November 2023 Actuarial User Group Call

Thursday, November 9, 2023
11:00AM - 12:00PM ET

To be able to ask questions during the call, join online at—

- https://cms.zoomgov.com/j/1607706178?pwd=SXZCRzZyYk8zT0xLSHBOOUhaMVovZz09
- Meeting ID: 160 770 6178
- Passcode: 372081

To participate in listen-only mode, join by phone at—

- Participant Dial-In Number: (833) 568-8864 US Toll Free
- Meeting ID: 160 770 6178
- Passcode: 372081

- Welcome
  - Reminder that an agenda for this call has been posted to the CMS webpage at:

    https://www.cms.gov > Medicare > Payment > Medicare Advantage Rates & Statistics > Actuarial Bid Questions
  - We have also posted an updated mockup of the draft CY2025 Part D Bid Pricing tool. It may be helpful to have these files open during the call.

- CY2024 Bid Review: Lessons Learned
  - We appreciate all the feedback we received during the industry comment period. We have shared pertinent comments with other areas within CMS and are taking the comments into consideration when developing the CY2025 BPTs and Bid Instructions.
  - Prior Acceptance
    - We would like to reiterate that a methodology or support accepted in a prior bid review does not guarantee acceptance in a subsequent bid review.
  - Supporting Documentation
    - A summary of a plan sponsor's historical trends is required by Appendix B item 11.2. This support must be provided regardless of whether those trends were applied to pricing.
    - Benefit changes play a key role in the development of projection factors. The MA bid instructions Appendix B item 11.3.3 requires an explanation of the changes in benefits from base period to contract year. Many plan sponsors have not provided adequate documentation to satisfy this requirement. OACT expects this item to be submitted in a format specific enough to explain the BPT projection factors.

        - We would like to remind bid sponsors and certifying actuaries to revise supporting documentation consistent with the final certified bid, prior to the final actuarial certification. Be aware that some documentation—like Appendix B, item 8.2 (Gain/loss margin support)—may not have applied with the initial bid submission but may need to be submitted with the final certified bid.
    - Gain/Loss Margin
        - Note that the gain/loss margin of 11.5 percent in Appendix B, items 8.6 and 38, is a threshold to determine when to provide support, not to determine whether the margin is appropriate.
        - For Part D BPTs that have a corresponding MA BPT, the Part D gain/loss margin as a percentage of revenue must be within 1.5 percent of the gain/loss margin for the MA component, as specified in the bid instructions. This relationship should be checked and maintained with each resubmission.
    - Related Party
        - All the costs for services with a related party should be reported in the related party cells on the BPTs. For example, if a settlement payment is expected as the outcome of a risk sharing arrangement, then the total cost of the services, including the settlement, must be reported in the related party cells. The related-party cells should be updated, as needed, upon resubmission.
    - Rebate Reallocation
        - We understand and appreciate the industry concern regarding the uncertainty surrounding the NAMBA and Base Beneficiary Premium for CY2025. We received many requests to give more margin tolerance and to extend the rebate reallocation timeline. We do not expect to give additional tolerance on gain/loss margin changes and expect the timeline to be consistent with prior years.
        - Examples of unacceptable changes observed during rebate reallocation:
            - We have noticed that plans are making “flow-through” pricing changes, when benefits are not being added or removed in the PBP. These plans are using capitation and/or risk sharing arrangements as justification for these “flow-through” pricing changes. Please note that “flow-through” pricing changes are not permitted unless benefits are added or removed in the PBP. In addition, “flow-through” pricing changes are not permitted as part of premium rounding.
            - We have noticed that plans are making material “flow-through” pricing changes to the A/B bid when a relatively minimal change has been made to the benefits in the PBP.
            - We have noticed that plans are making “flow-through” pricing changes when the rebate dollars that are allocated to the Part D basic premium do not change. If there are no changes made to the rebate dollars that are allocated to the Part D Basic Premium (and no changes to Part D supplemental premium for offsetting a negative Part D basic premium), the only changes that are allowed to be made on the MA BPT are acceptable margin changes for premium rounding.
            - We have noticed that plans are making changes to the total revenue requirement for mandatory supplemental benefits that are more significant than the rebates which are reallocated.

