CMS Response to Public Comments Received for CMS-10142

The Centers for Medicare and Medicaid Services (CMS) received comments from a single plan sponsor related to CMS-10142. This is the reconciliation of the comments.

Comment:

The plan sponsor suggested that more flexibility be offered around the corporate margin requirement. The first suggestion is that the aggregate margin guidance be eliminated in favor of relying on the medical loss ratio (MLR) and the Part D risk corridor mechanism.

Response:

CMS appreciates the comments. The statute requires review of projected total required revenue of which gain/loss margin is a component. Without including gain/loss margin in the pricing review, CMS cannot effectively review the projected total required revenue. The MLR requirement and risk corridor mechanism do not replace the need for gain/loss margin review of the bid pricing. Both MLR and Part D risk corridor are calculated on a retrospective basis whereas the statute requires bids to be reviewed on a projected basis. Further, the pricing review controls the beneficiary's cost, but the MLR remittances and Part D risk corridor payments do not affect the beneficiary.

Comment:

The plan sponsor expressed concern that the margin relativity requirement could result in unintended consequences, making it more difficult for health plans to offer competitive choices to beneficiaries seeking affordable coverage under Medicare, Medicaid, Medicare Supplement, and other commercial lines of business—including small and large employer coverage and individual plans. The plan sponsor states that the current guidance could discourage participation in non-Medicare lines of business putting pressure on commercial plans to avoid or pull out of markets to manage non-Medicare margin. They further state that the test disadvantages insurers with multiple lines of business when compared to MA/PD-only insurers that need to meet only the basic margin requirement and finally that the comparison could result in a reduction of Medicare benefits. The plan sponsor recommends that CMS eliminate the margin relativity test to avoid these unintended consequences.

Response:

CMS appreciates the suggestion by the commenter. The corporate margin requirement using the non-Medicare margin basis, which refers to all health insurance business that is not Medicare Advantage (MA) or Part D, ensures that the Medicare margin is reasonable and is not over-or under-subsidizing other lines of business.

Comment:

The plan sponsor requests that CMS consider allowing the aggregate margin test to be measured over a multi-year period or that the comparison be made only to other lines of business with similar risk to improve the accuracy, effectiveness and fairness of the test while reducing its burden and unintended consequences.

Response:

As noted in the May 2, 2017 User Group Call Q&A file posted on the CMS website, the corporate margin requirement can reflect a short-term or long-term expectation, as long as, actual corporate margin is consistent with the corporate margin requirement used for the MA pricing over the long term. In addition, plan sponsors have the option to submit an aggregate-margin exception request for consideration by CMS. With regard to similar risk, the current test which measures the corporate requirement using the non-Medicare margin basis, which refers to all health insurance business that is not Medicare Advantage (MA) or Part D, ensures that the Medicare margin is reasonable and is not over-or under-subsidizing other lines of business.

Comment:

The plan sponsor recommends CMS change the way sequestration is addressed in the margin comparison, stating that sequestration is unique to federal programs and does not affect commercial insurance. They state that since sequestration results in margin that is lower than is shown in the bid, comparing the pre-sequestration margin of an MA plan to non-Medicare business that is not affected by sequestration is not an accurate comparison.

The commenter suggests that increasing administrative expenses (similar to how the insurer fee is included in the bid) would be a more appropriate approach, rather than increasing the gain/loss margin in the BPT so that the resulting projected bid margin more accurately reflects expected results. Alternatively, the commenter suggests that CMS could reduce expected revenue in the margin calculation by the amount of sequestration.

Response:

Sequestration is applied in the payment process, while the bid shows the total required revenue prior to sequestration necessary to provide the plan's benefits. It is more appropriate to directly compare the margin in the bid to the margin for other health insurance lines of business. The bid cannot be developed based on a post sequestration amount.

Comment:

The plan sponsor notes that it is challenging for plans to properly manage initial June bid submissions without fully understanding the rules that CMS is imposing on plans that are deemed to have high margins. They therefore request that CMS add to the 2021 bid instructions the criteria that will be used to flag plans for margin changes and the criteria used to determine the

target margin to help alleviate some of the confusion and rework plans may experience through desk review.

