MERCER GOVERNMENT HUMAN SERVICES CONSULTING

HELPING GOVERNMENTS SHAPE TOMORROW'S HEALTH PROGRAMS

MEDICAL LOSS RATIO: NOT AS BAD AS IT SEEMS

New medical loss ratio (MLR) requirements play a prominent role in the Centers for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, including impacts on capitation rate setting. With all the MLR provisions put forward, it suggests a lot of work ahead for states; however, things may not be as bad as they seem. Although formal CMS MLR rules are new to Medicaid, they're in alignment with the Affordable Care Act private market and Medicare Advantage MLR standards, with minor deviations. Additionally, capitation rating processes may already be achieving the applicable MLR requirements.

MLR REQUIREMENTS

The CMS Medicaid and CHIP Managed Care Final Rule's MLR requirements go into effect for contract rating periods beginning on or after July 1, 2017. At least 85% of after-tax premium must go toward paying claims (including quality improvement activities). In other words, no more than 15% of after-tax premium can go toward administrative costs (which exclude taxes/fees) and underwriting gain (cost of capital and risk loading). For managed care contract rating periods starting July 1, 2019, or later, actuaries must certify that each capitation rate is set to reasonably achieve an MLR at or above an 85% minimum.

Here's what Mercer's seeing evolve from these requirements:

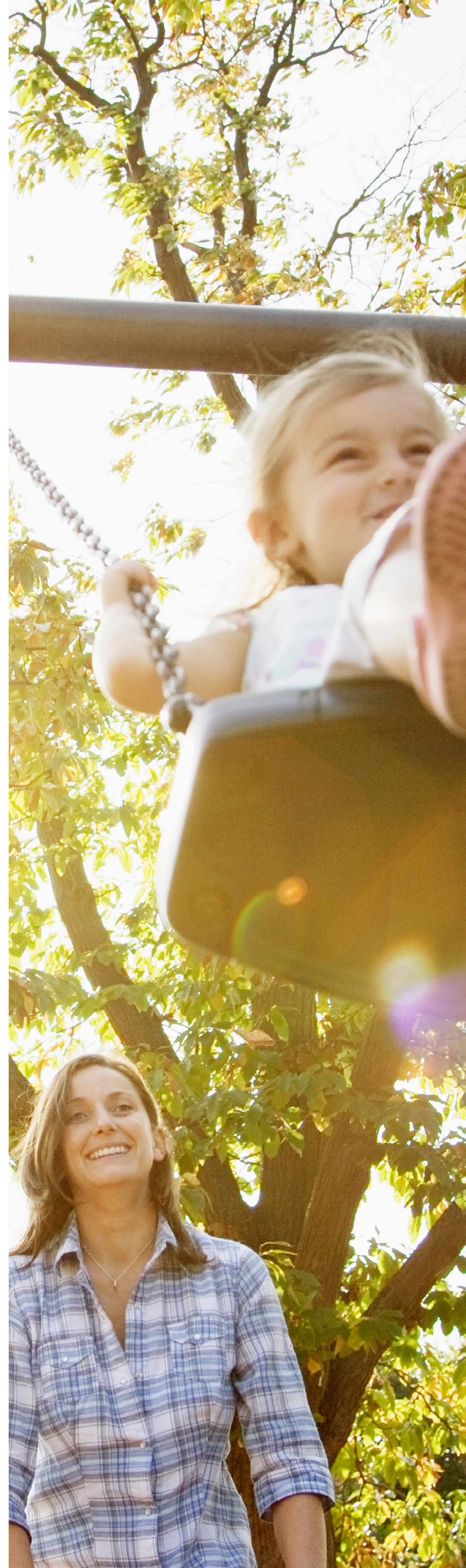
- **No later than rating period for contracts starting on or after July 1, 2017 — MLR Standards**
- **No later than rating period for contracts starting on or after July 1, 2019 — Section 438.4(b)(9): Develop capitation rates so that health plan can reasonably achieve an MLR of at least 85%**

WHAT ARE STATES CURRENTLY UP TO?

Updating MCO Contracts

For contacts that start on or after July 1, 2017, many states are requiring the calculation and reporting of MLR by the MCOs within 12 months after the end of the contract year.

Requirements of MCOs include providing calculation back-up detail,



demonstrating consistency (or a comparison) with financial reports, attesting to calculation accuracy and revising MLR if rates are adjusted retroactively.

Considerations made by states include determining when an MCO calculates, reports and attests to its MLR; establishing a minimum MLR higher than 85% — such as for managed long-term services — that supports populations that typically require lower administrative expenses on a percentage basis; and determining separation/aggregation of populations/contracts for measurement purposes, such as physical health, long-term care, CHIP and expansion populations. (MCOs may prefer MLR standards be set at the highest level of aggregation so that low/er MLRs on population segments can be offset by high/er MLRs on other segments. A state's decision about the level of aggregation will be significant.)

Developing MLR Reporting Templates and Instructions

Many states are developing templates to be used by MCOs, including determining details of the MLR calculation's numerator and denominator.

Considering Requiring Remittances From MCOs

These requirements may include:

a) Having discretion to exempt newly contracted MCOs from MLR requirements during their first year
b) Applying a credibility adjustment, to be developed by CMS for smaller MCOs, where lower membership leads to higher MLR volatility due to random statistical variation

Preparing State Oversight Standards

Standards include:

a) Reporting to CMS a summary of outcomes of MLR calculations
b) Publicly displaying MCO MLR performance annually
c) Specifying a methodology for the repayment of the federal share of any remittances
d) Considering optional "auditing" of MCOs' MLR calculations and reporting

Making a List of Challenging Aspects of the MLR Provisions

There may be alternatives, and states could be afforded flexibilities by engaging CMS in discussion:

a) For example, MCOs must submit MLR reports within 12 months of the end of the MLR reporting year. Is this enough time for states to reconcile incentive and withhold arrangements?
b) The calculation formula is relatively straightforward. However, CMS acknowledges that a lot goes on in Medicaid that is not part of the private market or Medicare Advantage. States may need more details. Here are a few examples of questions from states:

   Should fiscal intermediary administrative costs for self-directed services be accounted for in the numerator of the calculation?

   How are services rendered in an institution for mental disease accounted for in the calculation?

   If Medicaid and CHIP are accounted for in the same actuarial rate certification in a blended manner, how is the CHIP MLR to be calculated and reported?

WHAT'S NEXT?

The Final Rule explicitly connects MLR to capitation rates. The good news is that capitation rating processes that use current Medicaid managed care base data experience are likely already achieving this Final Rule requirement. Generally, actuaries build in less than 15% of premium for administration and underwriting gain. On the flipside, capitation rating processes that use older Medicaid managed care base data; other base data sources, such as fee-for-service data for newer managed care programs; or have historically had more than 15% of premium allocated to administration and underwriting gain for some rate cells will require special attention. Actuaries will be reviewing priced-for MLRs in rate development, but they will also consider that historical MLR is just one of many factors considered, and historical MLR results alone do not necessitate prospective rate adjustments. Higher targeted MLRs in capitation rates are allowable as long as rates "are adequate for reasonable, appropriate, and attainable non-benefit costs." – 42 CFR 438.4(b)(9).

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