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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
8		10 - 140.2	

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 13, 2003

This is the initial issuance of Chapter 8 of the Medicare Managed Care Manual. This chapter provides instructions and requirements for premiums and cost-sharing that M+C organizations can impose, including applicable limits. Chapter 8 also includes requirements for records that M+C organizations must retain, and instructions for reporting appropriate information to CMS in connection with premiums and cost sharing.

This is a new chapter therefore none of the material is redlined.

Medicare Managed Care Manual

Chapter 8 - Premiums and Cost-Sharing

Table of Contents

10 - Introduction

(Rev. 25, 06-13-03)

Each Medicare+Choice organization (M+C organization) must compute a separate adjusted community rate (ACR) for each M+C coordinated care, private fee-for-service, or religious fraternal benefit plan it offers to Medicare beneficiaries. If an M+C organization chooses to vary premiums or cost sharing in distinct parts of an M+C plan's service area, a separate ACR also must be submitted for each such distinct part. The ACR computations must be made and submitted to the Centers for Medicare & Medicaid Services (CMS) on its ACR spreadsheets. In addition to the ACR calculations, M+C organizations must prepare supporting documentation. All ACR documentation is subject to audit by CMS or its designee.

The CMS revises ACR forms from time to time to address identified problems or respond to changes required by statute and regulation. The ACR forms, spreadsheets, and instructions are available on the Internet at http://www.cms.hhs.gov/healthplans/acr/. The Web site also contains Plan Benefit Package (PBP) instructions and software, integral to the ACR process, as well as answers to questions from M+C organizations and others on the process.

The CMS provides additional ACR-related instructions and information in documents such as the 45-Day Notice, Rate Book, and the Annual Call Letter. A brief explanation of these three documents and a chart documenting release dates follows:

45-Day Notice - As required by §1853(b)(2) of the Social Security Act (the Act), CMS provides a notice to M+C organizations of proposed changes to be made in the methodology and assumptions used to compute the M+C payment rate for the coming contract year. The CMS will release the notice 45 days before the actual announcement of the payment rates, and provide M+C organizations an opportunity to comment on proposed changes in methodology and assumptions.

Rate Book - The M+C Rate Book is a compilation of the M+C payment rates for the coming contract year.

Call Letter - The Call Letter provides instructions to M+C organizations related to the coming ACR season. The CMS plans to release the Call Letter approximately 90 days before the ACR due date.

The following table shows key dates for the documents described above and mid-year benefit enhancements (MYBEs). Refer to CMS Call Letters for key dates for other items not discussed in this chapter such as ACRPs for new M+C organizations.

Item	Action	Date of Action		
		Contract Year 2004	**Contract Year 2005**	**Contract Year 2006**
45-Day Notice	CMS issues notice	March 28, 2003	March 27, 2004	Approx. January 15, 2005
Rate Book	CMS issues rates	May 12, 2003	May 10, 2004	March 1, 2005
Call Letter	CMS issues letter	Approx. June 10, 2003	Approx. June 15, 2004	Approx. April 3, 2005
ACRP Renewals	ACRPs due at CMS	September 8, 2003	September 13, 2004	July 1, 2005
MYBEs	CMS begins accepting MYBEs	November 1, 2003	November 1, 2004	November 1, 2005

20 - Terminology

(Rev. 25, 06-13-03)

The following definitions cover most of the specialized terminology used in this chapter.

Actuarial Equivalence - Actuarial equivalence is a term of art and refers to a type of CMS-approved waiver of certain M+C rules and regulations that might hinder the design of, development of, or the enrollment in M+C plans under M+C contracts with employers and unions. In this type of waiver, CMS allows M+C organizations to raise copays for a plan benefit for members of an employer group enrolled in a particular M+C plan in exchange for a modification of the plan premium, an increase in the benefit, or both. Because the premiums and cost sharing under such a trade-off must be "actuarially equivalent" in order for such a waiver to be granted, these are referred to as "actuarial

equivalence" waivers. While this type of waiver generally relates to prescription drug benefits in an employer or union plan, M+C organizations may use this waiver on other benefits.

Actuarial Swapping - Actuarial swapping is also a term of art and refers to a type of CMS-approved waiver of certain M+C rules and regulations that might hinder the design of, development of, or the enrollment in M+C plans under M+C contracts with employers and unions. In this type of waiver, CMS allows M+C organizations to add benefits preferred by an employer or union in exchange for a benefit of the same actuarial value in an individual plan. Actuarial swapping cannot include an exchange of any Medicare-covered benefit. In other words, M+C plans offered to the individual market **and** plans offered to employer or union groups must both include all Medicare-covered benefits (except hospice).

Additional Benefits - Additional benefits include direct health care services not otherwise covered by Medicare and indirect benefits (i.e., reductions in enrollee premiums for Part B of Medicare and reductions in premiums or cost sharing for Medicare-covered services). M+C organizations identify additional benefits and must offer them to Medicare beneficiaries at no additional premium. Additional benefits are funded by the adjusted excess amount (see §80), and must at least equal the actuarial value of any such excess amount.

Additional Revenue - Additional revenue is revenue collected or expected to be collected from charges for M+C plans offered by an M+C organization in excess of costs actually incurred or expected to be incurred. Additional revenue includes such things as revenue in excess of expenses of an M+C plan, profits, contribution to surplus, risk margins, contribution to risk reserves, assessments by a related entity that do not represent a direct medical or related administrative cost, and any other premium component not reflected in direct medical care costs or administration costs.

Adjusted Community Rate (ACR) - The ACR represents the rate that an M+C organization would charge commercially for the benefits in question, whether the Medicare package of benefits or a supplemental benefit, adjusted for the utilization patterns of the Medicare population. In the case of the Original Medicare benefit package, the ACR is used to determine the M+C organization's obligation to provide additional benefits. In the case of a mandatory or optional supplemental benefit, the ACR amount represents the maximum amount that can be charged. The ACR for a benefit (such as an optional supplemental benefit) or group of benefits (such as an M+C health care plan), is **usually** based on the base-period costs adjusted to account for the trend since the base period. However, in some limited cases (when data are not available) the ACR is simply an M+C organization's best estimate of the cost of an M+C plan or benefit. An M+C organization may not be able to fully calculate (rather than estimate) the ACR because it:

- Had no Medicare enrollees in the base period;
- Had no non-Medicare enrollees in the base period; or

- Expects not to have any non-Medicare enrollees in the contract year.

The term "ACR" also refers to the package of worksheets that M+C organizations must complete in support of their ACR calculations.

Adjusted Excess Amount - Adjusted excess amount is the excess amount (defined below) minus any amount withheld and reserved for an M+C organization in a stabilization fund (defined below).

Administration Costs - Administration costs generally are those for managing the type of health care plan being priced in an ACR. Examples of administration costs are occupancy, compensation of administrative employees, sales and marketing, premium taxes, and medical management. User fees (such as an Information Campaign User Fee) are included in the costs of administration. Administration costs should not include reinsurance premium, income taxes, or expenses related to investment activities.

Average Payment Rate (APR) - The APR is an M+C plan's average per capita rate of payment, i.e., the average amount the M+C organization estimates CMS will pay generally excluding any offsets or reductions The M+C organization calculates the APR without adjustment for transactions involving a stabilization fund for the period covered by the ACR for all Medicare beneficiaries electing, or expected to elect, the M+C plan.

Base Period - The base period is the calendar year before that in which the ACR is filed. For example, when the 2003 contract year adjusted community rate proposal (ACRP) filings were due on September 9, 2002, the base period was calendar year 2001.

Basic Benefits - Basic benefits include both Medicare-covered benefits (except hospice care) and additional benefits.

Benefit - A benefit is a health care item or service intended to maintain or improve the health status of enrollees for which an M+C organization incurs a cost or liability (not solely an administrative processing cost). An M+C organization may also fund the "indirect" benefit of payment of all or a portion of an enrollee's Medicare Part B premium from the adjusted excess.

Cost Sharing - Cost sharing includes copayments, coinsurance, deductibles, and any other charge to enrollees on a per-receipt of benefit basis, regardless of who collects it. (Premiums are enrollee charges **not** on a per-receipt of benefit basis and thus are not technically cost sharing.)

Direct Medical Care - Direct medical care costs are those for providing medical care (less the administration cost, reinsurance premiums (if any), and additional revenue).

M+C organizations should reduce total costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. M+C organizations that pay providers for benefits for which Medicare is the secondary payer must reduce total direct medical costs by the amounts that **could have been** recovered from the primary

payer (if the M+C organization made a consistent and concerted or good faith effort at recovery) - whether or not those amounts were actually recovered.

In contrast, M+C organizations **cannot** reduce direct medical care costs by the amount of any cost sharing paid by or on behalf of enrollees, regardless of who actually collects the cost sharing. Moreover, M+C organizations **cannot** reduce direct medical care costs reported on an ACR by the amount of cost sharing charged to, but not collected from, plan enrollees.

Employer or Union Health Plans - Employer or union health plans are those that M+C organizations build onto employer-only or union-only plans or M+C plans offered to the individual market. M+C organizations can offer employer or union health plans to:

- An employer's employees, former employees, dependents of employees or former employees, or a combination thereof; or

- A union's members, former members, dependents of members or former members, or a combination thereof.

