DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JAN 14 1999

From June Gibbs Brown
Inspector General

Subject Review of the 1997 Adjusted Community Rate Proposal for a Region V Risk-Based Managed Care Organization (A-05-98-00049)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

The attached final report is one in a series of reports that is part of our overall review of the administrative costs planned and incurred by managed care organizations (MCO) relative to their operating a Medicare risk managed care plan. Because MCOs view the use of administrative funds to be a sensitive matter and the Medicare managed care program is essentially a concentrated Health Care Financing Administration (HCFA) central office operation, we want to share these individual MCO reports directly with you.

On July 27, 1998 we issued a report entitled, "Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated" (A-14-97-00202). The adjusted community rate (ACR) proposal is integral to pricing an MCO benefit package, computing savings (if any) from Medicare payment amounts, and determining additional benefits that will be provided beneficiaries or reduced premiums that could be charged to the Medicare enrollees. We concluded that the methodology which allowed MCOs to apportion administrative costs to Medicare was flawed and that Medicare covered a disproportionate amount of the MCO's administrative costs. The attached report on selected administrative costs of a Medicare managed care risk contractor located in Region V provides some insight on where some of the excess administrative costs may be used.

The objective of this review was to examine the plan's administrative cost component of the 1997 ACR proposal, and assess whether the costs for judgmentally selected administrative cost items were appropriate when considered in light of the Medicare program's general principle of paying only reasonable costs. Because of the limited scope of our review, our results cannot be considered representative of the universe of administrative costs submitted by the MCO.

Of the MCO's $105 million total administrative expenses, we reviewed $2,406,120 of costs from selected categories which traditionally have been shown to be problematic areas in the

Medicare fee-for-service program. The MCO used 1995 financial records as their basis for the 1997 ACR proposal. We found $1,209,089 of administrative costs which were included in the plan's ACR proposal that would not be allowable if existing Medicare regulations were applied to risk-based MCOs. We considered these administrative costs questionable in comparison to Medicare's reimbursement principle of reasonableness. We believe inclusion of these costs unreasonably increased the funds needed to cover the costs under the risk-contract.

Presently there is no statutory or regulatory authority governing allowability of costs in the ACR process, unlike other areas of the Medicare program. For example, regulations covering MCOs that contract with HCFA on a cost reimbursement basis provide specific parameters delineating allowable administrative costs for enrollment and marketing. These same guidelines, however, are not used in administering the MCO risk contracts. Because the identification of allowable administrative costs to include in the ACR is not a requirement applicable to risk-based MCOs, we have made no recommendations to the MCO.

In responding to our report, the MCO indicated they believed we overstated the amount of unallowable costs. They also believe that the unallowable amount has little impact on the Government or beneficiaries because it represents only about one percent of total overall administrative costs expended by the health plan. The MCO also expressed their belief that, (i) Medicare direct costs rather than commercial allocations should be used in future guidelines governing Medicare risk-based organizations, and (ii) traditional cost and fee-for service reimbursement guidelines should not be adopted with respect to marketing activities of Medicare risk-based plans because the necessary activities to attract enrollment is intrinsically different from cost and fee-for-service programs.

We disagree that unallowable administrative costs do not impact the premiums paid by or benefits available to beneficiaries. Inclusion of these costs unreasonably increased the funds needed to cover the costs under the risk-contract and should be excluded. We agree that actual Medicare costs should be used in computing the ACR proposals. The changes brought about by the Balanced Budget Act of 1997 require MCOs to utilize their actual Medicare costs in computing their ACR proposals. We disagree with the plan's position on a separate criteria for the marketing activities of Medicare risk-based plans. The parameters for Medicare plans under cost contracts should apply to Medicare risk-based plans.

While this review examined only one plan, we have found similar problems in other MCOs and we believe that our results highlight a significant problem. Additional reviews are underway and preliminary results show there are similar findings at other MCOs. The

results of these reviews will be shared with HCFA in the coming months so that appropriate legislative changes can be considered. We invite HCFA comments on our review as it proceeds.

If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. To facilitate identification, please refer to Common Identification Number A-05-98-00049 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE 1997 ADJUSTED COMMUNITY RATE PROPOSAL FOR A REGION V RISK-BASED MANAGED CARE ORGANIZATION

JUNE GIBBS BROWN
Inspector General

JANUARY 1999
A-05-98-00049

Memorandum

Date JAN 14 1999

From June Gibbs Brown
Inspector General

Subject Review of the 1997 Adjusted Community Rate Proposal for a Region V Risk-Based Managed Care Organization (A-05-98-00049)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report presents the results of our review of the administrative cost component of the adjusted community rate (ACR) proposal submitted to the Health Care Financing Administration (HCFA) by a Region V managed care organization (MCO) for the 1997 contract year. The objective of our review was to examine the administrative cost component of the ACR proposal submitted by the MCO and assess whether the costs were appropriate when compared to the Medicare program's general principle of paying only reasonable costs.

