House Ways and Means Committee
Health and Oversight Subcommittees
Hearing on
"Medicare Advantage: Why Audit?"

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Chairman Stark, Chairman Lewis, Representative Camp, Representative Ramstad and other members of the Committee, thank you for inviting me to testify about compliance with regulatory requirements of the Medicare Advantage (MA) plans' bid proposal process. I am Harry Hotchkiss, an actuary and an actuarial Director for Senior Products for Humana Inc. in Louisville, KY. My responsibilities are limited to being a member of the team responsible for the development, review and submission of premium and benefit packages or Bids to CMS and responses to audits of those Bids under the MA program.

For more than twenty years, Humana has served Medicare beneficiaries through health plans that offer affordable, comprehensive health care coverage. We currently offer stand-alone prescription drug plans (PDPs) in 50 states, the District of Columbia and Puerto Rico; private fee-for-service plans (PFFS) in 50 states and Puerto Rico; regional preferred provider plans in 23 states; local preferred provider plans in 21 states; and HMOs in 9 states and Puerto Rico. We also offer Medicare Supplement products (Medigap) in 39 states, the District of Columbia and Puerto Rico. In addition, Humana offers private health plan options through the Department of Defense's TRICARE program to military families and retirees and plans to government employees through the Federal Employees Health Benefits Program. We offer Medicaid plans in Florida and a Medicaid-type plan in Puerto Rico. Finally, we offer health insurance coverage and related services to employer groups and individuals. In total, we provide medical insurance to over 11 million members.

My testimony today will address how Humana complies with the regulatory requirements for bid submission, both before the passage of the Medicare Modernization

Act of 2003 (MMA) when such submissions were called "Adjusted Community Rate Proposals" (ACRs) and after MMA, when such submissions are called "Bids." I will conclude with some remarks about overall regulatory compliance activities. I have divided my discussion about the ACR and bidding processes into four areas:

1. ACR (Bid) Development
2. ACR (Bid) Benefit Review
3. CMS ACR Review; Bid Negotiation
4. CMS Audits

Preparation of ACRs and Bids is an actuarial process that involves coordination among Humana's product development, sales, finance, market management, corporate management and actuarial staff. This process requires a robust project management and actuarial rate development plan. Included in the process are mechanisms for reviewing the accuracy of our ACRs and Bids. We use both internal and external reviewers and/or auditors to ensure that our filings comply and are consistent with statutory and regulatory requirements and CMS guidance. The findings from our own rigorous reviews permit us to continuously improve our submissions. As you will see, we act upon and use any findings or observations made in regulatory audits to inform and continuously improve our processes going forward. We take seriously the trust that the federal government has placed in us to offer coverage to Medicare beneficiaries and understand the vulnerability of the Medicare population. As in any regulatory audit or site visit, we seek to resolve expeditiously any issues brought to our attention whether by internal or external sources.

Now, I will explain the pre-MMA or ACR process in its entirety followed by the Bid process in its entirety, including any external audits that have occurred.

ACR Development Process

Prior to implementation of the MMA, contracted MA plans submitted ACR proposals to CMS that included both a description of benefits [Plan Benefit Package ("PBP")] and a premium rate filing ("ACR") that supported the benefits being offered. The PBP listed the benefits covered, the member's cost sharing for each benefit and the member's monthly premium for the benefit plan. The ACR detailed the average cost of the benefits per member, the value of the member's cost sharing, expected premium from CMS and the member's monthly premium for the benefit plan.

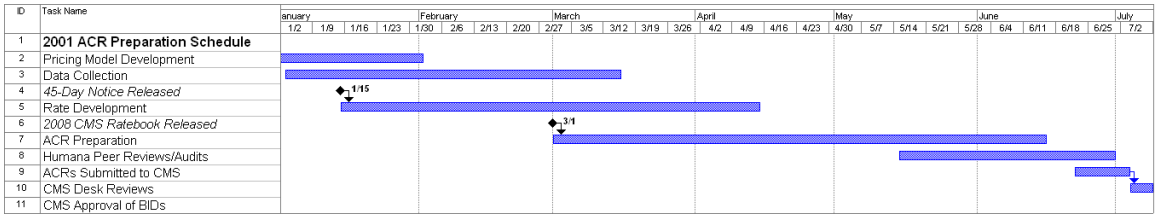

Exhibit 1 – ACR Submission Timeline

Our work on the ACR proposals began about 12-18 months prior to the actual due date for the filings. During that period of time, we developed and tested pricing models through which we would run the necessary pricing and benefit data. Six months prior to the filing date, we began to collect the data necessary to develop the proposals. During this period, CMS issued ACR instructions, modeling, and benefit software and conducted training sessions which we attended. We notified our local market offices of any new CMS requirements, provided estimates of the next year's revenue based on the ratebook published March 1 until 2004 (published late March for 2004-2005) and worked with an outside actuarial firm to review our proposals. We also used additional actuarial consulting firms on occasion for peer review. In addition to internal quality control

checks and peer-review activities throughout the process, from 2001-2005, Humana's Internal Audit Department performed company audits of the proposals.