Negotiations between M+C organizations and employers or unions determine the benefits of such plans, however, the plans must include at least all Medicare-covered benefits (except hospice). The M+C organizations cannot offer this type of plan to individual Medicare eligibles in the plan's service area who do not have an affiliation with the employer or union that has negotiated with the M+C organizations. The M+C organizations do not need to submit these plans to CMS for approval in their entirety. (However, CMS must approve the plan on which an employer or union health plan is built.)

Employer-Only or Union-Only Plans - Employer-only or union-only plans are M+C plans developed by M+C organizations exclusively for members of specific employer or union groups. By definition, M+C organizations cannot offer employer-only or union-only plans to the individual market. An employer-only or union-only plan must include at least all Medicare-covered benefits (except hospice). The M+C organizations must submit proposed employer-only or union-only plans to CMS for approval before offering them to the employer or labor organization. After initial CMS approval, M+C organizations can renew employer-only or union-only plans during the normal ACR season through the normal ACR renewal process.

Excess Amount - Excess amount is the amount by which the APR exceeds the actuarial value of the ACR determined under 42 CFR 422.310, reduced for the actuarial value of the cost sharing (i.e., deductibles and coinsurance) under Original Medicare. For M+C plans designed for enrollees covered by both Parts A and B of Original Medicare, deduct the actuarial value of the deductibles and coinsurance for both Parts A and B to obtain the excess amount. The M+C organizations must calculate a separate excess amount for Part B-only enrollees in an M+C plan limited to such enrollees. In that case, deduct only the actuarial value of the cost sharing for Part B to obtain the excess amount.

Hospice Rate - The hospice rate is the amount CMS pays to the M+C organizations for enrollees who have elected hospice and who remain in an M+C plan. It is the adjusted excess amount, less any amount withheld for reducing the Part B premiums plan enrollees pay to the government.

Initial Rate - The initial rate is the per-member, per-year rate (including premiums and cost sharing) that M+C organizations would charge to non-Medicare enrollees for the benefits offered under the same type of plan for the period covered by the ACR. (For ease of computation, all ACR entries are reduced to monthly amounts.) The initial rate is computed using one of two methods:

- A community rating system based on provisions in the Public Health Service Act; and
- A weighted average of all premiums and cost sharing to be charged to the public.

M+C organizations offering a type of plan that will not have an enrolled non-Medicare population would not be able to calculate an initial rate by this method, and would use an alternative approach discussed in §70 below.

Individual Market - Individual market refers to the M+C-eligible individuals in a given service area who are not members of an employer or union group.

Loss - Loss, for ACR purposes, is the amount by which the ACR (less the actuarial value of Medicare's deductibles and coinsurance) exceeds the APR. Because M+C organizations cannot pass losses through to Medicare enrollees, the losses cannot affect the premium charged to Medicare enrollees.

M+C (M+C) Organization - An M+C organization is a public or private entity licensed by a state as a risk-bearing entity, except for Provider Sponsored Organization (PSO) receiving CMS waivers, and certified by CMS as meeting the M+C contract requirements.

M+C Payment Area - An M+C payment area - generally a political subdivision of the 50 States known as a county or parish - is specified by the Secretary of the Department of Health and Human Services. In certain cases, outside the 50 States and the District of Columbia, it is equivalent to a commonwealth, territory, or political subdivision thereof.

M+C Plan - An M+C plan is a package of health care coverage offered under a policy, contract, or plan by an M+C organization that includes a specific set of benefits at a uniform price for all Medicare beneficiaries residing in the M+C plan's service area or segment of the service area. The benefits must include all Medicare-covered benefits (except hospice care) and can include additional benefits and mandatory supplemental benefits. If offered, additional benefits and mandatory supplemental benefits are part of the standard benefit package that every member electing a plan is entitled to receive. In addition, an M+C organization can offer optional supplemental benefits that plan enrollees can choose to purchase at their discretion. An M+C organization can offer multiple M+C plans within the same service area, but must offer each M+C plan to all

qualified, Medicare-eligible persons at the same premium and cost-sharing levels CMS approved for the plan.

M+C Plan Types - M+C plan types are coordinated care plans and M+C private fee-for-service plans (PFFS). Coordinated care plan types include health maintenance organization (HMO) plans, HMO plans with a point-of-service (POS) option, PSO plans, preferred provider organization (PPO) plans, religious fraternal benefit (RFB) plans, and other network plans . For more on M+C plan types, see 42 CFR 422.2 and 42 CFR 422.4.

M+C Service Area - M+C service area means a geographic area, approved by CMS, in which an eligible individual may enroll in a particular M+C plan offered by an M+C organization. For coordinated care plans only, the service area is also the area in which a network of providers resides that meets the access standards in 42 CFR 422.112. The service area also defines the area within which a uniform benefit package is offered. In deciding whether to approve the service area proposed by an M+C organization for an M+C plan, CMS considers the organization's non-Medicare service area for the type of plan in question (if applicable), community practices generally, and whether the boundaries of the service area are discriminatory in effect. In addition, in the case of coordinated care, CMS considers the adequacy of the provider network in the proposed service area.

M+C Service Area Segment - Under §1854(h) of the Social Security Act (the Act), an M+C plan can have a segmented service area, which means that premiums and cost sharing may vary from segment to segment. A segment must be composed of one or more M+C payment areas. In the case of segmented service areas, all M+C rules regarding service areas, such as the rule on uniformity of premiums, apply to each segment. Section 1854(h) of the Act also requires a separate ACRP for each service area segment. For purposes of this manual, the term "service area" generally also refers to service area segments.

Mandatory Supplemental Benefits - Mandatory supplemental benefits are those not covered by Medicare that beneficiaries must purchase as a condition of enrollment in an M+C plan. The M+C organizations can charge enrollees premiums, cost-sharing, or both for these benefits. Mandatory supplemental benefits can differ for each M+C plan offered by an M+C organization. The M+C organizations cannot use mandatory supplemental benefits to discourage enrollment by or discriminate against selected Medicare beneficiaries.

Medicare Enrollees, Members, or Beneficiaries of an M+C Plan - Medicare enrollees or members of an M+C plan (M+C plan enrollees or members) are Medicare beneficiaries who elect to join a plan offered by an M+C organization. In limited cases, for purposes of ACR preparation, Medicare enrollees can also be Medicare beneficiaries that an M+C organization expects to elect an M+C plan.

Non-Medicare Enrollees, Members, or Beneficiaries - Non-Medicare enrollees (members) are those that an M+C organization must consider in determining the actual

collections and initial rate for an ACR. Specifically, in determining these values, an M+C organization must consider the actual or projected costs (as appropriate) of the same type of plan (such as coordinated care or private fee-for-service), and all service areas of the organization for the type of M+C plan they are pricing in an ACR. Non-Medicare enrollees include any commercial enrollees, Medicaid-only enrollees, and in very limited cases, certain Medicare beneficiaries, such as those enrolled in a cost-contracting arrangement offered by the M+C organization, for example, §1876 or health care prepayment plan (HCPP) enrollees. The CMS considers these Medicare beneficiaries to be non-Medicare enrollees of the M+C organization for purposes of the ACR proposal.

An M+C organization cannot classify as a non-Medicare enrollee any Medicare beneficiary who has elected to join - or anyone an M+C organization projects will elect to join - the M+C plan being priced by an ACR proposal. The two categories - Medicare enrollees and non-Medicare enrollees - are mutually exclusive. Individuals who are dually eligible for both Medicare and Medicaid are generally **not** to be considered non-Medicare enrollees.

Optional Supplemental Benefits - Optional supplemental benefits are M+C plan benefits not covered by Medicare that beneficiaries can choose to elect or reject. M+C plan enrollees who choose such benefits pay for them directly, usually in the form of premiums, cost sharing, or both. Optional supplemental benefits can differ for each M+C plan. For marketing purposes, M+C organizations can group optional supplemental benefits, offer them individually, or offer a combination of groups and individual services. Nevertheless, M+C organizations must compute a separate ACR value for each optional supplemental benefit. The M+C organizations must include direct medical, administration, reinsurance premiums (if any), and additional revenue in the ACR value of each optional supplemental benefit, just as they do for any other benefit included in the ACR.

Premiums - For purposes of this manual, premiums include all charges to enrollees, paid to the M+C organization or its designee (as distinct from the Part B premium, which is paid to Medicare), that are not on a per-benefit basis. (Per-benefit charges are called "cost sharing.")

- **M+C monthly basic beneficiary premium** means, with respect to an M+C coordinated care plan, the amount authorized to be charged under 42 CFR 422.308(a)(1) for the plan, or, with respect to an M+C private fee-for-service plan, the amount filed under 42 CFR 422.306(d)(1).

- **M+C monthly supplemental beneficiary premium** means, with respect to an M+C coordinated care plan, the amount authorized to be charged under 42 CFR 422.308(a)(2) for the M+C plan, or, with respect to an M+C private fee-for-service plan, the amount filed under 42 CFR 422.306(d)(2).

