Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Colorado Department of Health Care Policy and Financing
Docket No. A-11-27
Decision No. 2407
August 22, 2011

DECISION

The Colorado Department of Health Care Policy and Financing (Colorado) appealed a determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $2,566,016 in federal funds claimed by Colorado under the Children's Health Insurance Program (CHIP). CMS determined that certain payments Colorado made to Anthem Blue Cross Blue Shield (Anthem) were CHIP administrative costs, rather than the costs of child health assistance. CMS therefore reclassified $7,424,541 in fiscal year (FY) 2007 expenditures to the administrative expenditures category. As a result, CMS determined that Colorado had $3,947,716 in non-primary expenditures (including administrative costs) for FY 2007 in excess of a 10 percent statutory limit on such expenditures. CMS disallowed $2,556,016, which is the federal share of the excess.

For the reasons stated below, we conclude that part of the amounts at issue paid to Anthem were for child health assistance in the form of health benefits coverage under Colorado's self-funded plan for certain CHIP enrollees. We further conclude, however, that part of the amounts paid to Anthem were for the costs of administering Colorado's CHIP program. Based on the record before us, we uphold the disallowance in the reduced amount of $318,635, the amount by which Colorado exceeded the 10 percent statutory limit after part of the payments to Anthem are reclassified as administrative expenditures.

Legal background

CHIP is established by title XXI of the Social Security Act (Act) and authorizes federal grants to the states to provide child health assistance to uninsured, low-income children. Under CHIP, "each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures" within broad Federal guidelines. CMS Br. at 2; *see* 42 C.F.R. § 457.1. States may provide health benefits coverage through a "Medicaid expansion program," through a

separate child health plan, or through a combination of the two. 42 C.F.R. § 457.70.[1] The regulations in 42 C.F.R. Part 457, subpart D, apply to "child health assistance provided under a separate child health program . . . ."

For purposes of subpart D, the term "child health assistance" is defined to mean "payment for part or all of the cost of **health benefits coverage** provided to targeted low-income children for the services listed at § 457.402." 42 C.F.R. § 457.10 (emphasis added). Section 457.402 lists services such as inpatient and outpatient hospital services, case management services, premiums for private health insurance coverage, enabling services (such as transportation, translation, and outreach services) designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals, and any other health care services specified by the Secretary and not excluded from coverage. The term "health care services" means "any of the services, devices, supplies, therapies, or other items listed in § 457.402." 42 C.F.R. § 457.10. "Health benefits coverage" means "an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services." *Id.*

A state such as Colorado that elects to obtain health benefits coverage through a separate child health program (rather than through Medicaid) must include in its state title XXI plan "a description of the child health assistance provided under the plan for targeted low-income children, including a description of the proposed methods of delivery and utilization control systems." 42 C.F.R. § 457.490. The state must—

> (a) Describe the methods of delivery of child health assistance including the choice of financing and the methods for assuring **delivery of the insurance products** and delivery of health care services **covered by such products** to the enrollees, including any variations; and
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> (b) Describe utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan.

Id. (emphasis added).

Payments to states for the federal share of CHIP program expenditures are at an "enhanced" Federal Medical Assistance Percentage (FMAP) rate, but the total amount paid is subject to a state's allotment amount for the fiscal year. In addition, the regulations distinguish two types of expenditures: "primary expenditures" and "non-

[1] The regulations use the terms "child health plan" and "child health program" interchangeably. *Compare* 42 C.F.R. §§ 457.401(b) and (c).

primary expenditures." "Primary expenditures" are "expenditures under a State plan for child health assistance to targeted low-income children **in the form of a standard benefit package**" and certain Medicaid expenditures. 42 C.F.R. § 457.618(a)(1) (emphasis added). Primary expenditures are also described as "[c]hild health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103 of the Act." 42 C.F.R. § 457.622(d)(1). Non-primary expenditures are reimbursed at the enhanced FMAP rate, but are subject to a 10 percent limit pursuant to section 2105(c)(2)(A) of the Act. The 10 percent limit is described in section 457.618(c) of the regulations. Under the regulations, non-primary expenditures include four categories: administrative expenditures, outreach, health initiatives, and certain other child health assistance. 42 C.F.R. § 457.618(a)(2).

