

MILLIMAN RESEARCH REPORT

Medical loss ratio (MLR) in the “Mega Reg”

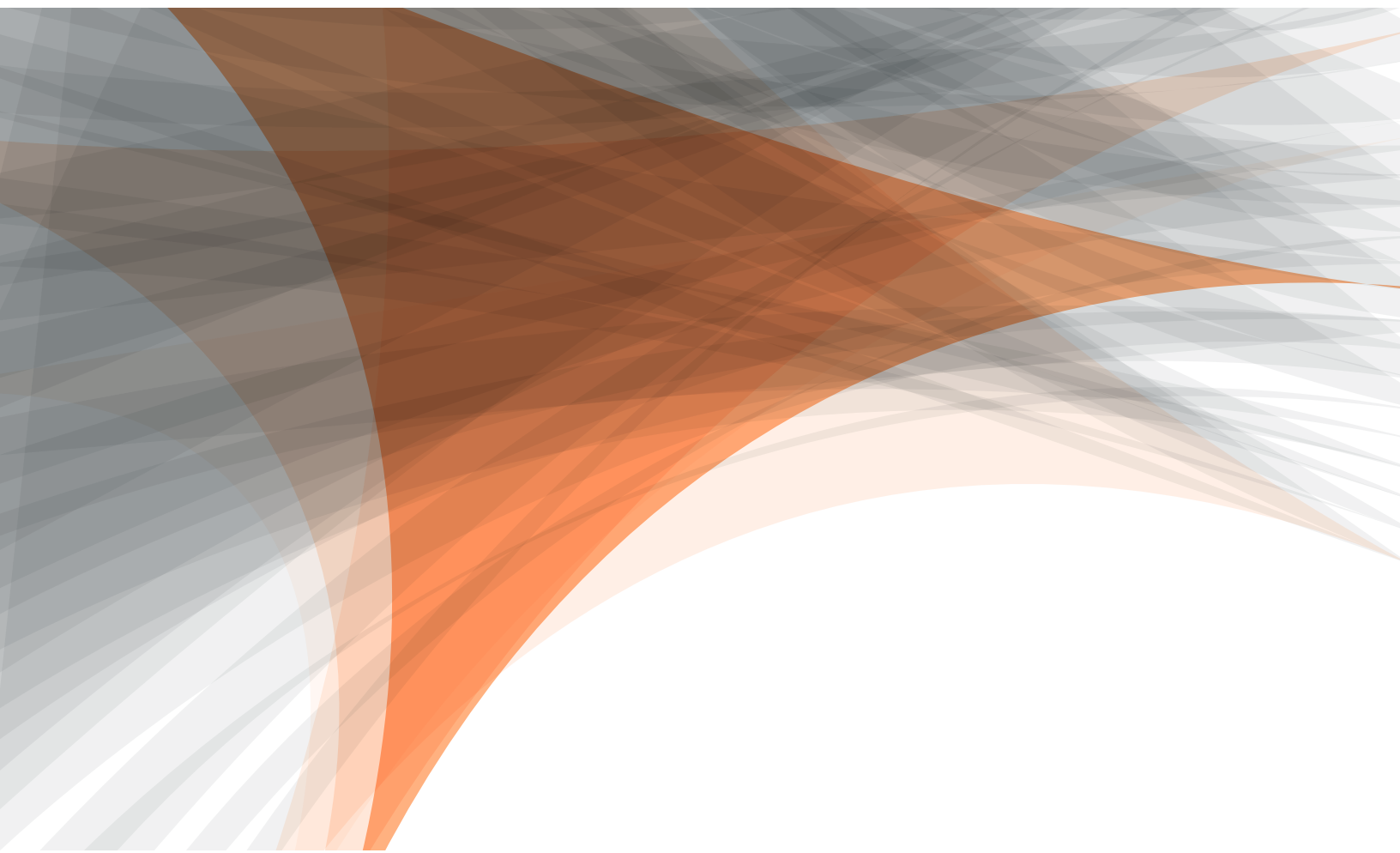
Medicaid adopts comprehensive
MLR standards

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[Jill Brostowitz](#), FSA, MAAA

[Scott Jones](#), FSA, MAAA

[Ian McCulla](#), FSA, MAAA



Executive Summary

With the release of the final Medicaid and Children’s Health Insurance Program (CHIP) managed care rule (final rule),¹ medical loss ratios (MLRs) will become a required part of financial reporting for Medicaid managed care programs in every state, effective for managed care contracts beginning on or after July 1, 2017. In addition, the final rule specifies that the capitation rates for rate periods beginning on or after July 1, 2019, must be developed in a way that projects a MLR of at least 85% for participating managed care organizations (MCOs). In terms of potential impact to the Medicaid managed care industry, more than 75% of MCOs analyzed in Milliman’s annual review of Medicaid-focused insurers had an estimated MLR above the 85% federal minimum in calendar year 2015.²

