Regulatory Oversight in Medicare Advantage

Prepared for:
Aetna

Prepared by:
Gabriela Dieguez, FSA MAAA
Principal and Consulting Actuary

Catherine Murphy-Barron, MBA, FSA, MAAA
Principal and Consulting Actuary

1 Pennsylvania Plaza
38th Floor
New York, NY 10119 USA

Tel +1 646.473.3000

milliman.com

June 24, 2016

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Health insurance organizations and health plans operating in the Medicare Advantage (MA) business provide health insurance coverage to beneficiaries eligible for Medicare benefits. Medicare Advantage differs from traditional Medicare in that, rather than the Centers for Medicare and Medicaid Services (CMS) paying providers directly on a fee for service (FFS) basis for benefits provided to Medicare beneficiaries, CMS pays Medicare Advantage organizations (MAOs) a per capita amount for each enrolled member to cover all Medicare benefits for that member in that year. Each year, Medicare enrollees can choose between traditional Medicare (possibly in conjunction with a Medigap plan to cover costs including copayments, coinsurance, and deductibles, and/or a Medicare prescription drug plan to provide insurance coverage for prescription drugs) and a Medicare Advantage plan.

CMS determines the baseline dollar amount of the capitation, called the benchmark. This benchmark varies by geographic area and the health status of the members enrolled in the plan. The plan has no influence on the amount of the benchmark; however, plans with a high quality score, called a star rating, receive an additional bonus amount that increases their revenue. New plans and low enrollment plans are also eligible to receive additional bonus payment amounts.

Each year the MAO must estimate its expected cost to provide benefits at least equal to traditional Medicare benefits to its members, including an allowance for administrative expenses and profit. This estimated cost is then compared with the benchmark. If the estimated cost is less than the benchmark, the MAO does not get to keep the entire surplus. Instead, CMS keeps a portion and the MAO must use the remaining surplus amount to provide supplemental benefits, which are additional benefits beyond traditional Medicare, thus making the plan more attractive to members. In such cases, members do not pay a monthly premium (although they are still subject to the standard premium for Medicare Part B) unless the cost of the supplemental benefits exceeds the remaining surplus. If the estimated cost is greater than the benchmark, then members are charged a premium equal to the difference plus an additional premium to cover the entirety of the costs for supplemental benefits. Consequently, the bids determine both the premium and the benefits of each product offered to consumers.

MAOs submit the calculation of the expected cost, administrative expenses, profit, and member premium, if any—collectively called the MA bid—to CMS by the beginning of June each year. During the initial “desk review” process, CMS reviews all assumptions and calculations used in the creation of the bid for reasonableness, accuracy, and consistency with MA rules and CMS regulations. At the same time, CMS reviews the benefits underlying the bid for compliance with regulations. MAOs must correct any noncompliance issues, including discrepancies, errors, omissions, or inconsistencies, between the bid and its underlying benefits, and then must resubmit the bid before it is approved. Once CMS approves the bid, auditors perform a more exhaustive review of all data that make up the bid, with an emphasis on reconciling the information used to prepare the bid and the MAO’s financial statements.

MA rules and regulations can be loosely categorized into rules related to access to benefits, affordability, and quality.

Rules affecting access to benefits:

- Plan must cover all Medicare Part A and Part B services
- Plan must comply with CMS maximum out-of-pocket limits to prevent excessive member cost sharing
- Plan benefits must be at least as rich as traditional Medicare benefits
- Member cost sharing on key services must be actuarially equivalent to traditional Medicare cost sharing
- Optional supplemental benefits must provide value
- The provider network must satisfy CMS’s network adequacy requirements
- There is a two-year prohibition for non-renewing MA contracts to reenter

Rules affecting affordability:

- Annual increases in member premium and cost sharing cannot be greater than CMS’s total beneficiary cost (TBC) limits
- Medical loss ratios must satisfy the minimum medical loss ratio requirements, which limit administrative expenses and profit margin to 15%

- CMS has multiple rules regarding the amount of profit margin a plan is allowed to include in its bid, and the allowable differences in profit margins among different types of MA plans offered by the same MAO
- Differences in profit margins for MA and an MAO's other lines of business are subject to limits

Rules affecting quality:

- Plans with high star ratings receive bonus revenue payments
- MAOs that consistently receive low quality ratings are terminated by CMS
- Plans failing to enroll a minimum number of members are terminated by CMS

Taken together, these rules protect beneficiaries from low-value products, restricted access to care, high out-of-pocket costs, excessive premium increases, and low quality of care. MA plans are regulated by a rate-setting, review, and approval process that spans several months and many different parties: plan actuaries, CMS, desk reviewers, and auditors.

This report was commissioned by Aetna. It reflects the authors' opinions and must not be construed as reflecting the views of Milliman. It is based on the authors' interpretation of Medicare Advantage regulation at the time of this writing. It should not be interpreted as an endorsement of any particular legislation by Milliman.

