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Medical loss ratio (MLR) in the "Mega Reg"

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Jill Brostowitz, FSA, MAAA

Scott Jones, FSA, MAAA

Ian McCulla, FSA, MAAA

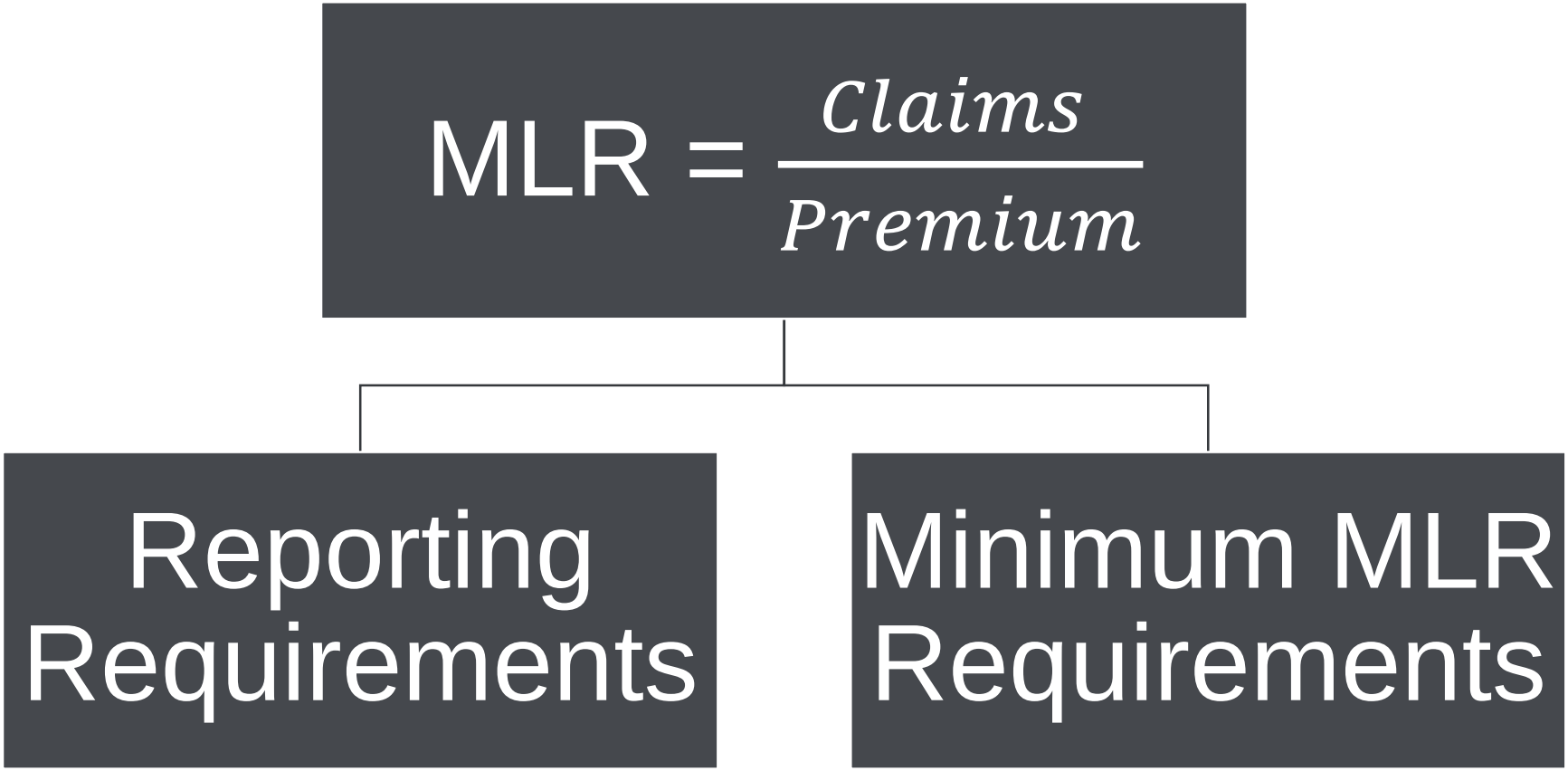
Additional Resources

- **http://www.milliman.com/medicaidmanagedcare/**
  - Medical loss ratio (MLR) in the “Mega Reg”
  - Institution for Mental Disease (IMD) as an "in lieu of" service
  - Encounter data standards: Implications for state Medicaid agencies and managed care entities from final Medicaid managed care rule
  - Pass-through payment guidance in final Medicaid managed care regulations: Transitioning to value-based payments

Presentation overview

1	MLR Background
2	Summary of final rule MLR formula components
3	Comparison to Commercial and Medicare MLR
4	MLR Formula Considerations
5	Actuarial Soundness and Other State Considerations

MLR Background – Overview



Source: https://www.federalregister.gov/articles/2016/05/06/2016-09581/ medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

