing process with the Health Care Financing Administration (HCFA).

### MEDICARE RISK ORIGIN

The Social Security Amendments of 1972 allowed HMOs to contract with HCFA to provide health care coverage to Medicare beneficiaries on either a cost or a risk basis. At a minimum, the coverage would be equivalent to benefits provided through the Medicare program. The following discussion is on the topic of risk plans. In order to level the playing field between HMOs and HMO look-alikes, (i.e., CMPs), the Tax Equity and Fiscal Responsibility Act of 1982 allowed CMPs to also contract with HCFA to provide Medicare coverage.

HCFA established criteria that needs to be met in order to be a qualified plan. First, the health care organization must provide minimum services (i.e., those currently provided under the Medicare program). Second, the health care organization must agree to accept compensation on a periodic prepaid capitation basis. Third,

services must be provided by physicians employed by the health care organization or physicians under contract with the health care organization. Finally, the health care organization must assume full financial risk on a prospective basis for the provision of health care services.

After qualifying, an organization must meet further tests. First, the plan must have at least 5,000 commercial and/or Medicaid members. Second, the Medicaid membership cannot represent more than 50% of total commercial and Medicaid membership combined.

The established criteria serves the purpose of a screening mechanism to protect Medicare eligibles from organizations who may only be testing the waters of the Medicare market. HCFA's primary concern is to the Medicare eligibles continued well-being with uninterrupted health care coverage.

Medicare program costs consist of Part A services (hospital inpatient, skilled nursing facility, and home health), Part B services (hospital outpatient, physician, and other), and the cost for HCFA to administer the program. The challenge for the HMO/CMP is to accept reimbursement at 95%, or often less, of the Medicare program costs while providing Medicare benefits plus additional coverage at a considerably higher cost of administration. The HMO/CMP must evaluate its ability to manage care within the fixed reimbursement provided by HCFA.

As of October 1995, there were 179 plans that were contracting with HCFA to provide health care coverage to Medicare eligibles.

**Mr. Kenneth E. Leinbach:** I am going to talk about some of the issues that arise when you realistically look at what it means to get into the Medicare risk business. Let me first discuss some of the key issues about Medicare risk programs. It's an aggressive market. Aggressive in two ways. First, many of the Medicare risk plans are trying to market a plan with a zero-dollar member premium. A zero-dollar member premium means that people pay no premium to join the risk plan. Compare this to an average Medicare supplement plan with a premium of about $100 a month. Second, risk plans are providing very aggressive or rich benefit plans. Several of the Medicare risk plans are offering coverage for prescription drugs while still charging a low premium.

A second issue has to do with the size of the average adjusted per capita cost (AAPCC). The success of a Medicare risk plan is often dictated by the size of the AAPCCs for the plan's geographical area. I'll give a couple of examples later that illustrate the significance of the AAPCC size.

A third issue is the level of health care management needed to be successful. In general, to make a Medicare risk contract work, you need to achieve a greater level of health care management than that needed for a commercial group population. This will be illustrated later.

I would now like to compare a commercial contract with a Medicare risk contract and highlight some of the key differences. Table 1 summarizes my comparison.

TABLE 1
CHARACTERISTICS OF MEDICARE RISK CONTRACTS

| | Commercial Group | Medicare |
|---|---|---|
| Plan Sponsor | Employer | Government |
| Relative Cost Level | 1.0 | 3.0 or more |
| Benefit Levels | Wide Variation | Slight Variation (limited by Medicare) |
| Premium Levels | Set by Ins. Co/HMO | Primarily Set by HCFA |

One difference is in the plan sponsor. The plan sponsor for a commercial plan is the employer although for Medicare risk it is the government. A second difference is the relative cost levels. Medicare costs are three or more times as much as commercial costs. One reason HMOs are interested in the Medicare risk business is because it represents many dollars and has the potential for significant profits when the plan is well managed. A third difference is in benefit levels. Commercial group benefits vary significantly. Under a Medicare risk contract there is not much variation, primarily because you have to start with what Medicare covers. Medicare risk benefits vary primarily by the size of the office visit copayment and based on whether the plan covers prescription drugs.

