DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 14 2004

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of PacifiCare of Oklahoma's Modifications to Its 2001 Adjusted Community Rate Proposal Under the Benefits Improvement Protection Act of 2000 (A-06-02-00060)

Attached is an advance copy of our final report on PacifiCare of Oklahoma's (PacifiCare) modifications to its 2001 adjusted community rate proposal (proposal) under the Benefits Improvement Protection Act (BIPA) of 2000. We will issue this report to PacifiCare within 5 business days. This is one of a series of reports on Medicare+Choice organizations' (MCO) use of the additional funding provided by BIPA.

Under Part C (Medicare+Choice) of the Medicare program, MCOs are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment. BIPA provided an estimated $11 billion in increased capitation payments to MCOs effective March 1, 2001. BIPA required MCOs with plans for which payment rates increased to submit a revised proposal to show how they would use the increase during 2001. According to Section 604(c) of BIPA, MCOs were required to use the additional amounts to reduce beneficiary premiums or cost-sharing, enhance benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers.

PacifiCare submitted a revised proposal that reflected an increase in Medicare capitation payments of about $16.4 million for 2001.

Our objectives were to determine whether PacifiCare (1) used the additional capitation payments in a manner consistent with BIPA requirements and (2) supported the modifications to the 2001 proposal.

We found that about $5.2 million of the $16.4 million increase in PacifiCare's revised proposal was not used in a manner consistent with BIPA or was not supported:

- Approximately $4.2 million was not associated with stabilizing or enhancing access to providers because PacifiCare did not renegotiate its provider contracts to increase provider payment rates as indicated in its revised proposal.

- A $1 million medical cost contingency did not comply with BIPA requirements and was unsupported.

We recommend that PacifiCare refund $5,204,042 to CMS or, as an alternative, deposit this amount in a benefit stabilization fund for use in future years. We also recommend that PacifiCare ensure that estimated costs in future proposals are properly supported.

Disagreeing with our findings, PacifiCare stated that it had compelling information at the time of the revised filing that some and possibly most of its provider contracts in Oklahoma would require increased compensation in order to stabilize its network. However, as the year unfolded, PacifiCare found it necessary to renegotiate only one provider contract. PacifiCare also stated that our report did not acknowledge that some BIPA funds increased payments to providers under percentage-of-premium arrangements. Further, PacifiCare said that it added the $1 million medical cost contingency to the proposal to adjust for "perceived uncertainty, expected volatility of future health care costs, and concerns regarding the stability of [its] provider network."

Even though PacifiCare may have intended to use the additional funds for permissible purposes under BIPA, it did not do so. PacifiCare's decision not to increase provider compensation, as called for in the revised proposal, resulted in $4.2 million of overstated costs. In determining this amount, we did consider that some BIPA payments were passed on to providers under percentage-of-premium arrangements. In addition, the $1 million medical cost contingency was not permitted by BIPA and was not supported by any calculations.

If you have any questions or comments about this report, please do not hesitate to call me or have your staff call George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Gordon L. Sato, Regional Inspector General for Audit Services, at (214) 767-8414. Please refer to report number A-06-02-00060 in all correspondence.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

JUN 17 2004

Report Number: A-06-02-00060

Mr. George H. Becker, Jr.
Senior Vice President, Southwest Region
PacifiCare of Texas, Inc.
5001 LBJ Freeway, Suite 600
Dallas, Texas 75244

Dear Mr. Becker:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of PacifiCare of Oklahoma's Modifications to Its 2001 Adjusted Community Rate Proposal Under the Benefits Improvement Protection Act of 2000." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official named below will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-02-00060 in all correspondence.

Sincerely,

Gordon Sato

Gordon Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
James R. Farris, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PACIFICARE OF OKLAHOMA'S MODIFICATIONS TO ITS 2001 ADJUSTED COMMUNITY RATE PROPOSAL UNDER THE BENEFITS IMPROVEMENT PROTECTION ACT OF 2000

JUNE 2004
A-06-02-00060

EXECUTIVE SUMMARY

BACKGROUND

Under Part C (Medicare+Choice) of the Medicare program, Medicare+Choice organizations (MCO) are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment. The Benefits Improvement Protection Act (BIPA) of 2000 provided an estimated $11 billion in increased capitation payments to MCOs effective March 1, 2001.