MLR Background – CMS Objectives

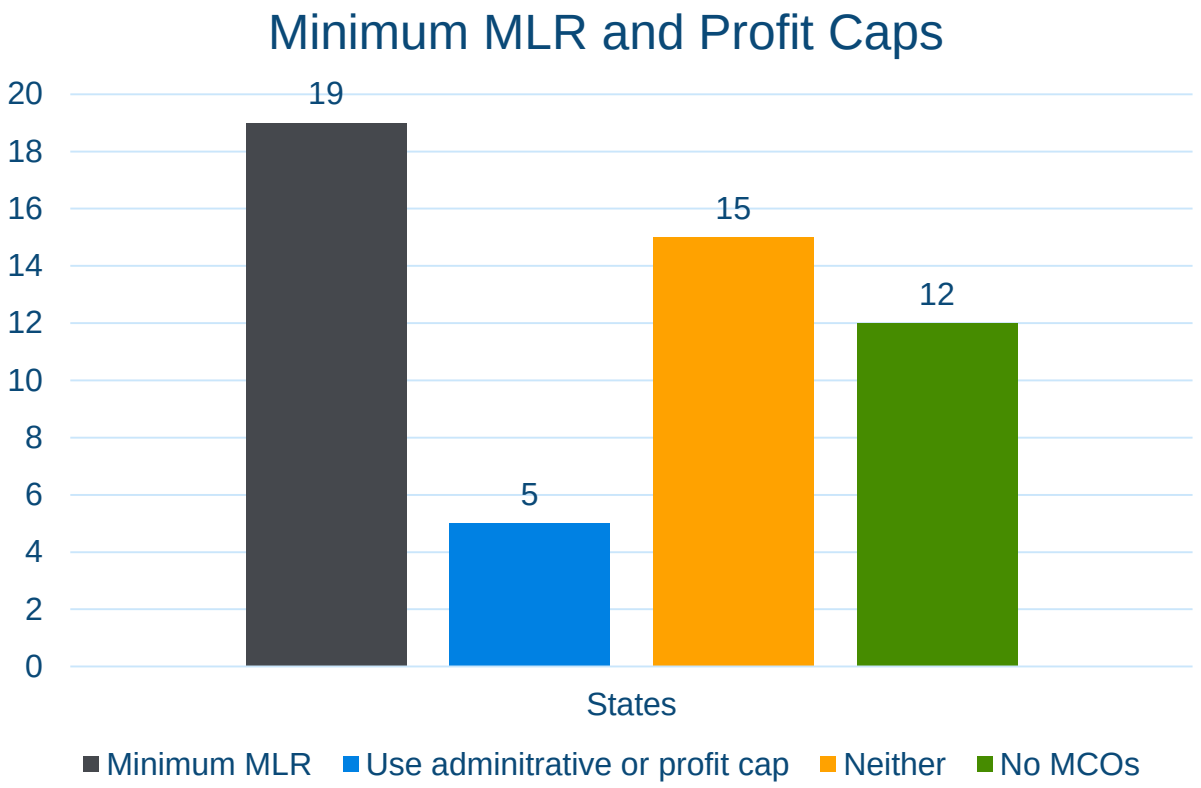
- CMS Intent
  - Alignment with commercial and Medicare Advantage markets
  - National standard
- Benefits of MLR
  - Insight into how Medicaid capitation revenue is spent
  - Capitation rate assessment tool

- *From the final rule discussion on MLR:*

  "MLR calculation and reporting results in responsible fiscal stewardship of total Medicaid expenditures by ensuring that states have sufficient information to understand how the capitation payments made for enrollees in managed care programs are expended."

Source: https://www.federalregister.gov/articles/2016/05/06/2016-09581/ medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

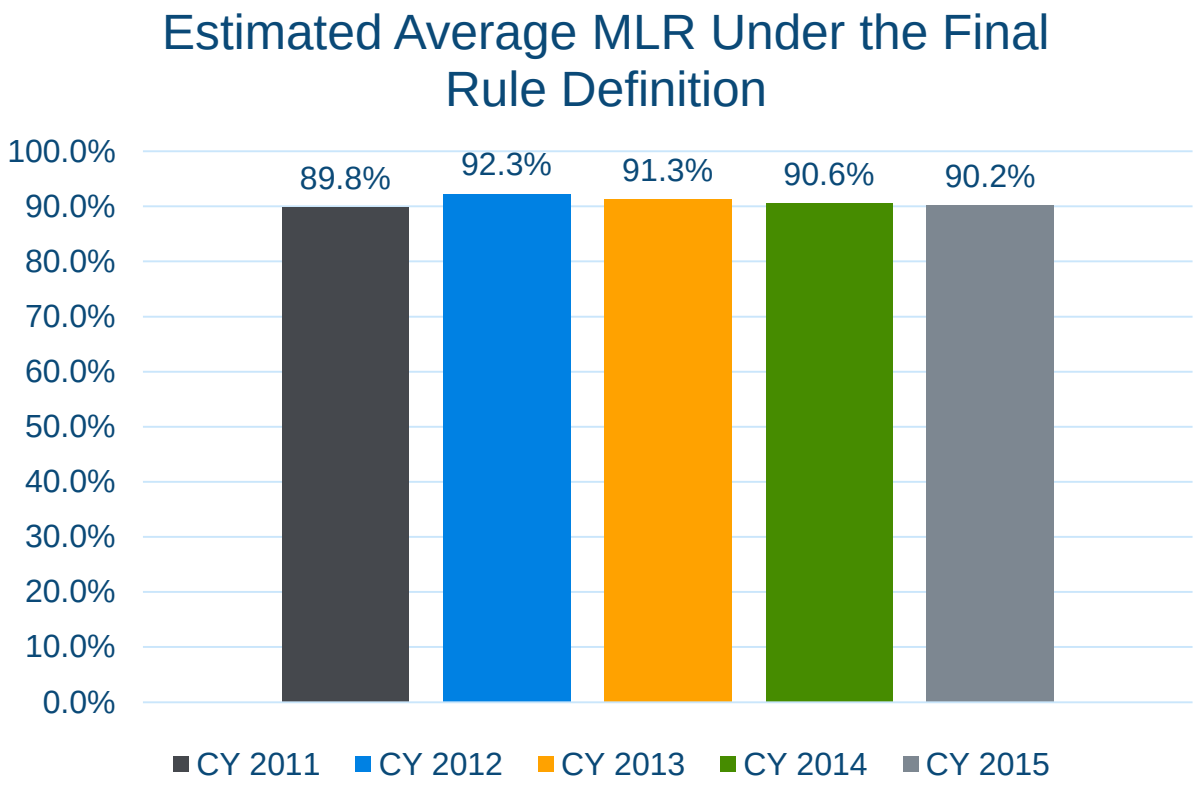
MLR Background – Existing Usage in Medicaid