A fourth difference is in the source of revenue. A risk contractor has two sources of revenue: it gets a payment from HCFA or the government and an enrollee premium, if any. The HCFA payment usually represents 95%–100% of the total revenue that the risk contractor will get.

Next, I want to discuss the AAPCC. It is a very important variable in evaluating the feasibility of success for a Medicare risk contract. AAPCC stands for adjusted average per capita cost. It is developed by HCFA, varies by county, is stated on a per month per member (PMPM) basis, and is the government's or HCFA's estimate of 95% of fee-for-service costs under the traditional Medicare program. For each county the AAPCC is determined by applying a county-specific area adjustment to the United States per capita cost (USPCC).

The USPCC is HCFA's projection of nationwide fee-for-service costs for a given calendar year. Both the USPCC and AAPCCs are developed annually.

Risk contractor payments are based on the AAPCCs. The AAPCCs are set at 95% of expected costs to provide HCFA with a 5% savings over traditional program costs on eligibles who enroll in risk contracts.

There is a very wide variation in AAPCCs by county. During 1996, the highest AAPCC for any county in the United States was $880 PMPM for Loving, Texas. However, there were few counties with AAPCCs above $600 PMPM. A few counties had AAPCCs in the low $200 PMPM. So there is a wide variation from a low of about $200 PMPM to a high of about $600 PMPM. There is some controversy over using the AAPCC as the basis to pay risk contracts. Congress has proposed regulations that would put a floor on how low the AAPCC can be. I've heard numbers like $300 PMPM or $325 PMPM. As I'll show later, even at $300 PMPM, a risk contract isn't very feasible.

It is important to understand that the AAPCC is not what a risk contractor will get paid. What the risk contractor actually gets paid is the AAPCC times a demographic factor. Along with the AAPCCs, HCFA also publishes demographic factors. The demographic factors vary by Medicare eligible category [institutionalized, Medicaid and noninstitutionalized/nonMedicaid (NINM)] and by age and gender. Table 2 summarizes NINM demographic factors for 1996.

TABLE 2
HFCA NONINSTITUTIONALIZED/NONMEDICARE DEMOGRAPHIC FACTORS

| | Part A | | Part B | |
|---|---|---|---|---|
| Age Group | Male | Female | Male | Female |
| 65-69 | 0.65 | 0.55 | 0.80 | 0.70 |
| 70-74 | 0.85 | 0.70 | 1.00 | 0.85 |
| 75-79 | 1.05 | 0.85 | 1.10 | 0.95 |
| 80-84 | 1.20 | 1.05 | 1.15 | 0.95 |
| 85+ | 1.35 | 1.15 | 1.15 | 1.00 |

If you composite the demographic factors relative to an average distribution of enrollees for a Medicare risk plan, you'll obtain something on the order of 0.85 (15% below the AAPCC). This is because most Medicare risk plan enrollees come from the NINM-aged Medicare eligible population. Therefore, if a county has an AAPCC of $400 PMPM, a Medicare risk plan operating in that county won't get

$400 PMPM in revenue. Instead, the risk plan will receive about 15% less or $360 PMPM.

Another somewhat interesting characteristic of the AAPCC is that it is based on data that are several years old. This is important when utilization levels are changing. Because of the lag, the AAPCC calculation process doesn't pick up these changes. The USPCC is based on data that are one or two years old, and the county-specific area adjustments are based on a five-year average of cost data that are 3–8 years old.

Table 3 details recent USPCCs.

TABLE 3
HISTORICAL UNITED STATES PER CAPITA COSTS (USPCC) AGED

| Year | Part A | Part B | Total | % Increase |
|---|---|---|---|---|
| 1996 | $275 | $166 | $441 | 10% |
| 1995 | 252 | 149 | 401 | 6 |
| 1994 | 237 | 141 | 378 | 5 |
| 1993 | 214 | 144 | 358 | --- |

There were moderate increases in 1994 and 1995. Then, in 1996 there was a large increase. Some publications are forecasting 1997's USPCC increase to, again, be in the 11% range. However, because the USPCC can be affected by what happens in Congress, that can always be changed. Another thing to notice is the size of the USPCC for 1996—roughly $440 PMPM.