        - We have noticed that the total change to benefit cost—including increases to the A/B bid due to financial arrangements with providers—is sometimes greater than the amount of the reallocated rebates. Where financial arrangements that cause this situation exist, it is best to limit the amount of mandatory supplemental benefits added such that the total benefit cost, including the effect on the A/B bid, are very close to the amount of the reallocated rebates.
        - We have noticed that plans are making significant changes to gain/loss margin.
    - Other
        - We've noticed inappropriate allocations of expenses between MA and PD. Please be mindful of allocations between MA and Part D, especially when updating models.
    - To help us respond in a timely manner to feedback that involves other areas of CMS, we remind you to please copy the appropriate resource mailboxes in addition to any emails sent to the actuarial-bids mailbox. These email addresses can always be found in the introductory note within the UGC Q&A file and a few are noted here.
        - For part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
        - For part D policy-related questions (including OOPC/TBC policy): partdbenefits@cms.hhs.gov
        - For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
        - For risk adjustment topics: riskadjustmentoperations@cms.hhs.gov and riskadjustmentpolicy@cms.hhs.gov.

- CY2025 Bid Pricing Tools (BPTs)
    - Reminder: List of draft BPT changes is included in the posted agenda. An updated mockup of the Draft CY2025 Part D BPT has also been posted at the same link.
    - No major changes anticipated to the MA, MSA or ESRD-SNP BPTs for CY2025.
    - Reminder that the mock-up does not contain updated Part D benefit parameters for CY2025 and does not contain working macros.
    - Major changes to Proposed Part D BPT from September Call (based on feedback):
        - Order of worksheets reverted to 2024 BPT sequence (Old 6A Gap Removed)
        - Removed proposed new PBP Cost Sharing worksheet, may consider in future years
        - Reintroduced cells and columns (now blank) where Gap cells were removed in order to limit the amount of cell location changes to minimize downstream risk
        - Adjusted formulas for reinsurance and net benefit cost on the two alternative worksheets (WS4 and 5) to account for the phase-in of the manufacturer discount

- Summary of Draft Part D Bid Pricing Tool Changes (These changes are from CY2024). See more detail on these changes below in the Bid Instructions Section:

Worksheet 1 – Rx BASE PERIOD EXPERIENCE

- Section II – Added risk score input cells split between LI and NLI (cells I14:I15). Total risk score now a calculated cell.
- Section III - Adjusted benefit phases consistent with IRA (removal of GAP phase).
- Section III - Added Manufacturer Discount input cell G38- Grayed out as not applicable until CY2027.
- Section III – Removed OON cells.
- Section IV - Added an input within Non-Benefit Expenses for Uncollected Cost Sharing Payments from the Medicare Prescription Payment Plan. Grayed out until CY2027.
- Added new Section VI for IRA Drug Experience – Includes Insulins, Vaccines, Negotiated Drugs – Negotiated Drugs grayed out for CY2025.
- Cell M60 - Total Non-LI Brand Discount Amount will be removed for CY2027 as will no longer applicable for a CY2025 base period. Remains in BPT for next two years.

Worksheet 2 – Rx PROJECTION OF ALLOWED/NON-BENEFIT EXPENSES

- Section II and Section III - Added rows for Maximum Fair Price Drug projection factors for both utilization and cost. Cells grayed out until CY2026.
- Section V - Added an input within Non-Benefit Expenses for Uncollected Cost Sharing Payments from the Medicare Prescription Payment Plan.
- Sections V and VII - Moved Gain/Loss and Related Party cells from Worksheet 3 to Worksheet 2.

Worksheet 3 – Rx CONTRACT PERIOD PROJECTION FOR DEFINED STANDARD COVERAGE

- Section II – Added risk score input cells split between LI and NLI (cells H12:H13). Total risk score now a calculated cell.
- Section III - Adjusted benefit phases consistent with IRA (removal of GAP phase). GAP PMPM column also removed.
- Section III - Added Manufacturer Discount PMPM input cell N31. This is calculated from WS6 Script Projection Inputs.
- Added Section IV for IRA Drug Experience – Includes Insulins, Vaccines, Negotiated Drugs – Negotiated Drugs grayed out until CY2026.
    - These cells will be calculated from inputs on WS6 Script Projection.
- Removed old lines 10 and 11 from Section III (Projected % OON).

