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To: Centers for Medicare and Medicaid Services
Submitted electronically via: regulations.gov

From: Shannon Schuster
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Date: November 30, 2018

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

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

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

Comments Submitted by
UnitedHealthcare
11/30/18

UnitedHealthcare (United) appreciates the opportunity to provide input to CMS regarding the Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP).

Margin
Non-Medicare Margin Test

The Medicare Advantage (MA) and Part D bid instructions require the aggregate margin of plans to be within 1.5 percent of the plan's margin on fully insured health insurance business other than MA and Part D. This requirement increases the regulatory burden on MA Plans and Part D Sponsors and creates unintended consequences, making it more difficult for insurers to offer valuable programs across Medicare, Medicaid, Medicare Supplement, and commercial lines of business. This test could discourage insurers from participating or expanding in Medicaid, for example, if the insurer's Medicaid plan has a significantly lower margin than the insurer's MA and/or Part D plans. Similarly, if an MA Plan or Part D Sponsor were making substantially more in commercial plans than it was in MA or Part D, the MA Plan or Part D Sponsor would likely either stop offering the MA or Part D plan or raise margins in the MA or Part D plan by reducing benefits. Neither result is in the interest of CMS or beneficiaries.

CMS previously offered more flexibility related to margin relativity by:

- Indicating the numerical comparison was an example of what would be in a reasonable range.
- Making clear that "comparisons to other lines of business must take into account the degree of risk or surplus requirements of the business."[1]
- Allowing plans to meet the test over a multi-year period.[2]

United recommends that CMS create more flexibility in meeting the corporate margin requirements by:

- Allowing corporate margin requirements to be measured over a longer timeframe such as three to five years. This allows MA Plans and Part D Sponsors to provide more stability in benefits since there would be no need to change benefits every year due to variable, short-term changes in the margin levels of its other lines of business.
- Reconsidering what is included in the non-Medicare margin and including only lines of business with similar risk profiles, i.e., those with products where the plans have discretion in rate setting and that are priced annually and include full medical risk. For example:
    - The Medicare Supplement business should be excluded from the non-Medicare margin because Medicare Supplement has a different level of risk than MA and is rated over a beneficiary's lifetime.
    - Medicaid business should be excluded from the non-Medicare margin because the rates are largely set by the state and as a result health plans have less control over their profit margins.

[1] 2009 MA BPT Instructions, Page 37
[2] CMS Office of the Actuary (OACT), CY2010 Actuarial Bid Questions. Page 19, Line 16. https://www.cms.gov/Medicare/HealthPlans/MedicareAdvtgSpecRateStats/Downloads/ActuarialBidQuestions2010.pdf

- Individual Exchange plans should be excluded from the non-Medicare margin because that product continues to evolve and therefore may have unsustainable and below-market rates.
- Eliminating the corporate margin requirement for Part D Plans (PDP). Due to the risk sharing arrangement around the PDP benefit, PDP business does not have a similar degree of risk as other lines of business. Therefore, it should not require the same level of surplus requirements. Also, due to the risk corridors, CMS already has a mechanism to control how much margin plans make on PDP business.
- CMS should change the way it addresses sequestration in the margin comparison. Sequestration is unique to Medicare and does not affect commercial insurance. If sequestration results in an MA Plan making less than appears in the bid, it does not make sense to compare the pre-sequestration margin of a plan to non-Medicare business that is not affected by sequestration. The BPT instructions indicate that MA should account for the potential impact of sequestration in their risk margin, as a temporary increase. The medical expenses are also reduced for the probability of reduced payments to providers. United thinks it would be more appropriate to increase administrative expenses (similar to how the insurer fee is included in the bid) rather than increasing gain/loss margin in the BPT so that the resulting projected bid margin more accurately reflects expected results. Alternatively, CMS could reduce expected revenue in the margin calculation by the amount of sequestration to address this issue.

Plan Level Margins Tests

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 be high margin. We respectfully request CMS to add the criteria that were used to flag plans for margin changes and also the criteria used to dictate the specific margin levels required to the 2020 bid instructions to help alleviate some of the confusion and rework plans may experience through desk review.

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. We respectfully request that CMS consider credibility as a business justification when reviewing plans with high margins.

End Stage Renal Disease (ESRD)

Section 17006 of the 21st Century Cures Act (Act) allows for Medicare beneficiaries with ESRD to choose to enroll in an MA Plan beginning in 2021. Prior to the passage of this Act, ESRD beneficiaries were excluded from enrolling in MA Plans; however, MA beneficiaries who developed ESRD post enrollment in an MA Plan were permitted to remain enrolled. The Act also excludes the cost of kidney acquisitions from capitation rates and MA benchmarks; the cost of kidney acquisitions will be covered under Fee for Service (FFS) Medicare beginning in 2021. By December 31, 2018, the Secretary of Health and Human Services is to release a report on the risk adjustment model for ESRD under MA.

As CMS reevaluates and revises the ESRD risk adjustment model under MA, United recommends that the impact of any changes on benchmarks, the current bidding structure, benefit plan, and eligibility status all be seriously considered. For example, CMS should adjust the benchmark to reflect the fact that as a result of the enrollment of more ESRD members, more members in total will reach the out-of-pocket maximum. Thoughtful consideration of these items, as well as stakeholder feedback and

engagement, should be key components in the crafting of a detailed, appropriate model. United welcomes the opportunity to have a discussion with CMS on this issue.