Section 2105(a)(1)(D)(iv) of the Act refers to the category of administrative expenditures subject to the 10 percent limit as "reasonable costs incurred by the State to administer the plan." In context, this is clearly referring to the State plan approved by the Secretary. The regulations do not define the term "administrative expenditures" but contain the following provisions with respect to administrative expenditures:

> (1) *General rule.* Allowable title XXI administrative expenditures should support the operation of the State child health assistance plan. . . .
> (2) *Exception.* FFP is available [for certain Medicaid administrative expenditures].
> (3) FFP is not available in expenditures **for administrative activities for items or services included within the scope of another claimed expenditure**.
> (4) FFP is available for activities [that are defined outreach activities].
> (5) FFP is available in administrative expenditures for activities [for coordinating CHIP] with other public and private health insurance programs . . . .

42 C.F.R. § 457.622 (emphasis added).

The preamble to the proposed rule for this provision states that "administrative costs are differentiated from the program costs referred to as 'child health assistance' in section 2105(a)(1) of the Act." 64 Fed. Reg. 10,412, 10,421 (Mar. 4, 1999). The preamble also refers to the definition of child health assistance, stating: "Payment for such program costs which are within the scope of the State's CHIP benefit package . . . are not considered to be payment for administrative costs and are generally not subject to the 10 Percent Limit." 64 Fed. Reg. at 10,421. In explaining subsection (e)(3) of proposed section 457.622, the preamble states that--

> the effective and efficient operation of the State plan should include reasonable costs which do not duplicate payments that are already included and paid as part of another payment mechanism, for example:
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> - Rates for outpatient clinic services;

- Case management services;
- Part of capitation rate;
- Other provider rate;
- Other program payments . . . .

64 Fed. Reg. at 10,422.

Factual background

Colorado has an approved state plan under CHIP. The Colorado CHIP program is the Child Health Plan Plus (CHP+). Under the program, Colorado provides for the delivery of health care services primarily through five "health plans," four of which are Health Maintenance Organizations (HMOs) and one of which is a "State self-funded plan" referred to as the "State Managed Care Network" (SMCN). CMS Br. at 3; CO Br., Att. D (CMS Financial Management Report), at 6. The SMCN is for enrollees in rural areas of Colorado where HMO services are not available. The SMCN also provides interim coverage for children whose parents choose an HMO plan, but the actual start date for the HMO coverage is subsequent to registration.

Anthem administered the self-funded plan in FY 2007 under a contract with Colorado. Under Colorado's contract with Anthem, Anthem received capitation payments to cover health care services for enrollees (for which network providers submitted claims to Anthem). Anthem also provided Administrative Service Organization (ASO) services, including network administration, claims processing and management, customer service, behavioral health benefits, pharmacy benefits management, professional support services, and utilization and case management.

A contracted actuarial firm calculated that the "administration rate" for the self-funded plan would be \$30.04 per member per month (PMPM) for FY 2007. CO Br., Att. C, at 2. Colorado paid \$27.45 of this amount to Anthem to cover the ASO services. Colorado paid the remaining \$2.59 directly to an independent insurer to obtain "stop loss" coverage. The stop loss coverage was for any individual who exceeded the specified claims maximum, in which case the independent insurer paid 90 percent of the excess claims, and Colorado paid the remaining 10 percent. CO Response to Order at 3.