Notes:
1. Responses as of July 2015 include all 50 states and the District of Columbia
2. Survey commissioned by Kaiser Family Foundation

Source: http://kff.org/other/state-indicator/minimum-medical-loss-ratio-mlr-policies-for-mcos/

MLR Background – Historical Results



Note: More than 75% of MCOs are estimated to have met a minimum MLR of 85% in CY 2015.

Source: http://us.milliman.com/insight/2016/Medicaid-risk-based-managed-care-Analysis-of-financial-results-for-2015/

MLR Background – Final Rule Formula

Traditional Medical Loss Ratio

$$\frac{Claims}{Premium}$$

Final Rule MLR

$$\frac{Claims + Quality\ Improvement\ + Fraud\ Prevention}{Premium\ - Taxes\ and\ Fees} + Credibility\ Adjustment$$

MLR Formula Components

Claims Component

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \text{Taxes}} + \text{Credibility}$$

Includes

- Amounts paid (or owed) to providers for Medicaid covered and value-added services
- Withholds, bonus, and incentive payments to providers
- Recoveries from COB, subrogation, and Rx rebates (including accruals)
- State solvency fund payments or receipts
- Portion of sub-capitation to providers attributed to claims
- Net fraud reduction recoveries ($0 maximum)
  - Example 1: Claims are -$30K if $100K recoveries and $70K recovery expenses
  - Example 2: Claims are $0 if $100K recoveries and $150K recovery expenses
  - Fraud recovery expenses exclude fraud prevention activities (beyond recovering specific claims) that are not allowed until Commercial MLR adoption

Excludes

- Portion of sub-capitation to providers attributed to administrative services
- Pass-through payments
- Prior year MLR refunds

Premium Component

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \text{Taxes}} + \text{Credibility}$$

Includes

- Regular capitation payments
- Event type premiums (e.g., maternity kick payments)
- Risk adjustment payments
- Risk corridor settlements
- Waived member cost sharing
- MCO withholds earned back from P4P
- Retrospective capitation adjustments (requires MLR reporting re-submissions)
- Unearned premium reserve changes (if on a financial statement basis)

Excludes

- MCO bonus incentives from P4P
- Pass-through payments

Taxes and Fees Component

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \boxed{\text{Taxes}}} + \text{Credibility}$$

Includes

- Taxes, licensing fees, and regulatory fees
- Federal, state, and local amounts
- For plans exempt from federal income taxes, community benefit expenses can be included up to the greater of 3% or the highest premium tax rate in the state multiplied by earned premium.

Excludes

- Fines and penalties
- Income taxes on investment income and capital gains
- Federal employment taxes

Quality Improvement

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \text{Taxes}} + \text{Credibility}$$

Includes

- Improve health outcomes
- Prevent hospital readmissions
- Improve patient safety and reduce medical errors
- Improve wellness and health promotion activities
- Enhance the use of IT to improve quality of care

Excludes

- Expenses for cost containment
- Concurrent and retrospective utilization review
- Fraud prevention (accounted for elsewhere)
- Provider networks / credentialing
- Claims adjudication / customer service for non-clinical questions

Examples

- Effort to detect harmful Rx interactions is QI, but generic substitution as a cost containment measure is not QI.

Quality Improvement

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \text{Taxes}} + \text{Credibility}$$

Considerations

- Inclusion in MLR numerator intended to recognize value to beneficiaries
- Ignoring QI in the MLR formula would discourage investments in quality
- Small item, but may make the difference in meeting minimum MLR

Process to Define QI

- May require clinical expertise
- Pass audit
- May involve allocating FTEs / software fees
- May require changes to general ledger, new cost accounting procedures

Fraud Prevention Activities

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \text{Taxes}} + \text{Credibility}$$

- Theoretically, expenses will be included in the numerator (limited to 0.5% of premium revenues), but implementation is suspended.
- Treatment of expenses for fraud prevention activities is tied to how it is handled in the Commercial MLR regulation
  - CMS has maintained that expenses for fraud prevention activities are excluded at least through 2017
  - This will be revisited, and may be permitted in the future
- Note: fraud *recovery* expenses already added to claims, up to amount of actual recoveries. Not part of the definition of fraud *prevention* activities in the final rule.