Worksheet 4 – Rx Standard Coverage with Actuarially Equivalent Cost Sharing

- Section IV - Removed "Amounts in Gap" Column.
- Section IV - Updated several formulas for the changes to script projection worksheet.
- Section IV - Hard coded 0% cost sharing above catastrophic, as no longer applicable.
- Section IV - Adjusted net cost of benefit to net out the manufacturer discount entered in script projection worksheet as this is not included in cost sharing in rows above.
- Section IV - Removed Actuarial Equivalence test for catastrophic cost sharing and coverage in the gap.
- Section IV – Removed Insulin AE Test, will be handled in PBP.
- Section V - Adjusted formula for Federal Reinsurance in L20 for IRA change.

Worksheet 5 – Rx ALTERNATIVE COVERAGE

- Section IV - Removed Type of Gap coverage and "Gap Amt" column.
- Section IV - Altered several formulas for the changes to script projection worksheet.
- Section IV - Adjusted net cost of benefit to net out the manufacturer discount entered in script projection worksheet as this is not included in cost sharing in rows above.
- Section IV – Removed Alternative Coverage ICL input cell.
- Section IV - Hard coded 0% cost sharing above catastrophic, as no longer applicable.
- Section IV - Adjusted formula for Federal Reinsurance in M51:M52 for IRA change.
- Section VI - Removed Coverage in Gap and Catastrophic Cost Sharing AE tests.
- Section VI – Removed Insulin AE Test, will be handled in PBP.

Worksheet 6 – Rx Script Projections for Defined Standard, Actuarially Equivalent, or Alternative Coverage

- Restructured worksheet for changes in benefit phases as a result of the IRA.
- Moved vaccines and insulins from their own separate section to within each benefit phase.
- Added manufacturer discount input cells within each phase.
- Removed Network Pricing inputs.
- Grayed out cost sharing above catastrophic, as no longer applicable.
- Added input cells for selected drug subsidy – Grayed out for CY2025.

Worksheet 7– SUMMARY OF KEY BID ELEMENTS

- Section II - Adjusted for new benefit phases as a result of the IRA.
- Section III - Replaced Prospective Brand Discount Amount with Manufacturer Discount Amount in cell F30.
- Section III – Added new cell for Maximum Base Beneficiary Premium.
  - This cell is an increase of 6% over CY2024 BPP.
  - BPP entered in line 3 above must be below the Max.

◦ Please submit any comments regarding the draft **bid pricing tool** changes by 11:59 PM Pacific Standard Time on **Thursday, November 16, 2023** to: actuarial-bids@cms.hhs.gov

◦ OACT plans to release BPTs for Industry Beta testing in February.

- CY2025 Bid Pricing Instructions
  - Credibility
    - We do not intend to revise the CMS credibility guidelines for CY2025.
  - Gain/Loss Margin
    - We do not intend to revise the instructions for gain/loss margin for CY2025.
  - Hospice
    - We intend to revise MA Worksheet 1 instructions for plans that participate in the VBID Hospice Benefit Component during the base period. Net Medical expenses reported for hospice enrollees are to reflect all claims incurred for enrollees until the end of the month of hospice disenrollment rather than until the disenrollment date.
  - Non-Benefit Expenses
    - We do not intend to revise the instructions for non-benefit expenses for CY2025.
  - Related Party
    - We propose to clarify the pricing consideration for related-party arrangements.
    - This clarification results in a new supporting documentation item, item 13.6 for MA and item 13.11 for Part D, requiring support when a plan sponsor has an arrangement for benefit services within their tax ID number and does not submit bid data that matches their financial statements. See Appendix 1 for more information.
  - Risk Arrangements
    - As a result of the clarifications made about DIR #10 guidance, we intend to revise the bid instructions to remove references to allocating settlements from risk arrangements proportionally between MA and Part D.
  - Service Area Expansions and Reductions
    - We intend to add a section to the pricing considerations and to Appendix B support item 2.1 giving guidance when there is a pending appeal to a service area change. If a decision on a service area change remains outstanding as of July 15th, then CMS will request a sample BPT omitting the pending change. The sample BPT will not to be uploaded to HPMS.