Reinsurance - A reinsurance contract represents an agreement between two organizations, in which a portion of the medical risk is transferred from the M+C

organization to another insurance organization (reinsurer). In consideration of the risk transfer, the M+C organization pays the reinsurer a reinsurance premium. Contractual reimbursements made to the M+C organization are classified as reinsurance recoveries.

Standard Benefit Package - The standard benefit package of an M+C health care plan includes Medicare-covered benefits, additional benefits, and mandatory supplemental benefits.

Union-Only Plans - See the definition of employer-only plans.

30 - Rules Governing Premiums and Cost Sharing - 42 CFR 422.304

(Rev. 25, 06-13-03)

30.1 - Monthly Premiums

(Rev. 25, 06-13-03)

The monthly premium charged to an M+C plan member is the sum of the M+C monthly basic beneficiary premium plus any M+C monthly supplemental beneficiary premium.

30.2 - Uniformity of Premiums

(Rev. 25, 06-13-03)

The general rule is that the M+C monthly basic beneficiary premium, and the M+C monthly supplemental beneficiary premium of an M+C organization may not vary among individuals enrolled in an M+C plan (or segment of the plan). In addition, the M+C organization may not vary the level of cost sharing charged for basic benefits or supplemental benefits (if any) among individuals enrolled in an M+C plan (or segment of the plan). (See Chapter 2, §50.3.1, for additional discussion of this issue related to "dual-eligible" individuals.) M+C organizations may not offer a discount to members who pre-pay M+C monthly basic or supplemental beneficiary premiums by paying them on a quarterly or annual basis. Nor can M+C organizations require that more than a single monthly basic or supplemental beneficiary premium be paid prospectively.

30.3 - Segmented Service Area Option

(Rev. 25, 06-13-03)

An M+C organization may apply the uniformity of premium requirements mentioned above to segments of an M+C plan service area (rather than to the entire service area) if:

- Any such segment is composed of one or more M+C payment areas; and
- The M+C organization submits the information specified at 42 CFR 422.306 separately, as provided in that section, for each such segment.

An M+C organization may vary premiums and cost sharing between and among segments of the same plan. However, the benefits that an M+C organization offers across all segments of the same plan may not vary.

30.4 - Timing of Payments

(Rev. 25, 06-13-03)

The M+C organization must permit monthly payments of M+C monthly basic and supplemental beneficiary premiums, and cannot terminate coverage for failure to make timely payments except as provided in 42 CFR 422.74(b)(1).

30.5 - Monetary Inducements Prohibited

(Rev. 25, 06-13-03)

An M+C organization cannot provide cash or other monetary rebates as an inducement for enrollment or for any other reason or purpose. However, see §80, "Requirements for Additional Benefits," for a discussion of the Part B premium reductions that M+C organizations can offer as M+C benefits.

40 - Submission of Proposed Premiums and Related Information – 42 CFR 422.306

(Rev. 25, 06-13-03)

40.1 - General Rule

(Rev. 25, 06-13-03)

Around every July 1 (or by the second Monday of September for 2004 and 2005 contract year ACR submissions), M+C organizations must submit the following to CMS, in the manner and form it prescribes, for each M+C plan (or service area segment) it will offer in the following year:

- Information specified in paragraph (b), (c), or paragraph (d) of 42 CFR 422.306 for the type of M+C plan involved;
- Service area and enrollment capacity (if any); and
- The APR.

Each year, CMS will notify M+C organizations of the due date for submitting proposed premiums and related information. If the submission is not complete, timely, or accurate, CMS has the authority to impose sanctions under 42 CFR Subpart O or can choose not to renew the contract.

40.2 - Information Required for Coordinated Care Plans and Private Fee-For-Service Plans

(Rev. 25, 06-13-03)

The following information is required for coordinated care plans as part of the ACR submission.

For basic benefits, the following information is required:

- The ACR as specified in 42 CFR 422.310;
- The M+C monthly basic beneficiary premium;
- A description of cost sharing to be imposed under the plan and the ACR value of the cost sharing;
- A description of any additional benefits to be provided pursuant to 42 CFR 422.312 and the ACR value of those benefits; and
- Amounts collected in the previous contract period for basic benefits.

For supplemental benefits (both mandatory and optional), the following information is required:

- The ACR;
- The M+C monthly supplemental beneficiary premium;
- A description of supplemental benefits being offered, the cost sharing to be imposed on plan enrollees, and the ACR value of the benefits and cost sharing; and
- Amounts collected in the previous contract period for supplemental benefits.

For M+C private fee-for-service plans, the following information is required:

- The information specified above under basic benefits;
- The amount of the M+C monthly supplemental beneficiary premium;
- A description of all benefits offered under the plan; and
- Amounts collected in the previous contract period for basic and supplemental benefits.

40.3 - Average Payment Rate (APR)

(Rev. 25, 06-13-03)

The APR is an M+C organization's estimate of its expected monthly revenues (payments) from CMS for an M+C plan. The M+C organizations can estimate an APR from aggregate data (such as county payment rates) provided by CMS. The organization should adjust the CMS data as appropriate for the related M+C plan.

The APR must include expected payments to an M+C organization from CMS for all the enrollees an organization projects to elect the plan to which the APR is related, including enrollees for whom CMS has special payment rates. For example, the APR must cover expected payments from CMS for projected enrollees who:

- Have end stage renal disease;
- Will elect or have elected hospice and will remain in the M+C plan; or
- Will be institutionalized.

The APR must include projected employer-sponsored or union-sponsored enrollees who live in the plan service area.

The APR must use the correct CMS payment rates for the different categories or types (demographic and risk-adjusted) of enrollees expected to enroll in an M+C plan.

Generally, the APR also must include any user fees (such as the Information Campaign User Fee and the End Stage Renal Disease Network Fee) that CMS normally withholds from its payments.

40.4 - CMS Review

(Rev. 25, 06-13-03)

Except as specified below, CMS reviews and approves or disapproves the information submitted under this section. It does not review, approve, or disapprove M+C monthly basic and supplementary beneficiary premiums for M+C private fee-for-service plans.

The Chief Actuary of CMS will review the actuarial assumptions and data used by M+C organizations with respect to rates, amounts, and values submitted under this section.

50 - Limits on Premiums and Cost-Sharing Amounts - 42 CFR 422.308

(Rev. 25, 06-13-03)

50.1 - Rules for Coordinated Care Plans

(Rev. 25, 06-13-03)

For basic benefits, the M+C monthly basic beneficiary premium charged (times 12) plus the ACR value of the cost sharing that applies, on average, to beneficiaries enrolled in an M+C plan may not exceed the annual actuarial value of the deductibles and coinsurance that would apply, on average, to beneficiaries entitled to Medicare Part A and enrolled in Medicare Part B if they were not enrollees of an M+C organization. For M+C plan enrollees enrolled only in Medicare Part B, the M+C monthly basic beneficiary premium charged (times 12) plus the ACR value of the deductibles, coinsurance, and copayments applicable on average to those beneficiaries enrolled in an M+C plan, may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable, on average, to beneficiaries enrolled in Medicare Part B if they were not enrollees of an M+C organization.

For supplemental benefits, the M+C monthly supplemental beneficiary premium charged (times 12), plus the ACR value of its cost-sharing, may not exceed the adjusted community rate (ACR) for those benefits, as determined annually.

If an M+C organization furnishes coverage of Medicare Part A-type services to a Medicare enrollee only entitled to Part B, the M+C plan's premium plus the ACR value of its cost sharing for these services may not exceed the lesser of the:

- ACR value of the Part A benefits provided in the plan being priced;
- Sum of the APR for the plan's Part A benefits, plus the actuarial value of Medicare deductibles and coinsurance for the services, plus the ACR value of Medicare Part A coordination of benefits for working aged; or
- Sum of the amount Medicare would charge for Part A services to an individual not qualified for Part A, plus the actuarial value of the Part A deductible and coinsurance.

50.2 - Rules for M+C Private Fee-For-Service Plans

(Rev. 25, 06-13-03)

The average ACR value of the cost sharing for basic benefits may not exceed the actuarial value of the cost sharing that would apply, on average, to beneficiaries entitled to Medicare Part A, and enrolled in Medicare Part B if they were not enrolled in an M+C plan.

For supplemental benefits, the ACR value of its cost sharing may not exceed the amounts approved in the ACR for those benefits as determined annually.

Remember that, by definition, cost sharing excludes premiums.

55 - Special Rules for Mid-Year (Benefit) Enhancements

(Rev. 25, 06-13-03)

55.1 - General Rule

(Rev. 25, 06-13-03)

The M+C organizations can enhance M+C plans during a calendar year if CMS approves the changes, known as mid-year benefit enhancements (MYBEs).

The M+C organizations proposing enhancements must submit the same material to CMS as described under §40. Generally, CMS will accept proposals to enhance M+C plans beginning November 1 (for MYBEs applying to the following calendar year) and continuing through August 1 (for MYBEs applying to the current calendar year). The CMS will approve changes in M+C plans as quickly as possible so beneficiary notification can occur in a timely manner. Proposed enhancements to M+C plans can be effective no earlier than February 1. The CMS will determine the effective date of any approved benefit enhancement when it approves the proposed enhancement.