I next would like to summarize Medicare benefits. Medicare benefits vary by major component, commonly referred to by Part A and Part B. Part A services consist of hospital inpatient facility, skilled nursing facility, and home health care. For Part A services, Medicare pays all allowable costs except for the following inpatient and skilled nursing facility cost sharing: an inpatient deductible (Part A deductible) of $724 in 1996, which is paid on the first admission during each benefit period; co-pays (percentages of the Part A deductible) that are paid per day on the 61st through 90th and 91st through 150th days of inpatient confinement; and a skilled nursing facility copayment per day for the 21st through 100th day of confinement. Home health care is covered at 100%. On average, Part A enrollee cost sharing amounts to about 3% of total Part A allowable costs. Most Medicare supplement policies will cover what's not covered by Medicare (about $10–$15 PMPM). Medicare risk plans will cover Part A services with no or a small copayment, for example $100 per admit.

Part B services include hospital outpatient and physician services. Part B services are covered, except for a $100 annual deductible followed by 20% coinsurance with no out-of-pocket maximum.

Medicare does not cover preventive health exams (hearing exams, vision exams, and annual physical exams), and also does not cover prescription drugs. Benefits for these services are commonly added by Medicare risk plans. Preventive exams are almost always covered as well as immunizations. Hearing aids and glasses are covered sometimes, often with limits: for example, $75 or $100 for glasses, $300 on hearing aids. Prescription drugs are covered by about 50% of current risk plans. Prescription drugs are often covered with a $5–$10 copayment and an annual maximum benefit of $500–$1,000.

Many of the HMOs that are considering starting a Medicare risk plan are looking at the feasibility of covering prescription drugs.

Next I want to go through a simplified example to show you the degree of savings that are needed to make a Medicare risk contract feasible. This simplified example is based on an average cost county, that is, a county whose AAPCC equals the USPCC. I also assumed the risk plan would cover all Medicare benefits, plus Medicare cost sharing, but no additional benefits, preventive exams, or drugs. Table 4 is a summary of costs for this average cost county.

TABLE 4
MEDICARE COST SHARING NATIONWIDE SUMMARY
1996 PMPM COSTS—MEDICARE COVERED BENEFITS

| | PMPM | Percent |
|---|---|---|
| Government Obligation | $441 | 86% |
| Beneficiary Obligation | 72 | 14% |
| Total | $513 | 100% |

The government pays $441 PMPM. That's to cover the expected costs for Medicare benefits, but doesn't include the beneficiary obligation or enrollee cost sharing under the Medicare program. I estimate Medicare cost sharing to be $72 PMPM or about 14% of the total cost. Therefore, the total cost for an average person in this average county is $513 PMPM, with Medicare paying about 86% or $441 PMPM.

This is an important point, Medicare risk plans are paid by HCFA on a net cost basis and use this payment to provide coverage on a gross cost basis.

Table 5 summarizes required costs under a Medicare risk contract in this average cost county.

TABLE 5
COST REDUCTIONS NEEDED UNDER RISK CONTRACT

| | |
|---|---|
| Total Medicare Costs | $441 |
| Payment to Risk Plan (95%) | $419 |
| Less Administrative Cost (20%) | $ 84 |
| Risk Plan Medical Cost Budget | $335 |
| Total Cost to Provide Benefits in Traditional Program | $513 |
| Required Reduction | 35% |

First, I take the $441 PMPM times 95% because the risk plan only received 95% of expected costs as a payment from HCFA. This leaves me with an average HCFA payment of $419 PMPM. Next, I need to reduce the HCFA payment for the estimated cost-of-plan administration. In this example I assume that administration costs average about 20% of revenue. So I multiply the $419 PMPM by 80% to obtain $335 PMPM. This represents the money the risk plan has left over to cover medical costs. The resulting ratio of risk plan costs to Medicare program costs is, therefore, 0.65 ($335/$513). This means that the risk plan will have to reduce either utilization or reimbursement by 35% to make the plan feasible.

Next, I would like to discuss two illustrative Medicare risk feasibility case studies. The first case study illustrates typical results for a county with a high AAPCC, and the second illustrates typical results for a county with a moderate AAPCC. Table 6 summarizes the two case studies.