BIPA required MCOs with plans for which payment rates increased to submit a revised adjusted community rate proposal (proposal) to show how they would use the increase during 2001. PacifiCare of Oklahoma, Inc. (PacifiCare) submitted a revised proposal that reflected an increase in Medicare capitation payments of about $16.4 million for contract year 2001.

OBJECTIVES

Our objectives were to determine whether PacifiCare (1) used the additional capitation payments in a manner consistent with BIPA requirements and (2) supported the modifications to the 2001 proposal.

SUMMARY OF FINDINGS

According to Section 604(c) of BIPA, MCOs were required to use the additional amounts to reduce beneficiary premiums or cost-sharing, enhance benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers. In addition, Centers for Medicare & Medicaid Services (CMS) instructions required that revisions be supported.

About $5.2 million of the $16.4 million increase in PacifiCare's revised proposal was not used in a manner consistent with BIPA requirements or was not supported:

- Approximately $4.2 million was not associated with stabilizing or enhancing access to providers because PacifiCare did not renegotiate its provider contracts to increase provider payment rates as indicated in its revised proposal.

- A $1 million medical cost contingency did not comply with BIPA requirements and was unsupported.

RECOMMENDATIONS

We recommend that PacifiCare refund $5,204,042 to CMS or, as an alternative, deposit this amount in a benefit stabilization fund for use in future years. We also recommend that PacifiCare ensure that estimated costs in future proposals are properly supported.

PACIFICARE COMMENTS

PacifiCare disagreed with our findings. PacifiCare stated that it had compelling information at the time of the revised filing that some and possibly most of its provider contracts in Oklahoma would require increased compensation in order to stabilize its network. However, as the year unfolded, PacifiCare found it necessary to renegotiate only one provider contract. PacifiCare also stated that our report did not acknowledge that some BIPA funds increased payments to providers under percentage-of-premium arrangements. Further, PacifiCare stated that it added the $1 million medical cost contingency to the proposal to adjust for "perceived uncertainty, expected volatility of future health care costs, and concerns regarding the stability of [its] provider network." The full text of PacifiCare's response to our draft report is included as an appendix to this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

Even though PacifiCare may have intended to use the additional funds for permissible purposes under BIPA, it did not do so. PacifiCare's decision not to increase provider compensation, as called for in the revised proposal, resulted in $4.2 million of overstated costs. In determining this amount, we did consider that some BIPA payments were passed on to providers under percentage-of-premium arrangements. In addition, the $1 million medical cost contingency was not permitted by BIPA and was not supported by any calculations.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare+Choice

Under Title XVIII of the Social Security Act, the Medicare program provides health insurance to Americans aged 65 and over, those who have permanent kidney failure, and certain people with disabilities. CMS administers the Medicare program.

The Balanced Budget Act of 1997 (Public Law 105-33) established Part C (Medicare+Choice) of the Medicare program, which offers Medicare beneficiaries a variety of health delivery models, including MCOs, such as health maintenance organizations; preferred provider organizations; and provider-sponsored organizations. MCOs are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment.

Proposal Requirements

Medicare regulations require each MCO participating in the Medicare+Choice program to complete, for each plan, an annual proposal that contains specific information about benefits and cost sharing. The MCO must submit the proposal to CMS before the beginning of each contract period. CMS uses the proposal to determine if the estimated capitation paid to the MCO exceeds what the MCO would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. MCOs must use any excess as prescribed by law, including offering additional benefits, reducing members' premiums, accepting a capitation payment reduction for the excess amount, or depositing funds in a stabilization fund administered by CMS. The proposal process was designed to ensure that Medicare beneficiaries are not overcharged for the benefit package being offered.

BIPA Requirements

BIPA provided for an additional $11 billion in increased capitation payments to MCOs effective March 1, 2001. MCOs with plans whose payment rates increased under BIPA were required by BIPA to submit revised proposals by January 18, 2001 to show how they would use the increase during contract year 2001. CMS instructions for the revised proposals required MCOs to submit a cover letter summarizing how they would use the increased payments.

PacifiCare submitted the required proposal for contract number H 3749-1.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether PacifiCare (1) used the additional capitation payments in a manner consistent with BIPA requirements and (2) supported the modifications to the 2001 proposal.

Scope

Based on PacifiCare's revised proposal, its Medicare capitation payments increased by about $16.4 million for contract year 2001. On a per member per month basis, the revised proposal increased direct medical care cost estimates by $61.37, increased administrative cost estimates by $0.04, and decreased additional revenue estimates by $10.12, for a net increase of $51.29 per member per month.