Credibility Adjustment

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \text{Taxes}} + \text{Credibility}$$

- **What is it?**
  - Intended to account for normal claim volatility
  - Larger for smaller MCOs
- **How is it applied?**
  - Back-end additive adjustment: *MLR + cred > 85%*
- **How is it calculated?**
  - Specific table unknown at this time
  - Credibility adjustment will not exceed 10% and will not be less than 1%
  - CMS outlined methodology in the proposed rule

Credibility Adjustment

$$\frac{\text{Claims} + \text{QI} + \text{Fraud}}{\text{Premium} - \text{Taxes}} + \text{Credibility}$$

COMMERCIAL TABLE				MEDICARE ADVANTAGE TABLE		
MINIMUM LIFE YEARS BY LINE OF BUSINESS				MINIMUM LIFE YEARS BY LINE OF BUSINESS		
INDIVIDUAL	SMALL GROUP	LARGE GROUP	ADDITIVE CREDIBILITY ADJUSTMENT	MA & MA/PD	PART D STAND-ALONE	ADDITIVE CREDIBILITY ADJUSTMENT
BELOW 1,000	BELOW 1,000	BELOW 1,000	NON-CRED	BELOW 200	BELOW 400	NON-CRED
1,000	1,000	1,000	8.3%	200	400	8.4%
2,500	2,500	2,500	5.2%	500	1,000	5.3%
5,000	5,000	5,000	3.7%	1,000	2,000	3.7%
10,000	10,000	10,000	2.6%	2,000	4,000	2.6%
25,000	25,000	25,000	1.6%	5,000	10,000	1.7%
50,000	50,000	50,000	1.2%	10,000	20,000	1.2%
75,000	75,000	75,000	0.0%	15,000	30,000	1.0%
				ABOVE 15,000	ABOVE 30,000	0.0%

Comparison to Commercial and Medicare MLR

Implementation in Commercial and MA Markets

Commercial

- Reporting requirement only for CY 2010
- Minimum MLRs (80%, 85%) enforced beginning in CY 2011
- Rebates paid back to policyholders (individuals and employer sponsors)
- The regulations for Commercial MLR set significant precedents, subsequently adopted or customized for Medicare Advantage and Medicaid

Medicare

- Minimum MLR (85%) enforced beginning in CY 2014
- Remittances collected by CMS directly, not shared with beneficiaries
- Suspension of new enrollment and contract termination may occur after multiple years of low MLR

Comparison of Formulas

	MEDICAID	MEDICARE ADVANTAGE	COMMERCIAL
Minimum MLR threshold and granularity of measurement	At least 85%, enforcement at state's option, level of granularity at state's discretion.	85%, for each contract.	80% individual 80% small group 85% large group
MLR Refunds	If enforced by the state, to be paid proportionally to state and federal based on federal medical assistance percentage.	Remittances paid to CMS.	Paid to individuals and group policyholders.
Treatment of risk adjustment in MLR calculation	Accounted for in denominator/ cap rate.	Accounted for in denominator/ CMS risk-adjusted revenue.	Transfer payment included in numerator.
MLR measurement period	One year.	One year.	Three years.
New MCOs reporting of MLR	State decision; considered a new MCO for only one year (even if a partial year).	Subject to MLR	MCOs with at least 50% new members may defer experience.

MLR Formula Considerations

MLR Formula Considerations

Provider Reimbursement

Scenarios

- Scenario 1: 60% of Medicare
  - $255 claims expense
  - $3 quality improvement
  - $45 administrative expense
  - $10 taxes and fees
- Scenario 2: 100% of Medicare
  - $425 claims expense
  - All else: same as scenario 1

Results

- Scenario 1:

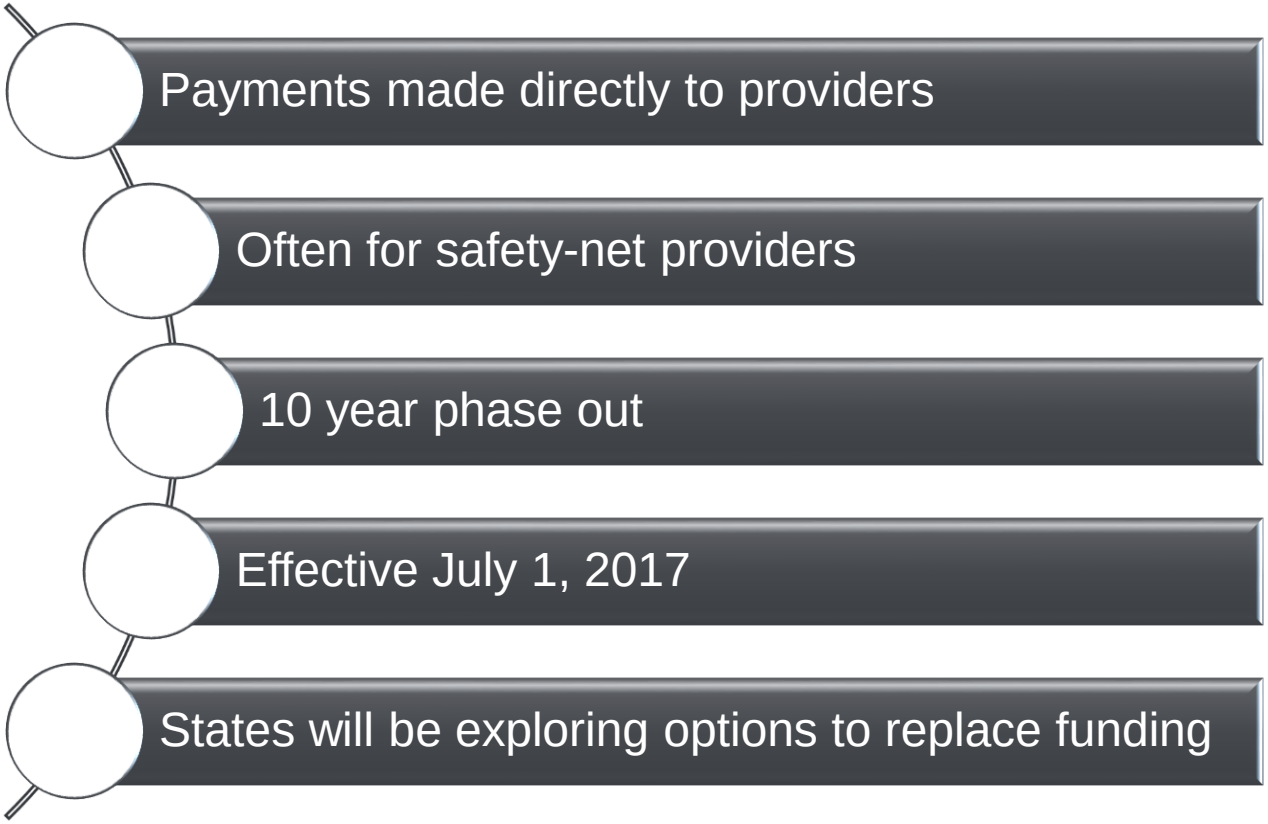
$$\frac{\$255 + \$3}{\$255 + \$45 - \$10} = 89\%$$

- Scenario 2:

$$\frac{\$425 + \$3}{\$425 + \$45 - \$10} = 93\%$$

MLR Formula Considerations

Pass-through payments



MLR Formula Considerations

Pass-Through Payments

Scenarios

- Scenario 1: 60% of Medicare
  - $255 claims expense
  - $3 quality improvement
  - $45 administrative expense
  - $10 taxes and fees
- Scenario 2: 100% of Medicare
  - $170 pass-through
  - All else: same as scenario 1

Results

- Scenario 1:

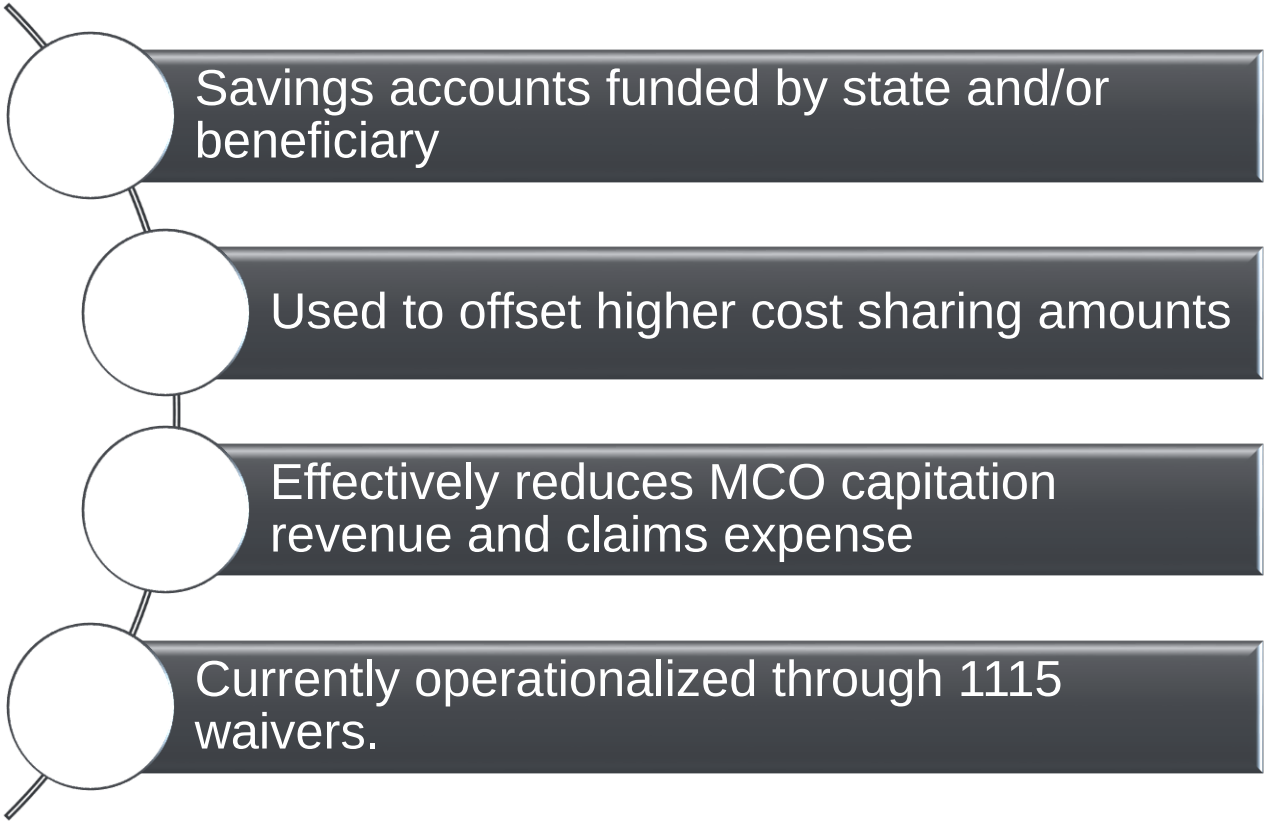
$$\frac{\$255 + \$3}{\$255 + \$45 - \$10} = 89\%$$

