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# Payer and provider “checklist” for alternative payment arrangements

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## INTRODUCTION

In recent years, there has been a push for price transparency and the realignment of provider accountability in managing healthcare services in an effort to reduce healthcare expenditures and improve coordination and quality of care. In 2008, Massachusetts, an early adopter of these ideas, passed “An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care,” and subsequently Massachusetts’s Attorney General released a report titled “Examination of Health Care Cost Trends and Cost Drivers,”<sup>1</sup> which made public the large discrepancies in the contractual rates that hospitals received from payers. Around the same time, Massachusetts’s largest commercial payer, Blue Cross Blue Shield of Massachusetts, began rolling out to many providers its risk-sharing payment model (the Alternative Quality Contract<sup>2</sup>) that transformed the typical provider contract formerly based on a fee-for-service model. With the adoption of nationwide healthcare reform, this trend has spread to other states through the development of accountable care organizations (ACO) and other forms of alternative payment arrangements.

Today, there are a variety of risk-sharing arrangements between providers and payers across all states and lines of business. Some arrangements are upside-only (shared savings), while in others providers share in downside risk as well. Some include quality measures, while others are only based on financial results. However, all of these arrangements attempt to move providers’ payments away from the fee-for-service model, which reimburses providers per service rendered, and toward population-based models, which reimburse providers more for outcomes and value to payers and members.

A true capitation contract typically prospectively reimburses a group of providers that assumes financial responsibility for all the healthcare needs of a defined population, a fixed dollar amount at regular intervals. This eliminates many fee-for-service transactions between the provider and the plan. However, most emerging alternative payment arrangements can be thought of as notional capitations where the plan continues to pay providers on a fee-for-service basis but additionally, at fixed intervals, compares total healthcare spend on a defined population with a contractually defined budget. The provider then receives a bonus or is financially penalized based on whether total spend is less than or greater than the budget.

In this paper, we provide a “checklist” of key contractual provisions found in many risk-sharing arrangements that we have developed through our work with both providers and payers on these types of arrangements.<sup>3</sup> While this is by no means an exhaustive list, our goal is to explain how key provisions will influence the financial outcome of the contract and how each can be used to achieve a balanced collaboration between the provider and payer.

Many contractual provisions are interrelated and should not be considered in isolation. However, for simplicity, we divide our key contractual provisions “checklist” into three broad categories:

1. Financial: Provisions that will determine the amount that the provider will ultimately receive for each service provided to the covered population
2. Insurance: Provisions that will determine the extent to which the provider has adequate protection from random events and changes in the underlying characteristics of the covered population
3. Other

We summarize the “checklist” in Appendix A.

1 Office of Attorney General Martha Coakley (April 24, 2013). Examination of Health Care Cost Trends and Cost Drivers. Report for Annual Public Hearing. Retrieved January 22, 2015, from <http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf>.

2 For more information, visit <http://www.bluecrossma.com/visitor/about-us/affordability-quality/aqc.html>.

3 For another recent article on this topic, please refer to Moody, S. (January 2015), Look before you leap: Shared risk programs and considerations for health systems, Milliman healthcare reform briefing paper, available at <http://us.milliman.com/uploadedFiles/insight/2015/shared-risk-programs.pdf>.

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## KEY CONTRACT PARAMETERS: FINANCIAL

In this section, we discuss the key financial provisions of an alternative payment arrangement that will determine how much the provider receives for the services it provides.

### Starting budget (target): Baseline and trend

In many gain-sharing or emerging alternative payment arrangements, savings and deficits are calculated by comparing actual claims amounts during a performance period with a predetermined negotiated target. If the actual experience is lower than the target, savings may be shared with the provider; if actual claims experience is higher than the target, the provider may be liable for a portion of these losses (in an arrangement with downside risk). As a result, a key driver of financial success for the provider is the calculation of the target.

Two methods are typically used for calculating the performance year target:

1. Historical baseline experience trended to performance year
2. A percent of performance-year premium

The approach of trending historical experience to the performance year is common in many recent commercial alternative payment arrangements and is also used by the Centers for Medicare and Medicaid Services (CMS) in its Pioneer and Medicare Shared Saving Program (MSSP) ACO models. This method establishes the performance-year target by using historical claims cost experience of the at-risk or attributed members. A provider with utilization and unit cost that is higher than average in the baseline year will have a higher performance-year target using this methodology compared with a provider with lower-than-average utilization and unit cost. Therefore, this type of arrangement will lead to higher targets for less efficient providers.