Proposed MYBEs may include one or a combination of the following elements:

- Adding a new benefit (or benefits) at no additional cost to a plan enrollee. A new "no cost" benefit can be added as an additional benefit or a mandatory supplemental benefit;

- Adding a new benefit (or benefits) with a premium, cost-sharing, or both. An M+C organization can offer a MYBE in this way as either a mandatory supplemental benefit or an optional supplemental benefit:

    - If a MYBE is offered as a mandatory supplemental benefit, it must be offered for $0 [additional] monthly premium. In other words, any beneficiary costs for mandatory supplemental benefits offered mid-year must all be in the form of cost sharing. In this way, enrollees retain the right either to use the new benefit (and become liable for the additional cost-sharing) or not to use the benefit.

    - An M+C organization also is permitted to offer certain MYBEs as optional supplemental benefits with an additional monthly premium (with or without additional cost sharing).

- Reducing premiums; and

- Reducing other cost-sharing amounts (that is, copayments, coinsurance, or deductibles).

An M+C organization cannot replace a coinsurance amount (i.e., cost sharing that is defined as a percentage of benefit cost) with a copayment amount (i.e., cost sharing that is defined as a fixed cost per service) during a calendar year because, in an individual case, this could increase a beneficiary's cost. However, an M+C organization can add additional cost-sharing options during a calendar year. For example, a plan could allow beneficiaries to pay the lesser of its coinsurance amount or copayment amount for a particular plan benefit. M+C organizations must offer all CMS-approved enhancements of an M+C plan to existing enrollees (and to new enrollees when an M+C plan is otherwise open to new enrollment) throughout the M+C plan's service area. The CMS will not approve proposed changes to M+C plan benefits or cost sharing that do not meet the above requirements.

60 - Incorrect Collections of Premiums and Cost Sharing - 42 CFR 422.309

(Rev. 25, 06-13-03)

60.1 - Definitions

(Rev. 25, 06-13-03)

Amounts Incorrectly Collected - Amounts incorrectly collected are those that:

- Exceed any of the limits on premiums and cost sharing imposed by 42 CFR 422.308;

- In the case of an M+C private fee-for-service plan, exceed the M+C monthly basic beneficiary premium or the M+C monthly supplemental premium submitted under 42 CFR 422.306; or

- Are collected from an enrollee who was believed not entitled to Medicare benefits, but was later found to be entitled.

Other Amounts Due - Other amounts due are those for:

- Emergency, urgently needed, or other services obtained outside the M+C plan; or

- Services initially denied but, upon appeal, found to be those the enrollee was entitled to have furnished by the M+C organization.

Basic Commitment

An M+C organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf.

60.2 - Refund Methods

(Rev. 25, 06-13-03)

The M+C organization must use lump-sum payments for the following:

- Amounts incorrectly collected that were not collected as premiums;
- Other amounts due; and
- All amounts due if the M+C organization is going out of business or terminating its M+C contract for an M+C plan.

If the amounts incorrectly collected were in the form of premiums, or included premiums as well as other charges, the M+C organization may refund by adjustment of future premiums or by a combination of premium adjustment and lump-sum payments.

If an enrollee has died or cannot be located after a reasonable effort, the M+C organization must make the refund in accordance with state law.

60.3 - Reduction by CMS

(Rev. 25, 06-13-03)

If the M+C organization does not make the refund required by the end of the contract period following the contract period during which an amount was determined to be due an enrollee, CMS reduces the premium the M+C organization is allowed to charge an M+C plan enrollee by the amounts incorrectly collected or otherwise due. In addition, the M+C organization is subject to sanction under 42 CFR Subpart O for failure to refund amounts incorrectly collected from M+C plan enrollees.

70 - Adjusted Community Rate (ACR) Process - 42 CFR 422.310

(Rev. 25, 06-13-03)

70.1 - General Information

(Rev. 25, 06-13-03)

Each M+C organization must compute a separate ACR for each M+C coordinated care or private fee-for-service plan (or segment) offered to Medicare beneficiaries. This section describes the standard method for computing ACRs. However, certain conditions discussed in §70.6 will require M+C organizations to use one of the other methods for computing ACRs.

70.2 - Standard Method

(Rev. 25, 06-13-03)

Under the standard method of computing its ACR, an M+C organization calculates an initial rate for the contract year and reports collections (on an accrual basis) from non-Medicare enrollees in the base period (the year beginning 2 years before the contract year). The initial rate represents the average rate (including both premiums and cost sharing) that the M+C organization would charge to non-Medicare enrollees for the same type of plan as the M+C plan priced in the ACR. The CMS requires M+C organizations to compare the initial rate (and selected components) that an M+C organization projects in its ACRP to the base-period charges (and selected components) to produce 2 year non-Medicare trend factors. At that point, the M+C organization applies the trend factors to base-period Medicare costs to produce Medicare trended values for the contract year.

The M+C organizations must compute an ACR for the standard benefit package of an M+C plan and for each individual optional supplemental benefit offered to enrollees of an M+C plan.

Generally, for each M+C plan and optional supplemental benefit offered, M+C organizations must calculate an ACR for enrollees eligible for both Medicare Parts A and B and a separate ACR for enrollees eligible for Part B only. However, CMS encourages M+C organizations to submit as few plans as possible for its grandfathered Part B-only members, rather than duplicating each of its Part A/B plans for them. (See §20.6 of Chapter 2 (Enrollment and Disenrollment) of this manual for a definition of grandfathered Part B-only members.) In fact, an M+C organization can submit one plan for all its grandfathered Part B-only members under an M+C contract if the enrollees are in the same type of plan. In addition, if an M+C organization offers grandfathered Part B-only members the same benefits as members eligible for both Parts A and B for the same price that it charges A/B members, it need not submit a separate ACR for the grandfathered Part B-only members.

As indicated in §20.1, Chapter 2 of this manual, individuals eligible for Part B only (except for grandfathered Part B-only members) cannot enroll in an M+C plan. However, see §130 of this chapter for an exception to this rule. The exception is related to enrollment of "new" Part B-only members in employer group and union group plans under the waiver authority in §617 of Benefits Improvement and Protection Act (BIPA) §1857(i) of the Act.

The M+C organization must have an adequate accounting system that is accrual-based and that uses generally accepted accounting principles (GAAP) to develop its ACR. The M+C organizations that are part of a government entity using a cash basis of accounting can develop ACR costs on a cash basis. However, such costs can include only depreciation on capital assets, rather than the total expenditure for the asset.

70.3 - Initial Rate Calculation

(Rev. 25, 06-13-03)

The M+C organization calculates its initial rate for each M+C plan on a 12-month basis for non-Medicare enrollees, using its choice of the following:

- A community rating system, as defined in §1302(8) of the Public Health Service Act (see below), other than subparagraph (C); or

- A system, approved by CMS, under which the M+C organization develops an aggregate premium for each M+C plan. The aggregate premium is created by weighting (by size) the various enrolled groups and individuals that constitute the M+C organization's non-Medicare enrollment. For purposes of this subsection, enrolled groups are defined as employee groups or other bodies of subscribers (including individual subscribers) that enroll in the M+C organization on a premium basis.

Excerpt from Section 1302(8) of the Public Health Service Act (Title 42 of US Code, Chapter 6A - Public Health, Subchapter XI - HMOs, Section 300e-1 - Definitions, (8) - Community rating):

(A) The term "community rating system" means the systems, described in subparagraphs (B) and (C), of fixing rates of payments for health services. A health maintenance organization may fix its rates of payments under the system described in subparagraph (B) or (C) or under both such systems, but a health maintenance organization may use only one such system for fixing its rates of payments for any one group.

(B) A system of fixing rates of payment for health services may provide that the rates shall be fixed on a per-person or per-family basis and may authorize the rates to vary with the number of persons in a family, but, except as authorized in subparagraph (D), such rates must be equivalent for all individuals and for all families of similar composition.

(C) A system of fixing rates of payment for health services may provide that the rates shall be fixed for individuals and families by groups. Except as authorized in subparagraph (D), such rates must be equivalent for all individuals in the same group and for all families of similar composition in the same group. If a health maintenance organization is to fix rates of payment for individuals and families by groups, it shall -

(i)

(I) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary,

(II) determine its revenue requirements for providing services to the members of each class established under sub-clause (I), and

(III) fix the rates of payments for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under sub-clause (II) for providing services to them as members of the classes established under sub-clause (I), or

(ii) fix the rates of payments for the individuals and families of a group on the basis of the organization's revenue requirements for providing services to the group, except that the rates of payments for the individuals and families of a group of less than 100 persons may not be fixed at rates greater than 110 percent of the rate that would be fixed for such individuals and families under subparagraph (B) or clause (i) of this subparagraph.

The Secretary shall review the factors used by each health maintenance organization to establish classes under clause (i). If the Secretary determines that any such factor may not reasonably be used to predict the use of the health services by individuals and families, the Secretary shall disapprove such factor for such purpose. If a health maintenance organization is to fix rates of payment for a group under clause (ii), it shall, upon request of the entity with which it contracts to provide services to such group, disclose to that entity the method and data used in calculating the rates of payment.