In April 2008, CMS performed a financial management review of Colorado's CHIP program and determined that the \$27.45 PMPM paid to Anthem for the ASO services were "administrative expenditures" subject to the 10 percent limit on non-primary expenditures. CMS allowed the \$2.59 PMPM for "stop loss" coverage as an expense for "child health assistance." The remaining \$27.45, CMS said, had to be claimed as administrative expenses. CMS therefore reclassified \$7,424,541 in expenditures to the administrative expenditures category. As a result, CMS determined that Colorado exceeded its 10 percent limit for FY 2007 by \$3,947,716, and CMS disallowed

$2,566,016 as the federal share of the excess.[2] (CMS also reclassified $79,653 in other expenditures, which Colorado agrees should have been claimed as administrative expenditures.)

Colorado asserts that it properly claimed the payments to Anthem as child health assistance. Colorado describes its self-funded plan as follows:

> The Self-Funded Plan provides the same benefit package through a managed care system that is provided through the HMO managed care system. Colorado outsources the claims processing, network relations, case and utilization management of its Self-Funded Plan with an Administrative Services Organization. Administrative Services Organizations are also referred to as Third Party Administrators in the commercial sector. Most Self-Funded Plans use a Third Party Administrator to process and pay medical claims; the Administrative Services Organization (Administrator) for Colorado's Self-Funded Plan performs the same tasks as a Third Party Administrator.

CO Br. at 4. According to Colorado, the actuary used the same general methodology to project the costs of all of the Colorado CHP+ plans. CO Br. at 5. For FY 2007, the actuary projected costs for both the self-funded and HMO plans that included a separate category referred to as administration costs, Colorado says. The administration rate for the self-funded plan was a flat rate of $30.04 PMPM, but the amount for the HMO plans was $13.65 PMPM, or 14.3% of gross projected costs for the HMO plans. Colorado describes the ASO services provided by Anthem as tasks that "chiefly and directly support the delivery of health services to the CHP+ population, rather than involve the administration of the program." CO Br. at 7. Colorado says that the HMOs perform the same tasks, which are reflected in the $13.65 PMPM rate that CMS accepted as child health assistance costs. Colorado asserts that its self-funded plan "essentially is a managed care organization, but with these tasks performed by a third party administrator, whereas the HMOs perform these tasks in-house." CO Br. at 7.

CMS contends that the payments of $27.45 PMPM to Anthem do not qualify as "child health assistance" because the activities Anthem performed are not in the list of health care services in section 457.402.

At the parties' request, the Board stayed its proceedings to permit the parties to discuss settlement. After the parties had indicated they could not resolve the case, the Board

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[2] Although CMS's management review referred to the payments and limit for FY 2007, Colorado clarified in response to the Board's Order to Develop the Record that the disallowance included payments through October 2007, even though CMS originally calculated the overpayment only for July 1, 2006 through June 30, 2007. CO Response to Order at 7 n.1. For simplicity's sake, we continue to refer to the expanded period as FY 2007.

issued an Order to Develop the Record, asking the parties to respond to a series of questions and to provide supporting documentation to assist the Board in resolving the parties' dispute over the nature of the payments to Anthem.

In response to the Order, CMS clarified that the focus of the disallowance is that the expenditures under Colorado's contract were "purely administrative" as opposed to being the costs of child health assistance. CMS Response to Order at 3. In its response, CMS also reiterates its position that the functions performed by Anthem were administrative because they were "not included in the list of expressly authorized services" and "are also not included in the catch-all of 'any other medical, diagnostic, screening, preventative, restorative, remedial, therapeutic, or rehabilitative services.'" *Id.* According to CMS, it is irrelevant whether Anthem assumed any risk under the contract and whether the self-funded plan operated as a fee-for-service system, with Anthem as Colorado's fiscal agent (rather than a managed care organization or other managed care entity) even though CMS's initial brief sought to distinguish the activities Anthem performed from the activities performed by the HMOs by alleging that Anthem did not assume any risk but operated as a fiscal agent for a fee-for-service system. Since CMS no longer relies on these allegations, we do not discuss them below.