The Medicare ACR process is designed for MCOs to present to HCFA their estimate of the funds needed to cover the costs of providing the Medicare package of covered services to any enrolled Medicare beneficiary. The MCO's anticipated or budgeted funds are calculated to cover medical and administrative costs for the upcoming year and must be supported by the individual MCO's utilization and expenditure experiences. All assumptions, cost data, revenue requirements, and other elements used by MCOs in the ACR proposal calculations must be consistent with the calculations used for the premiums charged to non-Medicare enrollees. The ACR process is a key element in the reimbursement methodology for Medicare risk-contracts. The ACR proposal is integral to pricing an MCO's benefit package, computing savings (if any) from Medicare payment amounts, and determining additional benefits or reduced premiums that may be applicable to Medicare beneficiaries.

Of the MCO's $105 million total administrative expenses for 1995, we reviewed $2,406,120 of costs from selected categories which traditionally have been shown to be problematic areas in the Medicare fee-for-service program. The MCO used 1995 financial records as their basis for the 1997 ACR proposal. We found $1,209,089 of administrative costs which were included in the plan's ACR proposal that would not be allowable if existing Medicare cost reimbursement regulations were applied to risk-based MCOs. We considered these administrative costs questionable in comparison to Medicare's reimbursement principle of reasonableness. We believe inclusion of these costs unreasonably increased the funds needed to cover the costs under the risk-contract. Specifically, the ACR proposal included:

- $365,000 in bad debt expense;
- $226,789 paid to a trade association representing health care organizations;
- $170,594 for a Medicaid study;
- $149,177 of costs relating to public relations and sponsorships;
- $128,448 of costs relating to donations, contributions, and community organization memberships;
- $122,434 of costs for gifts, entertainment, and social functions for customers independent insurance brokers, and employees; and,
- $46,647 of other costs also included in the development of the administration line of the ACR proposal.

The effect of including these costs in the plan's ACR proposal was to increase the amounts needed for administration, thus reducing any potential savings from the Medicare payment amounts. In addition, this methodology impacted the amount available to Medicare beneficiaries for additional benefits or reduced premium amounts.

Presently there is no statutory or regulatory authority governing allowability of costs in the ACR process, unlike other areas of the Medicare program. For example, regulations covering MCOs that contract with HCFA on a cost reimbursement basis provide specific parameters delineating allowable administrative costs for enrollment and marketing. These same guidelines, however, are not used in administering the MCO risk contracts. Consequently, there are no recommendations addressed to the MCO. However, we believe the use of Medicare trust funds in paying monthly MCO capitation payments should not exceed an amount that would be incurred using existing regulations applied in other areas of the Medicare program that include prudent and cost-conscious management concepts.

Because the identification of allowable administrative costs to include in the ACR is not a requirement applicable to risk-based MCOs, we have made no recommendations to the MCO. The results of these reviews will be shared with HCFA so that appropriate legislative changes can be considered. This audit is part of a nationwide review of the ACR process and is being performed at several MCOs.

In responding to our report, the MCO indicated they believed we overstated the amount of unallowable costs. They also believe that the unallowable amount has little impact on the Government or beneficiaries because it represents only about one percent of total overall administrative costs expended by the health plan. The MCO also expressed their belief that, (i) Medicare direct costs rather than commercial allocations should be used in future

guidelines governing Medicare risk-based organizations, and (ii) traditional cost and fee-for service reimbursement guidelines should not be adopted with respect to marketing activities of Medicare risk-based plans because the necessary activities to attract enrollment is intrinsically different from cost and fee-for-service programs. The MCO's response, in its entirety, is attached to the report.

We disagree that unallowable administrative costs do not impact the premiums paid by or benefits available to beneficiaries. Inclusion of these costs unreasonably increased the funds needed to cover the costs under the risk-contract and should be excluded. We agree with the plan that actual Medicare costs should be used in computing the ACR proposals. The changes brought about by the Balanced Budget Act of 1997 require MCOs to utilize their actual Medicare costs in computing their ACR proposals. We disagree with the plan's position of the marketing activities of Medicare risk-based plans. The parameters delineating allowable administrative costs for enrollment and marketing covering MCOs under cost contracts with HCFA should apply to Medicare risk-based plans.

