MILLIMAN WHITE PAPER

# Medicare Advantage and Part D: Compliance for actuaries

Chris Girod, FSA, MAAA
Shyam Kolli, FSA, MAAA

Milliman

Operating Medicare Part C (Medicare Advantage) and Part D (prescription drug) plans has become increasingly complicated. The Patient Protection and Affordable Care Act (ACA) and a growing number of rules and regulations added each year have ballooned the complexity and associated compliance burden for the health insurance companies that sell and administer these plans.

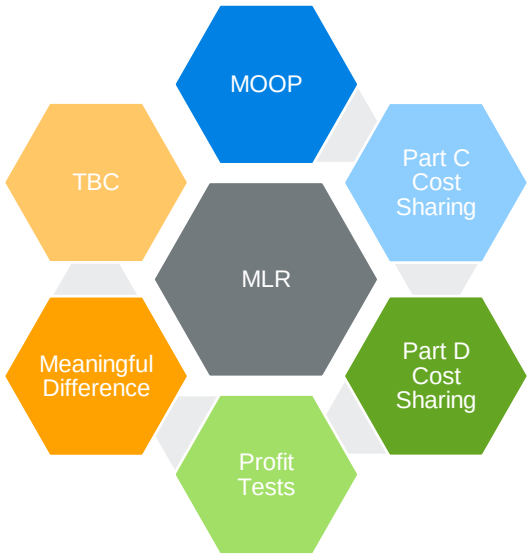
This paper focuses on one relatively narrow area of rules that is sometimes loosely referred to as actuarial compliance, and serves as a primer for actuaries or other professionals who are tasked with understanding and following these rules.

Actuaries are instrumental in developing the bids that plan sponsors submit annually to the Centers for Medicare and Medicaid Services (CMS). Those bids include a plan benefit package (PBP), which defines each plan's benefits, and Part C and Part D bid price tools (BPTs), which define the revenue a plan sponsor needs to cover its benefits, administrative expenses, and profit. The bid submission includes a set of supporting documentation describing how the financial projections were developed and demonstrating compliance with the myriad of bidding rules, including some of the compliance tests described in this paper.

Figure 1 identifies the primary tests discussed in this paper. During desk review, which occurs annually in June and July, CMS independently confirms that the bids pass these compliance tests. If a plan sponsor[1] submits a bid that fails one or more of the tests, CMS can elect to disapprove the bid. Therefore, it is critical that plan sponsors understand the tests and confirm compliance before bids are submitted.

In addition to the desk review, a more in-depth review may occur during a CMS bid audit. Plan sponsors should expect a bid audit every three years if there are no major issues uncovered in prior audits. Bid audits are conducted beginning in September, and typically last for several months. Noncompliance identified during a bid audit may result in further action from CMS.

**FIGURE 1: KEY TESTS FOR PART C AND PART D BID COMPLIANCE[2]**




## Compliance tests support CMS goals

The compliance tests support CMS's goals around affordability, equity, quality, and access. Consumer protection is a high priority. CMS pledges "putting patients first" and "supporting innovative approaches to improve quality, accessibility and affordability while finding the best ways to use technology to support patient-centered care." CMS also strives to advance equity by improving quality for underserved Medicare beneficiaries.[3] As illustrated through the various compliance tests discussed in this paper, CMS supports its goals by ensuring that private Medicare plans:

- Provide benefits at least as rich as traditional Medicare
- Limit annual increases in premium rates and cost sharing
- Limit the proportion of premium and other plan revenue that fund administrative expenses and profit
- Offer plan benefits that are clearly discernable to consumers
- Are stable financially, with sufficient enrollment to survive long-term