Analysis

In this section, we first explain why we conclude that the fact that the activities Anthem performed under the ASO contract were administrative in nature and were not in the list of services in section 457.402 does not necessarily mean they were not the costs of child health assistance. We then explain why we find, based on the record before us, that part of the payments to Anthem were for the costs of administering the SMCN, Colorado's self-funded plan, and therefore were the costs of child health assistance. Next, we explain why we find that some of the costs were costs of operating Colorado's CHP+ program (and State plan) and therefore should have been claimed as administrative expenditures. Finally, we explain why we uphold the disallowance of $318,635, as the amount of non-primary expenditures in excess of the 10 percent limit.

1. "Child health assistance" includes payments for certain administrative type activities if they are part of the cost of health benefits coverage.

As indicated above, CMS now bases its disallowance solely on its position that the activities Anthem performs under the contract are administrative in nature and are not for the services listed in section 457.402 . The key issue under the regulations, however, is not whether the activities are administrative in nature, but whether part or all of the payments to Anthem are the costs of "child health assistance," rather than the costs of administering a CHIP program/State plan that count toward the 10 percent limit.

Contrary to what CMS suggests, the regulations do not limit the term "child health assistance" to the cost of the services listed in section 457.402. Instead, as indicated above, the term "child health assistance means," for purposes of CHIP, "payment for part or all of the cost of **health benefits coverage** provided to targeted low-income children for the services listed at § 457.402." 42 C.F.R. § 457.10 (emphasis added). "Health benefits coverage" means "an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services." *Id.* The term "health care services" is the term used for the services and items listed in section 457.402. 42 C.F.R. § 457.10. CMS's position that only the health care services qualify as "child health assistance" is inconsistent with the regulations.

Moreover, in addressing what costs should be treated as administrative expenditures for purposes of the 10 percent limit, the preamble to the final CHIP rule states that payment for program costs within the scope of a state's CHIP benefit package "are not considered to be payment for administrative costs and are generally not subject to the 10 Percent Limit." 64 Fed. Reg. at 10,421. The preamble also recognizes that some administrative activities might be included in another payment, such as a payment for a case management service or a capitation payment made to a health plan. *Id.*

In other words, the regulations and preamble distinguish the costs of administering a **CHIP program/State plan** from the costs of administering an insurance plan providing a **health benefit package**.

Indeed, CMS itself recognized that the costs HMOs incur in administering their health plans are not subject to the 10 percent limit. This recognition is inconsistent with CMS's argument here that all costs other than the costs of actually providing the services listed in section 457.402 are "purely administrative." Because CMS recognized that the term "child health assistance" includes that part of the capitation payments made to the HMOs intended to reimburse them for the costs of administering their health plans to provide the basic benefit package to enrollees in a cost-effective way, similar costs incurred to administer Colorado's self-funded plan/SMCN in a cost-effective way can reasonably be considered to be the costs of "child health assistance." CMS acknowledged that it has provided no guidance distinguishing a state self-funded plan from the plan offered by a managed care organization (MCO) such as an HMO for purposes of determining how to

classify expenditures incurred in administering an insurance plan. CMS Response to Order at 5.[3]

2. ***Anthem performed some functions under the contract for administering the SMCN, Colorado's self-funded plan.***

CMS's initial brief recognized that a health insurance plan might incur costs for a type of case management designed to "reduce unnecessary health care costs through a variety of mechanisms, including . . . programs for reviewing medical necessity, controls on inpatient admissions and length of stay, . . . selective contracting with health care providers, and the intensive management of high-cost health care cases." CMS Br. at 6. CMS suggested, however, that CHIP would pay for case management services only if they involve direct interaction between a patient and a health care provider. *Id.* at 7. In response to the Order, CMS clarified that it did not intend to argue that it would pay for case management only if direct interaction between a patient and health care provider is involved. CMS Response to Order at 6. Instead, CMS says, it "intended to illustrate the difference between case management services focused on health care and Anthem's administrative services." *Id.* CMS does not deny that the costs a health plan incurs in delivering health services in a managed, cost-effective way could include functions such as medical management of cases. CMS asserts, however, that the functions Anthem provided for Colorado's self-funded plan did not include such medical management functions. *Id.* at 7.