Our ACR proposals were based on Medicare Fee-for-Service data for any new plans we offered. For existing plans, we used actual Humana claims cost experience. The value of member's cost share was based on actuarial factors. The expected premium from CMS was based on CMS-determined rates published first in a 45-day Notice (mid January of each year from 2001-2003 and the end of March for 2004-2005) outlining the methodologies it expected to use to calculate national/local rates as well as guidance for expected changes in reimbursement rates and other financial information. Secondly, CMS published its actual ratebook with per-member capitation rates by county on March 1 from 2001-2003 and the end of March from 2004-2005.

The ratebook provided the final instructions either confirming or modifying what was released in the 45-day Notice and provided any additional rate information pertaining to Medicare capitation payment rates. These capitation rates were the basis (starting point before adjustments) for the expected payment rates from CMS that were included in the ACRs. If a plan's cost of benefits was less than the CMS cost, the Plan would add benefits, lower premiums, lower cost-sharing, place extra monies in a Benefit Stabilization Fund for subsequent years or a combination of these actions. If the plan's costs were higher than the CMS cost, the plan would have to reduce benefits, increase cost sharing, add or increase a premium on the plan.

After the publication of the ratebook, we collected and summarized the claim, premium and enrollment experience for each of the existing Medicare plans as required by CMS. The actual experience became the basis for projecting the expected claims

costs in the rating period. Actuarial assumptions—such as claim cost trends, demographic or risk adjustments and benefit or cost sharing factors—were then applied to the experience period data to project expected claims costs for the rating period.

We developed actuarial assumptions in accordance with the appropriate actuarial standards. Some of the factors we used in developing our ACRs and the benefit designs included: CMS requirements, beneficiary preferences, provider contracts, CMS capitation rate increases, claim cost trends, competitors' benefits, product options, administrative feasibility (ability to administer the product design), geographic service area and affordability of member premiums. We also developed expected claim costs for prescription drug benefits. Some of the factors we considered in the development of expected costs and rates for prescription drugs included: CMS ACR instructions, expected enrollment, average number of prescriptions, cost per prescription and dispensing fees charged by pharmacies.

Based on the above data collection, our market office management staff, together with actuarial, product development, finance, sales and senior product leadership, determined what benefits, member premium and market/product expansions we would undertake as represented in our ACR submissions.

ACR Review Process

Before the filing deadline, we finalized the ACRs and benefits packages based on the most recent plan experience and any changes to provider contracting rates. We conducted internal and external audits of our ACRs the month prior to submission. First, the ACRs were peer-reviewed internally by senior actuaries for accuracy, reasonability and actuarial soundness. Necessary changes were made. They were then sent to an

outside, actuarial consulting firm for final peer review. Additional, as-needed changes were made prior to submission to CMS. Humana's Corporate Internal Audit Department also audited the proposals for 2001-2005. There were no material findings.

CMS ACR Review Process

Following ACR proposal submission, CMS reviewed the benefits using an accounting process that required the cost of benefits to be compared with the capitation rates offered by Medicare. CMS conducted desk reviews of the ACRs. We made any technical corrections or benefit adjustments required by CMS during this period. CMS then approved the ACRs. Following the approval of the ACRs, CMS approved the benefit packages.

CMS ACR Audit Process

CMS was required to audit the ACRs of at least one-third of the contracted MA organizations. CMS audited one or more of Humana's plans each year for contract years 2001, 2003 and 2004. There were no Humana plans audited in 2002 and 2005. We note that in 2001, there were two ACRs filed due to the passage of the Medicare Benefit Improvement & Protection Act (BIPA) which provided additional government payments to plans. Plans had ten days to refile ACRs following the publication of the new rates (effective March 1, 2001). CMS conducted an industry-wide training conference call on BIPA ACR instructions. It established certain rules as to how the extra monies could be spent and ultimately approved our refiled ACRs (which were based on their instructions) on February 1, 2001. The HHS Office of the Inspector General (OIG) later audited those proposals and disagreed with the allocation of extra monies. We provided all the support

documentation to substantiate our filings and maintained that we used the monies in accordance with requirements and instructions.