(D) The following differentials in rates of payments may be established under the systems described in subparagraphs (B) and (C):

(i) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of members:

(I) Individual members (including their families).

(II) Small groups of members (as determined under regulations of the Secretary).

(III) Large groups of members (as determined under regulations of the Secretary).

(ii) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.

(iii) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of Title 10 or under any other governmental program (other than the health benefits program authorized by chapter 89 of Title 5) or any health benefits program for employees of States, political subdivision of States, and other public entities **(The section above is quoted from the Public Health Service Act).**

Regardless of the calculation method used, the initial rate must equal the yearly premium the M+C organization would charge its non-Medicare enrollees enrolled in the same type of plan as the one being priced in the ACR.

Except as provided below for an M+C organization that does not usually separate its premium components, the M+C organization must identify in its initial rate calculation the following components, the rates for which must be consistent with those used by the M+C organization in calculating premiums for non-Medicare enrollees:

- Total initial rate including direct medical care, administration, reinsurance premiums, and additional revenue;
- Direct medical care with the following separately identified:
    - Recoveries from reinsurance; and
    - Other direct medical care.
- Administration;
- Reinsurance premiums; and
- Additional revenue.

An M+C organization that does not usually separate its premium components as described above may calculate its initial rate with the methods it uses for its other enrolled groups, if it provides CMS with the documentation necessary to support any adjustments it makes to the initial rate in accordance with requirements for supporting documentation listed below.

The initial rate calculation must not carry forward any losses experienced by the M+C organization during prior contract periods. The M+C organization must submit supporting documentation to assure CMS that ACR values do not include past losses, but only premiums for covered services, additional services, and supplemental benefits for the upcoming 12 months.

In calculating its initial rate, the M+C organization must identify and account for anticipated revenue collectible from other payers for those services for which Medicare is not the primary payer as described in 42 CFR 422.108.

An M+C organization that does not have or does not expect to have any non-Medicare enrollees in the relevant contract periods cannot compute an initial rate. In that case, the ACR should be computed using the method in §70.6.

70.4 - Initial Rate Adjustment by M+C Organization

(Rev. 25, 06-13-03)

M+C organizations must adjust their initial rate - calculated under the community rating system or weighted average method - as follows:

- Deduct revenue expected from non-enrollees and from sources unrelated to revenue collected for medical care. Show your total revenue requirements, per member per month, for providing medical benefits to non-Medicare enrollees. Eliminate all revenue required to service Medicare members.

- Subtract any revenue included to make up losses experienced by your organization under M+C contracts before the one covering the ACR on which you are working. The CMS regulations at 42 CFR 422.310(b)(5) specifically bar you from including such losses in your initial rate.

- Remove anticipated revenue from certain coordinated benefits for non-Medicare enrollees. For example, remove anticipated revenue from health insurance payers for Medicare-covered benefits where Medicare is not the primary payer, as described in §1862(b) of the Act, including the following:

    - Workers' compensation;

    - Automobile or liability insurance; and

    - No-fault insurance.

- Identify the portions of the total initial rate related to direct medical care and administration. The residual amount should reflect additional revenue.

Adequate supporting data must accompany adjustments made by the M+C organization. If an M+C organization does not have sufficient enrollment experience to develop these data, it may, during its initial contract period, use reasonable estimates acceptable to CMS to establish its ACR values.

70.5 - Initial Rate Adjustment by CMS

(Rev. 25, 06-13-03)

When CMS determines that an M+C organization does not have adequate data to adjust the initial rate to reflect the utilization characteristics of Medicare enrollees, CMS adjusts the initial rate. The CMS adjusts the initial rate based on differences in the utilization characteristics of:

- Medicare and non-Medicare enrollees in other M+C plans; or

- Medicare beneficiaries in the M+C organization's area, state, or the United States who are eligible to elect an M+C plan and other individuals in that same area, state, or the United States.

70.6 - Other Methods for Computing ACRs)

(Rev. 25, 06-13-03)

An M+C organization that does not have non-Medicare enrollees, sufficient Medicare enrollment experience to adequately calculate ACR values, or that did not operate the M+C plan in the base period, may calculate its ACR as follows:

- Estimate the ACR value for the direct medical (with reinsurance recoveries identified separately from other direct medical costs), administrative, and reinsurance premium components of a service or services offered using appropriate projection techniques.

- If the information is available, estimate the ACR value for the additional revenue component of a service or services offered **from the lesser of**:

    - The average of additional revenues received through risk payments for health services contracted to be furnished to an enrolled population of other organizations;

    - The average of additional revenues received for health services furnished; or

    - A reasonable estimate of additional revenues of other M+C organizations in the general marketplace.

70.7 - Special Rule for CMS APR or ACR Calculation

(Rev. 25, 06-13-03)

If CMS finds insufficient enrollment experience to determine the APR or ACR for an M+C plan (in the case of a newly operated provider-sponsored organization or other new organization), it can determine:

- The APR on the basis of the enrollment experience of other M+C organizations;

- The ACR using data in the general commercial marketplace; or

- Either or both rates using the best available information.

70.8 - CMS Review

(Rev. 25, 06-13-03)

An M+C organization's method and computation of its ACR are subject to review and approval by CMS, including an actuarial review of the assumptions and data used by the M+C organization to determine the appropriateness of those assumptions and data. When the M+C organization submits its ACR computation, it must include adequate supporting data. Except as provided in 42 CFR 422.306(e)(2), CMS authorizes the M+C organization to collect premiums and per-benefit cost-sharing amounts described in 42 CFR 422.306 that are the basis for the amounts calculated in the ACR.

If an M+C organization is dissatisfied with a CMS determination that the M+CO's computation is not acceptable, the M+C organization can, within 2 weeks of receipt of notification of this determination, file a request for a hearing with CMS. The request must state why the M+C organization believes the determination is incorrect, and must be accompanied by any supporting evidence the M+C organization wishes to submit. A hearing officer designated by CMS, under the hearing procedures described in 42 CFR Part 422 Subpart N, "Medicare Contract Determinations and Appeals," conducts the hearing.

70.9 - Sufficiency of Documentation and Periodic Audits

(Rev. 25, 06-13-03)

The M+C organizations must maintain records related to ACRs and their contract for 6 years. See 42 CFR 422.502(d) and Chapter 11 (Contracts with Medicare+Choice Organizations) of this manual, which discuss such records. The records include books, documents, and other evidence of accounting procedures and practices sufficient to accommodate the periodic auditing of financial records (including data related to Medicare utilization, costs, and computation of the ACR). These records should be available to DHHS, the Comptroller General, or their designees at any time during the period after the M+C organization submits the material described in this chapter to CMS.

In addition, M+C organizations **must** have all related entities, contractors, and subcontractors agree to the fact that DHHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit **any** pertinent information. For more on this matter, see 42 CFR 422.502(i) and §100.4 of Chapter 11 of this manual.

The CMS checks certain aspects of ACRs before approving them. The CMS then discusses certain errors or discrepancies with M+C organizations and obtains corrections or explanations as necessary. Additionally, CMS conducts periodic audits of M+C organizations to review other aspects of ACRs after CMS approves them. Errors auditors find during such post-approval reviews could have consequences for an M+C organization, despite the fact that CMS initially approved the ACR.

80 - Requirement for Additional Benefits - 42 CFR 422.312

(Rev. 25, 06-13-03)

80.1 - Definitions

(Rev. 25, 06-13-03)

Excess Amount - Excess amount is the amount by which the APR exceeds the actuarial value of the ACR determined under 42 CFR 422.310, reduced for the actuarial value of the cost sharing (i.e., deductibles and coinsurance) under Original Medicare. For M+C plans designed for enrollees covered by both Parts A and B of Original Medicare, subtract the actuarial value of the deductibles and coinsurance for both Parts A and B to obtain the excess amount. The M+C organizations must calculate a separate excess amount for Part B-only enrollees of a plan limited to such enrollees. In that case, deduct only the actuarial value of the cost sharing for Part B to obtain the excess amount.

Adjusted Excess Amount - Adjusted excess amount is the excess amount minus any amount withheld and reserved for the organization in a stabilization fund, as described below.

80.2 - General Information

(Rev. 25, 06-13-03)

Generally, when an ACR shows an excess amount, the M+C organization must make certain adjustments to the ACR that will eliminate the excess, and also benefit plan enrollees in the contract year or afterwards. An M+C organization has the option of aiding enrollees in the M+C plans offered after the contract period by contributing to a stabilization fund. An M+C organization has the option of aiding enrollees in the contract year by reducing enrollees' liability for Part B premiums, adding additional health care benefits, or by lowering the limit on the premiums and cost sharing that it can charge to plan enrollees.

80.3 - Stabilization Fund

(Rev. 25, 06-13-03)

An M+C organization may request that part of an excess amount be withheld and reserved, for a specified number of contract periods (the fund-holding period), in the Federal Hospital Insurance Trust Fund or the Federal Supplementary Insurance Trust Fund, in proportions that CMS determines appropriate. If an M+C organization requests withholding for a stabilization fund from the same M+C plan in different contract years (subject to the contract period and cumulative limits explained below), the fund-holding periods do not need to be the same.