Low Income Premium Subsidy Amount

For the 2019 bids, CMS added support for the estimate of the Low Income Premium Subsidy Amount (LIPSA) to the supporting documentation items that are required to be available upon request. We request that CMS clarify the purpose of this documentation in the 2020 BPT and related bid instructions. United estimates the LIPSA amount using multiple methods that are largely dependent on actions taken by other plans, which is extremely challenging to predict with any degree of certainty. There is often a wide range of possibilities and our ultimate estimate may not be based on any one point estimate, but rather based on selecting within a particular range of estimates. In addition, our choice of estimates within a particular range may vary by plan based on our confidence in the estimates (e.g., how much our own enrollment/bids impact the results). The administrative burden around supporting documentation requirements continues to increase each year and takes away from critical time needed to ensure that other bid assumptions and calculations are accurate. In addition, in situations where plans target the LIPSA, the bids are adjusted during rebate reallocation to get to the actual LIPSA. For these reasons, we request that CMS clarify the purpose of this documentation to help plans understand its value and the time that CMS desk reviewers spend reviewing it.

Additional Related Party Cost Method

The 2019 MA BPT Instructions required that the MA Plan disclose whether or not they are in a business arrangement with a related party. In addition, the 2019 MA BPT Instructions required that the financial arrangement between the MA Plan and the related parties are not significantly different from the financial arrangement that would have been in place for third parties. MA Plans can meet this standard by showing, for example, that the amount they pay to a related party is within 5% of the amount the related party receives from a third party. If the MA Plan cannot meet the related party standard, it can only include the actual cost paid to the related party in the bid, even if a higher amount would be reasonable.

In the 2020 BPT and related bid instructions, United recommends that CMS provide additional comparison methods for MA Plans when the market comparison is not within 5% of the third party payment, instead of requiring that MA plans only use the actual cost paid to the related party. In addition to using the actual cost paid to the related party, CMS should allow plans to choose among alternative comparison methods, including:

- Allow MA Plans to include a rate within 5% of what a third party pays for the same services even if the amount the MA Plan pays the related party is not within 5%. For example, if a plan pays a related party $10 PMPM for a service and a third party pays the related party $8 PMPM for the same service, the MA Plan should be able to include between $7.60 and $8.40 PMPM.
- Allow MA Plans to include the actual cost incurred by the related party plus a reasonable margin, such as 2% or 3% of cost.
- Allow MA Plans to use as a comparison a medical agreement with a third party that is not in the bid's service area, or a medical agreement between the related party and a third party that is not an MA Plan.

Allowing MA plans to choose among these alternative comparison methods would produce bids that were more in keeping with true market value of services provided by related parties. As it stands now,

two otherwise similar bids could have substantially different bid amounts based only on whether the MA Plan uses substantial services from related parties. While we understand the need to ensure that MA Plans do not overpay for related party services, we believe the changes suggested here would still meet that goal.

Reflect Value of A/B Savings in Pricing of Supplemental Benefits

As outlined in the 2019 MA BPT Instructions, CMS allowed MA Plans to offer as a supplemental benefit a waiver of the 3-day inpatient hospital stay prior to coverage of a Skilled Nursing Facility (SNF) and price the benefit as a Medicare-covered benefit, even though it would not be covered under FFS Medicare. United believes that CMS has taken that approach because the waiver results in a Medicare A/B cost-savings: waiving the three day hospitalization can avoid unnecessary hospital admissions when the beneficiary really needs to be admitted to a SNF, which is less expensive than a hospital admission.

In the 2020 BPT, United recommends that this approach be applied more broadly for other situations where offering a supplemental benefit results in a likely reduction in Medicare A/B costs. United recommends that MA plans be allowed to offer additional benefits and include the costs in their Medicare A/B bids when the additional benefit is offered primarily to lower other Medicare A/B costs. For example, if an MA Plan offers a zero-dollar in-home physician visit within 3 days after an inpatient or SNF discharge of members likely to be at risk for readmission, the rate of readmission would likely drop and the Medicare A/B savings would pay for the program. United recommends that the cost listed in the bid for that supplemental benefit is included in Medicare A/B costs. Additional examples include: transportation benefits targeted for primary care physician visits post-discharge, on call in-home physician visits for high emergency room utilizers, and meals following inpatient or SNF discharges. This change would incent MA Plans to offer benefits that reduce Medicare program expenditures by providing the right care in the right setting at the right time.

Desk Review/Substantiation/Bid Instruction Clarification

Appendix B of the 2019 Bid Instructions requires Part D sponsors and MAOs upload revised documentation consistent with the final bid and CMS indicated that would include additional information or materials provided during the bid review. We interpret that section as we need to add only pertinent items (e.g., an item was left out or an item changed due to a correction) to our final supporting documentation, and in 2017, our desk reviewer agreed. In 2018 and in 2016, the same desk reviewer interpreted that section as we were required to upload all of the questions and answers, including any attachment, we provided during desk review. Combining the seven sets of questions (each set covers a topic and covers any bid submitted by the parent organization) and associated files produces a 50+ page narrative document with approximately 20 embedded attachments. In addition, we updated our documentation for any missing items or updates from the summer during reallocation. In the 2020 bid instructions and bidders' training, we respectfully request clarification of the upload requirements in the bid instructions and bidders training and consistent application to all Part D sponsors and MAOs.

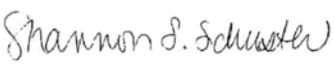
Bid Pricing Tool

We would like deductible sections added to WS6 of the Part D 2020 BPT so that the value of the deductible and cost sharing can directly feed from those exhibits for WS4 (cell E43) and WS5 (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. Any formula that references WS6

elsewhere in the BPT would need to be reviewed to adjust for the new rows on WS6. The current WS6 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.

If you have any questions on these comments, please feel free to contact me at 920-661-6217.

Respectfully,



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