- Supporting Documentation
  - We intend to update Appendix B item 2, to clarify that the product narrative must include a description of significant benefit changes.
  - We intend to update Appendix B item 11 to replace the term “benefit design analysis” with the term “Changes to benefit design”.
  - We intend to move from the sequestration pricing considerations section of the MA instructions to Appendix B item 22, the requirement to demonstrate that plan cost sharing for Medicare-covered benefits entered in the PBP is not greater than FFS cost sharing when the actuarial equivalent cost sharing test fails a red circle validation.
  - We intend to update MA Appendix B items 10.1.4, 11.3.7 and 12.5.1 to require support for DME rebates in addition to rebates for Part B Rx.
  - We propose to add Appendix B item 13.6 for MA and item 13.11 for Part D to address support required when the plan sponsor has an arrangement for benefit services within their tax ID number and does not submit bid data that matches their financial statements. See Appendix 1 for more information.
- Appendix E – Rebate Reallocation Guidelines
  - We intend to clarify rebate reallocation permissibility during the rebate reallocation period for various plan types and Part D premium scenarios. This clarification may include additional examples and other information to determine permissibility.
  - We propose to clarify the guidance for when an MAO chooses to change A/B mandatory supplemental benefits during rebate reallocation. See Appendix 1 for more information.
- Part D Specific
  - The definition of scripts is the same as in prior years. Scripts should NOT be normalized to a 30-day supply, even for insulins.
  - Worksheet 1 Section III – Part D Claims Experience
    - When completing the CY2023 base period experience in the CY2025 BPT, plan sponsors must enter the number of members with total CY2023 allowed costs equal to $0, between $1 and $504, between $505 and catastrophic, and above catastrophic.
    - For the purposes of completing Worksheet 1 of the CY2025 BPT, all members with TrOOP costs less Gap Discount amounts greater than $2,000 are considered to have reached the catastrophic phase.
    - This is a temporary transition for two years until the base period benefit phases align with the IRA.
    - Plan sponsors should not enter Gap Discount amounts into column J, Average Cost Sharing per Member on WS1. Gap Discount amounts will need to be a component of base period reconciliation to financials.

- For Plan-to-Plan transaction reporting on worksheet 1, please estimate the gap discount according to the values provided in the 2023 Rate Announcement. Specifically, for beneficiaries with total gross drug cost above the ICL for 2023, approximate the gap discount as (minimum (total gross drug cost, 11,206.28) – 4,660) x (92.13% x (94.969%-25%). Intuitively, the first term in the product estimates the gross cost in the coverage gap, while the second term represents the approximate value of the gap discount as a percentage of gross cost).
- With removal of OON cells – No longer requiring entry for percentage of OON in BPT (similar guidance for WS3).
- 2023 IRA subsidy amount (IRASA) for insulins and vaccines should be included in member cost sharing.

- Worksheet 1 Section IV – Non – Benefit Expenses
  - Line 5 - Uncollected Cost Sharing Payments M3P - This entry is to only include uncollected cost sharing payments from the Medicare Prescription Payment plan. This entry must not include any other types of bad debt. This entry should also not include any administrative costs incurred from administering the Medicare Prescription Payment Plan.
  - Similar guidance applies to the projection period Non-Benefit Expenses.
- Worksheet 1 Section VI – New IRA Drug Experience Cells
  - This section is not mutually exclusive from section III. This section is to include LICS but exclude the coverage gap discount amounts.
- Worksheet 2 Sections II and III
  - The new rows for Maximum Fair Price drugs are mutually exclusive from Type of Script lines 1-8.
  - Please note that WS2 and WS6 are not comparable in the same way as prior years due to the different drug type input requirements. The bid reviewers will be informed accordingly.
- Worksheet 3 Section III – Part D Covered Drug Claims
  - Cell N31 Projected Manufacturer Discount - Plan sponsor will be required to submit documentation which supports the development of the Manufacturer Discount PMPM for both LI and NLI for the projection period.
- Worksheet 6 Section II – Projections for Equivalence Tests
  - Data for Vaccines and Insulins are mutually exclusive of the preceding rows.
  - The manufacturer discount amounts should be entered only into rows 13, 26, 38, and 40. The manufacturer discount amounts should not be entered into any other cells on this worksheet. The discount amount, not the claims is what should be entered into these cells.
  - Consistent with the CY2024 BPT instructions, when an alternative coverage is modeled, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spending may be different because of the impact of the alternative benefits.