A percent-of-premium approach, more common with Medicare Advantage products, calculates the starting target as a percent of the payer's performance-year premium—usually expressed as a medical loss ratio (MLR) for the at-risk members. Under this approach, the premium is based on the payer's average contractual rates and utilization; therefore, providers who deliver more efficient care than average will typically benefit because they will receive a percent of premium that is representative of the average performing provider in that area. For more efficient providers, this will typically result in a starting budget that is greater than its trended historical experience.

### Trended historical experience approach

Key considerations when negotiating the historical baseline include:

- The baseline year (or years) selected
- The amount of run-out used in determining the baseline (at least three months is typical)
- When and if the baseline gets rebased at some future date
- Different baselines for different populations
- The trend adjustment applied to the selected baselines

The contract usually determines the performance year target by trending forward the baseline(s). Therefore, the historical experience in each baseline year and the trend adjustment applied will impact the target. A contract may consider weighting multiple years to establish the baseline in order to obtain a higher credibility or to mitigate the impact of an outlier year, particularly for smaller attributed populations.

Another consideration for multi-year risk-sharing contracts is whether the baseline target is calculated once at the beginning of the contract and trended forward at a predetermined annual rate or is recalculated for every performance year. Often, targets reflecting experience prior to the first performance year are beneficial to the provider because the baseline represents practice patterns prior to improvements resulting from increased investments in infrastructure and medical management.

Under the trended historical experience approach, once the baseline cost is established, it is trended forward to the performance year to establish the target. The negotiated trend is a main driver in the profitability for the provider. The trend should be clearly defined in the contract. Common approaches include:

- Using the observed trend of the payer's total book of business for the same insurance products
- Tying the trend to an externally validated metric, e.g., medical consumer price index (CPI)
- Having all parties agree to some other fixed trend for each year, not tied to any specific metric

Irrespective of the selected trend, many contracts also account for any known changes in fee schedules within the network that will be charged against the provider's budget. For example, if the payer increased all its providers' contracts 10% during the performance year, the baseline experience would not reflect these higher payments and therefore the target may require an adjustment. The contract should establish a threshold that triggers such an adjustment.

### Percent-of-premium approach

Key considerations when negotiating a percent-of-premium agreement include:

- The percent of premium used to calculate the target
- The expenses included in the numerator of the MLR
- The premiums included in the denominator of the MLR

The appropriate percent-of-premium target will ultimately depend on which expenses and premiums are included in the MLR. As a starting point, the provider should obtain reports of the payer's historical MLRs and adjust for any known changes (e.g., payment cuts from CMS).

The contract should clearly state which expenses and premiums are included in the MLR. Definitions for the MLR may differ from the definitions in state and federal insurance regulations. For example, common expenses included in the MLR are:

- Medical and prescription drug claims
- Capitation
- Quality of care programs
- Physician incentives
- Pharmacy rebates
- Incurred but not reported (IBNR) claims
- Stop-loss and reinsurance

Common elements of the premiums included in the MLR are:

- Payments to the payer paid by CMS
- Member premium
- Adjustments to the premium, such as sequestration

One approach to defining the MLR is to use the definition of medical costs and premium from the payer's audited financial statements. This provides a standardized, externally validated methodology and avoids some administrative overhead in the reconciliation process.

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For both the trended historical experience approach and percent-of-premium approach, different baselines should be calculated for populations with inherently different costs, such as:

- Different types of insurance products or attribution methodologies, e.g., health maintenance organization (HMO) versus preferred provider organization (PPO)
- Insurance products that cover prescription drugs versus those that only cover medical services

PPO products tend to have higher targets than HMO products because at-risk PPO members are typically attributed through a claims-based attribution methodology (i.e., only members that incur a claim are included in the attributed population), while HMO members are assigned based on their primary care physician (PCP) selection and therefore may or may not incur costs during the year.

### **Additional payments: Infrastructure**

Additional payments to the provider are included in many alternative payment arrangements that are intended to support the additional infrastructure needed to be successful in managing the increased financial risk. Different arrangements implement these infrastructure payments differently. Some contracts will not pay out savings until the infrastructure payments are repaid while others provide the infrastructure payment without conditions. Some infrastructure payments are risk-adjusted, as more time and effort may be needed to treat higher-severity patients. Infrastructure payments have become an important financial consideration for many recent alternative payment arrangements.