TABLE 6
ILLUSTRATIVE DEVELOPMENTS

| County | AAPCC | HCFA Payment | % of AAPCC |
|---|---|---|---|
| High AAPCC | $614 | $523 | 85% |
| Moderate AAPCC | $469 | $400 | 85% |

The high AAPCC county has an AAPCC of slightly more than $600 PMPM. I estimate its average HCFA payment to be $523 PMPM or 85% of the AAPCC. This is based on a standard NINM-aged Medicare population. The moderate AAPCC county has an AAPCC of $469 PMPM and an estimated average HCFA payment of $400 PMPM.

An AAPCC of $400 PMPM is at approximately the 70th percentile of all counties. So my moderate example of $469 PMPM is probably at around the 80th percentile of all counties. Therefore, there are many counties with an AAPCC below that in my moderate example.

Table 7 illustrates my estimate of costs in the high AAPCC county.

TABLE 7
ALLOCATION OF MEDICARE AND TOTAL FFS COSTS HIGH AAPCC COUNTY

| | Medicare Costs | Total Costs | Percent Allocation |
|---|---|---|---|
| Hospital Inpatient | $293 | $319 | 51% |
| Skilled Nursing Facility | 18 | 23 | 4 |
| Home Health | 40 | 40 | 6 |
| Hospital Outpatient | 50 | 83 | 13 |
| Physician/Other | 130 | 165 | 26 |
| Total | $531 | $630 | 100% |

3,190 Days/1,000 @ $1,200/Day
ALOS = 8.25 Days
Estimated HCFA Payment

In the table, I estimate the cost of what Medicare covers to be $531 PMPM. I also estimate total costs, which includes the Medicare costs and the beneficiary obligation. I estimate the beneficiary obligation to be approximately 14% of total costs. As you can see from the table, roughly 50% of costs in this county are due to hospital inpatient services. This is much different than what you would expect for a commercial plan, where hospital inpatient typically represent 25–30% of total costs. Home health costs are also relatively high. I've estimated home health costs to be $40 PMPM. Home health is a benefit where costs have escalated significantly over the last few years. For this county, home health costs are almost half of hospital outpatient and a fourth of the physician costs. The inpatient PMPM is consistent with a utilization rate of approximately 3,190 days per 1,000 members per year and an average charge of $1,200 per day. The inpatient utilization rate is based on an average length of stay of about 8.25 days. The average length of stay is slightly above the national average (7.8 days).

Table 8 shows the same analysis for the moderate AAPCC county.

For the moderate AAPCC county, only about 45% of costs are due to inpatient services. Counties with higher AAPCCs, as illustrated earlier, typically have a higher percentage of total costs because of inpatient services, accompanied by a higher utilization level. For the moderate county, the supporting inpatient targets are 2,425 days per 1,000 and $1,065 a day with an average length of stay of 7 days.

TABLE 8
ALLOCATION OF MEDICARE AND TOTAL FFS MODERATE COSTS
AAPCC COUNTY

| | Medicare Costs | Total Costs | Percent Allocation |
|---|---|---|---|
| Hospital Inpatient | $199 | $216 | 44% |
| Skilled Nursing Facility | 20 | 25 | 5 |
| Home Health | 54 | 54 | 11 |
| Hospital Outpatient | 23 | 52 | 11 |
| Physician/Other | 110 | 139 | 29 |
| Total | $406 | $486 | 100% |

2,425 Days/1,000 @ $1,065/Day
ALOS = 7.00 Days
Estimates HCFA Payment = $400

Table 9 consolidates the prior two tables.

TABLE 9
COMPARISON OF TOTAL COSTS

| | Total Cost PMPM | | Percent Allocation | |
|---|---|---|---|---|
| | High | Moderate | High | Moderate |
| Hospital Inpatient | $319 | $216 | 51% | 44% |
| Skilled Nursing Facility | 23 | 25 | 4 | 5 |
| Home Health | 40 | 54 | 6 | 11 |
| Hospital Outpatient | 83 | 52 | 13 | 11 |
| Physician/Other | 165 | 139 | 26 | 29 |
| Total | $630 | $486 | 100% | 100% |

The high AAPCC county has about $150 in extra costs with about two-thirds of the extra costs because of inpatient services. If you look at percentages, hospital inpatient services are a much higher percentage of total costs in the high AAPCC county. Percentages for other services, except home health, are all somewhat similar. Table 10 shows assumptions that support Medicare risk contracts in the two counties.

