

#### IV. Supplemental Coverage

The demonstration will be open to ESRD beneficiaries for whom Medicare is either primary or secondary payer. In the case of demonstration participants for whom another payer is primary, the demonstration organization must submit valid bills with the primary payer to collect the appropriate payment amount as specified by the demonstration's payment rules.

To make the demonstration financially viable, participating organizations may collect cost-sharing in the form of premiums, deductibles, and co-payments to beneficiaries in lieu of the cost-sharing amounts for which beneficiaries are responsible under the ordinary fee-for-service payment rules. To be financially attractive to beneficiaries, these should have actuarial values that are lower than current Medicare fee-for-service cost-sharing.

A beneficiary participating in the demonstration may choose to retain his or her Medigap policy. Participating organizations should clearly explain to beneficiaries the advantages of retaining and risks of discontinuing their Medigap coverage. Under the fee-for-service bundled payment option, participating organizations will be able to bill any supplemental insurance plan that the enrolled beneficiary holds for cost-sharing purposes. If a secondary payer is Medicaid or a group health plan, that payer may pay some or all of a beneficiary's monthly premium for enrollment.

Under the demonstration, an organization receiving a fully capitated payment may pursue the possibility of billing existing Medigap policies held by a beneficiary participating in the demonstration, or bill Medicaid, for the amount of cost-sharing that otherwise would be paid under Medicare fee-for-service. The demonstration organizations may attempt to make such arrangements with Medigap plans, State Medicaid agencies, and State insurance regulators.

Beneficiaries participating in the capitation demonstration will have the option of terminating supplementary coverage. In these cases, the selected demonstration organizations must work with the beneficiaries to ensure that either their policy is maintained at the end of the demonstration, or that beneficiaries understand that if they drop supplemental coverage, enrollment in their supplemental plans is not guaranteed at the end of the demonstration. It will be incumbent on the demonstration organizations to provide proper notice to potentially

participating beneficiaries about their Medigap rights if the individual's participation in the demonstration ceases. Specifically, the demonstration organization should be explicit in its marketing information to beneficiaries about the scope of rights that accrue to patients under age 65 in the particular State.<sup>1</sup>

If the beneficiary intends to cancel a Medigap policy and if the arrangements with the supplemental insurer do not guarantee that the beneficiary has the same coverage at the end of the demonstration, it must be clear that the beneficiary chooses to participate in the demonstration with full knowledge of this possibility. Providers and beneficiaries are advised that the demonstration is time-limited, and that dropping a Medigap policy presents a significant risk. We will ensure that demonstration organizations communicate the advisability of maintaining Medigap coverage to potential participants.

When demonstration awards are made, the Terms and Conditions will require that the awardee submit for our approval a Phasedown Plan explaining how demonstration participants are to be assisted in converting back to previous insurance coverage and fee-for-service care at the conclusion of the demonstration, as well as during the project. This requirement will apply to

<sup>1</sup> Generally, an individual who voluntarily disenrolls from a managed care demonstration will not have guaranteed issue rights. If an individual is enrolled in a managed care demonstration and enrollment ceases under circumstances set forth in section 1851(e)(4) of the Act (for example, the demonstration is terminated), the individual will have the right to buy certain Medigap plans on a guaranteed issue basis (generally Plans A, B, C or F). This right generally will not accrue to an individual who wishes to voluntarily disenroll from the managed care demonstration. It also generally will not apply if an individual is enrolled in the fee-for-service model of the demonstration, since the statutory provision in section 1882(s)(3)(B)(iii) of the Act provides guaranteed issue rights to individuals in a managed care organization.

If an individual drops a Medigap policy to enroll in the ESRD managed care demonstration and it is the first time the individual has enrolled in Medicare managed care, that individual has a 12-month trial period. The individual may disenroll from the demonstration within the first 12 months and purchase his or her former Medigap policy, if it is still available from the same issuer. If the former policy is not available, the individual can buy Medigap Plans A, B, C, or F. Individuals who join the demonstration upon first becoming eligible for Medicare Part A at age 65 would not have "trial period" rights.

It is important to note that Federal law does not require a Medigap open enrollment period for beneficiaries under age 65, so Medigap insurers do not have to sell policies to this population. State law governs what Medigap choices are available to Medicare beneficiaries under age 65. Currently, twenty-two States have laws that provide Medigap rights to beneficiaries under 65. The Medigap plans available to the under-65 population vary by State.

organizations under both capitation and fee-for-service bundled payment models.

#### V. Financial Risk

##### A. Risk-Bearing Requirements

We will work with organizations that have requested capitation payment in the pre-implementation period to assure they meet the risk-bearing requirements under their State. We will consider the individual circumstances of the provider in relation to State law and the demonstration project, but we cannot exempt organizations from State law. Organizations will be required to meet all of the State's insurance requirements to the extent applicable. There is no risk-bearing licensure requirement for the fee-for-service model.

##### B. Risk Sharing

Organizations may propose risk-sharing arrangements under either the capitation or fee-for-service bundled payment options. If risk sharing is included for the capitation option, a year-end reconciliation will be conducted to compare an actual Medical-Loss-Ratio (MLR) to a target Medical-Loss-Ratio. Any differences, either gains or losses, would be shared on a symmetrical basis by the organization and us. As part of the proposal, organizations should submit a projected revenue and expense statement showing calendar year 2004 estimated per member per month Medicare revenue and member premium; benefit expenses (hospital inpatient, hospital outpatient, dialysis, professional, other Medicare services, and non-Medicare services); and administrative expenses. The statement should show any co-payment credits for the various services and reflect payment from Medicaid or supplemental insurers. A target MLR will result from the ratio of benefit expenses to revenues. One year after the end of each operational year, the organization should send a certified actual revenue and expense report to determine the actual MLR.

If risk sharing is proposed, there should be three calculations of projected savings/losses—optimistic or best case assumptions, expected or normal assumptions, and pessimistic or worst-case assumptions. Budget neutrality should be assessed for each situation. The risk-sharing proposal must include a 2 percent full-risk corridor above and below the targeted Medical-Loss-Ratio. In addition, prior to awards, we will work with applicants to determine whether the proposed Medical-Loss-Ratio is set at a level where the risk-