The documentation Colorado provided in response to the Order, however, shows that Anthem was contracting to provide, among other things, medical management services such as review of medical necessity, controls on inpatient admission and length of stay, and intensive management of high-cost health care cases. For example, the contract between Colorado and Anthem refers to Anthem receiving "monthly capitation revenues to pay medical and medical management expenses incurred in the performance of work" under the contract. CO Response to Order, Attachment (Att.) 8. The Request for Proposal (RFP) issued by Colorado for the ASO contract refers to the ASO providing functions such as "case management to identify and manage high-risk cases." *Id.*, Att. 1, at 29. The ASO was to provide pharmacy benefit management and a behavioral health

[3] CMS acknowledged in its initial brief that it had "historically allowed states, including Colorado, to include more than ten percent in administrative fees when those expenditures are included in MCO capitated rates . . . ." CMS Br. at 8. The Board's Order pointed out that a regulation in the Medicaid program distinguished MCOs for purposes of determining what costs may be claimed at the FMAP rate and queried whether that regulation applied to CHIP. Order, at 7-8, citing 42 C.F.R. § 438.812. In response to the Order, CMS concedes that the Medicaid regulation does not apply, but asks us to apply it "by analogy." CMS Response to Order at 1-2. In our view, the programs are not analogous. The Medicaid statute defines "medical assistance" to include only payment for part or all of certain listed services provided to eligible individuals. Act , §1905(a). In contrast, "child health assistance" is defined to mean payment of part or all of health benefits coverage provided to eligible individuals.

benefit intended to reduce unnecessary costs for drugs and mental health services for the enrollees in the self-funded plan. *Id.,* Att.1 at 24-25. The RFP required an offeror, among other things, to describe how enrollees would access the "behavioral health system" to be provided, and to explain what types of clinical guidelines it had implemented, and what type of health promotion and disease management programs it had. *Id.,* Att. 1, at 56-63. Anthem's response described its experience, systems, and personnel qualifications in these areas. *Id.*, Att. 7. The response also described the role of Anthem's case managers in assessing member care needs, developing a member-centered case management plan (applying the benefits in the member's health benefit plan), and coordinating the interventions in the plan. *Id.*, Att. 7, at 6-8. In many places, the documents also refer to functions related to managing the network of providers with whom Colorado contracted to provide services under its self-insurance plan.

We also note that the record indicates that Colorado awarded separate contracts for such program administration functions as marketing and outreach for the CHP+ program, and eligibility and enrollment services for the CHP+ program.[4] *Id.*, Att. 1, at 9; CO Br., Att. D, at 9. In other words, major functions associated with operating a CHIP **program** (as opposed to managing a self- insurance plan) were included in separate contracts. In contrast, the Anthem contract focuses on activities related to managing the health care services to be provided by the self-funded plan/SMCN that CMS does not deny are the types of activities that were performed by the HMOs and would be expected to be performed by a third party administrator of a self-insurance plan.

Other than asserting that the activities under the Anthem contract were not in the regulatory list of health care services, CMS did not provide any explanation of why particular activities constituted administration of the CHP+ program, rather than costs of administering the self-funded plan comparable to the costs incurred by the HMOs. CMS's position that all of the functions Anthem performed under the contract were "purely administrative" appears to be based solely on some wording in the contract,

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[4] The regulations on administrative expenditures for CHIP make funding available for "outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in such a program." 42 C.F.R. § 457.622(e)(4).

rather than considering the contract together with the RFP and response, which are incorporated by reference.[5] Based on those documents, we conclude that some of the payments to Anthem under the ASO contract could properly be considered costs of the health benefits coverage provided through the self-funded insurance plan/SMCN and therefore were "child health assistance" within the meaning of that term as used in the CHIP program.