PacifiCare's revised proposal stated that it would use the additional funds to stabilize its provider network by increasing provider compensation. Therefore, we focused our work on the provider payments included in the direct medical care cost projections.

Our objectives did not require us to review the internal control structure of PacifiCare.

Methodology

To accomplish our objectives, we:

- reviewed applicable laws and regulations
- reviewed the cover letter PacifiCare submitted with its revised proposal, in which it stated how it would use the additional funds in the contract year
- compared the initial proposal with the revised proposal to determine the modifications
- reviewed support for changes in membership projections indicated in the revised proposal
- compared the provider payment assumptions used in the initial proposal with those in the revised proposal
- reviewed support for the revised direct medical care cost projections
- reviewed provider contracts in effect in 2001 to determine if PacifiCare had renegotiated its contracts in accordance with the supporting documentation for the revised proposal
- recalculated PacifiCare's provider payment projections based on the actual contract terms in effect for 2001, using PacifiCare's cost projection methodology
- verified the mathematical accuracy of the plan's direct medical cost projections
- interviewed PacifiCare officials
- calculated the increase in 2001 Medicare capitation payments using actual membership data obtained from CMS.

We performed our review in accordance with generally accepted government auditing standards. We conducted audit work from August 2002 through March 2003 at PacifiCare's Dallas office and our Baton Rouge field office.

FINDINGS AND RECOMMENDATIONS

Of the $16.4 million capitation payment increase in PacifiCare's revised proposal, the majority was used in compliance with BIPA. However, about $5.2 million was not used in a manner consistent with BIPA requirements or was not supported:

- Approximately $4.2 million was not associated with stabilizing or enhancing access to providers. Specifically, PacifiCare did not renegotiate its provider contracts to increase provider payment rates as indicated in its revised proposal.

- A $1 million medical cost contingency did not comply with BIPA requirements and was unsupported.

COMPLIANCE WITH BIPA REQUIREMENTS

Under section 604(c) of BIPA, MCOs were required to use the additional amounts under sections 601 and 602 to reduce beneficiary premiums, reduce beneficiary cost-sharing, enhance benefits, contribute to a benefits stabilization fund for use in future years, or stabilize or enhance beneficiary access to providers.

PacifiCare's revised proposal stated that it would use the additional BIPA funds to stabilize its provider network by increasing provider compensation. In its proposal, PacifiCare stated, "In order to provide stability to our networks and continued access to quality providers, we believe it is necessary to increase our compensation to providers by passing more of the revenue we receive . . . through to providers." PacifiCare specified that it would allocate the increased BIPA revenue to direct medical care costs, the additional health care costs related to "percentage-of-premium" contracts and renegotiated provider contracts. Thus, PacifiCare's proposal to enhance its provider network took a twofold approach: the automatic increase in provider payments as a result of percentage-of-premium contracts and an increase in provider payments through renegotiated provider contracts.

Percentage-of-Premium Contracts

A PacifiCare official stated that the majority of the cost increase in the revised proposal related to percentage-of-premium contract increases. Providers are paid based on contractual percentages applied to PacifiCare's Medicare premium revenue. As a result of the Medicare premium revenue increase from BIPA, payments to providers automatically increased in compliance with BIPA requirements.

Renegotiated Provider Contracts

Although PacifiCare proposed to increase its provider payment rates by renegotiating contracts, our review of provider contracts for 2001 found that PacifiCare did not renegotiate the contracts to reflect the provider payment assumptions in the revised proposal. As an example, for one contract, PacifiCare proposed to increase the payment rate for physician and hospital services by more than 4 percent. However, the actual payment rate during 2001 did not reflect the increase. Therefore, for this example, a proposed cost increase of approximately $1.3 million was not implemented.

Using PacifiCare's cost projection methodology, we recalculated provider payment projections using the actual rates in effect for 2001 and determined that $4,204,042 in the revised proposal was overstated.

Cost Contingency

CMS instructions for the revised proposals required that entries that changed from the original (pre-BIPA) filing be supported. PacifiCare included a medical cost contingency of $1 million in its revised proposal to allow for any costs that might have been omitted. Cost contingencies are not permitted by BIPA. Furthermore, PacifiCare's contingency was not supported by any calculations.

A PacifiCare official stated that historically PacifiCare did not include such contingencies in its proposals, but added this contingency after analyzing medical cost ratios based on revised revenue and cost projections. A medical cost ratio is the percentage of premium revenue the organization needs to meet its direct medical costs for a particular period. Managed care companies and their investors use this ratio in evaluating company performance.