For the high AAPCC county, the above assumptions support a $0 PMPM premium. The inpatient days per 1,000 target is 1,550 days with an average length of stay of 6.75 days. Therefore, the average length of stay must be reduced by about a day and a half, and total days per 1,000 must be reduced by about 50%. The Medicare risk benefit plan assumes a few copayments, a $25 emergency room and $5 office visit, and prescription drug coverage with a $10 copayment and a $500 maximum annual benefit. Because many successful Medicare risk plans are currently running below 1,500 days per 1,000, this seems to be a realistic or achievable scenario.

TABLE 10
COMPARISON OF WHAT WORKS

| | High | Moderate |
|---|---|---|
| Inpatient Utilization | 1,550 | 1,225 |
| Inpatient ALOS | 6.75 | 6.00 |
| Copayments | $5 Office<br>$25 ER | $5 Office<br>$25 ER |
| Drug Coverage | $10 Copayment<br>$500 Max | $10 Copayment<br>$500 Max |
| Premium (PMPM) | $0 | $33 |

For the moderate AAPCC county, which has a lower AAPCC, inpatient utilization needs to be lower. Inpatient days per 1,000 are targeted at 1,225 with an average length of stay of six days. We have assumed the same copayment and drug benefits as in the high AAPCC county. However, to make things work, a premium of $33 PMPM is required. In the high AAPCC county the risk plan is able to operate at a higher days per 1,000 rate and average length of stay and offer a lower premium. Table 11 is a detailed numerical illustration of the workable solution for the high AAPCC county.

The first two columns in Table 11 are the same as in Table 7. I added a third column that shows the estimated targets under the Medicare risk contract, and a fourth column that shows the reduction in total costs to obtain the target premium. Also, at the bottom of the table, I added the cost of administration and obtained a total required revenue equal to the estimated HCFA payment. As you can see, total costs were reduced by $211 PMPM. It should be noted that approximately three-quarters of the reduction in costs comes from inpatient services. So in those counties where inpatient utilization is high, you can achieve the majority of required savings from inpatient services.

Table 12 summarizes the workable solution for the moderate AAPCC county. For the moderate AAPCC county, about two-thirds of the savings come from inpatient services.

TABLE 11
WORKABLE SOLUTION: HIGH AAPCC

| Cost | Medicare PMPM | Total PMPM | Risk Plan PMPM | Required Reduction |
|---|---|---|---|---|
| Hospital Inpatient | $293 | $319 | $168 | ($151) |
| Skilled Nursing Facility | 18 | 23 | 16 | (7) |
| Home Health | 40 | 40 | 22 | (18) |
| Hospital Outpatient | 50 | 83 | 59 | (24) |
| Physician/Other | 130 | 165 | 130 | (35) |
| Additional Benefits | | | 3 | 3 |
| Prescription Drugs | | | 21 | 21 |
| Total Medical Costs | $531 | $630 | $419 | ($211) |
| Administration (20%) | | | 104 | |
| Require Revenue | | | $523 | |
| HCFA Payment | | | $523 | |
| Required Premium | | | $0 | |

TABLE 12
WORKABLE SOLUTION: MODERATE AAPCC

| Cost | Medicare PMPM | Total PMPM | Risk Plan PMPM | Required Reduction |
|---|---|---|---|---|
| Hospital Inpatient | $199 | $216 | $117 | ($99) |
| Skilled Nursing Facility | 20 | 25 | 17 | (8) |
| Home Health | 54 | 54 | 33 | (21) |
| Hospital Outpatient | 23 | 52 | 42 | (10) |
| Physician/Other | 110 | 139 | 113 | (26) |
| Additional Benefits | | | 5 | 5 |
| Prescription Drugs | | | 19 | 19 |
| Total Medical Costs | $406 | $486 | $346 | ($140) |
| Administration (20%) | | | 87 | |
| Required Revenue | | | $433 | |
| HCFA Payment | | | $400 | |
| Required Premium | | | $33 | |

Table 13 is an allocation of costs for the two workable solutions.