On the other hand, as we discuss next, we also find that not all of the contract payments qualified as "child health assistance."

3. Some functions performed by Anthem were related to the operation of the CHP+ program, and cannot reasonably be considered costs of administering the self-funded plan similar to the administration costs incurred by the HMOs.

The Board's Order to Develop the Record noted that certain statements in Colorado's brief appeared to concede that Anthem did perform some functions related to operation of the CHP+ **program** that were not performed by the HMOs. Order at 10, citing CO Br. at 8. The Order also noted that it appears that the PMPM amount Colorado paid to Anthem is substantially higher than the $13.65 PMPM paid to the HMOs for administrative activities. The Order noted Colorado's argument that the "Self-Funded Plan participants are typically new to the health care system, meaning they often have 'pent up' demand, resulting in above-average claim costs." CO Br. at 4. The Order recognized that the actuary's report appeared to indicate that the projected PMPM costs for health care services for the SMCN population (total costs minus the projected $30.04 PMPM in administration costs) were higher than the PMPM projected costs for the HMOs for health care services (total costs minus the $13.65 PMPM in projected administration costs). The Order noted, however, that these differences in the projected PMPM costs for health care services did not appear to account for the fact that the $30.04 rate the actuary determined for the self-funded plan is more than twice the $13.65 rate for HMOs.

The Order directed Colorado to clarify whether it was conceding that some of the amount paid to Anthem was for program administration, rather than administration of the self-funded plan/SMCN, and to address the discrepancy between the administration rate paid

[5] CMS's reviewer focused on the fact that the contract refers to Anthem acting as "fiscal agent" to process and pay provider claims for Colorado, and she describes the self-funded plan as a "fee-for-service program." CMS Ex. 1. In its response to the Order, however, CMS declined to address whether the self-funded plan qualified as a "managed care entity" under the CHIP regulations, rather than a fee-for-service entity. CMS Response to Order at 1-2. Colorado's response pointed out functions Anthem performed that Colorado's fiscal agent for Medicaid does not. CO Response to Order at 4. We also note that Colorado had negotiated discounts with network providers and paid primary care providers a capitated rate. CO Br. Att. D, at 16; CO Response to Order, Att. 1, at 20 and Att. 4 at 20-28.

to the HMOs and the amount paid to Anthem. In response to the Order, Colorado did not deny that the PMPM rate paid to Anthem for ASO services included costs for some activities related to administration of the CHP+ program. Moreover, this is confirmed by the documentation. For example, the RFP required the offeror to ensure that case management personnel have a thorough understanding of the Supplemental Security Income program and that appropriate referrals are promptly made. CO Response to Order, Att. 1, at 29. This activity appears to be the type of outreach considered an administrative expense under section 457.622(e)(4). The offeror was also to assist Colorado in designing and implementing "State strategies for overseeing the provision of health care services." *Id.*, Att. 1, at 26. Colorado did not assert that the HMOs were also required to perform such functions.

In light of Colorado's apparent concession that some of the costs of the Anthem contract should have been claimed as administrative expenditures and the record as a whole, we are left with the difficulty of parsing what part of the contract expenditures claimed as primary expenditures should be reclassified as non-primary expenditures subject to the 10 percent limit. We turn to that issue next.

4. *The record supports a finding that Colorado incurred $318,635 in non-primary costs in excess of the 10 percent limit for FY 2007.*

Colorado maintains that the PMPM rate it paid Anthem "primarily supported medical management-related services." CO Response to Order at 6. Colorado admits, however, that it cannot provide any detailed itemization of the costs for either the HMOs or Anthem that would permit it to separate administrative from health care delivery related services. *Id.* Indeed, the report on how the actuary set the PMPM administration rate for the self-funded plan for FY 2007 indicates the actuary merely trended forward the FY 2006 rate. *Id.*, Att. 4, at 10, Att. 6.