The creation of minimum MLR standards for Medicaid managed care follows the precedents set by the commercial health insurance market³ in 2011 and the Medicare Advantage (MA) market⁴ in 2014. While the Medicaid MLR formula itself largely follows the commercial and MA MLR formula, by including quality improvement expenses in the numerator and excluding most fees and taxes from the denominator of the calculation, there are key differences between the Medicaid minimum MLR standards and those currently established for the commercial and MA markets.

- States are encouraged but not required to collect capitation rate refunds when MCO MLRs are less than a minimum requirement
- States have the authority to determine the level of granularity for calculating the MLR, i.e., at the MCO population level—e.g., Temporary Assistance for Needy Families (TANF), disabled, Patient Protection and Affordable Care Act (ACA) expansion—or at the contract level (aggregation of financial results across populations)
- States are given the flexibility to determine other key issues, such as whether to require new MCOs to follow MLR reporting requirements in the first year participating in the state’s Medicaid program

KEY REPORTING ISSUES

While the Medicaid MLR formula is generally consistent with the commercial and MA markets, unique features of Medicaid managed care programs will necessitate state Medicaid agencies and Medicaid MCOs to consider the following issues in the development and completion of MLR reporting:

- *Defining quality improvement (QI) activities.* QI activities are an important component of the MLR calculation that increase the MLR results. However, identifying QI activities may pose a challenge for Medicaid MCOs, particularly those that do not have commercial or MA business. MCOs may need to revamp cost accounting methods to differentiate QI expenses and develop reasonable allocation methodologies to allocate QI expenses to lines of business.
- *Provider pass-through payments and reimbursement.* Provider supplemental pass-through payments are unique to the Medicaid market, where MCOs pass through capitation revenue directly to providers with no MCO financial risk. These payments are excluded from both the numerator and denominator in the MLR calculation. As these pass-through payments are phased out over the next 10 years, as required by the regulation, MCO provider reimbursement may need to increase. While pass-through payments are not incorporated into the numerator or denominator of the MLR formula, changes in provider reimbursement will affect claims costs and therefore the MLR calculation. States and MCOs will need to consider the impact provider reimbursement changes have on the MLR calculation.

1 CMS. CMS-2390-F, Final Rule: Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability.

2 Palmer, J. & Pettit, C. (May 2016). Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2015. Milliman Research Report. Retrieved June 17, 2016, from <http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf>.

3 Center for Consumer Information and Insurance Oversight (December 2, 2011). Final Rule Fact Sheet: Medical Loss Ratio: Getting Your Money’s Worth on Health Insurance. Retrieved June 17, 2016, from <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html>.

4 Medicare (May 25, 2016). Medical Loss Ratio. Retrieved June 17, 2016, from <https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/medcallossratio.html>.

- *Potential for future clarification.* Certain aspects of the MLR calculation are still unknown at this point and will need to be monitored by states and their MCO partners. For example, certain 1115 waiver benefit arrangements, such as beneficiary savings accounts, may require clarification from CMS on how they should be treated in the MLR formula.

MLR RATE-SETTING CONSIDERATIONS

Actuarial soundness guidelines in the final rule require Medicaid capitation rates to be developed in a manner such that MCOs would reasonably achieve a MLR of at least 85% for the rate year for contracts effective on or after July 1, 2019. The MLR requirement, by itself, does not determinate rate adequacy, rather it limits the percentage of revenue that can be used for administrative expenses (excluding quality improvement expenses) and margin. While MCO financial performance historically has been reviewed as a part of the Medicaid rate-setting process, the final rule may result in further scrutiny by CMS in terms of reviewing historical and projected MCO MLRs.

IMPACT TO MEDICAID MANAGED CARE INDUSTRY

The most significant change arising from the new MLR requirements may be the standardized MLR reporting requirements that are likely to provide more informative, transparent, and consistent information to support the rate-setting process, as well as aid CMS in the evaluation of Medicaid managed care programs across the nation. Between now and the implementation dates, state Medicaid agencies will need to familiarize themselves with the MLR mechanism and make key decisions within the flexibility granted by the rule. States will also need to work with MCOs to enhance financial reporting standards for MCOs to report MLRs and for the state to use for rate setting.