In both cases, about 30% of costs are due to inpatient, 3% or 4% for skilled nursing, 4–8% for home health, 10% for hospital outpatient, 25% for physician and other, 5% for additional benefits and prescription drugs, and 20% for administration.

TABLE 13
ALLOCATION OF COSTS—TWO SOLUTIONS

| Cost | High AAPCC | Moderate AAPCC |
|---|---|---|
| Hospital Inpatient | 32% | 27% |
| Skilled Nursing Facility | 3 | 4 |
| Home Health | 4 | 8 |
| Hospital Outpatient | 11 | 10 |
| Physician/Other | 25 | 26 |
| Additional Benefits | 1 | 1 |
| Prescription Drugs | 4 | 4 |
| Total Medical Costs | 80 | 80 |
| Administration (20%) | 20 | 20 |
| Required Revenue | 100 | 100 |

**Mr. Kopenski:** Ken has just discussed the analysis that an HMO/CMP performs before deciding upon applying for a Medicare risk contract with HCFA. The following information describes the application process from the financial perspective. There is also a clinical, management, and systems side to the process that are not discussed here.

## ACR FILING PROCESS

In order to speed up the application process, HCFA has established a format and criteria that must be included in an application for a Medicare risk contract. This format and criteria are ever changing, and the information provided here is applicable only as of this writing.

In summary, the process is to begin with filed and approved commercial medical cost targets. Then adjust these commercial targets to reflect Medicare benefit levels, adjust the targets again to reflect the Medicare risk benefits, and then apply volume and complexity factors provided by HCFA to go from a commercial population with Medicare risk benefits to a Medicare population with Medicare risk benefits.

### Section A

In Section A the HMO/CMP provides a summary of the commercial plan benefits that were filed and approved by the state of domicile. The commercial rate filing may or may not coincide with the period for which the Medicare risk product is effective. HCFA provides a Benefit Information File (BIF.EXE) diskette, which the plan completes. This file outlines the current Medicare coverage and asks for the respective Medicare risk benefits to be provided by the plan. A printout of these benefits is required along with the diskette version. One page of the BIF summarizes the maximum premium and the actual premium to be charged by the plan for Medicare eligibles who purchase Part B coverage or both Part A and Part B

coverages. This page should be filled out by the plan after the premiums are determined through the ACR process.

**Section B**

Section B contains the actual commercial rate filing, including a letter or stamp of approval from the Department of Insurance. Basic medical plan costs as well as rider costs may be necessary, given the benefits that are being offered under the Medicare risk plan. Utilization, average charge, and PMPM commercial targets are preferred by type of service (hospital inpatient, hospital outpatient, physician, and other) and make the documentation process much easier. For those plans that don't have all the detail, reasonable assumptions should be made to break up the total cost PMPM so that they are starting with the same line-item services that HCFA has in the ACR worksheet.

If the plan has rates that differ by area, a composite rate can be calculated using a recent member distribution by area. If the plan will be marketing the Medicare product in noncontiguous counties, separate filings will be necessary.

**Section C**

Section C provides HCFA with documentation of adjustments to go from the commercial benefit targets to Medicare standard benefits. In doing so, the plan must rely on published documentation in the form of periodicals, magazines, industry studies, and national data sources that would confirm the reasonableness of any adjustments used. If published information is not available, some form of written explanation should be included for review. Adjustments are generally made because of day or visit limit differences between commercial plans and Medicare.

**Section D**

In Section D the plan adjusts the commercial targets for Medicare benefits to reflect the increased demand for services of a Medicare population. The Medicare population is going to utilize services and incur average costs per service that differ from those assumptions used in the plan's commercial rate filing. To make this transition, HCFA publishes volume and complexity (V&C) factors by state and region that combine the utilization and charge differences into a single factor for various types of service. The V&Cs are an average of all information that has been provided by risk contractors on either a state or regional basis. Some factors may appear to be too low because of differences in reporting and certain benefits not being offered by all plans, specifically prescription drugs. The plan may use either the state or regional factors; however, if there is only one risk contractor in the state with less than two years of experience, no state factors will be published. There are a number of V&C factors that correspond directly with medical cost line items such as hospital inpatient, hospital outpatient, home health, skilled nursing, and

emergency to name a few. Other factors are somewhat nebulous such as physician, miscellaneous, and other, and they require an element of judgment in their application.