INTRODUCTION

BACKGROUND

Medicare payments to risk-based MCOs are based on a prepaid capitation rate. This rate reflects the estimated costs that would have been incurred by Medicare on behalf of enrollees of the MCO if they received their covered services under fee-for-service Medicare. Risk contractors are required by section 1876 of the Social Security Act to compute an ACR proposal and submit it to HCFA prior to the beginning of the MCO's contract period. The HCFA encourages the plans to support their ACR proposal with the most current data available. The Medicare ACR process is designed for MCOs to present to HCFA their estimate of the funds needed to cover the costs (both medical and administrative) of providing the Medicare package of covered services to any enrolled Medicare beneficiary.

The MCO calculates its ACR using its commercial rates adjusted to account for differences in cost and services used by Medicare and commercial enrollees. The development of a base rate is the first step of the process. The base rate is the amount that the MCO will charge its non-Medicare enrollees during the contract period. The next step in the process is to develop adjustments to arrive at the initial rate which the plan would have charged to its commercial members if the commercial package was limited to Medicare coverage. The adjustments eliminate the value of those services not covered by Medicare that were included in the base rate or add the value of covered Medicare services not included in the base rate.

After the calculation of the initial rate, the rate is multiplied by utilization factors to reflect volume, intensity, and complexity of service differences between Medicare members and non-Medicare members. This last calculation results in the ACR. If the average payment

rate is greater than the ACR, a savings is noted. The MCO was required to use this savings to either improve their benefit package to the Medicare enrollees, reduce the Medicare enrollee's premium, or contribute to a benefit stabilization fund. According to the MCO Manual, all assumptions, cost data, revenue requirements, and other elements used by MCOs in the ACR proposal calculations must be consistent with the calculations used for the premiums charged to non-Medicare enrollees. The MCO cost data will be especially important due to the changes in the ACR proposal brought about by the Balanced Budget Act of 1997. This information will be used as the basis for calculating the amount HCFA will allow an MCO to charge Medicare enrollees for a benefit package.

SCOPE

Our review was performed in accordance with generally accepted government auditing standards. The objective of our review was to examine the administrative cost component of the ACR proposal submitted by the plan, and assess whether the costs were appropriate under Medicare's principle of reasonableness. To accomplish our objective, we:

- reviewed applicable laws and regulations;
- discussed with MCO officials their ACR proposal process and how their administrative costs were derived; and,
- selected categories of administrative costs which traditionally have been shown to be problematic areas in the Medicare fee-for-service program.

The objective of our review did not require us to review the internal control structure at the plan.

Our review concentrated on the administrative cost component of the plan's ACR proposal for the 1997 Medicare contract year. The MCO used 1995 financial records as their basis for the 1997 ACR proposal. The administrative costs included the non-medical costs associated with reinsurance, taxes, compensation, reserves, and a contractual obligation. However, most of the administrative costs were from the general ledger categories of community relations, other public relations, promotional conferences, charitable contributions, meals and entertainment, meetings and retreats, other employee events, and bad debts. The MCO's 1995 general ledger did not segregate administrative costs between Medicare and Non-Medicare lines of business, however they developed a methodology to allocate administrative costs between Medicare and non-Medicare activities.

We judgmentally selected 248 administrative cost items from the general ledger categories totaling $2,406,120. Approximately 55 percent of this general ledger amount was allocated to the ACR proposal. The MCO's total administrative expenses for 1995 were

approximately $105 million. Because we reviewed a judgmental sample, our findings cannot be projected to the universe of administrative costs submitted by the MCO.

Our work was performed at both the MCO's headquarters and our field office. Field work was conducted from June 1998 to October 1998.

FINDINGS AND RECOMMENDATIONS

We identified $1,209,089 in administrative costs included in the ACR proposal that would be unallowable if MCO cost reimbursement contract or Medicare fee-for-service regulations had applied to this risk-based MCO. These costs related to expenses incurred for (i) bad debts, (ii) trade association fees, (iii) a Medicaid study, (iv) gifts, entertainment, and social functions for customers, independent insurance brokers, and employees, (v) public relations and sponsorships, (vi) donations, contributions, and community organization memberships, and (vii) other recorded administrative items.

Bad Debts

The MCO's ACR proposal included $365,000 in bad debt expense. These expenses would be unallowable under either an MCO cost reimbursement contract or Medicare fee-for-service reimbursement regulations.