### **Additional payments: Quality**

In addition to reducing cost, provider groups in a risk-sharing arrangement are expected to improve the quality of care for their patients. Most arrangements account for quality using one or more of the following approaches:

- Providing separate per member per month (PMPM) payment based on the provider groups' ability to meet quality targets
- Tying the percentage share of savings and deficits retained by the groups to their ability to meet quality targets
- Withholding savings until a minimum level of quality is achieved

The metrics should be ones that the provider can directly influence based on the attributed population and the targets should be attainable over the length of the contract. The quality metrics, for example, should vary depending on whether the at-risk population consists of commercial or Medicare lives.

### **Settlement: Paid vs. allowed basis**

Under the trended historical experience approach, the comparison of the target to the actual performance-year experience to calculate savings (or deficits) may be made on either an allowed basis or paid basis (net of member cost sharing). Many recent contracts compare the experience to the target on an allowed basis, but may apply an average cost-sharing factor to calculate final savings or deficits.

By using allowed costs to measure the target and experience, the impact of plan design changes on PMPM from year to year is less significant than if the contract bases the calculation purely on paid amounts. However, in the case of significant plan design changes, we recommend that the parties negotiate an adjustment factor to account for differences in induced demand. In recent years, cost sharing has increased and we would expect that trend to continue, resulting in reduced utilization and, in turn, lower targets.

In addition, adjusting the allowed dollars to a paid basis after comparing the target with actual experience aligns savings and deficits more closely with the payer's responsibility. For example, if a provider beats the target by \$10 PMPM on an allowed basis but the average plan cost sharing is 90%, the plan is only responsible for 90% of \$10 = \$9 of the claims.

### **Impact on fee schedules**

Often, risk-sharing arrangements are implemented alongside changes in the provider's fee schedules. For example, it is not uncommon for a provider to accept a lower fee schedule in exchange for the possibility of gaining higher payments, on average, through the savings calculation. These two pieces together will ultimately dictate the payments per unit that the provider will receive.

## KEY CONTRACT PARAMETERS: INSURANCE

In this section, we focus on contractual provisions that will assist in managing the random fluctuation in claims from year to year and changes in the underlying characteristics of the covered population that are difficult for a provider to control through practice patterns. As providers assume financial risk, it is important to consider insurance protections to mitigate claims risk so that the focus is on measuring reductions in cost and improvements in quality rather than outliers and changes in the underlying characteristics of the covered population.

### Randomness: Minimum risk corridors

Contracts often deal with the careful balance of weighing true provider improvements versus random fluctuations in experience by implementing “minimum risk corridors”—savings and deficits are not shared until a minimum percentage is reached. This minimum risk corridor is more common under trended historical experience contracts; because percent-of-premium arrangements have targets that are tied to the premium that the payer receives, this type of contract can be thought of as a form of profit sharing and the minimum risk corridor is omitted. It is worthwhile to note that no methodology of separating randomness and true provider improvement is perfect. Depending on the size of the minimum risk corridor, it may penalize providers who make small, incremental improvements each year, or the provider may incur a deficit because of random claims outside of its control.

Because larger membership increases claims stability, any risk corridor percentage should be smaller for a larger covered population. Appendix B-1 shows the upper 95th-percentile confidence interval for expected claims fluctuations under different group sizes for an average commercial population, and Appendix B-2 shows the same exhibit for an average Medicare fee-for-service population. These types of estimates can be used to help inform the discussion of the appropriate minimum risk corridor to use on varying population sizes.

Appendix B was developed by running a claims simulation to estimate the expected variability of different reinsurance attachment points on group size. The simulation drew random claims from Milliman’s 2014 nationwide Commercial and Over 65 Health Cost Guidelines™ (HCGs).<sup>4</sup> The at-risk population may vary greatly from contract to contract depending on factors such as geography, severity, attribution method, and product type; therefore, the estimates in Appendix B may not be appropriate without further adjustments.

### Membership

From the standpoint of projecting claims experience, the credibility of historical or projected experience increases as the size of the underlying population increases. To minimize random variation within the risk-sharing arrangement and to credibly measure savings, a minimum membership threshold should be met for each baseline target. This minimum threshold depends largely on the level of truncation or reinsurance built into the contract, the risk corridors, the type of members covered (e.g., commercial or Medicare), and other contract provisions that affect the volume of expected claims, such as member attribution methodologies.

For a commercial population with a \$250,000 per-claimant truncation point, the minimum membership threshold is often in the neighborhood of 5,000 members. Appendix B-1 illustrates that there is a sharp decrease in random fluctuations between groups of 1,000 and 5,000 members. As shown in Appendix B-2, for a Medicare population with a \$250,000 per-claimant truncation point, we expect less random fluctuation than we would in a commercial population, and the minimum membership threshold is often between 2,000 and 5,000 members.