**Section E**

In Section E the plan discloses the assumed administration load and coordination of benefits (COB) adjustments for the Medicare risk product. Most commercial rate filings assume that the medical costs are net of COB; however, if the rate filing identifies a COB cost line, there's a line in the ACR that allows you to adjust the commercial COB cost assumption to Medicare. A general rule of thumb is that the administrative load should be the same or less than that used for commercial rates. It may be difficult to explain to HCFA why the plan needs more than 20%, for example, of a $350 AAPCC rate when it currently covers administration for commercial groups using 20% of a $125 PMPM rate. Even though the marketing costs for the Medicare risk product will be higher because of its individual product nature, the difference in rates should more than offset the higher administrative cost. I have seen administration loads in the 10–20% range, with 10% really being fairly aggressive. The majority of plans would fall in the 15–20% range, unless forced to go lower because of intense competition.

**Section F**

In Section F the plan summarizes the expected average payment rate that it anticipates from HCFA. The actual reimbursement will depend on the demographic mix and Medicare eligibility category of the members enrolled. We would generally assume that the HMO will enroll noninstitutionalized/nonMedicaid aged-and-disabled Medicare eligibles in performing the expected payment calculation. Ken assumed only an aged population in his realistic analysis because, for the most part, the aged make up 95% of the Medicare population, and Medicare risk plans enroll few disabled eligibles. In the ACR process, we are developing costs that may not be realistic, and HCFA requires the use of both the aged and disabled eligibility categories. Section F also includes the cost of the Part A deductible and coinsurance and Part B deductible and coinsurance payment as published by HCFA. HCFA does not allow the plan to trend the published AAPCC payment to correspond with the expected effective date of coverage. This can produce a disparity if the commercial rates reflect a filed trend to project costs to the rating effective period.

The AAPCC payment rate derived in Section F is based on a composite of expected enrollment by county. The enrollment can be based on plan expectations or actual Medicare eligibles in each county as published by HCFA. The compositing process is not an issue if the filing is for only one county or the counties are not contiguous. Noncontiguous counties require separate ACR filings.

### Section G

In Section G we adjust from standard Medicare benefit levels to the actual benefits to be provided by the Medicare risk product. Costs developed in this section require a V&C factor adjustment, and are grossed up to include the increased administration.

### Section H

In Section H adjustments are made for the impact of member cost sharing. Member cost sharing is generally in the form of typical HMO copayments for such services as emergency room, office visits, and preventive care. If the plan provides prescription drug coverage, it is customary to have a maximum benefit of $500–$1,500 because of the high cost of prescription drugs for this population and the fact that Medicare only covers immunosuppressive-type drugs.

### Section I

The ACR process through Section H is to develop an expected cost for the Medicare risk product to be sold. In Section I we compare the expected cost to the expected AAPCC payment rate to be received as a capitation from HCFA and compute the difference. If the payment exceeds the cost, HCFA expects the plan to pay the difference. If the cost exceeds the payment, HCFA expects the plan to collect the difference in the form of a premium charged (maximum allowable cost) to the member for coverage. In reality, the plan often charges the member a premium less than the difference or nothing at all. In Section I, the plan summarizes what it believes to be the true cost of the product and reasons for charging the member less than developed in the ACR process. The concern here is for the solvency of the plan. The true cost is generally that which was developed in the realistic analysis that Ken mentioned.

### Section J

In this section the plan states that it will not charge employer groups more than the filed premium or provide benefits that are less rich than those summarized in this ACR. The ACR filing is viewed as an individual product filing and employer groups represent somewhat of a grey area when it comes to HCFA jurisdiction.

### Section K

The plan is required to include a copy of its recent financial statements generally in the form of a balance sheet and net worth statement. The information provides HCFA with a source for determining potential solvency concerns.

**Section L**

Section L lists the individuals who are familiar with the ACR filing that will be considered contacts if there are any questions from the HCFA reviewer.

**Section M**

The CEO of the plan is required to sign a certification stating that the information provided in the ACR is accurate and representative of the plan's intentions.