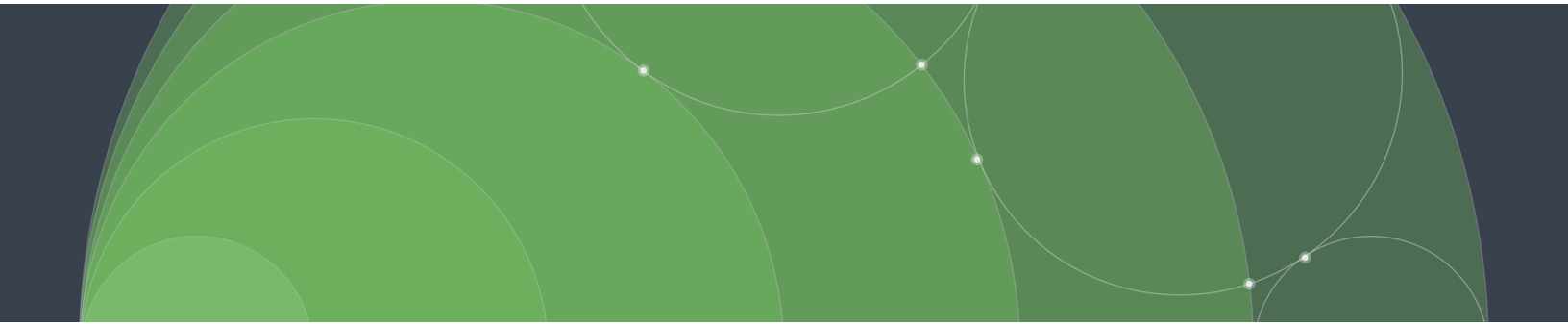

The Health Cost Guidelines–Ages 65 and Over are used to adjust national average costs to specific geographic areas and are used to rate Medicare Advantage, Medicare Supplement, and retiree medical plans.

The rating sections reflect the most recent Medicare payment systems. A separate section provides a basis for calculating prescription drug claim costs. The user can modify costs based on age/gender mix, geographic area, trends, and other rating factors.

The Ages 65 and Over Guidelines feature several characteristics that enhance their usefulness, including:

- Separate rating sections cover the unique pricing aspects of Medicare populations-Medicare Advantage, Medicare Supplement, and employer-based retiree medical benefits. Automated Managed Care and Medicare Supplement rating models use the updated starting claim costs and basic tables and allow for rating factors such as age/gender, area, and trend for product pricing development.
- The rating sections reflect the most recent Medicare payment systems. This feature allows for evaluation or limitation of provider reimbursement relative to Medicare-allowed charge levels.
- The Retiree Medical Rating Model (RMRM) is an automated spreadsheet developed for use with the employer-based retiree medical rating section. The RMRM utilizes user input to determine expected claim costs for plans offered to typical employer-based Medicare populations. The RMRM also allows the user to project claim costs for future years.
- A separate Prescription Drug Rating section provides for more detailed analysis of prescription drug costs and benefits. Various cost per prescription continuance tables can be used to model unit price variation and the effectiveness (expected versus nominal) of higher stated plan copays. The Prescription Drug Rating section is accompanied by the Prescription Drug Rating Model (RXRM), which automates the entire prescription drug rating process.

Managed Care Rating

The Managed Care Rating Structure provides a flexible basis to calculate claim costs for detailed benefit categories on a composite per-member-per-month (PMPM) basis for managed care plans offered by Medicare Advantage organizations. This rating structure allows the user to modify the composite claim costs for the age/gender mix of the members, geographic area, contractual limitations, level of healthcare management, coverage levels, trend, and negotiated reimbursement. Well-managed targets provide a basis for benchmarking experience and modeling changes in claim cost with improvements in efficiency.

A spreadsheet template is included with the Managed Care Rating Structure to supplement the information in the manual and to make the calculation process easier.

