Understanding the Bidding Process

Presented by

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Goals

- To understand generally the mechanics of the bidding process for coordinated care type health plans
- Review the changes from the proposed rules
- Focus on important dates
Medicare Advantage (MA) Contracting Process—Generally

- The final rules establish a bidding process for MA plans (Part 422) and MA prescription drug plans (MA PD) or stand alone prescription drug plans (PDP) (Part 423)

- The bidding concept for MA plans and prescription drug plans is similar; they vary in scope and deliverables
MA Contracting Process—Generally (continued)

- The MMA establishes two types of coordinated care plans
  - Regional and local MA plans—we will discuss this today
  - Specialized MA plans—this change allows an MA plan to focus on targeted groups
- Special rules for end-stage renal disease ("ESRD") beneficiaries—we will not review these
MA Contracting Process—Generally
(continued)

- The MMA bidding process changes how private plans contract with CMS—replaces the “adjusted community rate” (the “ACR”) payment process starting in 2006
  - Compare the bidding process to the prior contracting process in which plans were paid a fixed ACR rate
Enrollment Process—Generally

- Like the prior M&C program, individuals need to enroll in the MA program
  - Non-discrimination rules apply (compare to specialized plans)
  - MA organizations may be able to limit enrollment for capacity reasons
  - Time period set for enrollment, longer in 2006
  - Generally, have to be residents of the plan service area—regional or local areas
What is the Bidding Process?

• For 2006, bids are due on or before the first Monday in June for the upcoming year.

• Essentially, the rate setting process is a “bid-to-benchmark” comparison.
  – This process also determines the plan participant’s premium, if any.
What is the Bidding Process? (Continued)

• Not a true bidding arrangement
  – CMS engages in limited negotiation
    – Similar to negotiations for federal employee health care plans
    – Non-interference provisions of statute
  – CMS cannot require the plan to contract with designated providers or set a particular rate structure
    – CMS reviews MA plans to confirm actuarial values and that cost sharing does not exceed traditional benefit cost sharing
    – CMS reviews compliance with requirements
    – CMS analyzes profit or anticipated return
What is the Bidding Process?  
(continued)

- Detailed rules for a bid
  - Different submission rules for health benefits (Part C) and drug benefits (Part D) although concept is similar
  - We will discuss Part C bidding first
  - For MA plans, the bid includes one amount for:
    1. The statutory “unadjusted” non-drug monthly bid amount—essentially this is the MA plan’s estimated average monthly “required revenue” to provide traditional Part A and B benefits (the “A/B Bid”)
    2. The amount to provide basic prescription drug coverage, if any (MA plans are required to make a consolidated bid); and
    3. The amount to provide supplemental coverage, if any
  - Bid must give uniform benefits for service area
  - Must take into consideration “cost sharing”
    - Actuarial estimate
What is the Bidding Process? (continued)

• In submitting bids, the MA plan will need to provide, among other things
  – The monthly aggregate bid amount
  – Allocation of the bid amount among
    – A/B bid;
    – Prescription drug coverage; and
    – Supplemental benefits
      (This is needed to do the comparison of bid to benchmark)
  – Projected number of MA plan enrollees used to calculate the bid amount and the MA plan’s enrollment capacity
What is the Bidding Process? (continued)

- Actuarial basis for determining the bid—under the prescription drug bid process, need an actuary to certify estimates
- Description of MA plan’s deductibles, co-pays, coinsurance and their actuarial value
- Description of drug coverage (if applicable)
- Special provisions for regional plan—risk corridor information for MA regional plans—(this is to help buffer the increased risk) and relative cost factors in multiple counties
- “Rebate” information (if applicable)—we will discuss rebate later
What is the Bidding Process?
(continued)

- “Required revenue”—the MA plan’s estimate of the revenue required to provide traditional coverage in the service area for enrollees with a national average risk profile
  - The required revenue must take into consideration actuarial assumptions on cost sharing
What is the Bidding Process? (continued)

- CMS favors the “proportional” method to determine the actuarial equivalent of cost sharing
  - This is a change from the proposed rules and current approach
  - Cost sharing cannot exceed the actuarial value of the traditional benefit, similar to the prior M&C program, except do not count the premium, or for regional plans, the out-of-network cost sharing
- Not required to bid below the benchmark
What is the Bidding Process? (continued)

• Once the A/B Bid is accepted, the amount of the A/B Bid is compared against the “Benchmark” for non-drug costs, both as adjusted for risk factors
  – The Benchmark calculation differs for local and regional plans and is an amount computed by CMS; both essentially consider capitation rates, differ for weights and geographic areas
  – MA regional Benchmark is announced on or before November 15th, but after CMS receives bids from MA plans
What is the Bidding Process? (continued)

• Any excess of the adjusted Benchmark over the adjusted A/B Bid is the “savings,” subject to “rebate”
  – Measurement of risk factors is different for local and regional plans

• The purpose of comparing the A/B Bid to the Benchmark is to standardize the evaluation of bids, permit a more accurate cost comparison of basic Part A/B services and correctly determine the “savings” and the related “rebate”
Beneficiary Premium

- If the unadjusted A/B Bid is less than the unadjusted Benchmark, basic premium = 0
- If the unadjusted A/B Bid is greater than the unadjusted Benchmark, basic premium = the excess
  - Special rules for MSA plans
  - Subject to exceptions, premium must be same for all enrollees in the plan
  - Can apply for segmented area option
  - Cannot offer incentives to enroll
Beneficiary Premium
(continued)

• Premium must be consolidated and charged in a monthly lump sum
  – Payment options
  – Credit for “savings”
What is the Rebate?

