

CY2014 Actuarial Bid Training

Presentation: Points of Emphasis for Medicare Advantage and Part D Bids in CY2014

Slides and Script prepared by CMS Office of the Actuary

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[SLIDE #1] Title

Welcome to the training session “Points of Emphasis for Medicare Advantage and Part D Bids in CY2014”.

[SLIDE #2] In this session . . .

In this session, we will cover key changes to the Medicare Advantage (MA) and Part D bid pricing tools and bid instructions, other areas of emphasis from the instructions, and our compliance initiatives, including goals, CY2013 results, and CY2014 expectations, and tips.

[SLIDE #3] Clarifications and Updates

We continue to remind you to read the bid instructions in their entirety for all clarifications and updates. For example, there is required supporting documentation for significant differences in actual to expected claims and non-benefit expenses for the last 3 years and updates to pricing considerations for Capitation Arrangements for Medical Services, Enrollment, and Base Period Experience.

[SLIDE #4] Medicare Medical Loss Ratio (MLR) and BPT MLR

CMS posted a proposed Medicare Medical Loss Ratio (MLR) rule for CY2014 on February 15, 2013. Consistent with the proposed rule, the MA bid pricing tool (BPT) MLR formula now includes Part B only and optional supplemental benefits in the numerator and the denominator. The Part D BPT MLR formula now includes federal reinsurance in the numerator and denominator. New fields in the MA and Part D BPTs collect insurer fees, that is, the annual fee on health insurance providers required by the Affordable Care Act, which is a subset of taxes and fees. The BPTs no longer include a text box for listing specific items included in Quality Initiatives and Taxes and Fees.

[SLIDE #5] Medical Loss Ratio and BPT MLR (cont.)

Although the BPT MLR is designed to be consistent with the proposed Medicare MLR rule, there are some differences. The proposed Medicare MLR requirement applies to MA and PD aggregated at the contract level, and reconciliation will be based on actual CY2014 expenses collected in CY2015 as compared to projected bid-level data in the MA and Part D bid pricing tools.

This year CMS will take into account the MLR in the bid during bid review and require support for situations that appear to be in conflict with the Medicare MLR requirement. Therefore, it is important that Plan sponsors determine gain/loss margins in consideration of Medicare MLR requirements, that is, with appropriate consideration for the need to remit funds to CMS should the Plan sponsor's actual claims experience fail to meet the minimum Medicare MLR requirement. It is also important that all related entries, such as quality initiative expenses and taxes and fees, be populated with the certifying actuary's best estimate.

[SLIDE #6] Gain / Loss Margin

Next we'll cover other gain/loss margin points of emphasis and changes. Initial and final approved bids must satisfy all gain/loss margin requirements outlined in the Instructions for Completing the MA and Part D Bid Tools as well as comply with other CMS requirements. If there is a conflict between satisfying gain/loss margin requirements and other CMS requirements such as Total Beneficiary Cost (TBC) or Medicare MLR, flexibility will be given to the margin requirements only to the extent necessary to meet the other CMS requirements. In this case, the Plan sponsor must provide an adequate explanation of the need for flexibility in the margin in supporting documentation.

Note that a resubmission that changes the gain/loss margin in one bid may require margin changes in other bids in order to satisfy gain/loss margin requirements.

[SLIDE #7] Gain/Loss Margin Changes

The most significant change to gain/loss margin requirements is to the comparison of aggregate margins for general enrollment and institutional-special needs plans or chronic care-special needs plans (referred to in this presentation as GE plus IC plans) to the Plan sponsor's margin requirement for non-Medicare health insurance lines of business. Note that this requirement also applies to dual-eligible special needs plans (D-SNPs) or employer group waiver plans, if there are no GE+IC plans. The comparison depends on the volume of the Plan sponsor's non-Medicare health insurance business (for which it has discretion in rate setting) as compared to the Plan sponsor's total non-Medicare health insurance business (including Medicaid).

[SLIDE #8] Gain/Loss Margin Changes (cont.)

If the ratio of the non-Medicare health business to total non-Medicare health business is greater than or equal to 10%, then the aggregate GE+I/C margin must be within 1.5 percent (above or below) the Plan sponsor's margin for its total non-Medicare health insurance lines of business. On the other hand, if this ratio is less than 10%, or if the Plan sponsor has no non-Medicare health insurance business, then, the aggregate margin must be set by taking into account the degree of risk and capital and surplus requirements of the business. Refer to the session on non-benefit expenses and gain/loss margin for more information.