### Reinsurance

To protect from random high-cost claim outliers, providers will often obtain reinsurance protections either by purchasing it from a third party or building the protections directly into the contract. There are two basic types of outlier protections: individual and aggregate reinsurance. Individual reinsurance puts a limit on a specific member’s annual claims, while aggregate reinsurance puts a limit on the overall group’s annual claims.

A contract can include individual reinsurance by removing the claim, as a whole or in part, above a certain threshold or by completely removing a high-cost member from the baseline and measurement period. A payer will sometimes charge a reinsurance fee to include this type of protection. A common way of developing this fee is for the payer to base it on experience from the previous year on its total book of business, and it will often not include additional loads for administration or profit.

<sup>4</sup> The HCGs provide a flexible but consistent basis for the determination of health claim costs and premium rates for a wide variety of health plans. They are developed as a result of Milliman’s continuing research on healthcare costs. First developed in 1954, they have been updated and expanded annually since that time. They are continually monitored as they are used in measuring the experience or evaluating the rates of health plans, and as they are compared to other data sources.

Aggregate reinsurance is often contemplated under risk-sharing contracts through maximum downside caps. In these situations, the provider is not responsible for losses that occur beyond these caps. Therefore, they provide a way of measuring the absolute maximum liability to a provider. Providers should analyze their liabilities in determining the appropriate downside caps based on their internal risk appetites.

### **Membership risk characteristics: Severity<sup>5</sup>**

Risk adjustment helps adjust for unexpected changes in severity of the health status of members included in the baseline and performance periods to better measure actual savings. Risk adjustment can be either prospective or concurrent. Prospective risk adjustment uses a member's claims from a previous period to assign a risk score for the performance period. A concurrent risk adjustment method, by contrast, scores members for the performance period based on the performance period itself. Because concurrent risk adjusters explain the experience that they are applied to rather than future experience, they provide better statistical predictive accuracy than the prospective method.

Medicare Advantage uses prospective risk scores in determining the premium amounts CMS pays insurance companies, while many commercial risk contracts use concurrent risk scores. Medicare Advantage contracts sometimes do not specifically address risk adjustment in the calculation of savings and deficits because the target is based on the CMS premiums, which are already risk-adjusted.

Often, commercial contracts use concurrent risk scores to calculate health status adjustments from the baseline to the performance period by measuring the relative change of the provider's attributed members to the payer's other members in a defined region. Measuring the attributed member's risk score relative to a portion of the payer's book of business helps adjust for "coding creep." Each year we would expect a payer's book of business to have higher risk scores than the prior year, solely due to improvements in coding.

Three other items for consideration related to risk adjustment are as follows:

- The particular risk adjuster and model version that is used for the contract and whether the model can be updated during the duration of the contract. Different models may materially alter risk scores and the underlying profitability of the risk contract
- The risk model is often calibrated to the truncation point used in the risk contract. For example, if a payer is truncating all claims at \$250,000, that payer should use a risk adjuster that is based on a \$250,000 truncation
- The number of months of claims run-out used in scoring

### **Membership risk characteristics: Carve-outs**

Providers should consider excluding particular types of claims that they can't manage (either they do not have the facilities to do so or there is little room for improvement from medical management programs). For example, contracts often exclude members with transplants, certain types of cancer, AIDS, and neonate intensive care. Carve-outs are rarely applied to a Medicare risk contract because the Medicare reimbursement structure generally limits the risk and the variability associated with such claims (compared with what is observed in claims for a commercial population).

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<sup>5</sup> For a more detailed discussion of risk adjustment in risk-sharing contracts please refer to Leida, H.K. & Wachenheim, L.M. (January 2015), Risk adjustment and shared savings agreements, Milliman healthcare reform briefing paper, available at <http://www.milliman.com/uploadedFiles/insight/2015/shared-savings-agreements.pdf>.



## KEY CONTRACT PARAMETERS: OTHER

In this section, we discuss some other important contractual provisions.