That noted, CMS' audit of ACRs, conducted by outside actuarial firms, generally began in November and continued for four to six weeks. These audits began with an entrance conference call and a CMS list of requested data, followed by desk review and an onsite visit. The auditors evaluated the plan's base period experience, support for two-year projections, whether the base year experience reconciled with audited financial statements, the most recent year's budget, and what was prepared the previous year. The scope of the ACR audits was an audit of the plan's ACR, tying the plan's Medicare payment to its source documents and then to the plan's audited financial statements. To the best of our recollection, the 2001, 2003, 2004 CMS ACR audits did not produce any material findings that affected members' benefits or premiums.

MMA Bidding & Audit Process

Now I will discuss how we comply with the bidding process as implemented under the MMA. This process replaced the ACR process and resulted in significant changes to pricing models, training and staff to support the process. Exhibit 2 describes the general schedule for bid submission and approval.

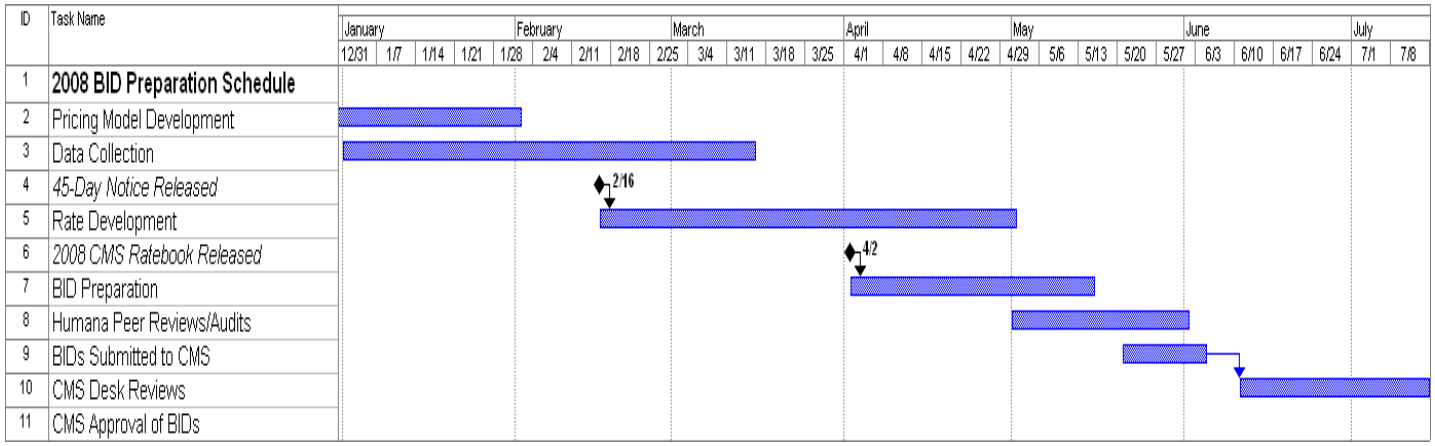

Exhibit 2 - Bid Submission Timeline

Bid Development Process

The MMA set forth a new timeline for the submission of premium and benefit filings. CMS publishes the 45-day Notice mid-February and the final ratebook (MA benchmarks), the first Monday in April. CMS generally issues instructions for completing bids 1-2 months prior to the filing date which is the first Monday in June. (We participate in CMS training sessions and technical guidance calls each year to ensure we meet statutory and regulatory provisions, as well as new CMS guidance.) The prescription drug benchmarks are generally published in August.

The Bids represent Humana's expected average cost for the Medicare covered benefits for each benefit plan. Bids can vary based on several factors—such as location (county) and risk characteristics of members. Like the ACRs, Bids are developed from actual claims cost experience for renewing plans. The expected average cost for Medicare covered benefits is then compared with the CMS MA benchmark (formerly capitation rates) found in the ratebook. If the plan's bid is below the benchmark, the plan must use 75% of the "savings" to increase member benefits, decrease member premiums or member cost-sharing. The remaining 25% of savings are returned to the federal Treasury.