Trade Association Fees

The ACR proposal included administrative costs of $226,789 paid to a trade association, representing health care organizations, to conduct a media campaign to call favorable attention to the State's health maintenance industry. These expenses would be unallowable under either an MCO cost reimbursement contract or a Medicare fee-for-service arrangement.

Medicaid Study

The administrative costs in the ACR proposal included a total of $170,594 for a Medicaid study and miscellaneous Medicaid related expenses. These costs were not Medicare related and would be unallowable under either an MCO cost reimbursement contract or Medicare fee-for-service reimbursement regulations.

Public Relations and Sponsorships

Administrative costs totaling $149,177 for public relations and sponsorships that would be unallowable under either an MCO cost reimbursement contract or a fee-for-service reimbursement arrangement were included in the ACR proposal. Costs pertained to:

- $75,850 for sponsoring golf tournaments;
- $40,725 for various other sponsorships including a marathon race, the state fair, a university alumni and foundation center, a walk for Alzheimers, and Senior Days at a local festival, and;
- $32,602 for a catered meal and lapel pins ($900) for 500 guests at the MCO tent during a seven day local golf tournament.

Donations, Contributions, and Community Organization Memberships

Administrative costs totaling $128,448 for donations, contributions, and community organization memberships were included in the ACR proposal. These costs would be unallowable under either an MCO cost reimbursement contract or a fee-for-service reimbursement arrangement. Costs pertained to:

- $34,963 for a donation to a local university for production of an educational video for use at schools;
- $30,000 for a contribution to a local foundation to fund their Health Preservation Project;
- $28,202 in membership dues in local and state chambers of commerce;
- $17,500 for a contribution to a camp for children with asthma;
- $9,280 in various donations to union related functions including parties, retirements, entertainment, and golf tournaments (includes $2,814 of alcohol purchases), and;
- $8,503 in other contributions and donations including a golf tournament.

Gifts, Entertainment, and Social Functions for Customers, Independent Insurance Brokers, and Employees

Administrative costs totaling $122,434 for gifts, entertainment, and social functions for customers, independent insurance brokers, and employees were included in the ACR proposal. These expenditures would be unallowable under either an MCO cost reimbursement contract or Medicare fee-for-service reimbursement regulations. Costs pertained to:

- $37,303 for wine gift baskets, flowers, gifts, and gift certificates for customers, insurance brokers, and employees;

- $25,057 for suite lease expenses at a professional sports arena and season tickets for customers and insurance brokers;
- $21,726 for golf, concerts, professional sporting events, and restaurant charges for customers and insurance brokers;
- $9,538 for employee boat outings;
- $8,208 for 55 Waterford vases for board members and senior management;
- $8,052 for employee parties and other social functions;
- $5,736 for other miscellaneous items including gold plated golf divot tools for customers and insurance brokers;
- $3,681 for miscellaneous food and organized lunches for employees; and,
- $3,133 for other miscellaneous items including massage therapists at employee social functions.

Other Administrative Costs

Other administrative costs totaling $46,647 that would be unallowable under either an MCO cost reimbursement contract or a fee-for-service reimbursement arrangement were included in the ACR proposal. Costs pertained to:

- $31,308 for office expenses of a foundation the MCO created; and,
- $15,339 of insurance premiums paid by the MCO on behalf of another corporation.

Summary

Our review demonstrated that the MCO's ACR proposal included administrative costs which would not be allowable if existing Medicare regulations were applied to risk-based MCOs. We considered these costs to be unallowable because they did not appear to be a reasonable estimate of funds needed to cover costs incurred under the managed care contract and only serve to increase the ACR. The unnecessary inclusion of these costs in the ACR affects the computation of potential savings from the Medicare payment amounts and ultimately impacts the amount available to Medicare beneficiaries for additional benefits or reduced premium amounts. Unlike other areas of the Medicare program, we recognize that there is presently no statutory or regulatory authority governing allowability of costs in the ACR process. For example, regulations covering MCOs that contract with HCFA on a cost

reimbursement basis provide specific parameters delineating allowable administrative costs for enrollment and marketing. These same guidelines are not used in administering the MCO risk contracts.

Notwithstanding the lack of specific guidelines for MCO risk contracts, we believe that these types of costs, which are unallowed under other Medicare reimbursement arrangements, should be eliminated from the Medicare ACR calculation. Although there is not a current statutory basis for requiring this cost exclusion, the Medicare trust funds should not be used to pay the monthly MCO capitation payments which exceed amounts that would be incurred under existing regulations applied in other areas of the Medicare program. We believe that prudent and cost-conscious management concepts should be utilized.