The M+C organizations can use the reserved funds to stabilize and prevent undue fluctuations in the additional benefits required under this section, and those provided during subsequent contract periods. Any amounts not provided as additional benefits during the fund-holding period for which the stabilization fund is established, revert to the use of the trust funds. Amounts remaining in the stabilization fund reserved for a plan that is not renewed also revert to the use of the trust funds.

80.4 - Establishment of a Stabilization Fund

(Rev. 25, 06-13-03)

An M+C organization's request to have monies withheld in a stabilization fund for a specific M+C plan must be made when the M+C organization notifies CMS under 42 CFR 422.306 of its proposed premiums, other cost-sharing amounts, and related information in preparation for its next contract period.

The CMS will reduce its payments to any M+C organizations that elect to reserve monies in a stabilization fund. The reduction will reflect the amounts reserved in the contract period.

80.5 - Limit Per Contract Period

(Rev. 25, 06-13-03)

Except as provided in the next subsection, CMS does not withhold in a stabilization fund more than 15 percent of the excess amount for a given contract period.

80.6 - Exception to the Limit per Contract Period

(Rev. 25, 06-13-03)

The CMS may grant an exception to the limit per contract period, if the M+C organization can demonstrate to CMS' satisfaction that the value of the additional benefits it provides to its Medicare enrollees electing this M+C plan, fluctuates by more than 15 percent from one contract period to another.

80.7 - Cumulative Limit

(Rev. 25, 06-13-03)

If CMS has established a stabilization fund for an M+C plan, it does not approve a request for withholding made by that M+C organization for a subsequent contract period that would cause the total value of the stabilization fund to exceed 25 percent of the excess amount that applies to the M+C plan for that subsequent contract period.

80.8 - Interest On and Accounting of Reserved Funds

(Rev. 25, 06-13-03)

Reserved funds are held in a stabilization fund uniquely identified to **each** participating M+C organization and within that, reserved funds are uniquely identified to **each** participating M+C plan. Within each stabilization fund, annual contributions and withdrawals are recorded separately by an M+C plan. The CMS accounts for the amounts withheld in a stabilization fund in accounts for which interest does not accrue to the M+C organization.

80.9 - Withdrawal From a Stabilization Fund

(Rev. 25, 06-13-03)

The M+C organization must request a withdrawal from a stabilization fund when it notifies CMS under 42 CFR 422.306 of its proposed premiums, cost-sharing amounts, and related information in preparation for its next contract period. With respect to the notification, an M+C organization must provide the following information to CMS:

- How it intends to use the withdrawn amounts;
- Justification for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;
- Documentation of the M+C plan's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and
- Documentation of its experience during the contract period previous to the one for which it requests a withdrawal to ensure that it will not be using the withdrawn amounts to refinance losses suffered during that period.

80.10 - Criteria for CMS Approval

(Rev. 25, 06-13-03)

The CMS approves a request for a withdrawal from a benefit stabilization fund for use during the next contract period only if the:

- Average of the APR for the M+C plan's next contract period is less than that of the previous contract period;
- The M+C plan's ACR for the next contract period is significantly higher than that of the previous contract period;

- The M+C plan's revenue requirements for the next contract period for providing the additional benefits it provided during the previous contract period is significantly higher than the requirements for the previous period; or

- The ACR for the next contract period results in additional benefits that are significantly less in total value than that of the previous contract period.

To the maximum extent possible, reserved funds must be used to benefit Medicare enrollees of the M+C plan under which the funds were originally withheld.

80.11 - Basis for Denial

(Rev. 25, 06-13-03)

The CMS does not approve a request for a withdrawal from a stabilization fund when the withdrawal would allow the M+C organization to refinance prior contract period losses or to avoid losses in the upcoming contract period. An M+C organization may not both contribute to and withdraw from a stabilization fund for the **same** plan in any contract year.

80.12 - Form of Payment

(Rev. 25, 06-13-03)

Payment of monies withdrawn from a stabilization fund is made, in equal parts, as an addition to the monthly advance payment made to the M+C organization for Medicare beneficiaries electing the M+C plan during the period of the contract.

80.13 - Additional Benefits

(Rev. 25, 06-13-03)

If an adjusted excess amount exists for the plan the M+C organization offers, it must provide additional benefits with an ACR value that CMS determines is at least equal to the adjusted excess amount. The additional benefits can be in the form of:

- Reductions of enrollees' Part B premiums;

- Additional health care benefits (less the ACR value of any cost-sharing associated with the benefits); or

- Reductions in the limit on monthly premiums and the ACR value of cost-sharing (see §50) that the plan can charge for basic benefits.

The M+C organization must provide the additional benefits uniformly for all Medicare enrollees electing the plan.

80.14 - Part B Premium Reduction as an Additional Benefit

(Rev. 25, 06-13-03)

As part of providing additional benefits as required under this section, an M+C organization can elect to provide an "indirect" financial benefit to plan enrollees that will reduce the Medicare Part B premium liability they have. The Part B premium liability reduction takes effect during the plan contract period for enrollees in the plan. The actual date that premium reduction will occur for specific beneficiaries is dependent on a complex interface between the Social Security Administration and CMS' computer systems. For beneficiaries enrolled on January 1, premium reduction might not occur until the February or March Social Security payment. For new enrollees during the course of a contract year, premium reduction might not take effect until 1or 2 months after the M+C organization electronically notifies CMS of the enrollment. In any case, premium reduction is effective as of the first month of beneficiary enrollment in the appropriate contract year. Therefore, Social Security payments to enrollees will be retroactively adjusted.

An M+C organization wishing to offer such an additional benefit must fund it by electing a reduction in its payments from CMS with respect to the M+C plan in which the M+C organization offers the indirect financial benefit. An M+C organization can elect a plan payment reduction as large as 125 percent of the standard Medicare Part B premium that CMS has announced for the year covering the contract period during which the M+C plan offering the indirect financial benefit will operate. The actual reduction of the Medicare Part B premium expected to be paid by an M+C plan's enrollees must:

- Apply uniformly to each enrollee of the M+C plan to which the reduction applies; and

- Equal 80 percent of the plan payment reduction that an M+C organization elects.

Before the ACR filing deadline, CMS will give M+C organizations an estimate of the standard Medicare Part B premium for the year covering the next contract period for M+C plans. If the actual Medicare Part B premium differs from the estimate CMS makes before M+C organizations submit premiums and other information for M+C plans, generally any related payment reductions the organizations have elected to offer in plans must not change. In other words, CMS will not permit M+C organizations to change the value of the payment reduction an M+C organization has elected with respect to an M+C plan simply because the estimate of the standard Medicare Part B premium was inaccurate, **except** in the following case. If CMS has under- or over-estimated the Part B premium, **only** M+C organizations that originally submitted ACRs showing the **maximum amount of reduction** permitted by the Part B premium estimate in CMS instructions, will be permitted to raise or lower (as appropriate) that amount to maintain full reduction of the actual standard Part B premium amount.

80.15 - Additional Health Care Benefits

(Rev. 25, 06-13-03)

M+C organizations can add additional health care benefits to reduce or eliminate an adjusted excess amount. By definition, additional health care benefits cannot include benefits covered by Original Medicare.

80.16 - Reduction of Charges to Enrollees for Basic Benefits

(Rev. 25, 06-13-03)

An M+C organization can reduce its proposed actual charges (i.e., premiums, the ACR value of cost-sharing, or both) to plan enrollees for basic benefits to reduce or eliminate an adjusted excess amount.

80.17 - Additional Supplemental Health Care Benefits and Related Premiums

(Rev. 25, 06-13-03)

Nothing in this section prevents an M+C organization from providing supplemental benefits in addition to those required under this section, and from imposing a premium for those supplemental benefits.

90 - Detailed Instructions

(Rev. 25, 06-13-03)

The CMS will issue detailed instructions for M+C organizations to use when they prepare and submit proposed premiums, cost-sharing, ACR calculations, descriptions of plan benefits, and related information. The CMS will update the instructions as needed. M+C organizations should submit the pricing data on forms separate from the description of plan benefits and the listing of plan premiums and cost-sharing, as directed by CMS.

100 - Enrollees Who Elect Hospice While Remaining Enrolled in an M+C Plan

(Rev. 25, 06-13-03)

The M+C plan Medicare enrollees who elect hospice generally receive health care related to their terminal illness from the Medicare-certified hospice, not the M+C organization. However, such enrollees may need other health care not related to their terminal illness. If an enrollee remains in an M+C plan after making a hospice election, the M+C organization (not the hospice) must provide any **other** health care its plan covers.

Costs of and payments for hospice benefits for M+C enrollees who remain in an M+C plan after electing hospice are not part of an ACR. In addition, costs of and payments for Medicare-covered benefits (not hospice) that an M+C organization provides to such enrollees are not covered in an ACR. On the other hand, costs of and payments for non-Medicare-covered services (additional and supplemental benefits) **other** than hospice that M+C organizations provide to these enrollees are covered by an ACR.

The following subsections detail how costs of and payments for these different types of benefits relate to the ACR.