Introduction

CMS has indicated MLR reporting standards are necessary for Medicaid managed care programs to assist in assessing the reasonability of capitation rates and to promote fiscal stewardship by allowing better insight into how the MCO capitation revenue is spent.⁵ For managed care contracts beginning on or after July 1, 2017, in all states, the new MLR requirements stipulate:

- Actual MLR for each MCO will be reported within 12 months following the end of the rating period
- Resulting MLR reports must be posted annually on each state's public website
- States are encouraged but not required to collect refunds from MCOs not meeting a minimum MLR requirement

Additionally, effective for contracts beginning on or after July 1, 2019, the projected MLR for the managed care capitation rates must be at least 85% to be considered “actuarially sound” (along with several other requirements).

While the final rule implements a federally mandated minimum MLR requirement for Medicaid managed care programs, many states have already imposed minimum MLRs or profit caps. According to a recent Kaiser Family Foundation report,⁶ as of July 1, 2015, 23 states and the District of Columbia are known to have minimum MLRs or profit caps in at least one Medicaid program. Under the final rule, states will maintain the discretion to adopt minimum MLRs above the 85% federal requirement.

The remainder of this report dissects the specifics of the Medicaid MLR formula and its implications for state Medicaid agencies and Medicaid MCOs, including:

- Medicaid MLR formula calculation components
- Medicaid MLR formula compared with commercial and Medicare versions
- Medicaid-specific MLR considerations
- How MLR requirements will need to be incorporated in the capitation rate-setting process.

5 Federal Register (May 6, 2016). Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Retrieved June 12, 2016, from <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>.

6 Kaiser Family Foundation (July 1, 2015). Minimum Medical Loss Ratio (MLR) Policies for MCOs. State Health Facts. Retrieved June 17, 2016, from <http://kff.org/other/state-indicator/minimum-medical-loss-ratio-mlr-policies-for-mcos/>. Eighteen states and the District of Columbia have a minimum MLR and an additional five states have profit caps.

The formulation of MLR

CALCULATION OVERVIEW

The Medicaid MLR formula includes claims, quality improvement expenses, and fraud prevention activities in the numerator, premium less taxes and fees in the denominator, and a credibility adjustment added to the overall calculation:

$$\frac{\text{Claims + Quality Improvement (QI) Expense + Fraud Prevention Activities}^*}{\text{Premium - Taxes and Fees}} + \text{Credibility Adjustment}$$

*The inclusion of fraud prevention activities in the MLR formula is contingent on their inclusion in the commercial market MLR, which disallows their inclusion at present time.

The inclusion of QI expenses in the numerator and the deduction of taxes and fees from the denominator is likely to result in the calculated MLR percentage being higher than a traditional MLR calculation, as illustrated below:

Components: Premium Revenue = \$300; Claims = \$255, QI = \$3, Fraud Prevention = \$0 Taxes/Fees = \$10
 Traditional Loss Ratio: $\$255/\$300=85\%$
 MLR: $(\$255+\$3)/(\$300-\$10)=89\%$

Based on calendar-year 2015 statutory statements, we estimate that QI expenses range from approximately 1% to 3% of earned premium for the typical Medicaid MCO.

Supplemental pass-through payments (discussed further in a later section) and prior-year MLR refunds are excluded from both the numerator and denominator of the calculation.

INCURRED CLAIMS

In addition to patient care typically classified as claims, incurred claims include value-added services that are non-state plan services, claims refunds and reversals, pharmacy rebates, other admitted and non-admitted receivables, and state solvency fund payments or receipts. To the extent that MCOs have sub-capitated arrangements with providers, any portion of the payment that is explicitly attributed to the provision of administrative services by the provider should be excluded from incurred claims in the MLR numerator. In light of this treatment of sub-capitated arrangements within the MLR formula, MCOs may want to renegotiate their sub-capitation contracts or develop an expense allocation methodology between benefit and non-benefit expenses.

Additionally, the final rule's definition of incurred claims includes "claim payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses," as well as specifically stating that incurred claims expenses exclude the amount related to fraud prevention activities.⁷

QUALITY IMPROVEMENT EXPENSE

The inclusion of QI expenses in the numerator of the MLR calculation is intended to incentivize investments in QI, recognizing its ability to improve the delivery of healthcare to consumers. Quality improvement expenses include care coordination, case management, outreach and community integration, and health information technology expense. When CMS developed regulations for identifying QI in the Medicare Advantage MLR formula,⁸ they aligned with the definitions already promulgated under the commercial MLR regulations. CMS has taken the same approach for Medicaid programs, and augmented the definition to include Medicaid managed care external quality review activities. Further discussion on defining QI activities is provided later in our report.

⁷ Section 438.8(e)(4) defines fraud prevention activities.