[SLIDE #9] MA Aggregate Gain/Loss Margin D-SNP

There is no change to the range for comparing aggregate margins for GE+I/C plans and D-SNPs; however, CMS may allow well-supported exceptions for CY2014.

[SLIDE #10] Medicaid Contracts

If the Plan sponsor has a separate contract with a state or territory for Medicaid services, then the sponsor must enter base period Medicaid revenue and cost in MA Worksheet 1, Section VI. Note that these items are defined in the same manner as for the projection period and are collected in total dollars in Worksheet 1 and as PMPM values in Worksheet 4.

[SLIDE #11] Medicaid Contracts (cont.)

The BPT uses this Medicaid data to calculate an adjusted gain/loss margin equal to: the gain/loss margin, plus Medicaid revenue, less Medicaid cost. The projected margin used to satisfy all gain/loss margin requirements is the adjusted gain/loss margin calculated in Worksheet 4.

[SLIDE #12] Medical Related-Party Agreements

A significant change to related-party requirements is in the use of Medicare Fee-for Service (FFS) costs in limited circumstances. Plan sponsors may be permitted to use 100% FFS costs as a benchmark in the comparable rates comparison or as an acceptable proxy for net medical expenses (PMPM) entered in the MA BPT in limited situations. See the “Related-Party Agreements” presentation for more information about these options.

[SLIDE #13] Risk Score

The CMS-HCC and the Part D Rx HCC risk adjustment models are recalibrated for CY2014. Additional information on the CMS-HCC model, including the 2014 normalization factors, is contained in the 2014 payment notice. In addition, the MA BPT was changed to allow the user to override formulas for base period and projected DE# risk scores.

[SLIDE #14] Claims Credibility

CMS reviewed the CMS credibility guidelines and determined that the MA guideline for full credibility will remain at 24,000 member months and the Part D guideline for full credibility will be changed to 18,000 member months. See the “Base Period, Data Aggregation and Credibility for MA and PD” presentation for more information.

[SLIDE #15] MA Optional Supplemental Benefits

The new MA optional supplemental benefits pricing consideration contains information from the CY2014 Call Letter regarding a maximum enrollment-weighted contract-level projected gain/loss margin of 15% and a similar maximum for retention of 30%. There is also a new contract-level section in Worksheet 7 to collect base period experience.

[SLIDE #16] CY2014 Compliance Initiative

OACT's compliance initiative will continue for CY2014. The over-arching goals of OACT's compliance initiative are to produce more accurate and transparent bids, and to enable more efficient and effective bid reviews. When preparing MA and PD bids for review by CMS, each actuary's work must comply with relevant professional standards; these include—the American Academy of Actuaries' Code of Professional Conduct, any applicable Actuarial Standards of Practice (ASOP); all applicable laws, rules and regulations; and any agency guidance, including the MA and Part D bid instructions, guidance promulgated by OACT during the User Group Calls, and notices released via the Health Plan Management System.

[SLIDE #17] CY2014 Compliance Initiative (cont.)

Note that these standards apply not only to how actuaries prepare bids, but also to their conduct during bid review and bid audit. As always, we emphasize that adequate peer review and documentation are paramount to compliance; keep in mind that your success in—using peer review to prevent errors and mistakes from being submitted (or re-submitted) to CMS and thoroughly documenting your methods and assumptions can reduce or eliminate reviewers' questions and lessen your burden during bid review.

[SLIDE #18] CY2014 Compliance Initiative (cont.)

In cases where certifying actuaries fail to comply with the standards outlined above, CMS may take action. The potential actions listed on this slide, include phone calls or written warnings by OACT to certifying actuaries to identify compliance issues and to discuss their remedy and other actions that CMS may take with the plan sponsor.

[SLIDE #19] CY2014 Compliance Initiative (cont.)

After examining the comments from the bid review teams, OACT identified 20 cases that warranted direct phone calls with actuaries to discuss compliance issues associated with contract year 2013 bid submissions. OACT forwarded two cases to compliance groups to initiate compliance action with the plan sponsor.