Gabriela Dieguez and Catherine Murphy-Barron are members of the American Academy of Actuaries and meet its qualification standards to render the opinions expressed in this report.

BACKGROUND

Medicare Advantage (MA) is a desirable option for some Medicare beneficiaries. According to a report by the Kaiser Family Foundation[i], the number of people enrolled in MA has grown at an annual rate of over 7.5% from 2008 to 2016, increasing from 9.7 million members to 17.6 million. By 2016, over 30% of all Medicare beneficiaries were enrolled in MA.

FIGURE 1: MEDICARE GROWTH, 2008-2016

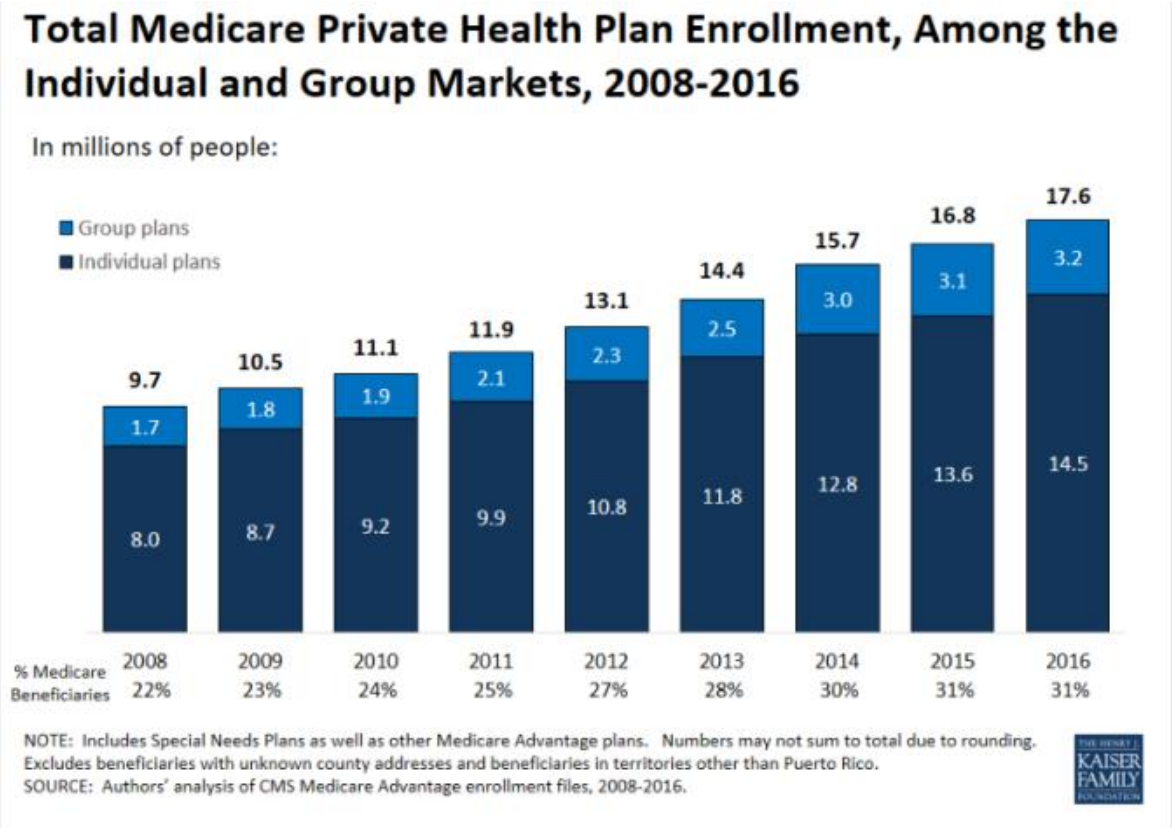


Figure 1: Total Medicare Private Health Plan Enrollment, Among the Individual and Group Markets, 2008-2016

Source: Kaiser Family Foundation Issue Brief, May 2016.

The complexity of MA regulation has grown and evolved over time. For calendar-year (CY) 2016, CMS recognized four major goals of MA regulation in its annual Call Letter to MAOs and Part D sponsors: stability, value, quality care, and plan compliance. These efforts are reflected in a myriad of rules, processes, and reviews that have accumulated over the years to increase the regulatory oversight on MAOs. As a result, established MAOs face many restrictions on setting benefits, premiums, and margins, while at the same time they are subject to quality and performance standards as well as increased competition.

This report explores the body of rules and regulations that affect Medicare Advantage bids, revenue, and benefit design. We begin with an introduction to the bid process to understand the program rules and participant constraints, and finish with a review of rules that were in place for the CY 2016 bid process.