⁸ Published in Title 42 CFR 422 Subpart X §422.2430.

FRAUD PREVENTION ACTIVITIES

The final rule also includes fraud prevention activities in the numerator of the MLR calculation, stipulated on whether such activities are included in the numerator of the MLR calculation for the commercial market. To fully understand this issue, it is necessary to review prior regulatory guidance in the commercial market:

- In the development of the final MLR regulations for the commercial market, CMS considered whether or not to include fraud prevention activities in the numerator of the MLR calculation, but ultimately decided against their inclusion⁹
- This debate was revisited in the release of the Notice of Benefit and Payment Parameters for 2017, but CMS ultimately decided to maintain its exclusion of fraud prevention activities from the MLR numerator¹⁰

Because the commercial market has not adopted the inclusion of fraud prevention activities in the numerator of the MLR calculation, the current Medicaid MLR calculation also excludes these amounts at present time.

However, it is important to remember that the definition of incurred claims does include claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses (consistent with the commercial market). These amounts are excluded from the definition of fraud prevention activities in the final rule.

PREMIUM REVENUE

In addition to regular capitation payments, premium also includes other revenue received by MCOs, such as maternity kick payments, retrospective capitation adjustments, risk adjustment payments, risk corridor settlements, and “withholds” of premium, which may be earned back through pay-for-performance arrangements. Unlike withholds, bonus incentives paid to MCOs (which are paid in addition to the actuarially sound capitation rate) are excluded from premiums. This treatment of bonus incentives within the MLR formula should be considered by states in their approaches to MCO pay-for-performance methodologies. As MCOs have to update MLR reporting every time the state applies a retrospective capitation adjustment, state Medicaid agencies should strive to make withhold payments to MCOs in a timely manner to allow incorporation of the payments into the MCOs’ MLR reports, which are due 12 months after the completion of the contract period.

Additionally, the regulations specifically address member cost sharing, which is typically collected by providers without the MCO’s direct control or monitoring. CMS recognizes situations where an MCO may intentionally waive the provider’s responsibility to collect member copays. In these cases, the amount of uncollected copayments must be added to MCO revenue in the denominator, thereby reducing the MLR. From our experience, waived copays are generally less than 0.5% of total MCO premium revenue. To the extent a MCO is waiving copays, it may need to develop information system capabilities to report waived copay amounts correctly for MLR reporting purposes.

TAXES AND FEES

The deduction for taxes and fees in the denominator helps to control for external drivers of cost that are out of the MCO’s control, as well as to standardize the measurement of MLR among states that have different taxes and fees. The deduction generally includes all taxes and fees incurred by the MCO, except for income taxes on investment income and capital gains, federal employment taxes, and fees associated with regulatory penalties and fines. MCOs that are exempt from federal income taxes may include community benefit expenses up to the greater of 3% or the highest premium tax rate in the state multiplied by earned premium.

9 Federal Register (December 7, 2011). 45 CFR Part 158: Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act; Final Rule, p. 76577. Retrieved June 17, 2016, from <https://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31289.pdf>.

10 Federal Register (March 8, 2016). 45 CFR Parts 144, 147, 153, et al.: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule, p. 12322. Retrieved June 17, 2016, from <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>.

CREDIBILITY ADJUSTMENT

The incurred claims experience for MCOs with lower enrollment will generally exhibit higher variability from expected levels. As a result, these MCOs may run a greater risk of falling below the minimum MLR in any particular year, which would be due to random fluctuations alone. Recognizing that elevated volatility could increase MLR refunds over time for smaller MCOs, CMS intends to develop and release credibility adjustments with principles similar to those used in the commercial market. The MLR credibility adjustment is an additive adjustment that effectively increases the MLR based on each MCO's member months, with larger credibility adjustments applied to MCOs with lower member months. The adjustment will be added to the MLR before comparing it with the minimum (e.g., 85%), and will not exceed 10% for any MCO. The smallest MCOs, with implied credibility adjustments over 10%, will be deemed non-credible and will not be required to pay refunds due to minimum MLR requirements.

Appendix 1 illustrates the credibility tables utilized in the commercial and Medicare Advantage markets.

MLR implementation in the commercial and Medicare Advantage markets

The Medicaid MLR formula is similar to the commercial and Medicare Advantage formulas, with a few key differences, as summarized in Figure 1.