Humana developed two separate bid pricing models to develop our bids: a medical benefits model and a prescription drug benefit model. These models were peer-reviewed and can be modified by our actuarial consultants. The models complete the bid forms in compliance with CMS' instructions. The average cost for Medicare-covered benefits is developed in a similar manner as the ACR process previously described.

To develop the benefits offered under our plans, our product development and actuarial staff and local market leaders develop preliminary benefit structures for each of the products we intend to offer in each geographic market and project enrollment. Actuarial pricing models are used to determine bid amounts for Medicare-covered benefits and to calculate the amount of savings for each plan. If there are savings, we calculate the cost of additional benefits to be offered. If Humana's cost is higher and/or if more benefits are offered than can be covered by 75% of the savings, the actuaries calculate the additional premium that members must be charged. Enrollment estimates are developed based on prior enrollment and the expected impact of benefit design, competition and member premiums.

The 45-day Notice and the ratebook are used to estimate CMS payments for the Bids. To estimate the expected CMS payments for the Bids, we use the same information previously described. These payments are adjusted by expected Medicare health risk adjustment factors and expected enrollment in each county in the benefit plan's geographic area. In April, we load CMS' ratebook into our pricing model and make any necessary adjustments to the bid and pricing. Our teams meet with our markets to finalize the specific benefits for each type of Medicare Advantage and Prescription Drug Plan products to be offered.

Humana Bid Review Process

MA and PDP bids are generally completed by the end of the first week in May. Those bids are then peer-reviewed by a team of qualified, internal actuaries. Any necessary changes resulting from their peer reviews are made by the Medicare pricing actuaries and then reviewed and approved again by senior actuaries. Bids are then

processed through an internal audit program that checks for consistency between the MA and PD bids where appropriate and identifies any outliers based on pre-established parameters. Consistency checks include: consistency of plan name, prescription drug premiums, membership between the two bids, acceptable administrative expenses levels, service level costs, and risk /profit margins. This process is similar to the process CMS uses after plans submit their bids. Each inconsistency or outlier is reviewed and adjustments or corrections are made where necessary. Both the rate and benefit packages are reviewed by the product development and actuarial teams to ensure the benefits are accurate and consistent.

Following the bid development, we develop the actuarial documentation required by CMS, including Two-Year Look-Back forms that summarize the claim cost experience by contract for the second prior year. This documentation is also peer-reviewed and any identified errors corrected.

Bids, Plan Benefit Packages, actuarial documentation and the Two Year Look-Back forms are then uploaded into the CMS system by the first Monday in June. Our teams work together to correct any errors identified by CMS in their validation tests. In mid-June, we submit actuarial certifications for the bids which are signed by the actuary responsible for the bid.

Bid Negotiation Process

From late June through mid-August, CMS' contracted actuaries conduct a thorough review of all bids based on instructions from the Office of the Actuary. CMS and their contract reviewers also review the benefit packages. If issues or questions arise, we generally respond within 48 hours and supply necessary documentation. For example, to

support the pricing assumption for the per-member-per-month cost of an inpatient facility benefit, Humana had to supply actuarial cost and utilization data. There are frequent conversations among the reviewers, CMS and Humana. As a result of these discussions, we may be required to resubmit bids and benefit packages to address any issues. All benefit changes after initial submission that impact bids must be re-reviewed by CMS' reviewing actuaries for bid impact. The contracted actuaries must sign-off on our bids to CMS before CMS will approve the bids.

In mid August, CMS releases the final prescription drug and Regional PPO benchmarks. Since the actual benchmarks will differ from the estimated benchmarks we included in our bids back in early June, we then adjust our benefits and/or premiums and bids based on the national benchmarks. CMS allows one week for the revised bids and benefits to be resubmitted. In early September, CMS approves our bids and attestations.

CMS Bid Audit Processes

Shortly after CMS' approval of the bids, they notify Humana of the bids that they will audit. CMS contracts with outside actuarial firms for these audits. The audits center around the reasonableness of the assumptions used for financial projections, the accuracy and reasonableness of the base period data and/or manual data supporting the bid submissions, ensuring the bids were developed consistent with the applicable Actuarial Standards of Practice as promulgated by the American Academy of Actuaries, and verifying that the bids were prepared consistent with the Instructions for Completing the Medicare Advantage or Prescription Drug Plan Bid Forms for a particular Contract Year.

