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To: Centers for Medicare and Medicaid Services
Submitted electronically via: www.reginfo.gov/public/do/PRAMain

From: Jennifer McKenna
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Date: January 22, 2021

Re: Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)

Attached for your consideration are UnitedHealthcare's comments regarding the Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP).

UnitedHealthcare Comments for the BPT for MA Plans and PDPs

UnitedHealthcare (UHC) appreciates the opportunity to provide input to the Centers for Medicare and Medicaid Services (CMS) regarding the BPT for MA Plans and PDPs.

Related Party Proposed Changes CY2022

UnitedHealthcare asks CMS to reconsider its proposed requirement that plans submit more detailed related party data for each related party. The Office of the Actuary (OACT) indicated in the November 12, 2020, actuarial user group call that the goal of the additional related party reporting requirements is to standardize the collection of information and to better understand the extent to which plan sponsors rely upon related parties to provide services reported in the allowed costs and non-benefit expenses of bid filings. However, collecting information by each related party is unnecessarily burdensome for plans and does not support OACT's stated goal to better understand plans' reliance on related parties within the bid filing context. Requiring information at this granular level will greatly increase the administrative burden for plans without providing additional clarity to CMS. Instead, CMS could meet its goal of understanding the extent to which the plan sponsor relies on related parties to provide services by collecting this information at the plan level rather than the related party level. For example, a plan might have multiple medical agreements with different related parties in a market, but projecting the required data for each agreement separately may be difficult. In addition, splitting the data by related party does not add value to the process and will not further CMS's goal of understanding the total spend associated with related parties. The current bid requirements already provide a fairly detailed review of related party arrangements during desk review and bid audit. To further CMS's goals of standardizing information collection and better understanding the total related parties spend, we recommend that CMS collect the data in the BPT in worksheets (lines z4 and z5) without requiring the additional detail in the supporting documentation by related party (Appendix B, 13.1.5).

UHC also recommends CMS amend the requirement so that the amounts in lines z4 and z5 reflect the related party expenses as filed in the bid (i.e., using Method 1-4, as appropriate). This would reduce the amount of work involved in this requirement while still providing CMS with a reasonable estimate of the related party dollars in the bid. For example, if a related party arrangement is reported in the bid at actual cost using Method 1, plans should include those actual costs in lines z4 and z5. The difference between the contractual costs and the actual costs are irrelevant to the plan's bids. Moreover, providing the contractual information (that does not affect the bids) at the plan level can be burdensome.

We request that CMS explain further what an entity within the same taxpayer identification number (TIN) as the plan sponsor is meant to capture. Under the current instructions, agreements within a TIN are not considered related party arrangements, which we believe means they should not be reflected in the bid. Instead, the intra-TIN arrangement would be ignored for bid purposes and the expenses would be included in the bid as a pass through. If the arrangement within the TIN is not reflected in the bids, collecting and disclosing such information provides no value, but imposes significant burden, especially if the information must be disclosed at the PBP level.

We recommend that the amounts entered in z4 only include those in which Medicare Advantage (MA) organizations have an arrangement for the related party services. For example, the MA organization may have a related party that is a non-contracted provider. If the MA organization needs to identify each of these related party non-contracted providers in the supporting documentation, there could be hundreds of these lines in a given Plan ID. Note that these claims would be reimbursed at 100% of fee-for-service (FFS) Medicare as required by regulation. Since these claims are treated exactly the same for related and non-related parties and it would be administratively burdensome to track these separately, we do not believe that it adds value.

Additionally, we ask for clarification on if related party dollars for Optional Supplemental services should also be included in z4 and z5.

Related Party Proposed Changes CY2023

UHC supports OACT's proposal to allow plans to report related party costs in the bid without adjustment and consistent with the actual related-party contractual terms as this will significantly reduce the burden on plans in preparing bids.

We do not support providing a best estimate of the related-party profit margin for the bids because it increases the amount of work required for the bids without providing additional value to the bid projections. This additional reporting requirement is extremely labor intensive, will distract from the goal of providing the best projections for 2023, and does not provide additional value to the member. CMS states in Appendix 3 that it believes these changes would reduce the amount of workload by plan sponsors. However, under the current process we only need to collect the actual cost information for the related parties when there is not a comparable contract. Gathering actual cost information from related parties is a significant undertaking and would increase the amount of work required if we need to collect this information for all related party contracts. In addition, in some situations, gathering this information from the related party is extremely difficult (in particular, when the MA organization has a minority interest in a related party). In many cases, the related party does not separately track margin for the MA organization versus margin for non-related entities. In addition, this is particularly challenging for related parties that are paid on a FFS basis. Historically, if the contracts were within 5% of FFS Medicare or comparable, the MA organization would be using Method 2 or 3 and not collecting profit levels from the FFS provider. Capturing the profit margin from each of these related party FFS providers will be extremely challenging and time consuming.