FIGURE 1: COMPARISON OF MEDICAID, MEDICARE ADVANTAGE, AND COMMERCIAL FORMULAS

	MEDICAID	MEDICARE ADVANTAGE	COMMERCIAL
Minimum MLR threshold and granularity of measurement	At least 85%, enforcement at state's option, level of granularity at state's discretion.	85%, for each contract.	80% individual 80% small group 85% large group
MLR Refunds	If enforced by the state, to be paid proportionally to state and federal based on federal medical assistance percentage.	Remittances paid to CMS.	Paid to individuals and group policyholders.
Treatment of risk adjustment in MLR calculation	Accounted for in denominator/cap rate.	Accounted for in denominator/CMS risk-adjusted revenue.	Transfer payment included in numerator.
MLR measurement period	One year.	One year.	Three years.
New MCOs reporting of MLR	State decision; considered a new MCO for only one year (even if a partial year).	Subject to MLR	MCOs with at least 50% new members may defer experience.

In general, states have greater flexibility to establish Medicaid MLR reporting guidelines and the granularity of the calculation itself than is allowed in the commercial and Medicare Advantage markets. States must develop the MLR calculation method, under the prescribed guidelines, and submit it to CMS for review and approval. States may require a minimum MLR higher than 85%. The optional enforcement of MLR refunds is in sharp contrast to the mandatory enforcement in the Medicare Advantage programs and the commercial market.

States also have the option to select the population groupings ("granularity of measurement") at which the MLR calculation will be reported, with the default set as all populations covered under the MCO contract reported together. The level at which the MLR is calculated may impact any state minimum MLR rebates. States may work with their MCO partners to determine the appropriate level of detail that balances rebate impact, usefulness of the reported MLRs, and administrative difficulties.

State Medicaid agencies may determine whether MCOs need to complete MLR reporting in their first year operating in a state. The regulation clarifies that a MCO is only considered "new" for one reporting year, even if the first year was a partial year. It also clarifies that a MCO is not considered "new" when it adds an eligibility category or expands its service area. These exemptions do not occur in the Medicare Advantage program; in the commercial market, MCOs with at least 50% new members may defer their experience and include it in a subsequent MLR reporting year.

Special considerations in MLR formula

As with most Medicaid topics, certain state-specific program characteristics need to be considered when reviewing the reported MLR results. This section outlines considerations that may materially impact the reported MLR in different states.

DEFINING QUALITY IMPROVEMENT EXPENSES

QI activities must be designed to improve health quality, be directed toward individual enrollees or segments of enrollees (or non-enrollees, if no additional cost accrues to enrollees to create those benefits), and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized bodies. QI activities are characterized as those activities which: (a) improve health outcomes,¹¹ (b) prevent hospital readmissions, (c) improve patient safety and reduce medical errors, (d) improve wellness and health promotion activities, and (e) enhance the use of health information technology (HIT) to improve the quality of care.¹²

CMS has also specifically excluded cost containment activities from QI, and this casts a broad net over activities that insurers routinely perform, such as concurrent and retrospective utilization review, fraud detection and prevention, development, execution, and management of provider networks, provider credentialing, establishing and maintaining a claims adjudication system, clinical data collection without subsequent data analysis, and customer service hotlines that address member nonclinical questions.

Process to define QI

Determining which activities qualify as QI may require clinical expertise, must stand up to audit, and should use definitions that are consistent from year to year. Generally, this process of defining QI activities requires creating acceptable cost accounting methodologies to identify QI and allocate their expenses. One suggested approach is to map the general ledger to QI categories in order to identify their scope and develop more refined cost accounting approaches, particularly if an identified QI activity is combined on the ledger together with non-QI expenses.

Company departments and programs may have functions that are not exclusively QI related. In addition, staff may perform both QI and non-QI activities. Finally, vendors and software may provide functions that cross into both QI and cost containment. As examples:

- Efforts to detect and prevent harmful prescription drug interactions among members would be considered QI
- However, a generic prescribing (substitution) program would probably not be considered QI because its focus is predominately on cost containment
- Discharge planning would probably be considered QI if its focus is on improving the recovery of the patient and reducing the risk of readmission, but would probably not be considered QI if its primary focus is on cost containment
- Preauthorization activities would probably not be considered QI
- However, evidence-based medical necessity review with prior authorization may be considered QI

11 Among commercial insurers in 2014, the average QI expense was approximately \$3 PMPM, of which nearly 50% was allocated to the improvement of health outcomes (effective case management, care coordination, chronic disease management, and medication and care compliance initiatives; identifying and addressing ethnic, cultural, or racial disparities in the effectiveness of identified best clinical practices and evidence-based medicine; quality reporting and accreditation fees directly related to quality of care activities).