THE MEDICARE ADVANTAGE BID PROCESS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the current MA program, allowing risk-bearing organizations to contract with CMS to provide benefits to Medicare-eligible individuals. Participating entities, or MAOs, offer their members benefits that are at least as rich as traditional Medicare Parts A and B in exchange for a per capita rate paid by CMS. CMS's mechanism for payment to MAOs for the provision of Medicare benefits is complex and depends on many factors, including an MAO's geographic area, quality ratings, and the relative health status of its members.

CMS updates Medicare Advantage per capita rates each year

CMS updates benchmark per capita rates for payment to MAOs each year, and announces the rate updates in April. The benchmark rate is the maximum amount that CMS will pay an MAO to provide traditional Medicare benefits in a given county. An MAO's benchmark rate is based on three major components:

- Geographic area: Benchmark rates vary by county and are based on the county's historical fee-for-service (FFS) costs, as follows:
    - Highest-cost quartile → 95% of FFS costs
    - Second-highest cost quartile → 100% of FFS costs
    - Third-highest cost quartile → 107.5% of FFS costs
    - Lowest-cost quartile → 115% of FFS costs

  If an MAO operates a contract in multiple counties, a member-weighted average benchmark rate is calculated across the counties in which it operates.
- Star rating: Benchmark rates also vary by the quality rating of the MAO contract. CMS assigns MAO contracts a "star rating" score, from one to five stars. MAO contracts with quality ratings of four or more stars receive a bonus or increase in the benchmark rate. [1]
- Risk score: Benchmark rates are adjusted by the relative health status of an MAO's membership. Through CMS's hierarchical condition category (HCC) risk adjustment model, CMS assigns a risk score to each member based on his or her diagnosis codes.

CMS multiplies the county-specific, star-rating-adjusted benchmark rate by the MAO's average risk score to determine the maximum payment that the MAO may receive.

Certain counties are affected by two additional rules that impact the payment rates: "double-bonus" counties are those counties with a combination of low-cost and high MA-penetration rate, and "capped" counties are those for which CMS payment rates have reached a predetermined ceiling.

In addition, special rules apply to "regional" plans, which are plans that cover all counties in a state or group of states. Issues specific to regional plans are summarized at the end of this section.

What is a Medicare Advantage bid?

Each spring, MAOs must submit a bid to CMS for each benefit offering (plan) or plan benefit package (PBP). A bid is an actuarial projection of the MAO's per member cost of providing traditional Medicare benefits plus administrative expenses and profit. The projection is based on the county of residence and relative health status of members expected to enroll in the PBP, in addition to care management practices, network contracting, and other rating variables.

CMS compares plan bid amounts with benchmark rates (adjusted for geographic area, star rating, new plan/low enrollment status, and risk score); if a bid is below the benchmark, a portion of the difference is returned to the MAO as a "rebate," which the MAO must then use to provide "supplemental" benefits (above and beyond what is covered by Medicare Parts A and B), such as non-Medicare-covered benefits, prescription drugs, and reduced member cost sharing for Medicare-covered services. However, if a bid is above the benchmark, the MAO will only receive the benchmark rate

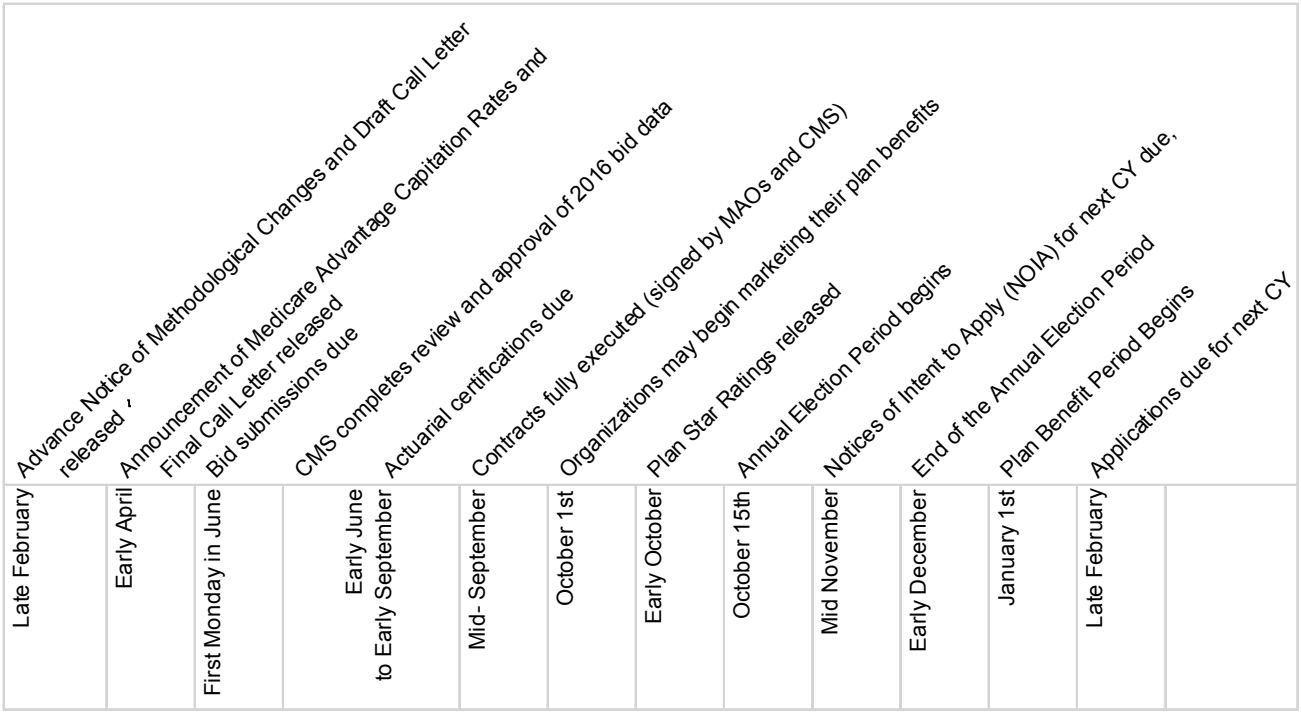
[1] New plans and low enrollment plans are also eligible to receive additional bonus payment amounts.