In addition, related parties are not necessarily projecting to 2023 at the time plans are working on the 2023 bid filings. In many cases, we need to use mid-year (2022 in the case of the 2023 bids) estimates of projected margin for cases in which we project actual costs. If CMS does require the reporting of related party margin, we recommend reporting the related party margin for the base period instead of the projection period.

CY2022 Gain/Loss Margin Bid Instructions

UHC remains concerned with the existing bid margin tests. The non-Medicare corporate margin and the risk-capital-surplus (RCS) tests are unnecessary given the medical loss ratio (MLR) requirements and competitive market dynamics that already regulate Medicare profitability. The MLR requirement ensures the profits of MA plans and Part D sponsors are restricted to a certain range, limiting the ability of an MA plan to earn "excess" profits. The MLR requirement is more effective than the margin test because it addresses actual rather than projected margins. It also fairly treats plans because the same standard is applied regardless of the types of product choices they offer to consumers. Medicare is a highly competitive market and seniors are price sensitive consumers. Insurers that file plans with excessive margins will be competitively disadvantaged on benefits and lose significant membership, resulting in material negative financial consequences to the health plan. Moreover, even without a formal margin test requirement, CMS reviews each bid to ensure compliance with bid instructions.

Eliminating the margin tests ensures Medicare profitability is regulated consistently between multi-line insurers and Medicare-only insurers, rather than being governed by two different sets of rules creating an uneven playing field and perverse incentives. The margin tests place unnecessary pressure on commercial and Medicaid plans to avoid or leave markets in order to allow MA plans to offer a stable and competitive product for beneficiaries. The margin tests also improperly disadvantage insurers with multiple lines of business when compared to Medicare-only insurers that need to only meet the basic margin requirement. The margin tests create an arbitrary distinction between plans and impedes those seeking to bring more competition, innovations, and choices to consumers.

If CMS retains the bid margin test, then CMS should make significant changes to address concerns, specifically:

- Change the definition of non-Medicare business by removing all Medicaid when defining non-Medicare business. As we note below, Medicaid business has changed in recent years such that it is almost always non-discretionary. Alternatively, CMS should exclude all non-discretionary non-Medicare business from the calculation regardless of whether the non-discretionary business is more than 10% of the non-Medicare business. Removing all non-discretionary business from the definition of non-Medicare will mean that MA carriers that also have commercial, or commercial and Medicaid business, will be treated similarly in that non-discretionary Medicaid business will not impact the test for either set of carriers.

- Create a safe harbor permitting plans to file bids with a reasonable range of margins regardless of what the margin tests would otherwise require. We suggest that any aggregation of bid margins in the range of 2% to 7% should be acceptable. This allows plans with high margin commercial plans or low margin Medicaid plans to still offer competitive MA products.

- Provide greater clarity on the RCS test methodology.

As we have recently shared with CMS, we recommend CMS consider all Medicaid business non-discretionary and exclude it from the non-Medicare margin test altogether. State Medicaid agencies typically establish Medicaid rates, unlike other insurance products. This approach to Medicaid rate setting has evolved from historical methods of "bidding" rates to "accepting" rates at very low margin levels (i.e., 1% to 2%) over the past several years. As a result, in our experience and confirmed by multiple external consultants, the vast majority of Medicaid business is already considered non-discretionary for margin test purposes. If, for example, these lower Medicaid margins were used as the basis for determining appropriate Medicare bid margins, as could be the case under the current rules, it would result in unsustainably low Medicare margins, especially given the fact that Medicare bid margins are typically 1% to 2% higher than projected GAAP margins due to bid exclusions and sequestration. The impact of these low Medicaid margins being included in the non-Medicare margin calculation creates a clear disincentive for multi-line insurers to participate in Medicaid business while those insurers that are not committed to serving the Medicaid population are allowed to achieve higher Medicare margins.

If CMS does not want to exclude Medicaid margins entirely, CMS could allow plans to show an adjusted 'non-Medicare' margin that was based on what a reasonable Medicaid margin would be if it were discretionary. This would allow for a more reasonable comparison to Medicare plans. For instance, if plan sponsors could treat Medicaid plans as if they has a 4% or 5% margin, the weighted non-Medicare margins may be a more reasonable comparison to Medicare business.

Further, UHC suggests CMS make all of the above changes in the BPT instructions rather than require plans to seek exceptions to make these adjustments. By making the changes directly in the rules, CMS will allow plan sponsors to understand the requirements and design bids accordingly. This will also create a level playing field allowing all plan sponsors to understand available options.

Finally, we request CMS clarify the specific changes in Section 8.1.1. We believe CMS intends that Section 8.1.1 (b) require plan sponsors to provide information for each line of business when the non-Margin test applies. When the RCS test applies, it does not make sense to refer to different lines of business. In addition, we believe CMS intends that Section 8.1.1 (c) require plans discuss required surplus, risk-based capital requirements, and return on equity when the RCS test applies. We ask CMS to clarify that 8.1.1(b) applies to the non-Medicare margin test and 8.1.1(c) applies to the RCS test.

Respectfully,

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