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March 13, 2009

Alissa Fox
Senior Vice President
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Blue Cross and Blue Shield Association
1310 G Street, NW, Twelfth Floor
Washington, DC 20005

Dear Ms. Fox:

I am responding to your request for an opinion regarding whether CMS is legally required to assume that the Medicare physician fee schedule will be reduced by 20 percent, as provided by current law, for purposes of developing the national per capita MA growth percentage.

As background, in the "Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," CMS announced its proposed 2010 national per capita growth percentage. One component of that growth percentage is the 2010 Trend Change, which was estimated at a negative 1.1 percent. The principal reason for the negative trend change was the assumption by CMS that the Medicare physician fee schedule will be reduced by about 20 percent, as provided for under existing law. The issue you have asked me to consider is whether CMS is obligated to assume that the physician fee schedule will be reduced by that percentage notwithstanding the widely held expectation that Congress will nullify the fee reduction, as it has done in previous years.

Section 1853 of the Social Security Act specifies the payment methodology used by CMS to develop the Medicare Advantage payment rates. The national per capital MA group percentage is a factor that affects the change in the MA benchmark amount from one year to the next. Section 1853(c)(6) of the Social Security Act defines national per capital MA growth percentage as follows:

> (A) In general. In this part, the "national per capita MA growth percentage" for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate

> determinations may be made for aged enrollees, disabled enrollees, and enrollees with end stage renal disease.

Under this language, the Secretary is directed to develop an "estimate" of the growth rate. The language of the statute does not specify how that estimate is to be made. Thus, the statute on its face does not require that the Secretary assume that existing law will continue in effect in making this projection. CMS' implementing regulations and its corresponding manual provisions repeat the reference to developing an "estimate" without elaborating on how CMS is to determine the estimate. See 42 CFR §422.308 and Section 20.1 of Chapter 8 of the Medicare Managed Care Manual (Payments to Medicare Advantage Organizations).

Because the statute and regulations do not explicitly require that CMS assume that existing law will continue, it is clear that there is no explicit legal obligation for CMS to estimate the growth percentage based on existing law. Thus, the key issue is whether a reasonable estimate of this growth percentage implicitly requires acceptance of existing law.

Because the estimates are developed through actuarial analysis, it is appropriate to consider the standards established by the Actuarial Standards Board in examining this issue. There are two standards that have been adopted by the Actuarial Standards Board in its Actuarial Standard of Practice No. 8 "Regulatory Filings for Health Plan Entities" that are directly relevant to this issue. These two standards are as follows:

> 3.2.4 Use of Past Experience to Project Future Results. When setting assumptions, the actuary should adjust past experience for any known or expected changes that, in the actuary's professional judgment, are likely to materially affect expected future results.
>
> 3.2.9 Reasonableness of Assumptions. The actuary should review the assumptions employed in the filing for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually. The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary. This information may include, but is not limited to, business plans; past experience of the health plan entity or the health benefit plan; and any relevant industry and government studies that are generally known and reasonably available to the actuary. The actuary should make a reasonable effort to become familiar with such studies.

Standard 3.2.4 is clear that an actuary has the obligation to consider "expected changes" that are likely to materially affect expected future results. In addition, Section 3.2.9 requires that the assumptions used be "reasonable." Given that there is widespread, or perhaps even universal, agreement that Congress will be compelled to nullify the 20 percent reduction in the Medicare physician fee schedule, the "expected change" is that this fee reduction will not go into effect. Thus, in my opinion, CMS would clearly have the authority to factor in that expected change in estimating the national per capita MA growth percentage. Moreover, I believe that CMS'

actuaries, who would have the same responsibility to follow these actuarial standards, should factor in legislation to nullify the fee cuts in making their growth projections.

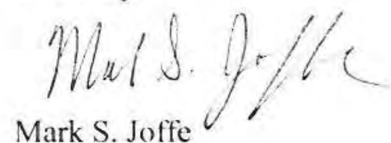
In addition, a conflict exists between CMS' view that it lacks the authority to assume that Congress will nullify the physician fee cuts and CMS' position allowing MA organizations to assume a rescission of the cuts in projecting their MA bid costs. CMS has permitted MA organizations to assume that Congress will nullify previous reductions in the Medicare physician fee schedule as part of the projections of its costs for purposes of its MA bids. Because the national per capita growth percentage directly impacts the revenue assumptions that an MA organization uses in its bids, there is a clear inconsistency in CMS allowing potential future legislation to be factored into cost projections, but not allowing that same factor in projecting revenues. It would appear that both projections would be governed by sound actuarial principles and those principles dictate acceptance of "expected changes" whether those expected changes are legislative or otherwise.

A final point to note is that in a related context CMS has exercised its administrative discretion to make a decision in anticipation of Congressional action to nullify a physician fee schedule reduction. Under Original Medicare, CMS' contractors are obligated by law to pay clean claims within 30 days of receipt. See 42 CFR §405.922. Notwithstanding, CMS directed that its contractors delay for 15 days until July 15, 2008, payment of claims in order to avoid paying physicians at a lower rate while legislation was pending to rescind the reduction in physician fees. This example illustrates the flexibility that CMS has been willing to exercise on this issue prior to Congressional action. Moreover, if CMS was willing to assume that Congress would nullify a 10.6 percent fee schedule reduction in 2008, it is at least equally reasonable to conclude that Congress would negate physician fee cuts of twice that size.

As explained above, in my opinion neither the MA statute nor its implementing regulations compel CMS to assume that the 20 percent fee cut will occur as part of its estimate of the national per capita growth percentage. The unprecedented level of this cut level warrants a change from past practice. Based on actuarial standards, I believe that CMS has the responsibility to use assumptions based on expected changes. Given the universality of the expectation that the payment cuts will be nullified, CMS arguably not only may, but has the responsibility to, assume the statute would be amended in these unique circumstances.

Feel free to contact me if you would like to discuss this issue further.

Sincerely,



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