and must charge a "basic" member premium to cover the difference. The comparison and any additional benefits and the applicable premium are included with the bid submission.

The Medicare Advantage program timeline

MAOs must submit bids to CMS by the first Monday of June each year. MAOs submit their bids, using CMS's bid pricing tool (BPT) software, accompanied by a large body of supporting documentation, including the actuarial data, methodologies, and assumptions. Independent actuaries hired by CMS review this package in order to ensure MAOs' compliance with CMS rules. This is referred to as desk review. MAOs are subject to bid audits in addition to desk review. Bid audits are scheduled at least every three years and are more comprehensive than a desk review, including audits of the data used to prepare the bids. Figure 2 illustrates key regulatory dates in the MA program.

FIGURE 2: KEY DATES IN THE MEDICARE ADVANTAGE PROGRAM



[1] Starting in CY 2018, the Advance Notice will be released in early February.

Determining plan revenue

MAOs base their bids on historical claims data. When available and credible, MAOs must use a plan's most recent full-calendar-year experience to develop the bids. These data include historical rates of utilization of healthcare services, average unit costs, risk scores, and administrative expenses. In addition, actuaries must consider plan-specific historical trends in developing projection factors.

CMS determines plan per capita monthly payments to the MAO based on the final approved bid submission. Because risk scores in bids are projected, CMS reconciles payments to the MAO the following year based on the actual plan risk scores. Figure 3 illustrates the calculation of the monthly benchmark, bid, revenue, and premium amounts.

FIGURE 3: HOW THE MONTHLY BENCHMARK, BID, CMS REVENUE, AND PREMIUM ARE DETERMINED[1]

	Determination of the benchmark		
A	County-specific unadjusted rate (1.0 risk score, no bonus)	$1,000.00	
B	Star rating bonus (4.0 star rating)[2]	5.0%	
C	Plan risk factor (HCC model)	0.90	
D = A * (1+ B) * C	**Plan-specific risk-adjusted benchmark**	**$945.00**	
	Determination of the bid amount	1. Medicare-covered	2. A/B mandatory supplemental[3]
E	Plan-specific costs for Parts A and B (at 0.9 risk score)	$900.00	n/a
F	Traditional Parts A and B cost sharing	$100.00	-$60.00
G	Cost of non-Medicare-covered services	n/a	$20.00
H = E - F + G	Plan-specific net medical costs	$800.00	$80.00
I	Nonmedical (administrative) expenses	$65.00	$6.50
J	Gain/(loss) margin	$40.00	$4.00
K = H + I + J	**Plan-specific risk-adjusted bid amount (revenue requirement)**	**$905.00**	**$90.50**
	Determination of plan revenue		
L = D	Plan-specific risk-adjusted benchmark	$945.00	
M	Rebate percentage (4.0 star rating plans)	65%	
N = Max{(L - K) * M, 0}	Plan rebates	$26.00	
O = K + N	Plan revenue from CMS	$931.00	
$P = K_1 + K_2$	Plan revenue requirement (Medicare-covered and supplemental)	$995.50	
Q = P – O	Member premium	$64.50	
R = O + Q	**Total plan revenue (at 0.9 risk score)**	**$995.50**	

[1] Values shown are for illustrative purposes only.
[2] Bonus is doubled for counties that meet certain criteria of cost and penetration rates.
[3] Mandatory supplemental benefits are additional benefits beyond traditional Medicare that make the plan more attractive to members. These benefits are financed through the rebate and/or a basic MA member premium. Mandatory supplemental benefits are available to all members in a plan.

