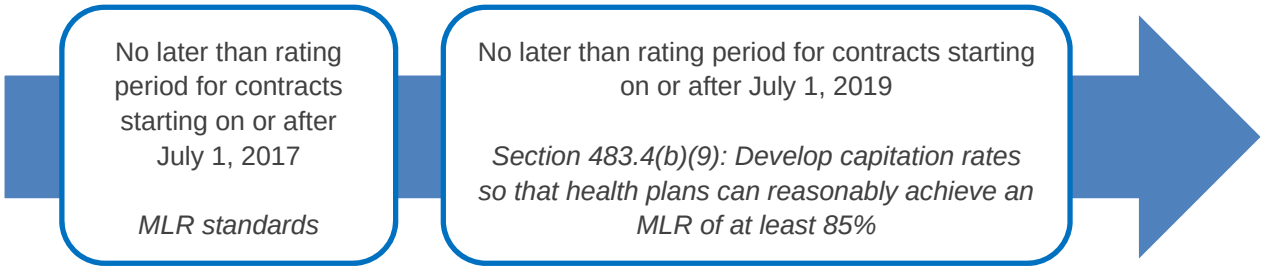
MEDICAL LOSS RATIO: NOT AS BAD AS IT SEEMS

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 to 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. While formal CMS MLR rules are new to Medicaid, they are 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 towards paying claims (including quality improvement activities). In other words, no more than 15% of after-tax premium can go towards 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 is what Mercer is seeing evolve from these requirements.



WHAT ARE STATES CURRENTLY UP TO?

Updating MCO Contracts that start on or after July 1, 2017 and 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 are time specific to when an MCO calculates, reports, and attests to its MLR; establishing a minimum MLR higher than 85%, such as for managed long-term services and 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 to be used by MCOs, including determining details of the MLR calculation's numerator and denominator.

Considering requiring remittances from MCOs:

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:

a) Reporting to CMS a summary of outcomes of MLR calculations
b) Public displaying of 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 mann*er, *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).