- The MA plan is required to “rebate” 75% of savings to participants
  - Remaining 25% is retained by Medicare Trust Fund
  - To be credited to mandatory supplemental benefits (drug and non-drug) premiums
  - Cannot be used to reduce the cost of optional supplemental benefits—CMS’ stated concern is that these benefits could be subsidized to attract enrollees
  - For MA-PD plans, must show how rebate is allocated between Part C and D benefits
What is the Rebate? (continued)

• Gives flexibility to MA plans to use the rebate to subsidize the cost of “mandatory supplemental” benefits
How is the MA Plan Paid?

• Starting in 2006, CMS makes advance monthly payments for the Parts A/B component based upon the A/B Bid to Benchmark comparison
  – If the A/B Bid is less than Benchmark, the MA plan essentially receives its A/B Bid amount plus the rebate (75% of savings), subject to reduction
  – If the A/B Bid is greater, it receives the Benchmark amount
How is the MA Plan Paid? (continued)

- There are risk adjustment factors applied to the Benchmark and the A/B Bid before making the calculation
  - Rate difference for service areas
  - Age, health, disability status

- MA-PD plan is also paid for prescription drug subsidies (direct and reinsurance subsidies)
  - Not all of the MA’s plans are required to offer prescription drug coverage
How is the MA Plan Paid? (continued)

• Other Payments
  – Reimbursements for premium and cost sharing reductions for low income enrollees
  – Special rules for ESRD enrollees
  – Reconciliation for actual number of enrollees (reconcile advance payments)
  – Catch up from later enrolling enrollees, if conditions met
  – “Risk corridor” payments for MA regional plans in 2006 and 2007
How is the MA Plan Paid? (continued)

- MA plans are required to provide data to make calculations
  - Timelines for data
  - Late data not accepted
Prescription Drug Bidding Process

• Prescription drug bidding process works in similar fashion
  – For MA-PD plans, they submit a consolidated bid
  – For PDP plans, submit a separate bid

• In each case, bidding process is analyzed under Part 423
Prescription Drug Bidding Process (continued)

• Same bid to benchmark type of comparison, although the mechanics are different. Like the MA-PD plans, the following apply:
  – Bids are due on first Monday in June, for upcoming year
  – Bids reflect “revenue required” to provide prescription drug coverage with national average risk profile
  – CMS’ regulations set forth requirements for bid submission, including actuarial assumptions, certain administrative costs, allocation of bid, supplemental coverage and profit on return
  – Additional risk factor adjustments
  – Special rule for negative premium
    – Either reduce supplemental premium (if any); or
    – CMS requires an enhanced benefit equal to negative premium
Prescription Drug Bidding Process (continued)

• Mechanics:
  – CMS uses the standardized bids submitted to determine “national average monthly premium.”
  – No geographic adjustment until CMS develops method
  – To calculate beneficiaries “base premium,” multiply “national average premium” by the defined beneficiary premium percentage (25.5%, adjusted for reinsurance and payments to MA plans)—this becomes the Benchmark
Prescription Drug Bidding Process
(continued)

– This amount is compared to the standardized bid and the premium adjusted by the difference
– There is a late enrollment penalty
Payments by CMS to PDP’s equal:
- Bid amount plus risk adjustments for health status less beneficiary premium
- Reinsurance subsidy payments
- Low income subsidy
- Risk sharing payments
- Retroactive adjustments for advance payment

Payments conditioned upon plan’s disclosure of information
Principal Changes from the Proposed Regulations

- Methodology—essentially the same
- MA plans
  - Selection of the “proportional” method in making the actuarial determinations
Principal Changes from the Proposed Regulations (continued)

- MA regional plans may request CMS to use plan specific variations in payment rates

- **MA-PD or PDP plans**
  - Clarified scope of bid review authority, including review of projected profit
  - Permits a negative premium, by adjusting premiums or benefits
  - Expressed a need to continue to refine required data elements
  - Methodologies for subsidies, low income, reinsurance and risk corridors are proposed, not yet resolved
Important Bid Process Dates

- On February 15, 2005—final date to submit application for 2005 coordinated care plan
- March 1, 2005—final date to submit MA service area expansion for 2005
- Late March 2005—CMS bid training in Baltimore
- March 23, 2005—Part D applications are due
- June 6, 2005—final date for MA (drug and non-drug) plans to submit bids for 2006