The bid pricing tool, desk review, and the role of the actuary

The bid pricing tool (BPT) is an Excel-based model that collects all of the actuary's inputs for the development of the bid and the calculation of the member premium; in addition, it contains a dedicated section for the reporting of historical plan results. The BPT has two types of fields:

- Inputs: These fields should be completed by the actuary with data and assumptions for the specific plan being bid on, and
- Formulas: These fields combine the actuary's inputs to perform calculations; they are predetermined and cannot be edited by the actuary.

Each of the inputs in the BPT must be substantiated by the actuary at the time of bidding in order to facilitate desk review. This requirement applies to inputs developed or relied upon by the actuary. The actuary is required to disclose the extent of any reliance on third parties, and to be ready to furnish substantiation material pertaining to the bid even if the actuary did not produce the inputs.

The BPT software has changed a few times since the program inception. In addition, there has been a significant increase in CMS requirements for bid support and in the level of scrutiny by desk reviewers. A list of items that must be substantiated is included in Appendix B of the MA BPT instructions. For CY 2016, this list contains 34 items to be provided at the time of bid submission and 11 additional items to be furnished to desk reviewers upon request. By contrast, the CY 2009 BPT instructions included only 18 items of substantiation at the time of bid submission, and 12 additional items upon request.

CMS encourages all MAOs to perform "sufficient due diligence to make certain their bids are accurate before submission."[ii] Compliance issues found during the review, including errors and omissions, are evaluated by CMS on a case-by-case basis and require a bid resubmission. MAOs that submit inaccurate bids may receive a compliance notice or request for a corrective action plan from CMS, and their bids may be denied.

Finally, as with all actuarial work, the actuarial work in connection with Medicare Advantage bids is subject to actuarial standards of practice[iii] (ASOPs), which provide guidance on what the actuary should consider, document, and disclose when performing an actuarial assignment. The standards are updated from time to time by the Actuarial Standards Board to reflect changes in market conditions or the regulatory environment. For CY 2016, BPT instructions place emphasis on six ASOPs related to the estimation of incurred health claims, regulatory filings, data quality, credibility, communications, and risk adjustment methodologies.

Issues unique to regional plans

Most MA members are enrolled in local plans; these plans service geographic areas that can include as many or as few counties as the MAO desires, as long as the plan meets network adequacy requirements as set forth by CMS. Further, MAOs are allowed to segment their plans such that premiums and cost sharing may vary by county, as long as benefits are uniform throughout the plan's service area. By contrast, a small percentage of MA members are enrolled in regional preferred provider organization (RPPO) plans, which are plans that service all counties in a state or group of states. There are 26 MA regions. All members enrolled in a regional plan are subject to the same benefits and premiums regardless of their counties of residence.

While most of the discussion above applies to both local and regional plans, a key difference in these types of plans is the determination of the benchmark rate. The regional benchmark has a statutory component and plan bid component; therefore the final benchmark for regional plans is impacted by competitive bidding. The plan bid component of the MA regional PPO benchmark is calculated as the weighted-average MA RPPO bid for each region and is announced by CMS after all bids are submitted (typically in August). For this reason, MAOs estimate the average RPPO bid amount in their initial bid submissions in June and are required to submit revised bids with the applicable average RPPO bid amount after the August announcement.

REGULATORY FRAMEWORK IN MEDICARE ADVANTAGE

Medicare Advantage regulation continues to evolve and expand. Every April, CMS releases a Call Letter to MAOs and Part D sponsors containing policies and considerations when preparing next year's bids. CMS states its four major goals in the Call Letter: 1) vibrancy and stability of the program, 2) value for beneficiaries and taxpayers, 3) better quality care for beneficiaries, and 4) improved compliance for plans and sponsors.

Regulatory oversight of MAOs has increased in recent years. This trend is reflected in the introduction of several new regulations, reporting requirements, and limitations that actuaries must consider when preparing bids. To illustrate the extent of this expansion of oversight, the Advanced Notice of Methodological Changes for *CY 2007* consisted of 13 pages, only a fraction of the 172 pages that make up the Advanced Notice of Methodological Changes for *CY 2016*.

A summary of CMS's rules affecting CY 2016 bid submissions is presented below. For simplicity, we have classified these rules as those affecting access to benefits, affordability, and quality, although there may be overlap.

Rules affecting access to benefits

The rules are to ensure that MA members receive adequate access to services, value for the premium they pay, and protection against discriminatory benefits:

Plan must cover all Medicare Parts A and B services
MA products must provide coverage for all Medicare Parts A and B services. However, because of the rebate component of the plan's revenue (available when bids are below the benchmark), most plans include coverage for several non-Medicare-covered benefits to entice members to enroll in their plans.