- Scenario 2:

$$\frac{\$255 + \$3}{\$255 + \$45 - \$10} = 89\%$$

MLR Formula Considerations

Medicaid Beneficiary Savings Accounts



MLR Formula Considerations

Medicaid Beneficiary Savings Accounts

Scenarios	Results
–Scenario 1: –$255 claims expense –$3 quality improvement –$45 administrative expense –$10 taxes and fees –Scenario 2: –$50 claims expense paid through savings account –All else: same as scenario 1	–Scenario 1: $\frac{\$255 + \$3}{\$255 + \$45 - \$10} = 89\%$ –Scenario 2: $\frac{\$205 + \$3}{\$205 + \$45 - \$10} = 87\%$

Actuarial Soundness and Other State Considerations

MLR in Actuarial Soundness

Final rule requires actuarially sound capitation rates effective on or after July 1, 2019 to have a projected MLR of at least 85%.

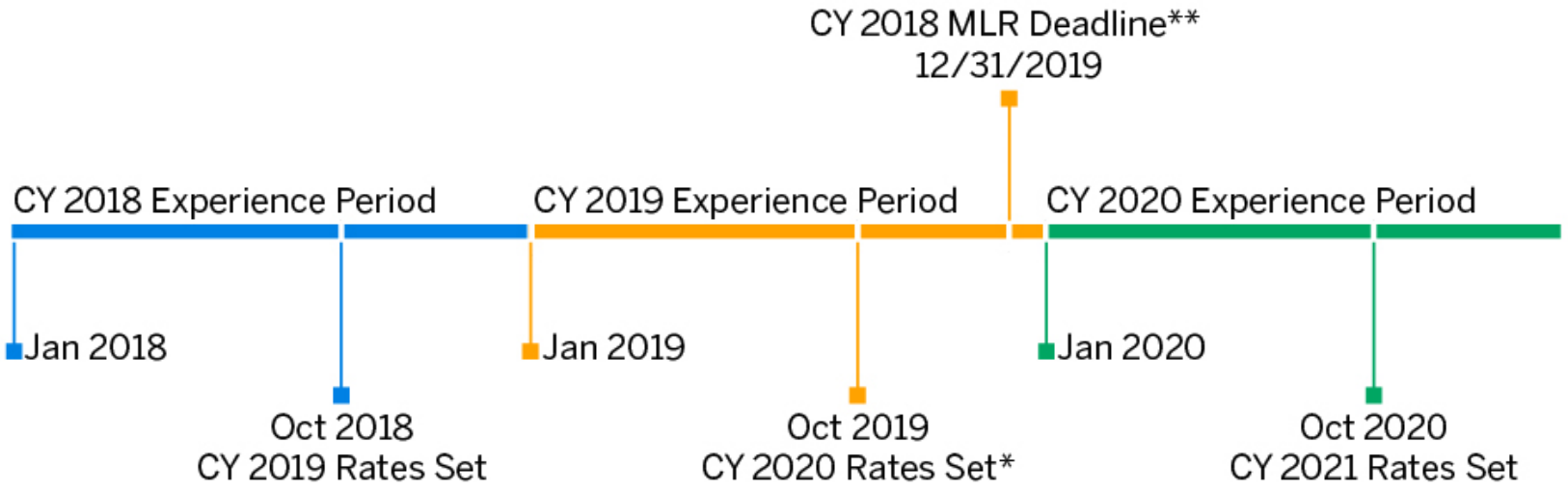
MLR does not determinate rate adequacy but limits the percentage of revenue used for administrative expenses (excluding quality improvement) and margin.

Many states and their actuaries already consider historical and projected MCO financial performance during the rate setting process.