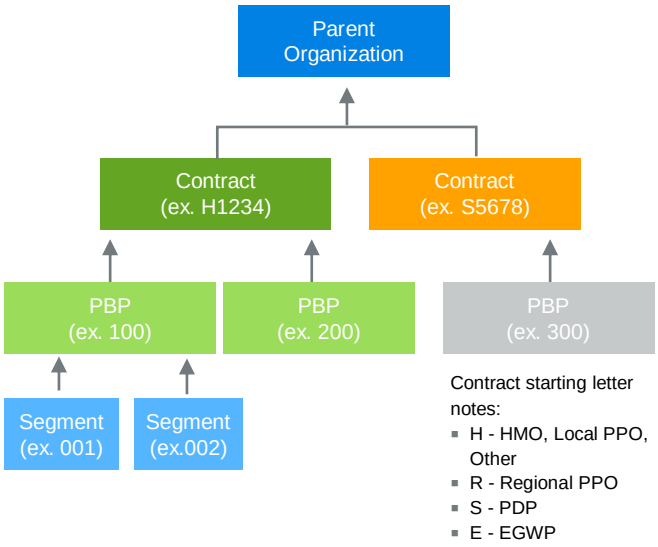
[1] Plan sponsors can offer MA/PD plans (with both medical and prescription drug coverage), Medicare Advantage (MA) plans with medical services only, or prescription drug plans (PDPs), standalone plans covering only prescription drugs.

[2] The meaningful difference requirement for MA (and MA/PD) plans was removed for 2019. PDP plans still have to comply with meaningful difference requirements for 2019.

[3] See the CMS website at https://www.cms.gov/.

In this paper, we discuss each of the tests shown in Figure 1. We expect that readers will have basic familiarity with Medicare Parts C and D, including definitions of different plan types and the relationships between parent organizations, contract numbers, PBPs, plan segments (as illustrated in Figure 2), and how they relate to service areas. Appendix A provides definitions of some key terms that are important for understanding the compliance tests.

**FIGURE 2: PLAN IDENTIFICATION HIERARCHY**




## MOOP limits

CMS establishes annual limits on enrollee out-of-pocket spending for Part C. The limits are published each year in a Call Letter, in early April. For MA/PD plans, the maximum out-of-pocket (MOOP) limit is only for medical coverage. Reaching the MOOP does not affect Part D coverage. CMS classifies MOOPs as either voluntary or mandatory. Voluntary MOOP amounts are lower than mandatory MOOP amounts. For plans adopting the lower voluntary limits, CMS allows additional flexibility in other aspects of Part C plan designs relative to plans that adopt the higher mandatory MOOPs.

### WHAT ARE THE LIMITS?

For 2019, the upper limit on voluntary MOOPs is $3,400 for health maintenance organization (HMO), HMO-point of service (POS) (in-network), preferred provider organization (PPO, in-network), and private fee-for-service (PFFS) plans. For PPOs using combined in- and out-of-network MOOPs, the voluntary upper limit is $5,100. Corresponding upper limits on mandatory MOOPs are $6,700 for HMO, HMO-POS (in-network), PPO (in-network), and PFFS plans. For PPOs using combined in- and out-of-network MOOPs, the mandatory upper limit is $10,000.

The mandatory MOOP upper limit has been the most popular choice among MA plans, with approximately 49% of plans using this limit in 2018, while 17% of plans used the voluntary MOOP limit.[4]

### APPLICABILITY

All bids, including those for employer group waiver plans (EGWPs), dual-eligible special needs plans (D-SNPs), chronic care special needs plans (C-SNPs), and institutional special needs plans (I-SNPs) have to comply with MOOP limits. MOOP limits do not apply to 1876 cost plans.

## Part C cost sharing

CMS enforces two types of Part C cost-sharing standards:

- Per member per month (PMPM) actuarial equivalent cost sharing
- Service category cost-sharing limits

### PMPM ACTUARIAL EQUIVALENT COST SHARING

This test ensures that MA cost sharing PMPM for certain Part A and Part B services does not exceed cost sharing for the same services in traditional Medicare, on an actuarially equivalent basis. Cost sharing is evaluated for the following major service categories:

- Inpatient
- Skilled nursing facility (SNF)
- Durable medical equipment (DME)
- Part B Rx

Excess cost sharing is identified by comparing two values found in Worksheet 4 of the Part C BPT. An example is included in Table 24 on page 198 of the 2019 Call Letter.