As indicated above, $13.65 PMPM is the amount that the actuary identified as the rate for the HMOs to administer their plans to deliver the services covered in the CHP+ health benefits package, and CMS allowed the $13.65 PMPM paid to the HMOs to be classified as child health assistance expenditures. Therefore, the Board's Order asked Colorado whether it would have exceeded the 10 percent limit on non-primary CHIP expenditures if it "had charged $13.65 PMPM of the $30.04 paid to Anthem" as program costs/primary expenditures and "the remaining $16.39 of the PMPM amount as administrative expenditures" subject to the limit. Order at 7. In asking this question, the Board used the $30.04 PMPM rate the actuary calculated for the self-funded plan.

In response, Colorado clarified that, since it paid the $2.59 PMPM "stop loss" amount to an independent insurer, it paid Anthem only $27.45 PMPM. CO Response to Order at 7. Colorado went on to say that "assuming $16.39 PMPM was the administrative expenditure subject to the 10% limit results in Colorado's total administrative

expenditures exceeding the 10% limit by $318,635." *Id*; *see also id.,* Att. 3 (showing Colorado's calculations using the $16.39 PMPM). Colorado asserts, however, that calculating $16.39 PMPM as the administrative expenditure subject to the 10 percent limit is flawed. Colorado asserts that "the correct hypothetical administrative expenditure would be $13.80 ($27.45 PMPM - $13.65 PMPM)." *Id.* at 7.

The actuary, however, treated the full $30.04 PMPM as the "administration rate" for the self-funded plan comparable to the $13.65 PMPM administration rate for the HMOs. CO Br., Att. B (Leif Affidavit) ¶ 6. Moreover, the actuary's report identifies the expenses based on which the $13.65 was calculated as including expenses for "reinsurance premiums." CO Response to Order, Att. 4, at 18. Thus, if the $2.59 PMPM for "stop loss" is subtracted from the $30.04 PMPM total administration rate for the self-funded plan a comparable amount should be subtracted from the $13.65 PMPM (leaving $11.06 PMPM). Subtracting $11.06 from $27.45 again gives $16.39. Thus, we conclude that, given the record before us, $16.39 is the best estimate of what part of the PMPM rate paid to Anthem is distinguishable from the amount paid to the HMOs for plan administration and therefore should be treated as subject to the 10 percent limit.

Colorado asserts that the allowable administration costs for the self-funded plan should be higher than the amounts for the HMOs. Colorado offers several justifications for a higher rate, including that the estimated medical costs for self-funded plan enrollees were higher, that service utilization was likely to be higher for new enrollees not yet covered by an HMO (the "pent up demand" theory), and that only the self-funded plan provided prenatal services (which can be more costly that ordinary CHP+ services). Colorado Response to Order at 5-7. In our view, these factors are sufficient to indicate that the PMPM allowable costs for the self-funded plan were likely at least as high as the PMPM allowable costs for the HMOs. Colorado has not, however, provided sufficient evidence based on which we can reasonably quantify what effect any of these factors had on the rate.

Thus, we conclude that, based on this record, the appropriate way to recognize what part of the payments to Anthem were costs of administering the self-funded plan/SMCN is to allow the same rate as the actuary calculated for the HMOs (minus the stop loss amount that was already allowed). Anthem performed activities for the self-funded plan/SMCN that were sufficiently similar to those the actuary described as included in the HMO administration rate. While we do not accept Colorado's proffered justifications for a higher rate for the self-funded plan, nothing in the record suggests that the costs for the self-funded plan were likely to be lower than comparable costs for the HMOs.

For purposes of this decision, we therefore accept Colorado's calculation showing that, when $16.39 PMPM of the payments to Anthem are reclassified to the administrative expense category, Colorado exceeded the 10 percent limit by $318,635. CMS did not provide any different calculation for this amount although the Board's Order permitted

CMS to respond to questions addressed to Colorado and to discuss any other relevant matter.

Conclusion

For the reasons stated above, we uphold the disallowance, but in the reduced amount of $318,635.

/s/
Stephen M. Godek

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member