Timeline: MLR Reporting Versus Rate Setting
For Calendar Year Contracts

*CY 2020 rate setting first needs to consider prospective MLRs (which is before the CY 2018 MLR reporting federal deadline)

**Historical MLR results may be three years older than the rate setting period (for example, CY 2018 reporting may first be available for CY 2021 rates)



Usefulness of Historical MLRs

Provides Standardized Measurement

- Identify potential rating issues in a given year
- Identify repeated patterns over time

Different View of MCO Performance

- MLR results are not the same as profit results

Potential for CMS Questions

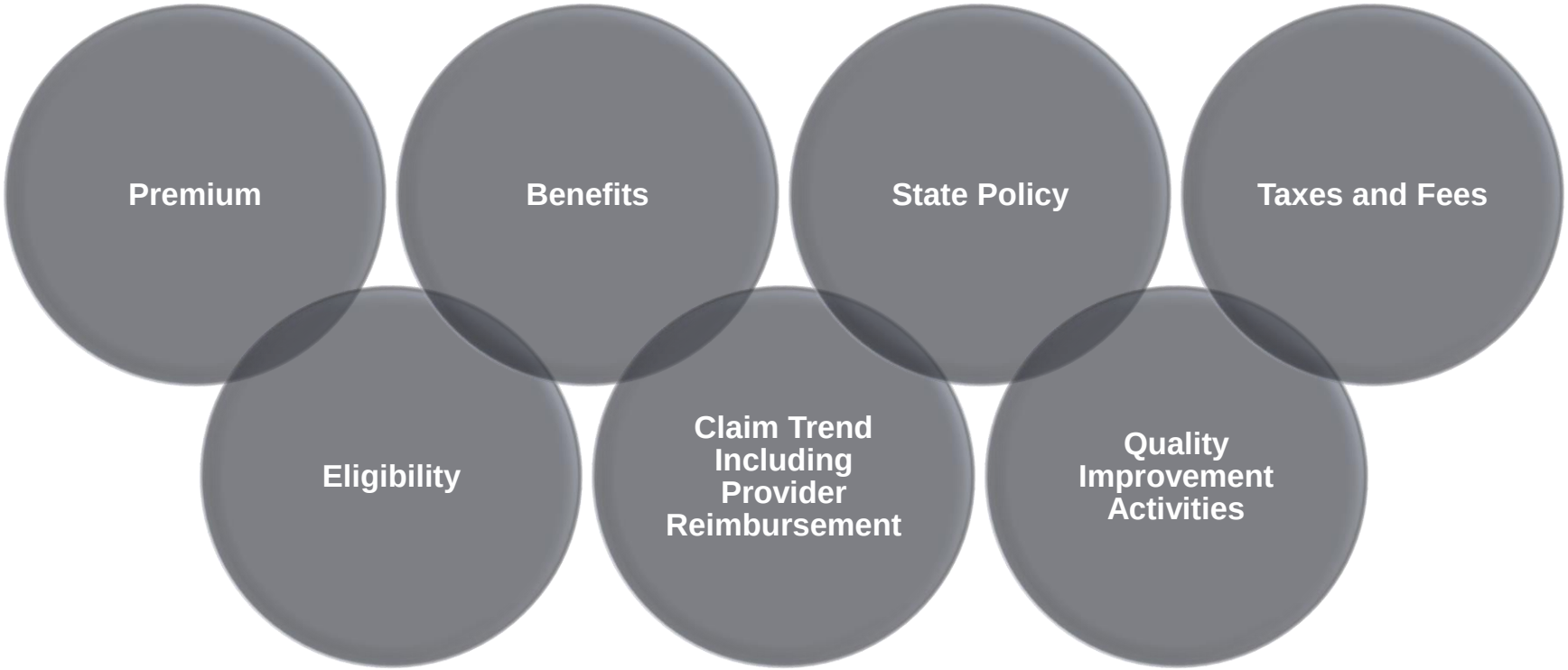
- Historical MLRs below 85%
- Excessively high historical MLRs