### Attribution methodology

Savings, deficits, and quality are measured for those members in the at-risk cohort. This at-risk cohort is determined through an attribution methodology. For HMO products, or those products with a gatekeeper, the attribution is straightforward: if a member selects a PCP that is participating in the risk arrangement, then that member is included. However, for other products that do not require a formal PCP selection, then the member is often assigned a PCP through a claims-based algorithm. No claims-based algorithm is perfect, but the methodology should be clear in the contract and should be agreed on by both parties, as it can significantly change the at-risk population. Some items for consideration include:

- The length of the look-back period (usually 12 to 36 months): A longer look-back period often reduces attributed member turnover and in return allows the provider to have a greater chance of a return on its investment for a particular member
- Prospective versus retrospective attribution
- Adjustments for terminations or deaths throughout the year

### Providers/groups/products: Adjustment to target

The baseline target and performance year experience should both be based on a population comprised largely of the same members. In reality, changes from year to year do occur and most contracts consider adjustments to the claims (or budgets) to account for this (e.g., risk adjustment, minimum membership thresholds). However, in some cases a major addition or termination of members could occur (e.g., through an addition or removal of employer groups or affiliated providers).

Generally, contracts define a major membership change as a change in eligibility status of an absolute number of members or a certain percentage of the experience period membership. When this change occurs, the experience target should be recalculated to reflect:

- The historical PMPM experience of new members
- Adjustments to unit cost, if the newly added historical provider's fee schedules are significantly different from the provider's average
- Adjustments to truncation points
- Changes in product mix

### ACA and other regulations

The Patient Protection and Affordable Care Act (ACA) introduces several new provisions to commercial insurance—risk adjustment transfers, federal reinsurance, and risk corridors. As insurers receive and make payments based on these provisions, it is important to understand if and how they impact the risk-sharing settlements. This would apply similarly to other changes in federal and state regulations as well (e.g., the impact of sequestration on Medicare Advantage payment rates).

### Services in and out of network

A key driver of financial success is the ability to reduce unnecessary utilization, redirect services to less expensive providers, or capture a greater portion of member spending. While not specific contract parameters, providers should also be considering, among others, the following questions:

- For the at-risk or attributed population, what percentage of services is currently being performed within my system?
- Can I shift services into my network from other providers?
- How do reimbursement rates differ between my system and those of other providers?
- Can I impact those services that are not currently performed inside my system?

## Administrative support

In most situations, a risk-sharing arrangement is a collaborative effort by the payer and provider. Lowering costs can be beneficial to both parties. To help the providers, the payer will often provide tools and support to the providers to ensure success. Above, we discussed that some of this support is financial, provided through direct infrastructure payments. In addition, it is important for providers to understand what other tools and support are available from the payer and if it is more cost-effective to rely on the payer for some services rather than build them internally, e.g., information technology (IT) solutions including provider reporting, medical management guidelines, risk adjustment/predictive modeling software, and episode grouping software.

Detailed data on utilization and cost for all members covered under the alternative payment arrangement is a key tool for providers to manage experience, and it is important that they understand how much and at what intervals data will be provided by the plan. We have observed a trend wherein plans provide all claims data (including the cost of services at unaffiliated providers) to providers as they assume financial risk under these arrangements. This allows providers to develop much more relevant and timely reports than the standard packages that plans typically provide.