CONCLUSION

By overstating its direct medical care cost projections by $5,204,042 ($14.78 per member per month), PacifiCare understated its excess of expected revenues over expected costs. PacifiCare should have used this amount to reduce member premiums or cost sharing, enhance benefits, contribute to a stabilization fund, or stabilize or enhance beneficiary access to providers.

RECOMMENDATIONS

We recommend that PacifiCare refund $5,204,042 to CMS or, as an alternative, deposit this amount in a benefit stabilization fund for use in future years. We also recommend that PacifiCare ensure that costs in future proposals are properly supported.

PACIFICARE COMMENTS

PacifiCare disagreed with our findings. PacifiCare stated that it had compelling information at the time of the revised filing that some and possibly most of its provider contracts in Oklahoma

would require increased compensation. However, as the year unfolded, PacifiCare found it necessary to renegotiate only one contract. PacifiCare also stated that our report did not acknowledge that a portion of the BIPA funds increased payments to providers under percentage-of-premium arrangements. Further, PacifiCare stated that it added the $1 million medical cost contingency to the proposal to adjust for perceived uncertainty, expected volatility of future health care costs, and concerns regarding the stability of its provider network. The full text of PacifiCare's response is included as an appendix to this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

Even though PacifiCare may have intended to use the additional funds for permissible purposes under BIPA, it did not do so. PacifiCare's decision not to increase provider compensation, as called for in the revised proposal, resulted in $4.2 million of overstated costs. In determining this amount, we did consider that some BIPA payments were passed on to providers under percentage-of-premium arrangements. In addition, the $1 million medical cost contingency was not permitted by BIPA and was not supported by any calculations.

APPENDIX

PacifiCare®

June 23, 2003

Mr. Gordon Sato
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Re: Common Identification Number A-06-02-00060

Dear Mr. Sato:

We thank you for the opportunity to respond to the Department of Health and Human Services ("HHS"), Office of Inspector General ("OIG"), Office of Audit Services ("OAS") on its initial draft report, titled: "Review of the Benefits Improvement Protection Act (BIPA) Modifications to PacifiCare of Oklahoma's Calendar Year 2001 Adjusted Community Rate Proposal ("ACRP") under Contract Number H-3749-1." The OAS has identified this draft report as Common Identification Number A-06-02-00060.

Basic Disagreement Concerning Use of Actual Costs to Recalculate Healthcare Costs for ACRP

We respectfully disagree with the approach adopted by OAS to evaluate PacifiCare of Oklahoma's ("PCOK") revised 2001 ACRP under BIPA. BIPA required a Medicare+Choice organization ("M+CO") with an approved 2001 M+C plan to resubmit its ACRP for 2001 if its payments rates were higher under BIPA than before the legislation. According to the BIPA ACRP instructions issued by the Centers for Medicare and Medicaid Services ("CMS"), an M+CO could do any of the following in its ACRP resubmission: "reduce beneficiary premiums, reduce beneficiary cost-sharing, enhance benefits, contribute to a benefit stabilization fund, or stabilize or enhance beneficiary access to providers." *Instructions to Medicare+Choice Organizations for the BIPA 2001 ACRP Season* ("BIPA ACRP Instructions") at p. 6. The instructions also provided that

> When submitting an ACR . . ., M+C organizations have the option to update direct medical cost **assumptions and projections** previously reported in [CMS]-approved ACRs for CY 2001 to the extent these additional costs will help stabilize or enhance the M+CO's provider network. BIPA ACRP Instructions at p. 8 (emphasis added).

The BIPA payment rates were announced January 1, 2001. The ACRP resubmission due date was January 18, 2001, and the effective date of the BIPA changes was March 1, 2001. Therefore, the only possible interpretation of the above instructions is that the submitting organization had to estimate its expected future costs based on reasonable assumptions developed from historical cost experience and then reasonably project expected changes to that historical cost experience for the 2001 calendar year. In fact, every ACRP submitted by an M+CO is an estimate of the organization's costs in light of prior experience and expected changes to future costs. Thus, the inquiry for the OIG's review should be: Were the assumptions used for projection of these expected changes to future costs reasonable at the time? It is in this framework that OAS must assess PCOK's ACRP under BIPA, and not with the hindsight of actual costs.