Recommendations

Because the identification of allowable administrative costs to include in the ACR is not a requirement applicable to risk-based MCOs, we have made no recommendations to the MCO. The results of these reviews will be shared with HCFA so that appropriate legislative changes can be considered. This audit is part of a nationwide review of the ACR process and is being performed at several MCOs.

Auditees Comments

In a formal response to our draft report, the MCO indicated they believe we overstated the amount of unallowable costs. The MCO stated that since only 55 percent of the administrative costs we reviewed are allocated to Medicare, the amount of unallowable administrative costs should only be $660,000 (55 percent of $1.2 million). They also believe that the unallowable amount has little impact because it represents only about one percent of total overall administrative costs expended by the health plan. Further, the MCO stated that the unallowable costs are not billed to the government nor do they impact premiums paid by or benefits available to beneficiaries because the MCO's reimbursement is limited to the Adjusted Average Per Capita Cost. The MCO's response also expressed their belief that, (i) Medicare direct costs rather than commercial allocations should be used in future guidelines governing Medicare risk-based organizations, and (ii) traditional cost and fee-for service reimbursement guidelines should not be adopted with respect to marketing activities of Medicare risk-based plans because the necessary activities to attract enrollment is intrinsically different from cost and fee-for-service programs. The MCO's response, in its entirety, is attached to the report.

OIG Response

We acknowledge that only 55 percent of the unallowable costs we identified are allocable to Medicare. However, to keep these costs in perspective, the same 55 percent allocation should be applied to the $2,406,120 total amount of costs we reviewed. Accordingly, we

reviewed $1,323,366 (55 % x $2,406,120) of the MCO's administrative costs that were allocated to Medicare and found that $664,999 (55% of $1,209,089) of those costs would be considered unallowable if existing Medicare regulations were applied to risk-based MCOs.

We disagree that unallowable administrative costs do not impact the premiums paid by or benefits available to beneficiaries. If the average Medicare payment amount received by the MCO is greater than the ACR, a savings is noted. If the MCO experienced such a saving, it was required to use the amount to either improve the benefit package to the Medicare enrollees, reduce the Medicare enrollee's premium, or contribute to a benefit stabilization fund. Thus, if the administrative costs used in ca'culating the ACR are inflated with unallowable costs, those costs could effectively prevent the MCO from experiencing a saving.

We agree with the plan that actual Medicare costs should be used in computing the ACR proposals. The changes brought about by the Balanced Budget Act of 1997 require MCOs to utilize their actual Medicare costs in computing their ACR proposals. We disagree with the plan's position on a separate criteria for the marketing activities of Medicare risk-based plans. The parameters for Medicare plans under cost contracts should apply to Medicare risk-based plans.

Attachment

RESPONSE TO OFFICE OF INSPECTOR GENERAL'S AUDIT OF HEALTH PLANS' MEDICARE ADMINISTRATIVE ALLOCATIONS: A-05-98-00049

This is in response to the Office of Inspector General's (OIG) report regarding the health plan's Adjusted Community Rate (ACR) filing with the Health Care Financing Administration for the 1997 contract year. We understand that the audit made no recommendations with respect to the health plan and the general guidelines relating to Medicare cost and fee-for-service reimbursement referenced therein are not applicable to Medicare risk plans at this time. However, we feel compelled to address four issues raised by your report in the hope that our comments may improve future allocation proposals made to the legislature as a result of the OIG's audit process. The issues we would like to address are as follows:

- Medicare direct costs, rather than commercial allocations should be used in future guidelines governing Medicare risk-based organizations.
- The impact of disallowances made in the OIG report is insignificant in that it represents less than 1% of total health plan administrative costs.
- Despite such suggestion in the report, disallowed administrative costs are not billed to the government, nor do they impact the premiums paid by or benefits available to beneficiaries; notwithstanding how the health plan calculates its administrative costs, the health plan is still subject to and only receives the AAPCC with respect to reimbursement.
- Traditional cost and fee-for-service reimbursement guidelines should not be adopted with respect to marketing activities of Medicare risk-based plans because the necessary activities to attract enrollment is intrinsically different from cost and fee-for-service programs.

