CLIENT ALERT

CMS Announces Medicare Advantage and Prescription Drug Program MLR Proposed Rule—Largely Follows Commercial MLR Rules

Feb.21.2013

CMS Announces Medicare Advantage and Prescription Drug Program MLR Proposed Rule—Largely Follows Commercial MLR Rules

On February 15, 2013, CMS issued a proposed rule implementing the Affordable Care Act's (ACA) medical loss ratio requirement for Medicare Advantage and the Prescription Drug Program (PDP) as set forth in section 1103 of Title I, Subpart B of the Health Care and Education Reconciliation Act. The ACA requires Medicare Advantage Organizations (MAOs) and Part D sponsors (referring to stand-alone Part D, as opposed to MA-PD, contracts) to spend 85% of contract revenue (including any member premiums) on the provision of clinical services, prescription drugs, quality improving activities (as defined in the proposed rule) and direct benefits to beneficiaries via reduced Part B premiums. The MLR rule will be effective January 1, 2014. The proposed rule is scheduled for publication in the Federal Register on February 22, 2013, with comments due by April 16, 2013.

In addition to the 85% MLR requirement, the key features of the proposed rule are as follows:

- MLR reported on a contract basis, rather than by state and market (as the commercial MLR rule requires), meaning that an MA-PD must combine non-drug costs and revenues with prescription drug costs and revenues across all plans under the contract;
- MLR would be calculated based on the cost and revenue data for a contract year, a one-year period;
- MAOs and Part D sponsors that fail to meet the 85% MLR must pay CMS "remittance payments" (similar to the commercial MLR rules' rebates) calculated as: total contract revenue x (0.85 – contract's MLR);
- MAOs and Part D sponsors would be required to report to CMS information including, but not limited to, the data needed to calculate and verify the MLR and any remittance payments;
- The first year of reporting would be in 2015 for the 2014 contract year;
- MAOs and Part D sponsors would be required to retain the data reported and related documentation for ten years and to require third-party vendors to be able to timely obtain and validate underlying data associated with their services prior to the preparation and submission of the MLR report to CMS;
- Failure to meet the 85% MLR for three or more consecutive contract years shall result in suspension of enrollment in the second year after the third consecutive MLR shortfall (because MLR reporting occurs the following contract year, the earliest the sanction could be in effect is the year after the report), *e.g.*, if an MAO fails to meet the 85% MLR for 2014, 2015, and 2016, the 2016 failure would be reported in 2017 and the sanction would be in effect for the 2018 contract;
- Failure to meet the 85% MLR for five consecutive contract years shall result in termination of the contract in the second year after the fifth consecutive shortfall, *e.g.*, if an MAO fails to meet the 85% MLR for 2014 – 2018, the 2018 failure would be reported in 2019 and the contract would be terminated in 2020;

- Failure to comply with the requirements to provide timely and accurate MLR reporting information would constitute grounds for contract termination, as well as other intermediate sanctions and civil monetary penalties.

Applicability

The proposed rule would apply to MAOs, Part D sponsors, and the Part D components, if any, of Cost Health Maintenance Organizations/Competitive Medical Plans (cost HMOs/CMPs) and Health Care Prepayment Plans (HCPPs). To the extent that a cost HMO/CMP or HCPP failed to satisfy the MLR requirement for the Part D portion of benefits, it would be subject to the same penalties and remittance requirements as MAOs and Part D sponsors (*e.g.*, suspension of enrollment in Part D after three consecutive years of MLR shortfalls, etc.).

The Medicare MLR rule would not apply to All-Inclusive Care for Elderly (PACE) plans offering Part D. CMS explained that PACE organizations are required to provide drug coverage, and potential termination of a PACE organization's Part D participation would effectively terminate the PACE organization itself. CMS has elected to waive the MLR requirement with respect to PACE organizations, reasoning that application of the MLR requirement would conflict with the intent of the PACE statute and its implementing regulations.