At the time of the BIPA filing, there was compelling information, as discussed in the following sections, that some and possibly most of the provider contracts in Oklahoma would require increased

compensation in order to stabilize our network. There was also compelling information that some providers would likely not continue their provider contracts with PCOK for our M+C product without increased compensation. This expected decrease in the provider network would likely place added financial stress on the remaining provider entities due to significant membership transfers. Thus, we believed increased compensation to the remaining network providers would be required in order to maintain a viable delivery system for our M+C members. As indicated in PCOK's cover letter accompanying the BIPA ACRP filing, these anticipated increases could occur as either automatic payment increases to PCOK providers under percentage of premium arrangements or pursuant to renegotiated compensation arrangements with providers.

At the time of the BIPA filing, it appeared that many of the PCOK provider contracts would either need to be renegotiated or they would terminate for one reason or another. As the year unfolded, we found that it was necessary to renegotiate only one split capitation contract. However, the other provider entities on percent of premium capitation contracts did, in fact, automatically receive compensation increases as a result of the BIPA legislation without the need to renegotiate their contracts. The draft audit report fails to acknowledge that a portion of the BIPA payments went directly to increase payments to PCOK providers who were under percentage of premium arrangements with the health plan. These contracts did not require renegotiation in order to increase provider payments. However, the draft audit report ignores this fact and focuses solely on whether or not the actual percentage rate that the provider received changed.

Reasonableness of Our Assumptions

Beginning in early 2000, several major capitated hospital contracts converted from capitation to a fee-for-service ("FFS") basis in other PacifiCare markets. The per member per month ("PMPM") hospital cost changes for such hospital contracts varied widely from cost decreases to a more than doubling of costs for some hospital organizations. The weighted average hospital cost increase for these conversions was very significant.

In addition, some provider entities in these markets became insolvent or filed for bankruptcy. Such circumstances increased plan costs even more.

In order to postpone wholesale conversions to FFS with resulting large cost increases in Oklahoma, we believed that it would be necessary to increase the percentage rate of premium paid to providers during 2001. We made certain assumptions for the 2001 budget and ACRP filings. These were believed to be reasonable expectations at the time of the preparation of the BIPA filing. We subsequently made changes to our assumptions between the original ACRP filing for 2001 and the BIPA refiling on January 18, 2001.

Our assumptions included expected compensation increases to the various provider contracts for 2001 at the time of the BIPA filing. They also identify concern for potential provider insolvencies, which is a key reason for the $1 million contingency included in our filing. In fact, one of the provider entities ceased operations during 2001.

We have also provided you with details on our membership by provider group during year 2000, our expected membership for 2001 which was used for the ACRP filing and the actual membership for the year (based on hindsight). Note that we assumed that three provider groups would terminate their contracts in 2001 and that most of their membership would transfer to another provider group, which would have been the only remaining provider capable of absorbing the transferred membership. We believed that this would result in an increase to the global cap for that remaining provider group, in order that this provider group would be willing and able to take on such a large influx of new members. As it turned out, only one provider group actually terminated their contract for 2001, leaving two provider group contracts in place for the year. However, one of the remaining provider groups did terminate its contract with PCOK at the end of 2001, and the other remaining provider group termed at the end of 2002. Therefore the large transfer of membership expected for 2001 was postponed to

subsequent years and the increase to the provider group that was expected to absorb the membership was not needed for 2001. This, however, was not known and could not possibly have been known at the time of the filing. Therefore, it is inappropriate for OIG to use this hindsight knowledge in its audit to calculate an amount due from PCOK for "unsupported forecasted capitation payments" calculated in our ACRP filing for the provider group that was expected to absorb the transferred members.

Similar logic applies to other groups. For example, it was believed that one group would require a conversion from a capitated hospital contract to a FFS contract and that our costs would increase for the year as a result of the conversion. The cause for our concern was that this group had not been paying hospital claims on a timely basis over an extended period of time and the group's management shared with PCOK information regarding its poor financial condition. Our concerns regarding the financial stability of this group were justified as the provider group ceased operations during the year leaving PCOK to pay unpaid provider claims that were the financial responsibility of the group. However, the point must be underscored that, at the time the BIPA ACRP was filed, PCOK anticipated that the compensation arrangement with this particular group would be restructured resulting in significant cost increases for PCOK. The fact that this group ultimately ceased operations during 2001 is not relevant to an evaluation of the reasonableness of PCOK's assumptions in the ACRP filing.