Usefulness of MLR Reporting

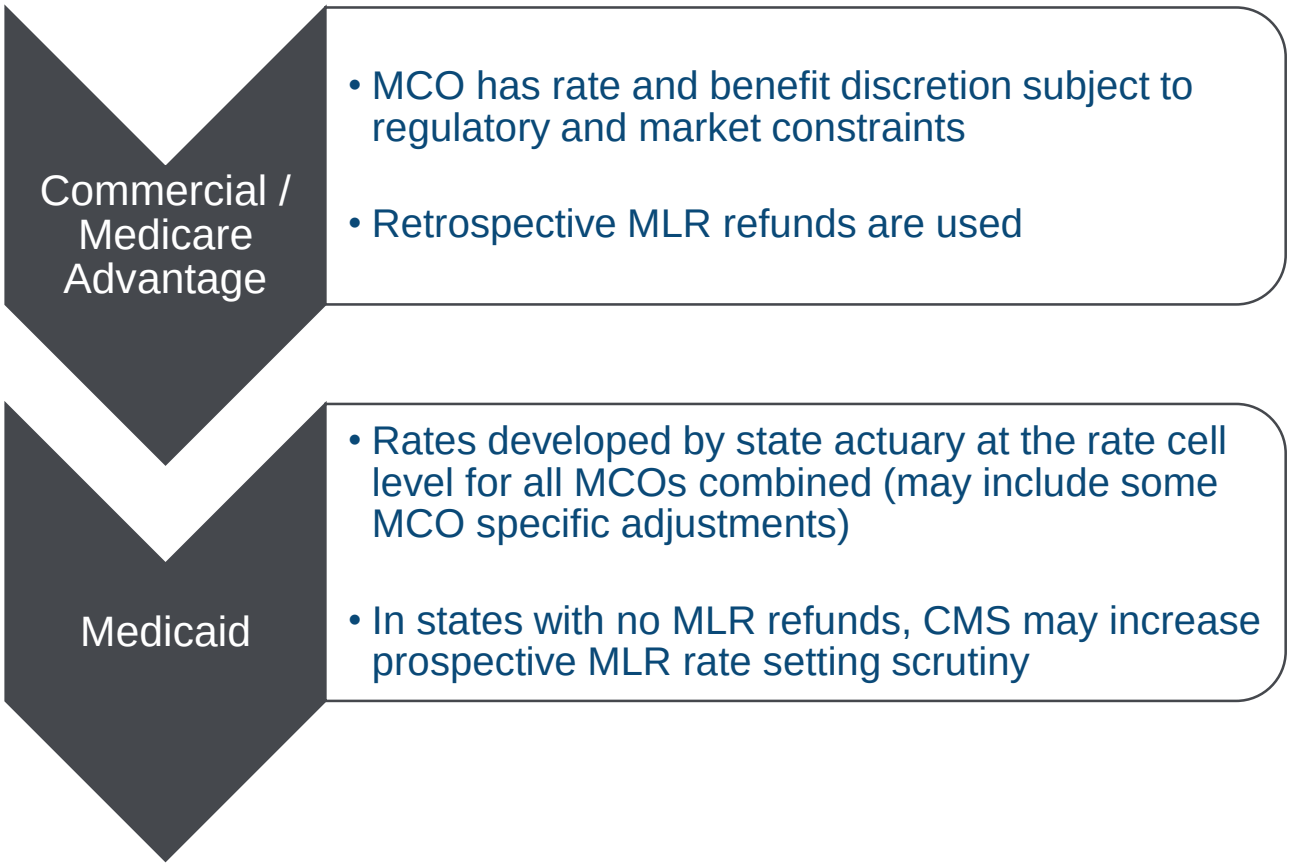
- Reporting by population level (TANF, SSI, etc.) more useful for rate setting
- State determines the reporting level; can differ from MLR refund level

Incorporating Historical MLRs into Rate Setting

- Three-year old MLRs reflect what happened three-years ago.
- Adjustments are needed to account for changes that have occurred or are projected to occur from the experience period.



Rate Setting in Medicaid versus Other Products



Use of Rate Setting for MLR Corrections

Purpose

- Rate setting may prospectively control the percentage of premium used for patient care and quality improvement activities

Data Needs from MCOs

- MCOs may need to provide projected amounts for certain MLR components

Rate Reasonability

- A MCO with low or high historical MLR will not necessarily need an increase or decrease in the final capitation rate amount
- Rates should provide for reasonable, appropriate, and attainable costs incurred by a MCO, but rate certification is not applicable to a particular MCO
- Projected MLRs should be reviewed for each MCO to assess the degree of estimated variability across MCOs participating in the managed care program.

State Decisions

Contract (rating) period	• What 12 month period to use
MLR report deadline	• No later than 12 months after contract period end
Financial statement versus incurred re-stated basis	• Fiscal year must be incurred re-stated
Collection of refunds	• Encouraged but not required
Experience aggregation level	• Reporting level can be more detailed than refund level • Same standards and minimum MLRs must apply to each eligibility
MLR range	• Minimum must be 85% or higher • Encouraged to set a maximum
New MCOs	• Whether subject to MLR reporting or not
Other	• E.g., MCO pay-for-performance withholds versus bonuses

MCO MLR Reporting Requirements

Reporting Components

- Report each MLR component separately, non-claim expenses, and member months
- Document methodologies for expenditure allocations
- Comparison with audited financial statement
- Description of aggregation methodology

Timing Provisions

- Third party vendors must provide data <180 days following reporting year or 30 days within MCO request
- Report submission within 12 months following end of MLR reporting year
- Maintain data records of MLR reports for 10 years

Additional Requirements

- Rebate amount owed (if applicable)
- Attestation of report accuracy
- Retroactive payments require report re-submission

State MLR Reporting Requirements

- Operation of managed care program (Section 438.66)
  - Financial data for each MCO, including MLR experience
- State oversight (Section 438.74)
  - Each MCO's MLR including numerator, denominator, member months, and rebates owed
- More detailed information may be requested during rate setting process
- Refund methodology
  - Reimburse CMS based on FMAP
  - If rebate owed, separate report must be developed illustrating state and federal share.
- Annual MLR reports posted to state's public website

Conclusion

Additional Transparency

- Consistent national standard
- Facilitate comparisons across MCOs and states within Medicaid and between other products

Actuarial Soundness

- 85% minimum MLR new component of actuarial soundness

Reporting Requirements

- Information gap analysis
- Assess available options
- Develop plan to ensure successful reporting by MCO partners
- Rebate requirements?

CMS “encourages” states to adopt minimum MLRs or to develop similar financial arrangements to “incentivize better plan performance”.

Limitations

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Visit http://www.milliman.com/medicaidmanagedcare/ for articles and upcoming webinars on the Medicaid managed care rule

Thank you

Jill.Brostowitz@Milliman.com

Scott.Jones@Milliman.com

Ian.McCulla@milliman.com