The auditing firm notifies Humana and conducts an initial audit entrance conference call among the auditors, the Office of the Actuary and Humana. Humana

compiles the data requested and provides the auditors with the necessary data. The audit firm conducts a desk review of the materials followed by a one-week onsite visit to review all material and request additional information. Soon after, Humana receives and responds to an initial draft of the firm's findings or observations. The auditing firm then issues a final "Agree/Disagree" letter which contains any findings or observations made by the auditors. Humana then issues a final response to that letter.

From 2006 to present, Humana plans have been and are being audited. For the 2006 plan year, CMS audited two contracts (a Regional PPO and an HMO). There were no material findings in either audit. There were two non-material observations which had no impact on the rates and benefits we offered: 1) lack of disclosure of our outside, consulting actuarial firm's study as a source used in calculating a certain factor and 2) an inconsistency in a utilization factor. There were no findings or observations noted for our PD/PDP plans. The final CMS audit was issued on June 26, 2006.

For the 2007 plan year, CMS audited two contracts and issued one finding and two observations for one of our HMOs. In that plan, we used a rate development factor for medical expenses that was an inadvertent error with the medical cost structure for the plans. The result of this inadvertent error was that members in the two affected plans received a slightly better benefit. The finding and observation resulted in improvements to our methodologies for the 2008 bids as mentioned. The final 2007 CMS audit was issued on May 14, 2007.

Finally, we believe it would improve the bid process if the final audit reports were issued in March of the contract year to allow plans to include the impact from any findings and/or observations into the next year's bids.

Other CMS Regulatory Oversight Activities

As an organization offering MA plans (and stand-alone PDPs), Humana is subject planned and unplanned regulatory site visits and other reviews. Let me state for the record that Humana expects our policies, procedures, systems, management and operational implementation activities to be audited by CMS. Over the years, we have used internal and external resources to review, audit and maintain contract compliance. We have a 44-member regulatory compliance department; employ corporate Internal Audit resources and sometimes contract with external organizations to examine our operations. If a regulatory agency identifies an issue, Humana implements corrective actions. We have been subject to sanctions. We strive for zero tolerance in compliance with the requirements--but no one who provides services to Medicare beneficiaries is perfect. What we CAN do is have appropriate internal and external oversight and auditing mechanisms in place and work with regulatory agencies in curing any deficiencies they may identify to ensure contract compliance and improved beneficiary services.

Given that MMA inaugurated the largest entitlement program expansion in decades, government and plan challenges of the 2006 contract year were great: information system issues, changing CMS policies (including those relating to the bidding process) to meet unexpected consequences of well-intended requirements, and the unexpected volume of beneficiary needs that stretched resources. In the end, most beneficiaries have coverage, most are satisfied with their coverage and nearly all are saving money.

Learning from the 2006 experience, Humana executed the following:

1) Conducted nationwide outreach to every state Department of Insurance, most State Health Insurance Assistance Programs (SHIPs), state Medicaid agency and other consumer advocacy groups to educate them about our plans and processes, providing them with a special toll-free number to call with questions and issues and contact names for assistance;
2) Created a 20-person Performance and Process Improvement Department that developed process management systems and controls for areas of highest risk to our members;
3) Overhauled our sales management system including reducing dependence on contracted or delegated agents/brokers (we believe we have the largest employed sales force in the industry);
4) Required contracted agencies to have compliance programs in place and meet certain sales practice performance standards
5) Increased Humana sales management oversight;
6) Redesigned agency licensing management system and operations as a result of systems' flaws identified through state insurance exams and an Internal Audit; and
7) Redesigned, systematized and added resources to our process for handling sales-related complaints including strengthening agent obligations and corrective action oversight.

Our Medicare operations management meets weekly to review performance metrics.

Conclusion

Let me reiterate that we take seriously the trust that the federal government has placed in us to offer MA coverage to beneficiaries and understand the vulnerability of this population. Humana continues to strive to comply with the statutory and regulatory provisions as well as CMS guidance and instructions as they relate to our contract obligations. In any regulatory audit or site visit, we seek to correct any issues brought to our attention whether by internal or external sources. Our internal findings as well as findings from outside sources are used to inform and continuously improve our operations. The challenges we faced in the operational implementation of the provisions of the MMA have been largely overcome. Our company has reported that sales-related complaints have represented about ½ of 1 percent of all our agent-assisted sales. We take ALL complaints seriously and work hard to resolve them. We report violators. We work closely with state and federal agencies in these efforts.

Thank you for the opportunity to discuss the processes we have in place to meet the statutory, regulatory and contractual obligations in the MA Bid and audit process and issues identified in recent MA reviews.