The Commercial MLR Rules & Calculation

The proposed rule generally tracks the requirements set forth in the medical loss ratio for commercial plans, albeit with some Medicare-specific changes. By way of summary, the commercial MLR rules generally require commercial health insurers to spend at least 80% (in the individual and small group markets) and 85% (in the large group market) of premiums on provision of care. Insurance companies that fail to do so are required to provide rebates to beneficiaries. Health insurers are permitted to "increase" their MLR by including in the numerator certain amounts spent on quality improvement activities in addition to amounts spent on claims.

A simplified version of the commercial MLR calculation is:

$$\frac{\text{Incurred Claims (including changes in contract reserves)} + \text{Quality Improvement Expenses}}{\text{Earned Premiums - Federal Taxes, State Taxes, Assessments, and Fees}} + \text{Cre}\ \text{Adj}\ \text{t}$$

The proposed rule estimates (based on 2013 bids) that 14% of MA-PD contracts and Part D standalone contracts will be required to make a remittance payment to CMS for the 2014 contract year.

The Proposed Medicare MLR Calculation

CMS has explained that it is using the commercial MLR rules as the "reference point" for the Medicare MLR requirements to limit the burden on entities that participate in both markets and to facilitate comparison and evaluation of commercial and Medicare plans.

The proposed rule's Medicare MLR calculation is:

$$\frac{\text{Incurred Claims} + \text{Reduction in Part B Premium for Enrollees} + \text{Quality Improvement Expenses} - \text{Prescription Drug Rebates} - \text{Overpayment Recoveries}}{\text{Total Contract Revenue} - \text{Federal Taxes and Fees} - \text{State Taxes, Assessments, and Fees} - \text{Community Benefit Expenditures (for tax-exempt MAOs)}} + \text{Cre}\ \text{Adj}\ \text{t}$$

The Numerator

"Incurred claims" includes direct claims that an MAO pays to providers (such as under a capitation contract), drug costs that are actually paid by the Part D sponsor (meaning claims net of any rebate or indirect remuneration) including the reinsurance portion of claim costs in the catastrophic portion of the benefit, the amount of any provider incentive and bonus payments, and several additional factors to be codified at 42 C.F.R. §§ 422.2420(b)(2)(iii) – (xi) and 423.2420(b)(ii) – (x). Where an MAO or Part D sponsor has an assumptive or 100% indemnity reinsurance agreement, the ceding entity may not report any incurred claims for the contracts under the agreement. Rather, the assuming entity must report those claims as incurred claims. Medicare plans would follow the same guidance as has been provided for commercial plans permitting plans to treat as claims expense payments to risk-bearing entities that furnish or arrange for the provision of care and meet certain criteria. In contrast, if the plan pays a vendor that does not meet those criteria, the only amount that could be counted as claims expense would be the amount that the vendor pays to the provider, rather than any higher amount that might be paid by the plan to the vendor. The plan could also include amounts that qualify as quality improvement activity expense.

Unlike the commercial MLR statutory requirement, the Medicare MLR statutory provision does not include language regarding expenditures on quality improvement activities. Nevertheless, the proposed rule provides that MAOs and Part D sponsors may include certain quality improvement expenses in the numerator of the MLR. Like the commercial MLR rules, the proposed rule would permit MAOs and Part D sponsors to count a non-claims expense as a quality improvement activity if it is designed to improve health outcomes, prevent readmissions to hospitals, improve patient safety, promote health and wellness, or enhance the use of health care information technology. In addition to fitting within one of those broad categories, the activity must be designed to meet all of the following criteria: (1) improve health quality; (2) increase likelihood of desired health outcomes in ways that are capable of objective measurement and producing verifiable results; (3) target individual enrollees or specified segments of enrollees or provide benefits beyond the population of enrollees without increasing costs to enrollees; and (4) be grounded in evidence-based medicine. Quality improvement activities may satisfy more than one category, but may not be double-counted. Moreover, any shared quality improvement expenses must be apportioned among entities and lines of business or products.

