AMERICAN ACADEMY *of* ACTUARIES

October 4, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4069-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Sir or Madame:

This letter presents the comments of the American Academy of Actuaries'[1] Medicare Steering Committee regarding the Centers for Medicare and Medicaid Services' (CMS's) proposed regulations on the Medicare Advantage (MA) program (CMS-4069-P).

In particular, this letter discusses issues related to the calculation of monthly savings—a step in determining beneficiary rebate amounts (as defined in section 422.266) for MA plans—and payment adjustments based on the variation in costs among different areas including input prices, utilization, and practice patterns.

The proposed rule requires Part D plan sponsors, Medicare Advantage plans, and employers to make a number of certifications and attestations based on prospective actuarial estimates of future prescription drug costs and utilization. As with any other actuarial projection, it is inevitable that actual experience will deviate from projected results—regardless of how carefully they are performed. Such deviations do not, of themselves, indicate that the projections were inappropriate or invalidate attestations based on the projections. The Academy strongly recommends that the standard of reasonableness for prospective actuarial estimates required under the rule be based on conformance with recognized standards of actuarial practice.

We provide comments, where appropriate, based on specific requests from CMS. We would be glad to have further discussions with you on other issues related to the proposed MA regulations where you feel our perspective would be useful. In particular, the proposed rule presents many issues at a conceptual level, with the detailed mechanics to be worked out later. These details may have a significant impact on beneficiaries, Medicare Advantage plans, and the Medicare

[1] The Academy is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification and practice standards, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of objective analysis. The Academy regularly prepares comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

program. The Academy would welcome an opportunity to review and comment on the detailed regulations before their final publication.

SUBPART F—SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION AND PLAN APPROVAL

422.254 Submission of Bids

Issue: Plans must include adjustments for the effect that providing reductions in Parts A, B, or D cost-sharing has on utilization of basic A/B benefits when pricing supplemental benefits. CMS does not describe how it will evaluate such adjustments.

Comment:

- It should be recognized that fee-for-service Medicare experience is a blend of beneficiaries with and without employer-coordinated and/or Medicare supplement products, which makes this required adjustment somewhat tenuous.

- We suggest that CMS provide its review criteria for this adjustment.

422.264 Calculation of Savings

Issue: What is the best method to risk-adjust the benchmarks and bids to calculate the savings? The MMA suggests using a statewide (or region) factor representing the average of the MA enrollees in the state (or region), but gives CMS the authority to use each MA plan's specific risk factor instead (or some other geographic average such as metropolitan statistical areas). In the preamble, comments were invited on the desirability of using plan-specific risk adjusters as an alternative to statewide or region-wide averages, because risk adjusters based on these broad averages could disadvantage some plans with less-healthy populations.

Comment:

- In theory, the two methods produce the same aggregate Medicare payments under either the statewide average or the plan-specific method if the plans are equally efficient, even though the risk profiles may vary. However, this would not likely happen in practice since the statewide average factor would be determined from some historical perspective point and the plan-specific factor is a prospective estimate at the time of filing. This would especially be true in areas where there has not historically been an MA presence or in which the MA presence is growing and/or changing.

- The current ACR methodology has a component that includes a plan-specific risk adjustment. If the savings in the bid process is determined using the statewide average method, there would be more market disruption in benefits offered than if the plan-specific method is used. For example, a benefit plan with a risk profile lower than the statewide average would have somewhat lower benefits that could be funded by rebates under the plan-specific method than by current ACR Excess (due to rebates being only 75 percent of the savings vs. Excess equal to 100 percent of the difference). But the rebate would be higher under the statewide average method. On the other hand, a benefit plan with a higher risk profile than the state average would have significantly fewer rebates under the statewide

average method. This situation acts to disenfranchise populations that would ideally be targeted for greater involvement in the MA program, especially Special Needs Plans.

- Since actual plan payments are based on each benefit plan's own risk profile, there should be greater consistency between the rebate calculation and the basis for payment (i.e., supports use of the plan-specific method).

- There will be competition between local plans and regional plans, so the methodology should keep a level playing field among competitors. Note that if the "statewide" method is selected, the factors for regional plans and local plans could vary since regions may cover more than one state. This inconsistency could prove to be problematic.

- The plan-specific method gives higher rebates for higher risk profiles, which allows greater mitigation of the (presumably) higher cost of providing benefits to these sicker members. This fits the general insurance objective of spreading risks. Use of the statewide method could result in spirals, with "sicker" plans losing better risk members. Note that this comment presumes that the rebates are applied toward purchase of benefits (including cost sharing reductions) versus a flat amount such as reduction in Part B premium. This is the normal situation today, but if the Part B premium reduction were to become the norm, then the statewide method might be better. This scenario is unlikely.

- Use of the statewide method would require a decision on how to handle plans that cross state lines. The proposed regulation implies that the plan's members would be segregated and calculated separately, but this approach would result in varying rebates and benefits, which is a violation of the requirement to have the same benefits for all members.

SUBPART G—PAYMENTS TO MEDICARE ADVANTAGE ORGANIZATIONS

422.308 Adjustments to Capitation Rates, Benchmarks, Bids, and Payments

Issue: What is the best approach with respect to adjustments for intra-area variations?
Comment: The proposed regulation properly recognizes that per capita costs may vary within the region served by an MA plan. If the actual geographic distribution of enrollees differs from what was assumed when the plan's bid was submitted, the plan's costs could vary from the expected results. CMS is considering two cases separately: regional MA plans, and local MA plans. It seems that the basic methodology would be the same—both would be based on variations in payment rates between local areas within a region or within a service area. A key factor is the cost index used to measure variations in costs. Two approaches are being considered: an index of fee-for-service costs to national average FFS costs, and an index based on "input prices, utilization, and practice patterns."

- While there may be administrative differences, the methods used for regional MAs and local MAs should be consistent with each other.
- The cost index used should be consistent with the cost patterns experienced by a typical MA plan; fee-for-service costs may or may not be appropriate (the same concern applies to an

input-price/utilization index—the inputs and utilization should be those for a typical MA plan).
- The Academy would welcome the opportunity to review and comment on these adjustments before their final publication.

Members of the Academy are available to work with you as you finalize the proposed Medicare Advantage and Medicare prescription drug benefit regulations. If you would like to discuss these issues further, please contact Academy senior health fellow, Cori Uccello (Uccello@actuary.org or 202-223-8196), or senior health policy analyst (federal), Holly Kwiatkowski (Kwiatkowski@actuary.org or 202-223-8196).

Sincerely,

Thomas F. Wildsmith, FSA, MAAA
Chairperson, Medicare Steering Committee
American Academy of Actuaries

Members of the Medicare Steering Committee include: Michael S. Abroe, FSA, MAAA; Stuart H. Alden, FSA, MAAA, FCA; David V. Axene, FSA, MAAA, FCA; David J. Bahn, FSA, MAAA; Alan D. Ford, FSA, MAAA, EA; P. Anthony Hammond, ASA, MAAA; Dennis J. Hulet, FSA, MAAA, FCA; Kent E. Levihn, FSA, MAAA, FCA, EA; James J. Murphy, FSA, MAAA, FCA; Donna C. Novak, ASA, MAAA, FCA; John J. Schubert, ASA, MAAA, FCA; Michael J. Thompson, FSA, MAAA; Gordon R. Trapnell, FSA, MAAA; Lynette L. Trygstad, FSA, MAAA; and George B. Wagoner, FSA,MAAA, FCA.