12 HIT expenses that are consistent with Medicare/Medicaid meaningful use requirements (45 CFR 158.151) may be treated as QI. These activities may include the provision of electronic health records and patient portals, and the monitoring, measuring, and reporting of clinical effectiveness measures. To this end, CMS has encouraged states to support the adoption of certified health information technology that enables interoperability across providers and supports seamless care coordination for enrollees.

PASS-THROUGH PAYMENTS

While the managed Medicaid MLR formula was developed based on the definitions in the commercial and Medicare Advantage markets, there are certain unique aspects to the Medicaid market. One example of a situation requiring special consideration in the Medicaid managed care MLR formula is pass-through payments, which MCOs pass to providers with no MCO financial risk. Pass-through payments are state-directed payments to providers that historically were used to increase provider reimbursement from the MCO-contracted reimbursement rates to a higher reimbursement rate (often Medicare).

For purposes of the MLR calculation, the final rule excludes pass-through payments from both the numerator and the denominator, resulting in a lower MLR calculation. The impact of excluding these payments will vary depending on the extent states have historically used pass-through payments and for which provider types, as the final rule requires pass-through payments to be phased out over time, with different schedules for different provider types. The general treatment of supplemental payments is further discussed in another recently released Milliman issue brief.¹³

PROVIDER REIMBURSEMENT

A related consideration to the treatment of supplemental pass-through payments is the effect of provider reimbursement on the MLR calculation. Because provider reimbursement affects paid claims, the provider reimbursement has a direct impact on the MLR calculation. To the extent that the provider fee schedule is increased, the calculated MLR is likely to increase because the incurred claims amount will increase.

The Medicaid reimbursement levels may materially affect the MLR calculation, as shown in the following example:

$$\text{MLR} = \frac{\text{Incurred claims} + \text{QI}}{\text{Incurred claims portion of capitation} + \text{Administrative and margin component of capitation} - \text{Taxes and Fees}}$$

Scenario 1: The base incurred claims cost is \$255, assuming provider reimbursement is 60% of Medicare reimbursement, QI is \$3, and the administrative and margin component of capitation is \$45, which includes a \$10 provision for taxes and fees. Note that values reflect revenue and cost on a per member per month (PMPM) basis.

$$\frac{\$255 + \$3}{\$255 + \$45 - \$10} = 89\%$$

Scenario 2: Provider reimbursement is increased to 100% of Medicare reimbursement, resulting in an incurred claims cost of \$425.¹⁴

$$\frac{\$255 * (1/60\%) + \$3}{\$255 * (1/60\%) + \$45 - \$10 * (1/60\%)} = 94\%$$

The example illustrates how changes in Medicaid provider reimbursement may affect the MLR calculation. Supplemental pass-through payments must be phased out over the next 10 years, and if states choose to replace the funding with higher provider reimbursement levels, then it will be important to consider the corresponding impact on the MLR calculation. States with existing minimum MLR refund arrangements may consider increasing the minimum MLR threshold to the extent there is a significant increase in provider reimbursement.

Similarly, medical inflation is generally anticipated to be greater than wage inflation, resulting in the claims cost component of the capitation rate increasing at a faster rate than the administrative component. To the extent that this occurs, the reported medical loss ratios will naturally increase over time.

¹³ Overview of pass-through payment guidance in the final Medicaid managed care regulations; Mytelka, Gaffner, and Laudenschlager.

¹⁴ The adjustments made to the terms in the formula are rough approximations, for illustrative purposes only.

MEDICAID BENEFICIARY SAVINGS ACCOUNTS

One type of Medicaid benefit arrangement that is not explicitly addressed in the final rule is the Medicaid beneficiary account.¹⁵ In this arrangement, beneficiaries receive funds through a savings account, similar to health savings accounts or flexible savings accounts, which are used to cover their copayments.¹⁶ The savings accounts are then used to offset increased beneficiary cost-sharing requirements in the program. The overall program is intended to align beneficiary financial incentives toward a more efficient use of healthcare.

Payments into these accounts may be funded by the state (with matching federal dollars) and/or the Medicaid beneficiary, and payments are separate from the MCO's capitation rate. As the authors of this report interpret the rule, funds from these accounts that are used to pay for claims costs would not be considered a part of the MLR numerator, nor would the funding of the accounts be included in the denominator. The capitation rate paid to the MCOs is reduced by the amount of enhanced cost-sharing requirements in these benefit arrangements, and because the program is not likely to decrease MCOs' administrative costs, MCO-reported MLRs may be lower in states where such accounts are used extensively. The following simplified example illustrates the potential impact:

Scenario 1: The base incurred claims cost is \$255, QI is \$3, and the administrative and margin component of capitation is \$45, which includes a \$10 provision for taxes and fees. Note that values reflect revenue and cost on a PMPM basis.

$$\frac{\$255 + \$3}{\$255 + \$45 - \$10} = 89\%$$

Scenario 2: A beneficiary savings account is implemented, resulting in a \$50 reduction in the incurred claims cost component of the capitation rate.¹⁷

$$\frac{(\$255 - \$50) + \$3}{(\$255 - \$50) + \$45 - \$10} = 87\%$$

The impact of beneficiary savings accounts on the MLR calculation in this example is similar to the impact of supplemental payments, as both program structures effectively equally reduce amounts included in the numerator and denominator of the calculation.