### APPLICABILITY

All bids, including EGWPs and all SNPs, have to comply with this test. However, EGWPs are no longer required to submit BPTs, which means that CMS can only run the test during audits.

### SERVICE CATEGORY COST SHARING

CMS requires enrollee cost sharing in Part C plan designs to be less than the amounts shown in Table 25 on page 201 of the 2019 Call Letter. CMS may update these limits from year to year. The cost-sharing limits generally only apply to in-network Part A and Part B services, unless otherwise indicated. For example, in 2019, copays for in-network primary care physician services cannot exceed $35. CMS allows higher cost-sharing limits for plans that adopt the voluntary MOOP limits compared to plans that adopt the mandatory MOOP limits. For example, copays for

[4] Medicare.com. What is MOOP or the Medicare Advantage maximum out-of-pocket limit? Retrieved April 17, 2018, from https://q1medicare.com/q1group/MedicareAdvantagePartDQA/FAQ.php?faq=What-is-MOOP-or-the-Medicare-Advantage-maximum-out-of-pocket-limit-&faq_id=605&category_id=149.

emergency care cannot exceed $120 for plans adopting voluntary MOOPs, or $90 for plans adopting mandatory MOOPs.

CMS has not established specific cost-sharing limits for all services. MA plans that use coinsurance or copays on Medicare-covered services for which CMS has not established a specific limit must restrict cost sharing to 50% or less of the contracted rate (for in-network services), and must provide documentation demonstrating that the 50% rule is satisfied.

This supporting documentation is submitted through the Health Plan Management System (HPMS) section titled "Cost Sharing Justification," which is applicable for MA plans but not standalone PDPs.

#### APPLICABILITY

All bids, including EGWPs and all SNPs, have to comply with service category cost-sharing limits.

## Part D cost sharing

Part D sponsors can offer four different plan types: 1) Defined Standard, 2) Actuarially Equivalent, 3) Basic Alternative, and 4) Enhanced Alternative. The first three types are sometimes collectively referred to as Basic coverage, because they all offer a level of coverage that is actuarially equivalent to the Defined Standard plan.

CMS provides the Defined Standard Part D plan parameters in the Final Payment Notice and Call Letter. For the other three plan types, Chapter 5 of the Prescription Drug Benefit Manual provides detailed guidance on plan design requirements and restrictions. These requirements are tied to deductible, cost sharing in the pre-initial coverage limit (ICL) phase, cost sharing in the coverage gap, and supplemental premium. In addition, CMS does not permit PDPs to offer enhanced alternative coverage in a service area unless they also offer plans that provide Basic coverage in that service area. MA/PDs can offer enhanced alternative coverage without offering basic coverage, but they must offer at least one plan in each service area having a $0 Part D supplemental premium, after application of Part A/B rebate dollars.

Table 26 on page 231 of the 2019 Call Letter provides maximum copay amounts and maximum coinsurance percentages that will be allowed for each formulary tier in 2019.

## Profit tests

CMS does not explicitly define maximum allowable profit targets (called "gain/loss margins" by CMS) for Medicare bids. However, CMS requires that MA and Part D plan sponsors pass certain reasonableness tests. The tests apply to gain/loss margin assumptions in the bids and apply at two levels:

- Bid level
- Aggregate level

#### PROFIT TARGETS: BID LEVEL

Gain/loss margin requirements at the bid level are very similar for MA and Part D bids. Both types of bids have flexibility in setting margins. However, they have to comply with the following principles and guidelines:

- Bids must provide benefit value in relation to the margin
- Very high or low margins may draw more scrutiny from bid reviewers and auditors, and may be rejected
- Negative margins necessitate a "business plan" demonstrating return to profitability within five years, unless the benefit plan can be "paired" with another benefit plan having a positive margin