        - We are continuing to consider the changes to benefit phase progression and actuarial equivalence under the IRA benefit and welcome feedback.
    - Please submit comments regarding these proposed **bid instruction** topics by 11:59 PM Pacific Standard Time on **November 22, 2023** to: actuarial-bids@cms.hhs.gov

- Other Bidding Topics/Announcements
    - Information on Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease
        - The following are key assumptions made by OACT in its recent assessment of the cost of Medicare coverage of drugs, such as Leqembi, under the National Coverage Determination for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease through a registry for a Coverage with Evidence Development study.
        - We modeled the cost of the drugs themselves, the cost for administration of the drug, the associated diagnostic testing and office visits, and the costs related to potential adverse events resulting from the treatment.
        - A full year of treatment was assumed to cost approximately $29,000, based on current Part B payment rates under Fee-For-Service Medicare coverage, clinical guidance from the Center for Clinical Standards and Quality, and public data sources. Approximately 86%, or $25,000, of the total annual cost was due to the drug cost and administration, while the remainder was for ancillary services expected for treatment.
        - To estimate the number of utilizers,
            - We considered public research by Julia Cave Arbanas, BA1; Cheryl L. Damberg, PhD2; Mei Leng, MS1; et al JAMA Intern Med. Published online May 11, 2023 doi:10.1001/jamainternmed.2023.1749).
            - We considered public statements from the manufacturer of Leqembi that they expected 100,000 users by 2026, which can be found at https://www.eisai.com/news/2023/news202302.html.
            - We assumed that there would be 100,000 Medicare users by January 2025, since additional drugs are likely to have traditional approval prior to 2025,
            - And estimated the average Medicare utilizers to be 988 for 2023 and 55,875 for 2024.
    - Following are responses to questions regarding representation of 340B-acquired drugs in the USPCCs
        - **Question:** How much of the $1.5 billion in 2022 340B-acquired drug claims that were processed or reprocessed at the default drug payment policy rate was accounted for in the 2022 FFS USPCC published in the 2024 announcement?
        - **Response:** The reprocessed 340B acquired drug claims were not directly accounted for in the 2022 FFS USPCC supporting the 2024 MA ratebook and published in the 2024 Rate Announcement.

        - **Question:** Did the Part B drug trend used in the development of the 2024 ratebook account for the change in the 340B payment policy that was effective September 28, 2022?
        - **Response:** Yes, the Part B trend for 2023 and later supporting the 2024 MA ratebook growth rate reflected the projected effect of 340B-acquired drug claims policy and corresponding offset to outpatient hospital expenditures other than 340B-acquired drugs.

        - **Question:** When developing the USPCCs for the 2025 ratebook, will CMS restate historical FFS claims to include the proposed $9 billion in additional 340B remedy payments? Since CMS is not reprocessing claims and instead issuing lump sum payments, what year(s) will be restated?
        - **Response:** A description of the proposed handing of reprocessed 340B-acquired drug claims supporting the 2025 ratebook growth rates will be included in, or communicated in conjunction with, the 2025 Advance Notice.

    - Bid Improvement Initiative Program
        - OACT is seeing continuous improvement in the bids being submitted.
        - Outreach is complete.
        - If you have heard from us, we ask that you take the feedback constructively to address our concerns in the next bid submission.
        - If you did not hear from us, please continue to evaluate your supporting documentation and peer review process and make improvements where possible.
    - The Cumulative User Group Call Q&A File has been updated with questions and answers from CY2007 to CY2024 and can be found at: https://www.cms.gov > Medicare > Payment > Medicare Advantage Rates & Statistics > Actuarial Bid Questions

- Live Q&A

- Conclusion

Appendix 1
Proposed Changes to the CY2025 Bid Instructions

Medicare Advantage (MA)

II. PRICING CONSIDERATIONS

Related-Party Arrangements

The related-party requirements apply to any MAO entering into any type of arrangement with, or receiving services from, an entity that has a different tax identification number than that of the MAO but is associated with the MAO by any form of common, privately held ownership, control, or investment, including any arrangement in which the MAO does business with a related party through one or more unrelated parties.