The plan sponsor further comments that for plans that are manually rated, there can be large swings in projections from year to year due to changes in the manual rate and/or other pricing factors. Benefits for non-credible plans are set in line with marketplace competition and an assumption for where the market might be in the bid year. The plan sponsor requests that CMS consider credibility as a business justification when reviewing plans with high or low margins

Response:

CMS has provided the details in the bid instructions Appendix B section 8 with regard to what information is required to support the margin. Each bid situation is unique; thus particular values used in the bid review discussions with plan sponsors cannot be added to the instructions.

Comment:

The plan sponsor requests that CMS provide additional comparison methods for related-party arrangements and offered three suggestions. First, allow plan sponsors to include a rate within 5% of what a third party pays for the same services even if the amount the plan sponsor actually pays the related party is not within 5%, second, allow plan sponsors to include the actual cost incurred by the related party plus a reasonable margin, and third, relax the service area and line of business requirements for the related party comparison.

Response:

CMS appreciates the suggestions by the commenter. CMS believes that the options provided in the bid instructions for entering costs associated with related-party arrangements in the bid pricing tool provide adequate flexibility for plan sponsors. Additionally, plan sponsors are allowed to adjust their gain/loss margin in the bid to include the gain/loss margin of the related party, provided all gain/loss margin requirements are still met.

Comment:

The plan sponsor expressed concern that since the 21st Century Cures Act allows Medicare beneficiaries with ESRD to enroll in MA plans starting in 2021, the volume of ESRD beneficiaries in MA plans will grow considerably. Thus the plan sponsor recommends that CMS allow the ESRD subsidy to fall under Medicare-covered services rather than retain its current status as mandatory supplemental benefits. Further, with regard to the MA ESRD risk adjustment model, the plan sponsor recommends that CMS consider the impacts of changes to benchmarks, the current bidding structure, benefit plan design, and eligibility status. They further recommend that CMS adjust the benchmark to reflect the fact that as a result of the enrollment of more ESRD beneficiaries, more total beneficiaries will reach the out-of-pocket maximum. Finally. They express concern that the highly concentrated dialysis provider market will result in

challenges for any MA organization to negotiate contracts with dialysis providers and recommend that CMS reevaluate network adequacy requirements for these provider types given this market dynamic.

Response:

CMS appreciates the forethought in this matter. We note that CMS does not have statutory authority to add items to Medicare-covered benefits. The remaining recommendations are outside the scope of the bid instructions.

Comment:

The plan sponsor suggests that MA plans should be allowed to offer additional benefits and include the costs in their A/B bids when the additional benefit is offered primarily to lower other Part A/B costs. They offered examples of these benefits which included an MA plan offering a zero-dollar, in-home physician visit within three days after an inpatient or SNF discharge for beneficiaries with a probable readmission risk, transportation benefits targeted for primary care provider (PCP) visits post-discharge, on call in-home physician visits for high emergency room (ER) utilizers, and meals following inpatient or SNF discharges.

Response:

CMS appreciates the suggestions by the commenter. The bid pricing tool (BPT) reflects the pricing of the benefits as classified in the plan benefit package (PBP) and defined by policy. CMS does not have broad authority to reclassify additional benefits as Medicare covered for pricing purposes.

Comment:

The plan sponsor requests that the CY2021 Part D Bid Pricing Tool be adjusted to add deductible sections to worksheet 6 so that the value of the deductible and cost sharing can directly feed from those exhibits for worksheet 4 (cell E43) and worksheet 5 (cells F39:G40 and F46:G46). There would be deducible rows for Population below the Initial Coverage Limit (ICL) and deductible rows for Population that exceeds the ICL. The plan sponsor notes that the current worksheet 6 structure produces an incorrect weighted average cost sharing because it uses all ICL dollars as weights for the cost sharing and not just the post-deductible ones.

Response:

CMS appreciates the suggestions by the commenter and intends to make these changes to the CY2021 BPT. These changes were modeled in a mock up released on the December 5, 2019 Actuarial User Group Call and will be included for testing in the February beta release.