Maximum out-of-pocket (MOOP) limits prevent excessive member cost sharing
CMS establishes a mandatory maximum out-of-pocket cost (MOOP) limit ($6,700 in CY 2016) for services rendered by network providers, but encourages plans to implement lower, voluntary levels of MOOP ($3,400 in CY 2016). MOOP benefit features limit a member's exposure to catastrophic cost-sharing levels. Plans that choose the voluntary MOOP level receive greater flexibility in their benefit designs through higher limits in allowable copayments for several services.

Plan benefits must be at least as rich as traditional Medicare
Traditional Medicare has a deductible and coinsurance structure, but some members prefer the predictability of fixed copayments. While MA plans are allowed to use copayments instead of coinsurance, CMS specifies copay limits[iv] for a large number of services to avoid discriminatory benefits, with greater flexibility for plans offering voluntary MOOP levels. Maximum allowable cost-sharing levels for CY 2016 by MOOP option are shown in Figure 4.

FIGURE 4: MA COST-SHARING LIMITS BY MOOP OPTION (CY 2016)

	Maximum member cost sharing	
Service Category	Mandatory MOOP	Voluntary MOOP
Inpatient, 60 days	$4,209	N/A
Inpatient, 10 days	$1,955	$2,444
Inpatient, 6 days	$1,774	$2,218
Mental Health Inpatient, 60 days	$2,079	$2,599
Mental Health Inpatient, 15 days	$1,562	$1,953
Skilled Nursing Facility, First 20 days	$0/day	$40/day
Skilled Nursing Facility, Days 21 through 100	$160/day	$160/day
Emergency Care/Post-Stabilization Care	$75	$75
Urgently Needed Services	$65	$65
Partial Hospitalization	$55/day	$55/day
Home Health	$0	20% or $35
Primary Care Physician	$35	$35
Chiropractic Care	$20	$20
Occupational Therapy	$40	$40
Physician Specialist	$50	$50
Psychiatric and Mental Health Specialty Services	$40	$40
Physical Therapy and Speech-language Pathology	$40	$40
Therapeutic Radiological Services	20% or $60	20% or $60
DME, Equipment	20%	N/A
DME, Prosthetics	20%	N/A
DME, Medical Supplies	20%	N/A
DME, Diabetes Monitoring Supplies	20% or $10	N/A
DME, Diabetic Shoes or Inserts	20% or $10	N/A
Renal Dialysis	20% or $30	20% or $30
Part B Drugs, Chemotherapy4	20% or $75	20% or $75
Part B Drugs, Other	20% or $50	20% or $50

Member cost sharing on key services must be actuarially equivalent to traditional Medicare

In addition to the limitations described above, the bid pricing tool includes a test of actuarial equivalence of total member cost sharing. This test is intended to prevent plans from designing plan benefits such that average member cost sharing on inpatient, skilled nursing facility, durable medical equipment (DME), or physician-administered (Part B) drugs would be higher than what an average member would pay under traditional Medicare.[v]

Meaningful difference requirement streamlines plan selection

CMS has established a "meaningful difference" rule to limit the number of plan options offered by the same MAO in a given service area. This effort is aimed at reducing seniors' confusion about multiple, often duplicative options. MAOs calculate the out-of-pocket cost (OOPC) values for all of their plan offerings. The OOPC value is the sum of the expected member cost sharing and member premium. The OOPC values for all benefit offerings in a given county are compared to

determine whether the plans offered are "substantially different." CMS requires a difference in OOPC values of at least $20 (for CY 2016) per member per month for the purpose of demonstrating meaningful differences.

Optional supplemental benefits subject to member premium must provide value
Plans are allowed to offer optional supplemental benefits to their members for services not covered by traditional Medicare. These benefits are optional to the member; those that opt to receive them are subject to a supplemental premium. However, the premium charged must be such that 1) at least 70% of the premium is expected to cover the cost of providing benefits, and 2) the MAO's margin on the optional supplemental benefit is expected to be no more than 15%.[vi]

Network adequacy
CMS monitors an MAO's compliance with network adequacy standards to verify adequate access of members to covered services. CMS can sanction MAOs that fail to have sufficient providers in their networks and those unable to maintain accurate directories.

Two-year MA prohibition for non-renewing contracts
MAOs that voluntarily exit are subject to a two-year prohibition from reentering. This measure is designed to prevent MAOs with adverse experience from terminating their MA plans in the hope of reentering under more favorable circumstances.

Rules affecting affordability

Consistent with the stated goals in prior year Call Letters, CMS implemented regulations attempting to provide stability in the market and ensure the value of Medicare Advantage products. These rules include annual limits on increases in member premium and cost sharing, minimum medical loss ratios, and strict rules on permissible profit margins.