Medicare Supplement Rating Structure

This section provides a flexible basis for estimating claim costs for Medicare Supplement benefits. Medicare Supplement policies are assumed to provide scheduled benefits that cover Medicare deductibles and coinsurance for beneficiaries with both Medicare Part A and Part B coverage. The Medicare Supplement policy might also provide benefits not previously covered by Medicare, such as the amounts above Medicare allowable charge levels.

The costs in these Guidelines are not appropriate for plans that offer long-term care coverage, except for skilled nursing facility and home health agency coverage that is offered as part of a broad package of benefits supplementing Medicare, where service is provided only in a Medicare-approved facility or by a Medicare-approved home health agency and is subject to Medicare's definition of medical necessity.

Retiree Medical Rating Structure

This section provides a basis and spreadsheet template to determine claim costs for retiree health programs integrated with Medicare that are not scheduled or Medicare Supplement plans. The Retiree Medical Rating Model (RMRM) includes expected claim costs for the current year and several prior years. The historical claim costs are included to allow comparisons between actual experience and expected costs from the RMRM.

Prescription Drug Rating Structure

The Prescription Drug Rating Structure and accompanying rating model can be used to determine claim costs for a wide variety of prescription drug benefit plans. The Rating Structure recognizes variables for age/gender mix, area, benefit coverage, reimbursement, pharmacy and physician incentives, mail order availability, and cost management programs. Additional information is provided by drug therapy class and for highly utilized drugs.

Basic Tables

The Basic Tables summarize the claim cost assumptions used throughout the Ages 65 and Over Guidelines. Costs are shown by age and gender for each major benefit category with composite costs by gender and in total. Utilization and charge level information is provided for each type of service category. The Basic Tables reflect claim cost assumptions for the year centered on July 1.

Starting Claim Costs

The tables in this section summarize the claim costs from the Basic Tables within three general categories: Medicare Part A services, Medicare Part B services, and Medicare D services.

The utilization assumptions underlying all of these costs are consistent with projected Medicare aged population experience, adjusted to reflect the utilization level characteristic of the non-institutionalized, non-Medicaid, non-end stage renal disease (ESRD) population. The utilization assumptions do not apply to the actively at-work population over age 65.

Charge level assumptions for hospital and other institutional care reflect actual billed levels, which are generally higher than the reimbursed cost levels determined by Medicare. Charge level assumptions for professional services reflect usual, customary, and reasonable fee limitations, which are considerably higher than Medicare-allowed charges.

Trend Factors

The claim costs presented in the Ages 65 and Over Guidelines are representative of claims incurred on July 1. For an experience period with a midpoint other than July 1, an adjustment is necessary to reflect estimated changes in the utilization and cost of medical care.

Medical trend assumptions will vary significantly depending on factors that are often unique to each situation. Such factors include type of plan, benefit structure, and geographic area. Moreover, these factors tend to be dynamic, requiring continuous analysis and subjective evaluation. For these reasons, it is difficult to establish a set of recommended trend factors for all users. Rather, we have developed a framework for establishing trend assumptions for a variety of situations.

This section includes considerations in establishing trend assumptions, special considerations for Medicare Supplement plans, and guidelines for secular trend factors. Historical trends for Medicare Supplement and Medicare Advantage as well as trend assumption worksheets are included.

Area Factors

The claim costs contained in the Ages 65 and Over Guidelines represent average costs based on nationwide average utilization and charge levels. Area factors are included to adjust these national costs to specific areas. The factors are shown by state and Metropolitan Statistical Area.

The utilization area factors reflect Medicare utilization patterns. The cost PMPM area factors are expressed using both Medicare-allowed charges and billed charges.

Claim Probability Distributions

The Ages 65 and Over Claim Probability Distributions are used to estimate the value of plan deductibles and out-of-pocket maximums. These distributions are consistent with the Basic Tables. The distributions are provided on the basis of Medicare-allowed charges.

For more information, contact your Milliman consultant or the Health Cost Guidelines manager at **hcgmanager@milliman.com** if you are interested in licensing this product.