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## APPENDIX A: “CHECKLIST” OF CONTRACTUAL PROVISIONS

FINANCIAL PARAMETERS	
CONTRACTUAL PROVISION	KEY NEGOTIATION CONSIDERATIONS
Starting Budget: Historical Baseline Trended	<ul style="list-style-type: none"> <li>▪ Baseline year</li> <li>▪ Run-out period</li> <li>▪ Rebasing</li> <li>▪ Changes for different population mixes</li> <li>▪ Changes for fee schedule adjustments</li> </ul>
Starting Budget: Percent of Premium	<ul style="list-style-type: none"> <li>▪ Percent of premium</li> <li>▪ Expenses included in the numerator of the medical loss ratio (MLR)</li> <li>▪ Revenue included in the denominator of the MLR</li> </ul>
Infrastructure Payments	<ul style="list-style-type: none"> <li>▪ Risk adjustment</li> <li>▪ Included/excluded from savings and/or deficit amounts</li> </ul>
Quality Payments	<ul style="list-style-type: none"> <li>▪ Relevant and achievable</li> <li>▪ Savings or deficit percentages or payment based on meeting quality targets</li> </ul>
Settlement	<ul style="list-style-type: none"> <li>▪ Budgets and claims on a paid or allowed basis</li> <li>▪ Adjustments for plan design mix changes</li> </ul>
Fee Schedules	<ul style="list-style-type: none"> <li>▪ Increases/decreases in fee schedules</li> <li>▪ Interim payments before settlement</li> <li>▪ Adjustments to budgets to account for fee schedule changes</li> </ul>
INSURANCE PARAMETERS	
CONTRACTUAL PROVISION	KEY NEGOTIATION CONSIDERATIONS
Randomness: Minimum Risk Corridors	<ul style="list-style-type: none"> <li>▪ Expected population size</li> <li>▪ Both upside and downside payments</li> </ul>
Reinsurance	<ul style="list-style-type: none"> <li>▪ Individual and/or aggregate reinsurance protections</li> <li>▪ Cost of the reinsurance protection (implied or explicit)</li> <li>▪ Truncation points consistent with the anticipated population size</li> <li>▪ Risk appetite and financial reserves</li> </ul>
Membership Risk Characteristics: Severity	<ul style="list-style-type: none"> <li>▪ Concurrent or prospective</li> <li>▪ Appropriateness of risk adjuster for the covered population</li> <li>▪ Alignment of risk adjuster with stop-loss truncation points</li> <li>▪ Changes/updates to risk adjuster</li> </ul>
Membership Risk Characteristics: Carve-outs	<ul style="list-style-type: none"> <li>▪ Exclusion of services that the provider is unable to manage from both claims and budgets</li> </ul>
OTHER PARAMETERS	
CONTRACTUAL PROVISION	KEY NEGOTIATION CONSIDERATIONS
Adjustment to Target	<ul style="list-style-type: none"> <li>▪ Large provider group additions</li> <li>▪ Changes in product mix</li> </ul>
Administrative Support	<p>Information technology (IT) solutions including:</p> <ul style="list-style-type: none"> <li>▪ Provider reporting</li> <li>▪ Medical management guidelines</li> <li>▪ Risk adjustment/predictive modeling software</li> <li>▪ Episode grouping software</li> <li>▪ Claims data</li> </ul>
ACA and Other Regulations	<ul style="list-style-type: none"> <li>▪ Impact on budgets and settlement</li> </ul>
In and Out of Network	<ul style="list-style-type: none"> <li>▪ Programs/policies to steer patients to providers within system</li> <li>▪ Impact of utilization steerage on total anticipated financial outcomes</li> </ul>

## APPENDIX B-1: NATIONWIDE COMMERCIAL HEALTH COST GUIDELINES

Individual Attachment Point	UPPER 95TH CONFIDENCE INTERVAL OF ANNUAL COST / EXPECTED ANNUAL COST					CLAIMS ABOVE ATTACHMENT POINT AS % OF TOTAL CLAIMS
	GROUP SIZE					
	500	1,000	5,000	10,000	25,000	
\$25,000	107.3%	106.4%	103.9%	103.3%	100.6%	34.0%
\$50,000	109.7%	108.4%	105.1%	103.3%	100.9%	21.5%
\$75,000	111.2%	109.5%	105.1%	103.4%	100.9%	15.5%
\$250,000	111.3%	115.3%	107.0%	105.1%	101.3%	0.4%
No Reinsurance	133.2%	127.4%	112.4%	108.7%	102.6%	0.0%

Note: Annual costs include a "pooling" charge equal to the actual cost above the attachment point.

The simulation is based on 10,000 trials per cell. Re-running the simulation with the same or different number of trials will change the results.

While we typically would expect a Medicare population to have less variance, all things being equal, than a commercial population, any individual simulation run may produce the opposite results for some cells if the expected variance is fairly close.

## APPENDIX B-2: NATIONWIDE MEDICARE HEALTH COST GUIDELINES

Individual Attachment Point	UPPER 95TH CONFIDENCE INTERVAL OF ANNUAL COST / EXPECTED ANNUAL COST					CLAIMS ABOVE ATTACHMENT POINT AS % OF TOTAL CLAIMS
	GROUP SIZE					
	500	1,000	5,000	10,000	25,000	
\$25,000	105.7%	105.2%	103.7%	102.3%	100.3%	34.4%
\$50,000	107.8%	107.2%	105.3%	103.1%	100.5%	17.3%
\$75,000	108.8%	108.0%	105.7%	103.3%	100.7%	9.6%
\$250,000	111.3%	110.2%	107.7%	103.7%	100.7%	0.4%
No Reinsurance	112.3%	110.6%	108.0%	105.5%	100.8%	0.0%

Note: Annual costs include a "pooling" charge equal to the actual cost above the attachment point.

The simulation is based on 10,000 trials per cell. Re-running the simulation with the same or different number of trials will change the results.

While we typically would expect a Medicare population to have less variance, all things being equal, than a commercial population, any individual simulation run may produce the opposite results for some cells if the expected variance is fairly close.

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