TBC test limits annual increases in premium and member cost sharing
Total beneficiary cost (TBC) is calculated as the sum of the plan's member premium and the estimated member out-of-pocket cost. TBC is calculated every year for each plan, and TBC amounts are compared from one year to the next as part of the bid submission process. CMS limits plans' annual changes in TBC to reduce the total financial impact on MA members, and takes into account changes in county benchmark rates and bonus payments in setting these limits. Bids that exceed the TBC change threshold are typically rejected by CMS.[vii]

The TBC change threshold is $32 per member per month in CY 2016. This generally means that, for plans that had no changes in benefits, county benchmark rates, or star ratings from 2015 to 2016, premium increases cannot exceed $32 per month. The relative premium increase is not relevant in the context of the TBC rule: a 100% increase in premium may be acceptable as long as it is below the $32 limit, while a 10% premium increase that translates to a $33 TBC would be unacceptable.

Premium increases and/or benefit reductions (for example, through member cost-sharing increases) cause TBC amounts to increase. If an MAO's projected plan costs increase by more than the allowable TBC change threshold, the MAO must reduce proposed premiums or increase proposed benefits to meet the limit, even if these changes cause negative profit margins. CMS allows some flexibility in margins for plans in order to meet TBC requirements.

Minimum MLR rules limit MAOs' administrative and profit load to 15%
Minimum medical loss ratio (MLR) requirements went into effect in CY 2014. The goal of the minimum MLR requirement is to ensure that MAOs spend at least 85% of their revenue dollars providing benefits to their members. Under the minimum MLR rules, the combined cost of administrative expenses and profit may not exceed 15% of the total plan revenue. MLR is calculated as the ratio of medical expenses (numerator), including spending to promote quality, to the risk-adjusted per capita rates plus member premiums (denominator).

A credibility factor is added to the MLR of low-membership plans, for which experience may not be credible. The adjustment effectively increases the experience MLR to account for likely fluctuations in medical expenses, making it easier for low-membership plans to comply with minimum MLR requirements.

Plans that do not meet the minimum MLR requirement must refund to CMS the difference between their MLRs and 85%. In addition, CMS has established sanctions to plans that consistently fail to meet the minimum MLR threshold for three

consecutive years, and reserves the right to terminate the contract with MAOs that fail to meet the MLR threshold for five consecutive years.[viii]

Profit margin requirements to promote competition and sustainability

CMS has revised its bid margin requirements in recent years. For CY 2016 bids, MAOs were required to meet a number of profit margin requirements, not only at the bid level but also at the organization level.

CMS targets three main goals with the implementation of bid-level margin requirements:

- Provide value to members: CMS states in the bid instructions that "significantly high margins" are not permissible in bids; however, CMS has not defined a threshold for margins to be considered significantly high. An exception to this rule is when a plan is part of a "product pairing," where two or more plans of the same type are offered in one service area and cross-subsidies among them are expected. For example, a "high" option plan with high margins may be paired with a "low" option plan with negative margins.
- Promote competition: While negative margins are acceptable for start-up MAOs and new plans, CMS rejects bids with "significantly low or negative margins" for plans with substantial and stable enrollment. CMS has not provided a threshold for margins to be considered significantly low.
- Ensure sustainability: When MAOs submit bids with negative margins, the bid must be accompanied by a business plan demonstrating that the MAO is able to achieve profitability within five years. After a bid is submitted with negative margins, CMS requests follow-up reporting in subsequent years to monitor that the MAO is meeting the projected margins contained in the business plan.

The aggregate-level requirements vary by segment and apply separately to each category of plans:

1. General enrollment plans and institutional/chronic care special needs plans (I-SNP/C-SNP)
2. Dual special needs plans (D-SNPs)
3. Employer group waiver plans (EGWPs)

For all three categories, long-term consistency in margins is required. While CMS expects some level of fluctuation between bid and actual margins in any given year, over time actual aggregate margins are expected to be consistent with aggregate bid margins. In addition, CMS establishes the following limitations for each category of plans:

1. General enrollment plans and I/C-SNPs
    - Consistency with corporate margins: For MAOs with a significant volume of business outside of Medicare Advantage and Part D, CMS expects aggregate MA margins to be within 1.5% of the margin on the MAO's non-MA lines of business.
2. D-SNPs
    - Consistency with general enrollment plans and I/C-SNPs margins (if also offered by the MAO): The aggregate D-SNP margin must be within -5% and 1% of the aggregate margin for general enrollment plans and I/C-SNPs.
    - Consistency with corporate margins: If general enrollment plans and I/C-SNPs are not offered, CMS expects aggregate MA margins to be within 1.5% of the margin on the MAO's non-MA lines of business (for MAOs with a significant volume of business outside of Medicare Advantage and Part D).
3. EGWPs
    - Consistency with general enrollment plans and I/C-SNPs margins (if also offered by the MAO): The aggregate EGWP margin must be within -5% and 1% of the aggregate margin for general enrollment plans and I/C-SNPs.
    - Consistency with corporate margins: If general enrollment plans and I/C-SNPs are not offered, CMS expects aggregate MA margins to be within 1.5% of the margin on the MAO's non-MA lines of business (for MAOs with a significant volume of business outside of Medicare Advantage and Part D).