Notably, MAOs may include in the numerator the amount by which the Part B premium is reduced, if any, for the MA plans under the contract for the contract year. CMS explained that because a Part B premium reduction is a permissible use of Part C rebate dollars under 42 C.F.R. § 422.266(b) (based on the MAO's savings, and not to be confused with any MLR-related rebate), MAOs may include it in the numerator. This may nudge more MAOs to use the Part C rebate dollars in this way, as CMS also stated that MAOs must account for Part C rebates in the denominator as part of Total Contract Revenue. Thus, an MAO may offset the impact of including the Part C rebate in the denominator by using it to reduce Part B premiums in the numerator.

The Denominator

"Total Contract Revenue" includes CMS payments for all enrollees under a contract, direct subsidy and reinsurance payments, premiums paid by or on behalf of enrollees, low-income subsidy payments, changes in unearned premium reserves, risk corridor payments, and unpaid premium amounts that an MAO or Part D sponsor could have collected from enrollees under the contract. MAOs and Part D sponsors would be permitted to exclude from total contract revenue the amount of unpaid premiums that they made a reasonable effort to collect, in accordance with 42 C.F.R. §§ 422.74(d)(i) and 423.44(d)(1)(i).

Credibility Adjustment

The credibility adjustment is used to mitigate the risk of claims variability faced by contracts with fewer members. The credibility adjustment is designed to increase a contract's MLR. MAOs with contract enrollment greater than or equal to 2,400 member months but less than 180,000 member months shall be deemed to have "partially credible" experience and shall be entitled to a credibility adjustment ranging from 8.4% (for 2,400 member months) to 1.0% (for 180,000 member months). Part D sponsors with contract enrollment between 4,800 member months and 360,000 member months shall be deemed to have "partially credible" experience and shall be entitled to a credibility adjustment ranging from 8.4% (for 4,800 member months) to 1.0% (for 360,000 member months). MAO and Part D sponsor contracts with experience above threshold for partial credibility shall be deemed to have "fully credible experience" and shall not receive a credibility adjustment. If an MAO or Part D sponsor contract is below the minimum threshold for partial credibility, CMS has indicated that it will not enforce sanctions, penalties, or remittances if the contract does not satisfy the 85% MLR requirement.

Areas for Comment and Development

Despite significant differences in benefits provided between Medicare Advantage and Part D plans, and the efforts of some Part D sponsors to the contrary, MAOs and Part D sponsors are subject to the same MLR standard. Part D sponsors provide prescription drug coverage, which is but a fraction of the total benefits offered by an MAO, yet incur substantially similar administrative costs. While CMS has demonstrated willingness to waive penalties and take a more flexible approach to implementing or enforcing the MLR requirement—such as the proposed rule's waiver for PACE plans—the express statutory language imposing the MLR requirement specifies an MLR of 85%. Indeed, section 1103 explicitly targets Medicare Advantage, but also impacts Part D because the Part D program incorporates by reference the requirements of Social Security Act Section 1857(e), as amended by the ACA. Thus, there may not be much wiggle room, if any, for Part D sponsors to modify or mitigate the 85% MLR requirement.

Furthermore, the proposed rule has not established the timing for when MAOs and Part D sponsors must report the data needed to calculate and verify the MLR and any remittance payments. CMS specifically invited comment on the timing of the report and outlined several possible timeframes. CMS is considering requiring reporting: (1) in July, before risk adjustment

reconciliation is complete; (2) in September, after risk adjustment reconciliation but before Part D reinsurance and risk corridor reconciliation; or (3) in December after Part D reinsurance and risk corridor reconciliation—though this would be after the start of open season and could result in disruptions for members who are newly enrolled in plans that are subject to suspension or termination sanctions.

Click here for a brief PowerPoint summary [PDF].

The material contained in this memo is provided solely for informational purposes and is considered attorney advertising. Prior results do not guarantee a similar outcome.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Kevin B. Kroeker
Partner – Los Angeles
Phone: +1 213.443.5586
Email: kkroeker@crowell.com

A. Xavier Baker
Partner – Washington, D.C.
Phone: +1 202.624.2842
Email: xbaker@crowell.com

Jacinta Alves
Partner – Washington, D.C.
Phone: +1 202.624.2573
Email: jalves@crowell.com