100.1 - Hospice Benefits

(Rev. 25, 06-13-03)

As stated above, when an M+C plan Medicare enrollee elects hospice, the Medicare-certified hospice provides the enrollee with the Medicare hospice benefit. An M+C organization cannot bill Medicare for the costs of those benefits. Original Medicare pays the hospice directly for such costs. Therefore, neither the hospice costs nor Original Medicare's reimbursement for them should be included in an ACR.

100.2 - M+C Non-Medicare-Covered Benefits

(Rev. 25, 06-13-03)

All costs that an M+C organization incurs for benefits during a period of hospice election, other than those that are the responsibility of a Medicare-certified hospice, and other than those that are for Medicare-covered benefits, should be reflected in an ACR. An ACR also should reflect payments by CMS or by a plan enrollee (i.e., premiums or cost sharing) for such benefits during a period of hospice election.

100.3 - M+C Medicare-Covered Benefits (Except Hospice)

(Rev. 25, 06-13-03)

An M+C organization should bill (or should authorize the provider of the service to bill) Original Medicare for any Medicare-covered benefits an M+C plan provides to an enrollee who elects hospice, if the benefits are not hospice related (as defined in 42 CFR 418). Costs for such Medicare-covered benefits should not be included in an ACR. Finally, Original Medicare's reimbursement to M+C organizations for the costs of non-hospice Medicare-covered benefits should not be included in the ACR.

100.4 - M+C Non-Medicare-Covered Benefits

(Rev. 25, 06-13-03)

An M+C organization should report the ACR costs for non-Medicare-covered benefits (additional benefits, mandatory supplemental benefits, and optional supplemental benefits) provided to enrollees electing hospice. The CMS payments for M+C non-

Medicare-covered benefits for enrollees electing hospice are included in the APR. Cost-sharing paid by the enrollees for such benefits should be included in the ACR.

CMS Payment during Hospice Election (Hospice Rate)

The CMS payment to an M+C organization on behalf of a Medicare enrollee who has elected hospice care, and who remains enrolled in the M+C plan, covers only the portion of the payment applicable to additional benefits. This partial payment is effective from the first day of the month following the month of hospice election and continues until the first day of the month following the month in which the enrollee terminates the election. During the time of hospice election, CMS reduces its monthly capitation payment to the M+C organization to equal the adjusted excess amount less any amount withheld for reducing plan enrollees' Part B premiums.

110 - Enrollees with ESRD

(Rev. 25, 06-13-03)

Generally, Medicare eligibles with end stage renal disease (ESRD) cannot enroll in an M+C plan. However, an exception applies to people with ESRD who were non-Medicare members of the managed care organization in the month preceding the month of enrollment as a Medicare member. In addition, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits ESRD enrollees of an M+C plan that has not been renewed or has been terminated to enroll in another M+C plan in their area. Finally, Medicare eligibles that develop ESRD while enrolled in an M+C plan can remain in the plan.

The CMS has a special payment rate for ESRD enrollees. If the plan had ESRD enrollees in the year before the contract year, the ESRD payments will be included in CMS' actual payment rate for that year.

The M+C organizations should reflect in their ACRs any costs that an M+C organization incurs for enrollees with ESRD.

During an onsite audit of their ACRPs, M+C organizations must be able to document the justification for projecting no ESRD enrollees in the contract year or for projecting significantly fewer ESRD enrollees in the contract year than in previous years.

(**NOTE:** Generally, Medicare is the secondary payer for health care for people covered under an employer group health plan of any size in the first 30 months of ESRD. Generally, Medicare becomes the primary payer for health care for people in the 31st month of ESRD.)

120 - User Fees

(Rev. 25, 06-13-03)

The CMS charges user fees to M+C organizations. The following section discusses the relationship of the ESRD Network Fee and the Information Campaign User Fee to ACRs.

120.1 - ESRD Network Fee

(Rev. 25, 06-13-03)

The CMS reduces the payment rate for enrollees with ESRD by the equivalent of 50 cents per renal dialysis treatment, (which works out to $5.25 per Medicare ESRD member per month). The funds are used to help pay for the ESRD Network program.

The M+C organizations can charge the ESRD Network Fee as an administrative expense. If they include the ESRD Network Fee as a cost, they must also include it in the plan's APR. However, CMS suggests that M+C organizations consider not including the ESRD Network Fee as an administrative expense in the ACR. Thus, they would not have to adjust their APR calculations to ensure consistent treatment.

During an on-site audit of their ACRPs, M+C organizations should be able to document that they have made any required adjustments for the ESRD Network Fee. If they have not made the adjustments, the M+C organization should be able to show that the adjustments would not materially affect the adjusted excess amount for the plan.

120.2 - Information Campaign User Fee

(Rev. 25, 06-13-03)

The CMS assesses the Information Campaign User Fee on each M+C plan offered by M+C organizations. The purpose of the user fee is to defray CMS expenses for disseminating M+C enrollment information, and operating a health insurance counseling and assistance program.

For purposes of the ACR, that user fee is handled in almost the same way as the ESRD Network Fee described above. The only exception is that CMS generally withholds the Information Campaign User Fee from government payments to M+C organizations over the first 9 months of each year. Therefore, ACR preparers need to remember to average, over a 12-month interval, the total annual user fee withheld. Doing so will yield the correct per-member, per-month values for the ACR.

For example, some organizations use one of CMS' monthly demographic reports as the basis for APR calculations in an ACR. Because of ACRP due dates, the report they use will cover one of the first 9 months of the year before the relevant contract year. The actual monthly government payment shown in such reports will be one-ninth of the total user fee, rather than one-twelfth. Therefore, M+C organizations need to convert the amount to a 12-month basis for purposes of the ACR.

130 - Waivers for M+C Organization Contracts With Employer or Union Groups

(Rev. 25, 06-13-03)

This section explains how CMS can facilitate M+C organization contracts with employer or union groups by waiving certain M+C rules. See §150, Chapter 11 (Contracts With Medicare+Choice Organizations), of this manual for additional discussion of this issue.

130.1 - Background

(Rev. 25, 06-13-03)

The M+C organizations can offer customized health care plans to Medicare-eligible members of employer groups and labor organizations (unions). The CMS will make capitated payments to those M+C organizations to cover the costs of Medicare-eligible enrollees. The final benefit package of such plans is developed through private negotiations between an M+C organization and an employer or union. **All such plans, except those created for Part B-only enrollees (see item number 4 below) must cover all Medicare Part A and Part B benefits (except hospice).**

Section 617 of BIPA gives CMS authority to waive or modify requirements that hinder the design of, offering of, or enrollment in M+C plans under contracts between M+C organizations and employers or unions. The next subsections discuss the waivers CMS makes under BIPA authority.

130.2 - Section 617 Waiver Categories Approved

(Rev. 25, 06-13-03)

The CMS has approved four categories of waivers under BIPA authority. Two of the categories, "actuarial swapping" and "actuarial equivalence," enhance flexibility of build-ons to M+C plans designed for the individual market where the build-ons are part of an enhanced package intended only for members of an employer or union group. The other two categories allow an M+C organization to design a plan (such as an employer-only or union-only or a Part B-only plan) that cannot be offered to the individual market, but that can be modified to meet the needs of contracts with employers or unions.

1. **Actuarial swapping of benefits not covered by Original Medicare.** The M+C organizations can swap different types of benefits (not covered under Original Medicare) of equal actuarial value between an M+C plan offered to the individual market and an employer or union plan. The M+C organizations can make the swaps when an employer prefers a benefit package for its employees that differs from one that the M+C organization offers to the individual market. For example, when contracting with an M+C organization that offers a supplemental dental benefit in a plan offered to the individual market, an employer may prefer to offer its employees a vision benefit rather than the dental benefit. Without an approved

waiver, swapping benefits would violate the uniformity-of-benefits rules related to M+C plans in the Social Security Act.

The M+C organizations do not need to obtain specific advance approval from CMS in order to take advantage of this increased flexibility. Rather, when submitting ACRPs for the M+C plans it intends to offer to individuals, an M+C organization must inform CMS of its intention to make actuarial swaps. It must identify for CMS both the benefits that might be swapped-out from M+C plans offered to individuals, and the "new" benefits that might be swapped-in for employer or labor groups. After CMS gives the M+C organization its general approval for the possible swaps, the organization can make specific swaps in negotiations with employers or unions, in the context of CMS's general approval, without obtaining further approval from CMS.

2. **Actuarial equivalence.** When negotiating with employers or unions, M+C organizations can raise cost-sharing (coinsurance, copayments, and deductibles) for certain plan benefits by providing a higher benefit level, a modified premium, or both compared to what is offered to the individual market. Generally, this category of waiver would affect prescription drug benefits. For example, assume an M+C organization offers the individual market a $500 drug benefit with $5 cost-sharing per prescription, but it wants to offer employers or unions an M+C plan that includes an unlimited drug benefit with cost-sharing of $10 per prescription or a $500 drug benefit with $10 cost sharing and a reduced premium.

   An M+C organization may take advantage of this flexibility by informing CMS of its intentions when it submits its ACRP for M+C plans it intends to offer to the individual market. The M+C organizations must identify the following for CMS:

   - The cost-sharing amounts it intends to increase and the M+C plan containing the cost-sharing;
   - Any modification to the premium it will charge; and
   - Any improvement in the benefit related to the changed cost sharing.