#### PROFIT TARGETS: AGGREGATE LEVEL

This test compares enrollment-weighted average gain/loss margins for groupings of Medicare bids to the company's profit requirements for other lines of business, or to return-on-investment (ROI) requirements if the company does not have other lines of business. For this test, plan sponsors must:

- Select a level of bid aggregation
- Define their corporate margin requirements

The level of aggregation describes how the plan sponsor's bids will be grouped together for purposes of demonstrating compliance with the test. Bids may be aggregated at the 1) organization level, or 2) parent organization level.

CMS expects that over the long term the gain/loss margin assumptions used by actuaries in the bids are consistent with the actual gain/loss experience.

Corporate margin requirements can be defined either based on the company's target margin for non-Medicare lines of business or using a "risk-capital-surplus" approach. The risk-capital-surplus approach must be used when the plan sponsor does not have any non-Medicare business, or when the premium volume of the company's non-Medicare business for which it has discretion in premium rate setting is less than 10% of the company's total non-Medicare business. Once the corporate margin requirement is defined, the following tests are performed.

#### PROFIT TESTS: PART C

For general enrollment plans, I-SNPs, and C-SNPs, if the corporate margin basis is "non-Medicare," then the MA bid profit margin should be within +/- 1.5% of the non-Medicare business margin. For example, if the corporate margin target on non-Medicare business is 3%, then the MA bid margin must be between 1.5% and 4.5%. If the corporate margin basis is a risk-capital-surplus approach, then the aggregate MA margin should be set "considering the degree of risk and capital/surplus requirements" of MA and Part D business. The aggregate margin requirements for D-SNPs plans are similar, but the limits vary from those applicable to general enrollment plans, I-SNPs, and C-SNPs. The margin requirements for D-SNPs vary depending on whether or not general enrollment plans, I-SNPs, and C-SNPs are offered. In general, D-SNP margins must be within -5% and 1% of the margin of other Medicare products, and within -5% and 1.5% of the corporate margin requirement.

#### PROFIT TESTS: PART D

For standalone PDP plans, the Part D aggregate profit level test is very similar to the Part C profit test of MA plans. MA/PD plans, however, have two options for setting their Part D margins:

1. Set Part D margins at the bid level. Margins can vary by bid, but each bid's Part D margin must be within 1.5% of the margin on the corresponding Part C bid.
2. Set Part D margins at the "plan-category level" (i.e., D-SNPs vs. general enrollment plans and other SNPs). All Part D margins in each plan category must be equal and must be within 1.5% of the corresponding aggregate MA margin.

## Meaningful difference

CMS requires plan sponsors offering more than one benefit plan in a service area to comply with a meaningful difference test. CMS estimates and compares each plan's out-of-pocket cost (OOPC) to identify meaningful differences in benefits across the same plan types. CMS's OOPC model uses information from the PBP and formulary files submitted by plan sponsors to estimate out-of-pocket costs. No plan-specific experience is considered in the OOPC model.

#### MA PLANS

For 2018, MA and MA/PD plans were considered meaningfully different if their expected OOPC differed by at least $20 PMPM. However, for 2019, CMS has eliminated the $20 meaningful difference requirement. The 2019 Call Letter promises that additional guidance on meaningful differences is forthcoming from CMS.

#### PDP PLANS

For 2018, PDP plans are meaningfully different if their out-of-pocket costs differ by at least $20 PMPM between Basic and Enhanced Alternative (EA) plans, and by at least $30 among EA plans if more than one is offered. Testing must be done for each PDP region. For 2019, CMS is eliminating the meaningful difference requirement between EA plans, but keeping the meaningful difference between Basic and EA plans. This threshold has been increased to $22 for 2019 as shown in Table 26, on page 231 of the 2019 Call Letter.