MLR considerations in the rate-setting process

The final rule requires actuarially sound capitation rates effective on or after July 1, 2019, to have a projected MLR for participating MCOs of at least 85% for the rate year.¹⁸ The MLR requirement, by itself, does not determinate rate adequacy, rather it limits the percentage of revenue that can be used for administrative expenses (excluding quality improvement expenses) and margin.

While the final rule establishes a new requirement for managed care capitation rates, many states and their actuaries already consider historical and projected MCO financial performance during the rate-setting process. The next sections explore the use of historical MLR in rate setting, the process for projecting MLR in the rate period, and the potential impacts of the codification of the minimum MLR into the rate-setting process.

15 See http://www.in.gov/fssa/hip/files/DF-CS-100714_HIP_2.0-POWER-account-infographic_v1r12.pdf for an example of Indiana's program.

16 These program designs are currently implemented through 1115 waivers.

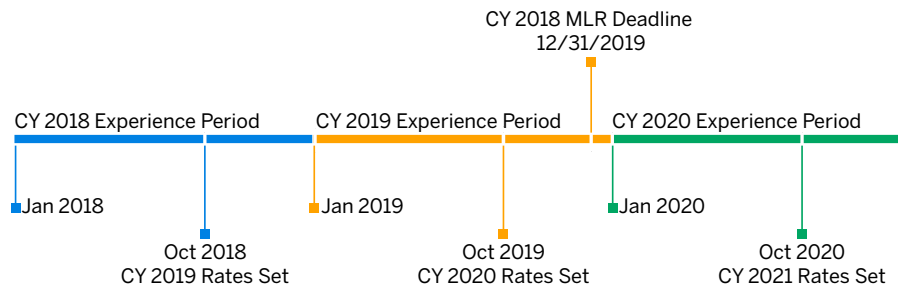
17 The adjustments made to the terms in the formula are rough approximations, for illustrative purposes only.

18 As defined by Section 438.8.

USING HISTORICAL MLR RESULTS FOR RATE SETTING

Historical MLR results, based on the 12-month reporting deadline, may be three years older than the rating period when they are considered in the rate-setting process. Figure 2 shows an illustration of the MLR versus rate-setting timeline for calendar year (CY) contracts.

FIGURE 2: MLR VS. RATE-SETTING TIMELINE FOR CALENDAR YEAR CONTRACTS



Contracts on a CY basis need to report CY 2018 MLR experience by December 2019. By the time CY 2018 MLR reporting occurs, CY 2020 rates will probably already be developed and may have already been reviewed by CMS. As a result, CY 2018 historical MLRs will likely first be considered when developing CY 2021 rates, which is a three-year lag from the experience period. In order to incorporate three-year-old MLRs in the rate-setting process, adjustments will be needed to account for changes that have already occurred or are projected to change between the experience and rating periods, such as program and reimbursement changes. Additionally, it is likely that audited financial statements and other information provided by MCOs will provide a preliminary estimate of the final calculated CMS-defined MLR aggregated across all Medicaid-eligible populations. For example, the development of CY 2018 capitation rates should have such information available for the CY 2016 rate period.

Historical MLRs are a standardized measurement that may be used to identify potential rating issues in a given year or to identify repeated patterns over time. It is important to emphasize that MLR results are not the same as profit results, especially for MCOs with high or low expenses as a percentage of premium and for those with high amounts of quality improvement activities. If MLRs are below 85% or are excessively high (e.g., above 100% or a state-defined maximum MLR), questions will likely be asked during the CMS rate review process concerning how the rate development year is estimated to have different MLR results than the historical period.

If states choose to require MCOs to report MLRs at the aggregate level across all rate cells and managed care programs, it will be harder to identify where rates could be excessive at the rate cell level and to make appropriate adjustments to the rating period. This type of aggregate reporting could be especially challenging when there are many MCOs participating in the program.

RATING PERIOD MLR PROJECTIONS

Because CMS encourages but does not require states to adopt Medicaid MLR refunds, CMS may scrutinize projected MLRs in the capitation rate development more than commercial and Medicare Advantage products. In states without a MLR refund requirement, the capitation rate development may be the best way to prospectively control the percentage of premium used for patient care, administrative costs, and quality improvement activities.