   The M+C organization must retain any computations in the backup materials for the affected ACR. The CMS will allow this category of waiver without restriction to M+C organizations that need it for purposes of a contract with an employer or union group. The waiver can apply to either Medicare-covered or non-Medicare-covered benefits, but M+C organizations cannot design an employer or union plan that denies enrollees access to medically necessary health care items and services.

3. **Employer-only or union-only plans.** The M+C organizations can develop an employer-only or union-only plan for use as the basis for developing packages offered exclusively to Medicare beneficiaries who are members of an employer or union group. Before August 2001, CMS rules only permitted employers and unions to add benefits to an M+C plan through private negotiations, thereby making an enhanced benefit package that was available only to Medicare

beneficiaries of that group (see 42 CFR 422.106). However, under those rules, the employer or union package was "built on" to an M+C plan, which by definition must have been made available to individual Medicare beneficiaries. In contrast, this type of waiver allows M+C organizations to develop a minimal base package that they could customize for individual employers or unions, but that they could not market or make available in the Medicare market for individuals. In addition, the "Medicare Health Plan Compare/Medicare Personal Plan Finder" would not disclose any such customized plans.

Employer-only or union-only plans are subject to monitoring by CMS to ensure compliance with other regulatory requirements such as appeal and grievance processes.

4. **Part B-only plans.** Certain state and local employers do not deduct Federal Insurance Contributions Act (FICA) taxes. Therefore, their retirees may not have earned entitlement to Part A of Medicare. Sometimes these employers would like to offer enrollment in an M+C plan for their Part B-only retirees. The M+C organizations can develop plans for Part B-only Medicare beneficiaries who are members of employer or union groups. In permitting such plans, CMS is waiving the existing regulations that prohibit individuals eligible for Part B only from enrolling in M+C plans. See §20.1, Chapter 2 (Enrollment and Disenrollment), of this manual for more on enrollment of Part B-only individuals.

   In order to enroll new Part B-only employer group or union group members in an M+C plan, an M+C organization **must** create a separate Part B-only employer-group or union-group plan. Do not confuse this requirement with the different rules CMS has established for M+C plans covering grandfathered Part B-only enrollees (see §70 of this chapter).

   The annual ACR instructions tell M+C organizations how to create a Part B-only plan.

130.3 - Service Areas

(Rev. 25, 06-13-03)

Service areas of employer-only or union-only plans are not restricted or linked to the service areas identified by the M+C organization for its M+C plans offered to the individual market. Therefore, the service area of an employer-only or union-only plan may be larger or smaller than the service areas of the organization's M+C plans offered to the individual market. However, M+C organizations must ensure that enrollees have reasonable access to providers in order to obtain covered benefits.

The CMS has relaxed the requirement for either a new plan application or a service area expansion when the service area is larger than the one currently approved under the M+C contract. The service area for employer-only or union-only plans must comply with other regulatory requirements (that is, those not waived, as described in this subsection).

Additionally, M+C organizations must notify CMS of the expanded service area related to an employer-only or union-only plan with sufficient lead-time (usually 30 days prior to the ACR due date or the date the ACRP will be uploaded to HPMS) to allow CMS time to add these additional counties to HPMS before the ACR-submission.

An entity must be an M+C organization to avail itself of these waivers. An M+C organization must be licensed by the state as a risk-bearing entity in each state in which it seeks to offer an M+C plan. In addition, it must offer an M+C plan under that license. Therefore, the M+C organization must offer at least one M+C plan to individuals somewhere in the state in which an employer-only or union-only plan is offered.

130.4 - ACR Filings

(Rev. 25, 06-13-03)

M+C organizations are permitted to have more than one employer-only or union-only plan in a state, but they must submit an ACR for each one. The M+C organizations should submit initial ACRs, covering at least 12 months, before the period for which the plan will be offered. The M+C organizations must submit renewal ACRs, covering 12 months, on the dates specified in §10. Base-period costs in an employer-only or union-only plan should reflect only employer or union group members' costs for Medicare-covered and additional benefits. The costs should reflect the employer or union group member costs for the members in the plan service area, but if an M+C organization cannot follow this rule, it can request an exception from CMS.

140 - Coordination of Benefits

(Rev. 25, 06-13-03)

Payments to M+C organizations exclude the actuarial value of those items or services that would not be paid for, in whole or part, under Original Medicare because Medicare is not the primary payer under §1862(b) of the Act, and Part 411 of Title 42 of the Code of Federal Regulations (CFR). The M+C organization must, for each M+C plan:

- Identify payers that are primary to Medicare under §1862(b) of the Act and 42 CRF Part 411;
- Identify the amounts payable by those payers; and
- Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

Payers identified in §1862(b) of the Act and in 42 CFR Part 411 include:

- Group health plans that cover working aged individuals and their spouses;
- Large group health plans that cover disabled individuals and their families based on the current employment status of that individual;

- Group health plans that cover individuals entitled to Medicare on the basis of end stage renal disease;
- Workers' compensation plans;
- Property and casualty insurance; and
- Liability or no-fault insurance plans, including self-insured plans.

The M+C organization may bill or authorize a provider to bill other individuals or entities for covered Medicare items and services for which Medicare is not the primary payer.

If a Medicare enrollee receives covered items and services that are covered under another insurance policy or plan, the M+C organization may bill or authorize a provider to bill any of the following:

- The insurance carrier, the employer, or any other entity that is liable for payment for the services under §1862(b) of the Act and 42 CFR Part 411; or
- The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or other entity for covered medical expenses.

An M+C organization also can bill, or authorize a provider to bill a group health plan or large group health plan for services it furnishes to a Medicare enrollee who is also covered under the group health plan or large group health plan. In addition, the M+C organization may bill the Medicare enrollee to the extent that he or she has been paid by the group health plan or large group health plan.

Consistent with 42 CFR 422.402 concerning the Federal preemption of state law, the Medicare secondary payer (MSP) rules established under the M+C program supersede any state laws, regulations, contract requirements, or other standards that would otherwise apply to M+C plans only to the extent that those state laws are inconsistent with the standards established under the M+C program. A state cannot take away an M+C organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. Section 1852(a)(4) of the Act does not prohibit a state from limiting the amount of the recovery; thus, state law could modify, but not negate, an M+C organization's rights in this regard.

The M+C organizations always must provide the benefits they offer even though another entity might be financially liable for them. In other words, M+C organizations must provide covered benefits before other liable payers must pay for them. This is because the requirement to provide covered services takes precedence over the right M+C organizations have to recover from liable third parties. The M+C organizations have the legal right to collect and retain funds from other entities that are liable for any health care benefits the M+C organizations provide to enrollees.

The M+C organizations can also authorize providers to collect and retain funds subject to coordination of benefits (COB) procedures. In other words, if an M+C organization receives a claim for payment for covered services which the M+C organization knows is the responsibility of another insurer (for instance, for injuries resulting from an automobile accident); the M+C organization is permitted to return the claim to the provider with instructions to first bill the liable third party. It is important to note that Medicare law only permits subrogation in cases where there is a **reasonable expectation** of third party payment. In cases where legally required insurance (auto-liability, no-fault, workers compensation, etc.) is not actually in force, Medicare (and an M+C organization) is required to assume responsibility for primary payment.

140.1 - Effect on M+C Plan Cash Flow

(Rev. 25, 06-13-03)

The M+C organizations can enhance their cash flow by recovering or avoiding costs related to COB. Therefore, as long as the cost of making recoveries or avoiding costs under COB doesn't exceed the amount actually recovered, M+C organizations have an incentive to try to recover funds under COB.

140.2 - Effect on ACR Calculations

(Rev. 25, 06-13-03)

When submitting ACRs, M+C organizations must estimate potential collections of funds (what they should collect) under COB procedures. When estimating potential collections M+C organizations should base such estimates on the recoveries they would make if they made a consistent and concerted ("good faith") effort to recover from liable third parties. If an M+C organization makes a "good faith" effort at recovery, but as a practical matter fails at recovery, then such lost recoveries do not need to be included in its estimate of COB recoveries. For instance, if an M+C organization attempts in a court of law to recover COB funds due it, and the court rules against the M+C organization's recovery efforts, then the M+C organization generally has made a "good faith" effort at recovery and the unrecoverable funds should not be included in their estimate. Similarly, if a potentially liable third party is bankrupt or if there is no reasonable expectation of actual recovery from a liable third party for some other reason, then M+C organizations also should exclude these potential recoveries from their estimate.

The M+C organization must deduct its estimated potential collections from other direct medical costs reported on an ACR. The potential collections are deducted from ACR costs so that the costs reflect only items and services for which original Medicare would be the primary payer. On the other hand, an M+C organization that initially avoids making payments for which another entity is liable (i.e., the other entity pays first), does not have to estimate the payments avoided as long as costs reported in the ACR do not include them.

See §40.8 of Chapter 4 (Benefits and Beneficiary Protection) of this manual for an additional discussion of coordination of benefits in the M+C program. In addition, you may visit the Medicare Web site dedicated to coordination of benefits issues in Original Medicare at http://www.cms.hhs.gov/medicare/cob.