First, we are concerned with the basic methodology for administrative allocation that starts with using the health plan's commercial business as the foundation for allocating administrative costs. It appears that, as a result of your audit activities, legislation may be proposed to establish allocation requirements for Medicare + Choice organizations on a going forward basis. Since this is an opportunity to start fresh, we recommend that administrative allocations be based directly upon actual Medicare costs rather than extrapolated from existing commercial business. This approach is more accurate, reduces ambiguity for health plans when building their ACRs, and is feasible, in light of changes in the filing methodologies. Commercial business could continue to be a base for building ACRs for new Medicare plans with insufficient experience to base their filings on actual Medicare costs. As long as health plans must use commercial business as a base for allocations, they will have difficulty making appropriate allocations and will be subject to scrutiny that could be avoided if a direct cost method was applied.

Second, page four of the OIG report is currently misleading in that it overstates the projected disallowance and its overall impact to the plan as well as to Medicare beneficiaries in terms of applicable benefits and premiums. The OIG report overstates the disallowance in that it is based on an initial administrative cost base of $2.4 million dollars, which are used to support plan-wide administration. The OIG report itself concludes that allocation to Medicare of such costs is no greater than 55%. Thus, at a minimum, the disallowance should only be 55% of $1.2 million dollars or $ 660,000. The report also implies that Medicare disallowances are as high as 55% of total administrative costs plan-wide. However, the OIG report disallowed $1.2 million of a $105 million administrative budget. Thus, the impact of the OIG's disallowance is only about 1%, not 55%, of total overall administrative costs expended by the health plan.

Third, the administrative costs that the OIG would disallow if Medicare cost and fee-for-service reimbursement guidelines were applied would not be billed to the government, nor do they impact the premiums paid by or benefits available to beneficiaries. Notwithstanding how the health plan calculates its administrative costs, the health plan is still subject to and only receives the AAPCC with respect to reimbursement. As a history of our filings reflect, AAPCC reimbursement to the health plan has resulted in negative savings and/or premium waivers over the years, eliminating any possibility for additional benefits and reducing any potential for increased premiums. This would be true with or without the disallowance. In sum, while there is certainly benefit in clarifying the allocation process and setting clear standards, at this point it is somewhat of an intellectual exercise as it will not alter the available AAPCC in this marketplace and will not impact the health plan's ability to reduce premiums or increase benefits. For this very reason, application of cost or fee-for-service reimbursement guidelines is probably not appropriate or the best means of assuring accountability in Medicare risk administrative allocations. As suggested above, direct cost allocation would be more appropriate.

Finally, blindly following cost or fee-for-service reimbursement guidelines with respect to marketing costs is inappropriate in the Medicare risk plan setting, especially in markets that are highly saturated. Medicare beneficiaries who join risk plans assign their Medicare benefits to their selected plans and, therefore limit some of their flexibility to visit doctors outside of the health plans' networks. This type of enrollment decision requires familiarity with and trust of a health plan that is greater than that required of a beneficiary enrolling in a cost or fee-for-service program, where they retain Medicare benefits. Before such familiarity and trust can be established, a health must engage in a number of activities that build awareness of the plan and its services.

Many of the activities that were disallowed in your report reflect activities that are designed, in whole or in part, for a Medicare eligible potential member. In a market where nearly 40% of eligible beneficiaries are already enrolled in some kind of managed care, traditional marketing techniques, such as direct marketing meetings, are not effective if a beneficiary is not generally aware of the organization and its distinguishing features in the community. Consequently, some of the most effective marketing is of a type that furthers the image and community participation of our organization, which sparks an interest in the health plan, ultimately triggering inquiries regarding membership and enrollment. This is best accomplished through events such as sponsorship of "Senior Days" at the State Fair, county senior festivals, and special events with a senior focus such as Alzheimer's Walks and a golf tournament (which incidentally is the single largest charity fund-raiser in the State). Strict application of a direct versus indirect marketing standard to determine allowance is simply inappropriate in our setting and will significantly hinder Medicare risk plans from reaching potential membership. Instead, we would propose a standard that determines allowability based upon the intended audience and purpose of the event. If a significant proportion of an event is intended to spark interest and subsequently increase Medicare membership, it should be eligible for inclusion in allowable administrative costs.

We hope these comments will be influential in revising your initial report and in shaping any resulting legislative proposals. It is our understanding that the OIG report is designed to raise general opportunities for improvement in administrative allocations for risk-based plans. While there is great advantage in establishing and clarifying administrative cost allocation for Medicare health plans, it should be done in a way that is as accurate and reasonable as possible and that reflects appropriate expenses in different marketplaces, even if not fully consistent with current guidelines for cost and fee-for-service programs.