While the state actuary should consider historical MLRs in the capitation rate development, a low or high historical MLR will not necessarily necessitate an increase or decrease in the final capitation rate amount. By CMS's definition of actuarial soundness, the capitation rate development should provide for reasonable, appropriate, and attainable costs incurred by a MCO, but the capitation rate certification is not applicable to a particular MCO. For example, to the extent MCOs' experience contained in the historical MLR reports reflects poor healthcare management practices, increasing the capitation rates by an amount to allow the MCOs to have more favorable financial experience, while not improving healthcare management efficiency, may not be warranted.

Some MLR components, like quality improvement activities, may be difficult to project by MCO, especially before historical results are available. States may need MCOs to provide projected amounts for certain components such as quality improvement expenses and taxes and fees, along with historical amounts to evaluate the projected amounts for reasonableness. Projected MLRs should be reviewed for each MCO to assess the degree of estimated variability across MCOs participating in the managed care program.

INFORMATION GAIN AND TRANSPARENCY

While the MLR requirement itself is not likely to significantly transform the Medicaid rate-setting process, the greater change to Medicaid managed care programs may come from the standardized MLR reporting requirements that are likely to provide more informative, consistent data to support the rate-setting process. Moreover, MLR reporting should make it easier to compare historical and projected rates between states,¹⁹ similar to how MLR reporting requirements have led to much greater visibility into commercial insurers' financial experience by line of business at the state level.²⁰

Conclusion

The MLR reporting requirements will give the public greater visibility on MCOs' expense structures, permit comparisons among MCOs, and allow for more direct comparisons among the Medicaid programs in each state.

Even though MLR reporting first applies to rating periods effective July 2017, and reporting does not occur for another 12 months after the rating period ends, there is much to start working on now to properly consider and prepare for the implementation of these MLR requirements. States and their MCO partners will need to begin to review the implications of the new MLR requirements and potential impacts to their Medicaid programs, and to make informed decisions within the flexibility each state has in implementing the requirements.

19 There will still be key differences to consider when comparing MLRs among states. For example, programs that do not cover prescription drugs may have lower MLRs compared with programs that do.

20 See <http://us.milliman.com/uploadedFiles/insight/2016/2014-commercial-health-insurance.pdf> for more information.

Appendix 1

The commercial and Medicare Advantage credibility tables²¹ are shown below.

COMMERCIAL TABLE				MEDICARE ADVANTAGE TABLE		
MINIMUM LIFE YEARS BY LINE OF BUSINESS			ADDITIVE CREDIBILITY ADJUSTMENT	MINIMUM LIFE YEARS BY LINE OF BUSINESS		ADDITIVE CREDIBILITY ADJUSTMENT
INDIVIDUAL	SMALL GROUP	LARGE GROUP		MA & MA/PD	PART D STAND-ALONE	
BELOW 1,000	BELOW 1,000	BELOW 1,000	NON-CRED	BELOW 200	BELOW 400	NON-CRED
1,000	1,000	1,000	8.3%	200	400	8.4%
2,500	2,500	2,500	5.2%	500	1,000	5.3%
5,000	5,000	5,000	3.7%	1,000	2,000	3.7%
10,000	10,000	10,000	2.6%	2,000	4,000	2.6%
25,000	25,000	25,000	1.6%	5,000	10,000	1.7%
50,000	50,000	50,000	1.2%	10,000	20,000	1.2%
75,000	75,000	75,000	0.0%	15,000	30,000	1.0%
				ABOVE 15,000	ABOVE 30,000	0.0%

Linear interpolation is used to calculate credibility adjustments for intermediate life year counts within each range. As an example, if a health plan whose commercial small group line of business in a state has 12,000 average life years and a 79% MLR, then the credibility-adjusted MLR is calculated as:

$$79.0\% + 2.5\% = 81.5\%, \text{ WHERE } 2.5\% = [1.6\% \times (12,000-10,000) + 2.6\% \times (25,000-12,000)] \div (25,000-10,000)$$

²¹ The Medicare Advantage table has a "cliff" at the 1% credibility adjustment, and any enrollment count higher than the cutoff implies a 0% credibility adjustment. The commercial table allows for a smooth transition to 0% credibility.



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CONTACT

Jill Brostowitz, FSA, MAAA
jill.brostowitz@milliman.com

Scott Jones, FSA, MAAA
scott.jones@milliman.com

Ian McCulla, FSA, MAAA
ian.mcculla@milliman.com