Similar arguments can be made for two other groups. A large hospital system was responsible for the hospital portion of contracts for both of these groups. The contract of one of these two groups was on a global capitation basis, and the contract for the other group was a split capitation contract. The hospital system wanted to terminate the hospital portion of contracts for 2001. Perhaps because of the automatic increase that resulted from BIPA legislation, this was not needed for 2001. The hospital contract of one of the two groups did convert to a FFS basis for 2003.

As for still another group, the contract rate/expected cost did in fact increase as expected. However, in this case, it was assumed at the time of filing that this new contract cost would be made retroactive to January 1, 2001. The contract negotiations required several months to complete and by the time negotiations were completed PacifiCare had adopted a corporate-wide policy of "no retroactive provider contracts." Our BIPA ACRP filing assumed a certain percentage contract cost for the entire year (i.e., retroactive to January 1, 2001), which was consistent with the effective date we expected for the rate increase at the time of the filing. However, the OIG used its own estimates for the first four months and the plan's estimates for the rest of the year, based on 20/20 hindsight with regard to the actual new contract effective date. Again, this type of retroactive evaluation of PCOK's actual contract effective dates and costs should not have been performed in assessing the reasonableness of the health plan's BIPA ACRP filing.

We believe that our assumptions as reflected in the BIPA filing were reasonable at that time and PCOK should not be penalized for the fact that our actual costs or contract changes did not exactly match our assumptions. If CMS wanted certainty, then M+COs would have needed significantly more time than 17 days to renegotiate all their provider contracts before filing their BIPA ACRPs.

Finally, it should be noted that actual cost information is ultimately taken into account in the ACR process. PCOK's actual healthcare costs for 2001 were used as the basis for projecting costs in its 2003 ACRP filing and at least partially for 2002 projections. These lower than expected healthcare costs enabled PCOK to provide better benefits and/or lower member premiums for those years than would have been possible if the higher costs initially projected for 2001 had materialized. For example, PCOK was able to hold member premiums without any increase at $29 for 2002 and was able to eliminate member premiums entirely in Tulsa for 2003. So the ACR process has a self-correcting mechanism that adjusts future year relationships between the CMS capitation payments to health plans and the benefit packages the health plans deliver to their members by using the most recent period actual costs as the basis for the subsequent ACR filings.

Addition of Medical Cost Contingency

Because of the perceived uncertainty, expected volatility of future healthcare costs and concerns regarding the stability of PCOK's provider network, PCOK added a $1 million contingency into its estimate of 2001 healthcare costs. Reasons for this uncertainty included the following:

- The likelihood of some provider insolvencies
- The wide range of healthcare cost increases experienced with capitation conversions in other markets
- The perception that PCOK could experience conversions from capitation for most, if not all, hospital contracts
- The expectation that some provider contracts would terminate resulting in large member transfers to the remaining provider entities
- Expected pressure to increase provider compensation as competition decreased due to fewer participating providers

Because of these concerns, we believed it was prudent to add the contingency in our ACRP filing to help mitigate this risk. We included the contingency in the line item, "Other Providers," in our ACRP filing and in a line item, "Other Contingencies", in our documentation based on projections done for Oklahoma City, because the greatest risks for additional costs were in Oklahoma City. We accounted for the contingency in this manner so there would be no confusion as to its purpose. The contingency was available to stabilize access to providers that was jeopardized by the uncertainties listed above in order to pay claims to providers that had not been compensated for services rendered to M+C members prior to the insolvency. We have, in fact, paid a significant amount for exactly this purpose for two failed provider entities. The $1 million is a small charge compared to the potential amount to which such costs could accumulate and actually have accumulated in the case of some insolvencies in other PacifiCare markets. It is only about 0.6% of the total healthcare cost of $156.6 million expected for PCOK for the 2001 CMS contract year.

In Conclusion

We believe that the assumptions used in our BIPA ACRP filing were reasonable at the time and that the OIG audit should be addressing the reasonableness of the assumptions as of the time they were made and not based on information that later came to light. It is not appropriate to use hindsight as the basis for evaluating those assumptions. After all, if the plan had underestimated expected contract cost increases, OIG would not be recommending additional payments to PCOK, and PCOK would have no recourse to collect additional funds from CMS to make up the shortfall. This is, however, the very nature of the Medicare+Choice program.

PacifiCare believes that the draft audit findings are unwarranted and that no adjustment is due CMS as a result of PCOK's 2001 BIPA ACRP filing.

Yours truly,

George H. Becker Jr.

George H. Becker, Jr.
Senior Vice President, Southwest Region