## Total Beneficiary Cost (TBC)

CMS monitors the change in expected beneficiary expenses from one year to the next using a metric called TBC that captures the combined financial impact on enrollees of premium changes and cost-sharing changes. The TBC test helps protect beneficiaries from large increases in premium and cost sharing and large reductions in benefits. This test only applies to MA and MA/PD plans, and not to standalone Part D plans.

#### HOW IS IT TESTED?

Enrollee out-of-pocket costs are measured with the OOPC model, and added to the plan-specific Part B premium and the MA or MA/PD plan premium. The TBC amount may not change from one year to the next by more than a threshold. CMS updates this threshold in the Call Letter every year. The TBC change threshold is $36 for changes from 2018 to 2019.

#### ADJUSTMENTS AND ALLOWANCES

CMS incorporates two types of adjustments into the TBC calculation to account for other changes from one year to the next. They are categorized as technical adjustments and payment adjustments. Technical adjustments include:

- OOPC model changes. The model is updated annually to reflect inflation and other healthcare system changes. CMS makes an adjustment to each plan's TBC calculation to offset OOPC changes resulting solely from changes in the model.
- Changes to the maximum allowable Part B premium buy-down amount. Although it is no longer common, in the past some MA plans have used their Part A/B rebate dollars to buy down enrollees' Part B premiums. When such a buy-down occurs, the TBC formula gives the health plan credit for the amount of the buy-down, recognizing that it reduces the enrollee's total out-of-pocket expenses.

The other type of adjustment, payment adjustments, includes changes in a health plan's funding from CMS due to:

- Changes in county benchmarks
- Changes to plan star ratings, which can impact county benchmarks and rebate percentages

CMS has historically provided TBC calculation examples in the annual "Medicare Advantage Bid Review and Operations Guidance" memo. That document also describes other rules on how the TBC test is performed for plans that consolidate or are segmented.

## Medical Loss Ratio (MLR)

Starting in 2014, MA and Part D plans were required to report their MLRs and meet a minimum requirement of 85% at the contract level. This requirement was established to ensure that plans provided significant value to enrollees and taxpayers and to reduce the use of funds for administrative expenses and profits. Plan sponsors are subject to financial and other penalties if they fail to meet the minimum.

The MLR calculations for MA and Part D plans are similar to those of commercial health plans, but with a few key differences. CMS provides detailed information about Medicare MLR reporting on its website.[5]

## Other rules

CMS requires MA and Part D sponsors to comply with many other rules. Some of the other notable rules actuaries have to be aware of are discussed below.

### PLANS WITH LOW ENROLLMENT

CMS evaluates and implements low enrollment requirements on an annual basis. CMS may choose to terminate plans that have been in existence for more than three years and have fewer than 500 enrollees as a non-SNP plan, or fewer than 100 enrollees as a SNP plan. The low enrollment requirements do not apply to MSA plans, 1876 cost plans, and employer plans. There are also some exceptions to the minimum enrollment threshold. For example, plans with low enrollment located in service areas that do not have a sufficient number of competing options of the same plan type will not be terminated.

Low enrollment plans can provide justification for renewal, which CMS evaluates on a case-by-case basis.

### PART C OPTIONAL SUPPLEMENTAL BENEFITS

CMS wants to ensure that enrollees electing optional supplemental benefits receive reasonable value and that benefits are not discriminatory against enrollees having specific health needs. Compliance testing is performed at the contract level, and requires that:

- The gain/loss margin is no greater than 15% of premium
- The gain/loss margin + non-benefit expenses are no greater than 30% of premium

## Resources to support bid development and compliance testing

CMS makes available a variety of resources to help plan sponsors construct their bids and perform the required compliance testing. Those resources include:

- Early Preview of Medicare Advantage Growth Rates, in November
- Advance Payment Notice, in February
- Final Payment Notice and Call Letter, and Final Rule, in early April
- Medicare Advantage Bid Review and Operations Guidance memo, in early April
- Part C and Part D Actuarial User Group calls
- Actuarial bid training
- PBP and BPT instructions
- Medicare Managed Care Manual and Prescription Drug Benefit Manual
- Health Plan Management System (HPMS) memos

The resources listed above include those most relevant to bid development and the compliance testing discussed in this paper. CMS releases other notifications and modules during the year, many of which are listed in the calendar published near the beginning of the Call Letter.