The main areas of concern resulting in compliance action by OACT for contract year 2013 were—

A large number of errors and/or repeated errors in submissions and resubmissions, both of which demonstrate a lack of adequate peer review;

Initial supporting documentation and responses submitted in response to bid review inquiries that fail to meet the standard stated in ASOP 41 that “another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.”; an apparent lack of knowledge of the bid requirements when questioned by reviewers; and

Disregard for prior year bid audit findings or observations.

It should be noted that OACT did not take explicit action on every case reported by reviewers. OACT maintains historical feedback from reviewers and will incorporate that information into the initiative as needed. Although compliance issues may not necessarily warrant OACT action in one year, continued non-compliance over several years is likely to result in OACT action. So if you did not receive a compliance phone call regarding your 2013 bid, that does not mean that you were 100% compliant or that there is no room for improvement.

[SLIDE #20] CY2014 Compliance Initiative (cont.)

This slide highlights lessons learned from our phone conversations with certifying actuaries; many of these articulate responsibilities of the certifying actuary. For example, we are holding the certifying actuary responsible for timely response to all inquiries. This is true even when the information is needed from others at the plan sponsor therefore, communicating any potential delays to the bid reviewer is important to compliance with CMS requirements. We encourage certifying actuaries to reach out to OACT when assistance is needed in highlighting the urgency of a timely response to others at the plan sponsor. The certifying actuary is also responsible for ensuring that supporting documentation is consistent with the BPT. It's useful to take the time between bid submission and the initial actuarial certification deadline to ensure this consistency.

[SLIDE #21] CY2014 Compliance Initiative (cont.)

Compliance issues are treated like audit findings and observations, which means that 2013 issues must be remedied in 2014 bids, and a description of those remedies must be included in supporting documentation for the applicable bids. As for audit findings and observations, this requirement applies to ALL compliance issues even those with which the certifying actuary disagreed.

[SLIDE #22] CY2014 Bid Tips and Recommendations

We offer tips and recommendations taken from comments made by both internal and external bid reviewers. They are intended to help actuaries avoid the pitfalls that have constrained the bid process in the past. Of primary importance is adequate and thorough documentation that meets the standard that “another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.” By definition, this documentation will prevent many reviewers’ questions and can significantly increase the efficiency of the review. CMS requires that plan sponsors develop and upload bid-specific information. Supporting documentation should include ALL the necessary information about that bid, without providing extraneous information that is applicable to other bids or contracts. The support must explain why the pricing assumption is appropriate for the circumstances of the bid, especially when data and studies are not available. Plan sponsors must upload additional supporting documentation during bid review to explain any bid values that have been revised.

[SLIDE #23] CY2014 Bid Tips and Recommendations (cont.)

Attention to detail is critical to avoiding resubmissions. It is recommended that plan sponsors and certifying actuaries—review all flagged data validations and correct those that are in error; check the accuracy of every upload; and avoid carelessness (for example: repeatedly uploading incorrect files and/or uploading files to the wrong bid). Additionally, ensuring that BPT to PBP consistency exists is another pro-active way to lessen the burden of the bid review process and/or make it more efficient.

[SLIDE #24] Planning Information

Since responsiveness is one of the evaluation categories in OACT's compliance initiative, we provide information on this slide to assist certifying actuaries in planning resource availability for bid review. OACT expects its contracted reviewers to send all initial correspondence by June 28th. Additionally, OACT will be conducting several reviews internally. These include a review of red-circle validations and other data checks, such as the Part D national average bid amount and low income premium subsidy estimates; MA BPT to PBP consistency; and optional supplemental pricing. These reviews are conducted by different individuals. To the extent possible OACT will attempt to consolidate correspondence on these areas of review. However, inquiries can be avoided through the due diligence described in this presentation, namely peer review and thorough documentation.

[SLIDE #25] Planning Information (cont.)

In order to facilitate resubmissions for rebate reallocation, similar to last year the gate will automatically reopen after a resubmission during the rebate reallocation period. This gives plan sponsors the opportunity to resubmit multiple times until the rebate reallocation deadline.

[SLIDE #26] Questions?

For more details on the information contained in this presentation, please refer to the CY2014 MA and Part D bid instructions. In particular, the "Bidding Resources" section of the Introduction contains links to various types of bidding guidance. This concludes the presentation on "Points of Emphasis for MA and Part D Bids in CY2014".