CMS requires all MAOs to disclose whether or not they are in a business arrangement with a related party. MAOs in such an arrangement must: (i) enter related-party expenses on lines z1 and z2 of Worksheet 4, and (ii) provide additional documentation for each related party in accord with the requirements in Appendix B.

APPENDIX B – SUPPORTING DOCUMENTATION
Initial June Bid Submission

…

13.6 When a MAO has an arrangement for benefit services within their tax ID number and does not submit bid data that matches the reporting of these internal transactions in their financial statements, then the plan sponsor must submit supporting documentation—required by Appendix B, items 13.1 to 13.5—that explains and compares how these costs are reflected in the bid versus the MAO's financial statements.

APPENDIX E – REBATE REALLOCATION AND PREMIUM ROUNDING
II. REBATE REALLOCATION GUIDELINES
A. Primary Guidelines

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10. CMS will not allow MAOs to substantially change A/B mandatory supplemental benefits during the rebate reallocation period. CMS expects only marginal adjustments during this period and will evaluate material differences.

    10.1 For a non-RPPO plan, the value of the added, eliminated, or changed A/B mandatory supplemental benefit cannot exceed the amount of unallocated rebate dollars after achieving the target plan intention for the Part D basic premium.

    10.2 For a RPPO plan, the value of the added, eliminated, or changed A/B mandatory supplemental benefit cannot exceed—

        10.2.1 For an MA-PD plan, the amount of unallocated rebate dollars after (i) applying the MA regional benchmark, and (ii) achieving the target plan intention for the Part D basic premium.

        10.2.2 For an MA-only plan, the amount of unallocated rebate dollars after applying the MA regional benchmark.

10.3 Therefore, in conjunction with changing A/B mandatory supplemental benefits during the rebate reallocation period, —

10.3.1 The change in Worksheet 4, cell R108, must be between $0.00 and the amount of the unallocated rebate dollars as described above; and

10.3.2 The gain/loss margin as a percent of revenue must not increase or decrease by more than one-tenth of one percent (0.1%) of revenue; and

10.3.3 CMS will not allow the MAO to eliminate or significantly reduce one benefit for the purpose of adding or significantly enhancing another benefit (or vice versa). For example, if the MAO has an excessive allocation of $3, CMS will not allow the reduction of an A/B mandatory supplemental benefit by $2 to add $5 into a different mandatory supplemental benefit. We consider this to be a substantial change in the A/B mandatory supplemental benefit; and

10.3.4 Changes in MA pricing assumptions for the incremental change in A/B mandatory supplemental benefits and the associated impact on other pricing assumptions (that is, flow-through pricing), as described in section III of this appendix, are permitted only for the bids involved in rebate reallocation.

Prescription Drug (PD)

II. PRICING CONSIDERATIONS

Related-Party Arrangements

The related-party requirements apply to any Part D sponsors entering into any type of arrangement with, or receiving services from, an entity that has a different tax identification number than that of the Part D sponsor but is associated with the Part D sponsor by any form of common, privately held ownership, control, or investment, including any arrangement in which the Part D sponsor does business with a related party through one or more unrelated parties.

CMS requires all Part D sponsors to disclose whether or not they are in a business arrangement with a related party. Part D sponsors in such an arrangement must: (i) enter related-party expenses on lines 1 and 2 of Section VII of Worksheet 2, and (ii) provide additional documentation for each related party in accord with the requirements in Appendix B.

APPENDIX B – SUPPORTING DOCUMENTATION
Initial June Bid Submission

…

13.11 When a Part D sponsor has an arrangement for benefit services within their tax ID number and does not submit bid data that matches the reporting of these internal transactions in their financial statements, then the plan sponsor must submit supporting documentation—required by Appendix B, items 13.1 to 13.10—that explains and compares how these costs are reflected in the bid versus the Part D sponsor's financial statements.