For the purposes of determining whether an MAO has a significant volume of non-MA business, CMS considers the MAO's ability to set rates for the other products; that is, whether the MAO is able to set its own premium levels, or the revenue that the MAO receives is set by the government (Managed Medicaid). A share of 10% or more of revenues in products with rate-setting discretion is considered a significant volume of business for the purpose of triggering the above

rules. For MAOs without a significant volume of business outside of Medicare Advantage and Part D, CMS expects aggregate MA margins to be within 1.5% (CY 2016) of the MAO's corporate margin requirements

For MA plans that also offer Part D benefits (MA-PD plans), the aggregate MA margin for all MA-PD bids in each category must also be within 1.5% of the Part D margin.

CMS does offer flexibility on margin requirements for MAOs that cannot meet the rules above while still meeting the TBC requirements.

Rules affecting quality

MAOs are rewarded with higher revenue for higher quality ratings

CMS assigns each MAO a star rating, with scores from 1.0 to 5.0 stars, rounded to the nearest 0.5 star. MAOs with quality scores of 4.0 stars or higher are eligible for a bonus payment, which effectively increases the plan's benchmark rate. An MAO's star rating impacts not only the benchmark rates but also the "rebate" percentage (the share of the savings that the MAO receives from CMS when a plan's bid is below the benchmark). See Figure 3 above for a demonstration of the impact of an MAO's star rating on its bid. The bonus payment and rebate percentages by star rating are shown in Figure 5.

FIGURE 5: MA PAYMENT RATE BONUS AND REBATE PERCENTAGES BY STAR RATING

Star Rating	<3.0	3.0	3.5[1]	4.0	4.5	5.0
Bonus payment[2]	0%	0%	0%	5%	5%	5%
Rebate	50%	50%	65%	65%	70%	70%

[1] Low-enrollment and new contracts are assigned a 3.5 quality star rating.

[2] Note: Payment caps and double bonus rules may limit or amplify the impact of the star ratings above.

MAOs that achieve the maximum quality star rating (5.0) are further rewarded with the ability to market their products outside of the annual open enrollment period, which provides a competitive advantage over lower-rated organizations.

Termination of underperforming contracts

CMS has regulatory authority to terminate the contracts of MAOs that fail to achieve a 3.0 star rating for three consecutive years.

Termination of plans that fail to enroll a minimum number of members

Plans that fail to enroll at least 500 members (or 100 members if the plan serves a special needs population) within three years are terminated by CMS, unless there are not sufficient other plans in the area.

MAOs must be able to handle grievances and appeals

CMS monitors the result of appeals and grievances and the Part D coverage determination. In order to make appeal and grievance processes more understandable and accessible for members, CMS recently released clarifications and guidance on existing requirements.

CONCLUSIONS

While Medicare Advantage continues to be a desirable option for Medicare beneficiaries, the rules and regulations that govern the program have grown and evolved. CMS has stated that it has four major goals with respect to MA regulation: stability, value, quality of care, and plan compliance. These are reflected in the myriad of rules, processes, and reviews that have accumulated over the years to increase the regulatory pressure on MAOs and to protect consumers. As a result, established MAOs face many restrictions on setting benefits, premiums, and margins, and must satisfy strict rules with respect to quality and performance.

CAVEATS

This report reflects the authors' opinions and must not be construed as reflecting the views of Milliman. It is based on the authors' interpretation of Medicare Advantage regulation at the time of this writing. It should not be interpreted as an endorsement of any particular legislation by Milliman.

Gabriela Dieguez and Catherine Murphy-Barron are members of the American Academy of Actuaries and meet its qualification standards to render the opinions expressed in this report.

REFERENCES

i Gretchen Jacobson, Giselle Casillas, Anthony Damico, Tricia Neuman, and Marsha Goldet all. The Henry J. Kaiser Family Foundation. May 2016 Issue Brief: Medicare Advantage 2016 Spotlight: Enrollment Market Update. Available at http://kff.org/medicare/issue-brief/medicare-advantage-2016-spotlight-enrollment-market-update/. Retrieved June 13, 2016.
[ii] CMS.gov (April 6, 2015). Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Retrieved June 1, 2016, from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2016Announcement.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.
[iii] Actuarial Standards Board. All Actuarial Standards of Practice. Retrieved June 1, 2016, from http://www.actuarialstandardsboard.org/standards-of-practice/.
[iv] CMS.gov, ibid., Table 4, p. 126.
[v] CMS.gov, ibid., p. 124.
[vi] CMS.gov, ibid., p. 127.
[vii] CMS.gov, ibid., p. 120.
[viii] 2014 MLR Reporting Year Filing Instructions (April 8, 2015).