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CMS Releases Proposed Rule on Medicare Advantage and Medicare Prescription Drug Plan MLR Requirements

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Background: What is an MLR?

- MLR stands for Medical Loss Ratio.
- An MLR is expressed as a percentage, generally representing the percentage of revenue used for patient care, rather than for such other items as administrative expenses or profit.
- Sometimes also referred to as a Health Benefit Ratio or HBR.

Background: Commercial MLR Regulations

- ACA enacted a new MLR requirement for issuers of employer group and individual market private insurance.
- CMS issued an interim final rule implementing this “private insurance” or “commercial” MLR on 12/1/2010 and has made various revisions and technical corrections since then.
- Under that IFR, health insurance issuers must report an MLR and related supporting data by state and market (individual, small group or large group).

Background: Commercial MLR Regulations

- Generally, the minimum MLR requirement is 85% in the large group market and 80% in the small group or individual market.
- CMS adopted NAIC's calculation methodologies.
- If the required MLR threshold is not met, health insurance issuers must provide a rebate to enrollees.

Commercial MLR Performance Report

- 24.5% of health insurers did not meet MLR standards in at least one market in 2011 and therefore owed rebates to beneficiaries.
- Rebates totaled about $1.1 billion, an average of $137 per family, based on 13.1 million families getting rebates.
- Profits for companies owing rebates averaged 5.2% after payment of expenses, taxes, and rebates.

MA and PDP MLR Proposed Rule

- CMS released Proposed Rule on Feb. 15, 2013, and it will be published in the Federal Register on Feb. 22, 2013.
- These new MLR requirements apply to both the Medicare Advantage and Part D program.
  - Does not apply to PACE Organizations
- MA orgs and Part D sponsors are now required to report their MLR and supporting data, and are subject to financial and other penalties if they fail to have an MLR of at least 85%.
- CMS largely used the Commercial MLR rules in developing the MA/PDP MLR proposed rule.

How Would the MA/PDP MLR Calculated?

- MLR = contract "costs" / contract "revenues"
  - Numerator: the amounts spent on incurred claims (cost of clinical services, prescription drugs), activities that improve health care quality, and direct benefits to beneficiaries in the form of reduced Part B premiums.
  - Denominator: total revenue minus certain licensing and regulatory fees; federal and state taxes and assessments; and community benefit expenditures.
- MA orgs and Part D sponsors allowed to increase MLRs of low-enrollment contracts with a credibility adjustment.
  - MA-PD Contracts < 180,000 MM; PDP Contracts < 360,000 MM

What Happens If MLR Drops Below 85%?

- ACA requires 3 levels of sanctions for failure to meet the 85% minimum MLR requirement:
  - Remittance of funds to CMS in the amount equal to the product of (1) the total revenue under the contract for the contract year; and (2) the difference between 0.85 and the contract's MLR.
  - Prohibition on enrolling new members if fail to meet the 85% threshold for 3 or 4 consecutive years.
  - Contract termination if fail to meet the 85% threshold for 5 consecutive years.
- Also, failure to provide accurate and timely MLR data can result in termination, intermediate sanctions, and civil money penalties

How Do the MA/PDP MLR Rules Differ From the Commercial MLR Rules?

- MA /PDP MLRs will be reported on a contract basis, rather than by state and market.
- If 85% threshold not met, remit to CMS rather than to enrollee.
- 1-year reporting period in contrast to 3-year blended reporting for commercial issuers.
- The numerator includes the amount to reduce the Part B premium, if any, for all MA plans under the contract for the contract year.

CMS's Predictions

- Estimates for CY 2014 remittances are $717 million for MA-PD contracts and $141 million for Part D stand-alone contracts (based upon CY 2013 bid data).
- Estimate 14% of the total contracts subject to the remittance requirement will be required to pay a remittance.
- Each MA org and Part D sponsor would incur approximately a $16,000 one-time administrative cost (per report), and about $5,000 in annual ongoing administrative costs (per report) to comply with requirements.

Why?

"The new minimum MLR requirement… is intended to create incentives for MA organizations and Part D sponsors to reduce administrative costs, and marketing, profits, and other uses of the funds earned by plan sponsors and help to ensure that taxpayers and enrolled beneficiaries receive value from Medicare health plans."

Why? (Cont.)

"[G]reater market transparency and improved ability of beneficiaries to make informed insurance choices. The uniform reporting required under this proposed rule, along with other programs such as www.Medicare.gov, a website with plan-level information, will mean that beneficiaries will have better data to inform their choices, enabling the market to operate more efficiently."

Comments on the Proposed Rule Due By April 16, 2013.