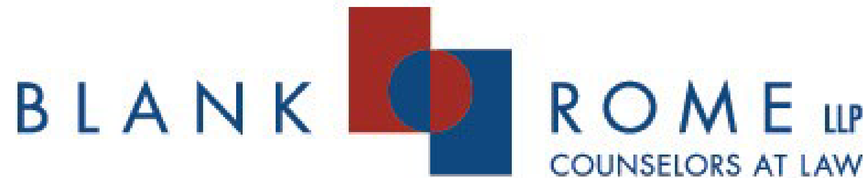
Understanding the Bidding Process

Presented by



William E. Gramlich, Esquire
One Logan Square
Philadelphia, PA 19103
215-569-5739 (tel)
215-832-5739 (fax)
Gramlich@blankrome.com

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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 <u>one</u> 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

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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) <u>and</u> 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 <u>less than</u> the unadjusted Benchmark, <u>basic</u> premium = 0
- If the unadjusted A/B Bid is <u>greater than</u> the unadjusted Benchmark, <u>basic</u> 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 <u>plus</u> 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

Prescription Drug Bidding Process
(continued)

- Payments by CMS to PDP’s equal:
  - Bid amount <u>plus</u> risk adjustments for health status <u>less</u> 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 <u>request</u> 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