## Caveats and limitations

The information in this paper is intended to assist actuaries and management at MA and Part D plans with understanding bid compliance requirements. MA and Part D rules are continually evolving. This paper reflects our best understanding of the current rules. To the extent that the rules and requirements change in the future, the compliance rules in this paper may no longer be valid. Additionally, this paper is only a brief summary and does not capture every item in the rules. This paper may not be appropriate for other purposes, and our interpretations should not be relied on as legal interpretations. Please consult your legal counsel for legal interpretations.

The material in this report represents the opinion of the authors and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views in this report related to Medicare Advantage and Part D compliance.

[5] CMS.gov (November 28, 2017). Medical Loss Ratio. Retrieved April 17, 2018, from https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/MedicalLossRatio.html.

## Appendix A: Commonly used terms

**Bid:** The MA or PDP carrier's projection of what it costs to cover a single beneficiary. This includes projections of claim costs, administrative expenses, and profit. The term "bid" is often also used to refer to the package of BPT, PBP, supporting documentation, and other required items that is submitted to CMS by the health plan.

**BPT:** Bid pricing tool, an Excel workbook used to document pricing of MA and Part D plans.

**Contract:** The contract between CMS and an MA or Part D plan pursuant to which the company offers plans in a specified service area or region.

**EGWP:** Employer group waiver plan, MA or Part D plans that are offered to large employers.

**HMO:** Health maintenance organization, Medicare Advantage plans that offer in-network coverage only.

**HMO-POS:** HMO-point of service, Medicare Advantage plans that offer comprehensive in-network benefits like HMOs, but also offer out-of-network benefits for specified services.

**LPPO:** Local preferred provider organization, serving the counties included in the plan's service area. These plans offer comprehensive in-network benefits and benefits at higher cost sharing for out-of-network.

**MA/PD:** Medicare Advantage/prescription drug, plans that provide both medical and prescription drug coverage and meet all requirements of both Parts C and D.

**MSA:** Medical savings account, a type of MA plan having a high deductible and a savings account that can be used to pay for healthcare costs.

**Parent organization**: An organization that holds at least the majority of the voting stock in a legal entity that holds an MA or Part D contract.

**PBP:** Plan benefit package, a set of benefits for an MA or Part D plan.

**PDP:** Prescription drug plan, standalone plans that meet all requirements of Medicare Part D.

**PFFS:** Private fee-for-service, MA plans that do not have any network requirements, unlike HMOs and PPOs.

**RPPO:** Regional PPOs, similar to LPPOs but serving a much broader geographic region. They serve one or more of the 26 regions established by Medicare. An RPPO cannot serve only a partial region.

**Segment:** A distinct portion of the service area of an MA local plan consisting of at least a full county in which benefits, premiums, and cost sharing are uniformly offered to all Medicare beneficiaries residing in that distinct portion.

**Service area:** A geographic area where a Medicare plan accepts enrollees. For local MA plans, this constitutes a county or multiple counties. For regional plans, the service area is a region approved by CMS.

**SNP:** Special needs plans, Medicare Advantage plans that offer all Part A and Part B services for specified populations having special needs, such as dual-eligibles (D-SNPs), people with chronic illness and conditions that require focused care management (C-SNPs), or people who are institutionalized (I-SNPs).

Milliman



**FOR MORE ON MILLIMAN'S PERSPECTIVE ON MEDICARE:**

Visit milliman.com/medicare-insight

Visit our blog at healthcaretownhall.com

Follow us at twitter.com/millimanhealth

**CONTACT**
Chris Girod
chris.girod@milliman.com

Shyam Kolli
shyam.kolli@milliman.com