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# *Correspondence Memorandum*

**Date:** May 14, 2018

**To:** Group Insurance Board

**From:** Arlene Larson, Manager Federal Health Programs & Policy
Office of Strategic Health Policy

**Subject:** Medicare Advantage Final Rates and 2019 Contract Update

**ETF requests the Group Insurance Board (Board) approve UnitedHealthcare's (UHC) final rate bid as well as approve the Medicare Advantage contract as part of the overall Health Program Agreement subject to final negotiations.**

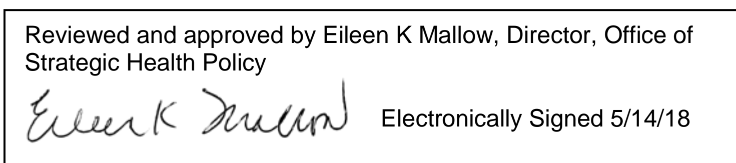
This memo is to update the Board on the final rate for the Medicare Advantage plan and the status of negotiations on the agreement with UnitedHealthcare (UHC).

UHC provided final rates in April. The medical-only rate is $103.81 Per Member Per Month (PMPM) and was established following the Centers for Medicare and Medicaid Services (CMS) approved rates for 2019. The $103.81 PMPM rate is lower than UHC's preliminary PMPM rate of $170.00, which was shared with the Board at the March 21 meeting.

UHC submitted rates for 2020 that may remain the same or be lowered, based on federal actions such as delayed implementation of the Affordable Care Act's Insurer Fee, and CMS's claim risk scores based on the prior year's insured members. UHC also provided a summary of potential rate changes for 2021, based on a number of factors. Segal Consulting (Segal) reviewed the submission and stated the rate was reasonable and favorable, as expected with favorable CMS funding. Segal's memo appears as Attachment A to this memo.

The 2019 Uniform Benefits changes that will be presented to the Board today have been shared with UHC. UHC has confirmed its rate will remain the same after any 2019 benefit adjustments are approved by the Board.

For comparison purposes, the following table shows Medicare individual medical-only rates in 2018 for the most popular health plans and UHC's rate for 2019.



Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy

Electronically Signed 5/14/18

| Board | Mtg Date | Item # |
|---|---|---|
| GIB | 5.16.18 | 3B |

## Medicare Individual Rate without PBM, Dental, Fees

| Health Plan Name | 2018 post buy-down | 2019 |
|---|---|---|
| Dean | $233.72 | N/A |
| IYC Medicare Plus | $175.62 | N/A |
| Network | $257.06 | N/A |
| Quartz UW | $220.92 | N/A |
| UHC | N/A | $103.81 |
| WEA Trust East | $232.54 | N/A |

The Board approved UHC's Medicare Advantage plan proposal to include the current Pharmacy Benefit Manager (PBM), Navitus Health Solutions, on March 21, 2018. Following that decision, we adjusted the agreement, Exhibit 1, that had been issued in the Request for Proposal (RFP), in order to remove all provisions that were not adopted by the Board. This included references to a Medicare Advantage-only PBM and a benefit plan that was an alternative to Uniform Benefits. We found after these language changes, that most of the Medicare Advantage agreement aligned with the Health Program Agreement signed by all other health plans. Therefore, ETF recommends that these two agreements be combined for administrative simplicity. Provisions that apply to only Medicare Advantage versus all other plans have been made specific to the appropriate contractor. UHC has reviewed the revised agreement and has no concerns.

ETF negotiations with UHC are nearing conclusion. A few technical changes are being finalized and we expect to have the contract signed in early June. UHC has demonstrated a willingness to partner with ETF and flexibility and extensive knowledge about CMS Medicare Advantage regulations. Negotiations are resulting in a few contractual changes. These changes to the overall Health Program Agreement appear in Attachment B; the most significant are as follows:

- In cases where federal Medicare Advantage regulations do not align with state law, federal supersedes state law. Following analysis, ETF believes that the federal processes and outcome goals are similar to the state's. State law can continue to be applied after federal law in most cases, but after review, ETF recommends that the contract follow federal law for the following: grievances and appeals, provider network access standards, coordination of benefits and continuity of care including reimbursement.
    - However, for interest due for late payment of out-of-network providers, ETF recommends the contract require that the higher, state- mandated interest rate be paid instead of the lower federal rate.
- Only individuals and families where all members are enrolled in Medicare Parts A and B are eligible for Medicare Advantage. If a Medicare Advantage member dis-

enrolls from Medicare Part B, then the individual or family contract will change to IYC Medicare Plus, effective the date that Part B coverage ends. In this circumstance, the IYC Medicare Plus certificate of coverage requires that the member pay the portion of the claim that Part B would have paid if the member had been enrolled in Part B. Thus, the member will typically pay 80% of the charge after Medicare's deductible.

The attachment does not include clerical changes regarding:

- when text was simply moved within the agreement or to the Department Terms and Conditions,
- when Medicare Advantage language from Exhibit 1 of the RFP was placed into the Health Program Agreement and
- 2019 contract changes that will be discussed with the 2019 Health and Pharmacy Program Changes memo.

Staff will be at the Board meeting to answer any questions.

Attachments:

A: Memo from Segal
B: Agreement changes grid

Attachment A

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# MEMORANDUM

**To:** Eileen Mallow

**From:** Kirsten R. Schatten

**Date:** May 9, 2018

**Re:** Medicare Advantage Pricing for 2019-2021

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As part of the Medicare Advantage procurement, a preliminary bid was required for the cost proposal and used for analysis purposes. The preliminary bid was necessary because timing for finalizing the procurement was prior to CMS's release of funding for the 2019 plan year. The CMS funding varies by year and is an important component of the final pricing, primarily since it is such a large portion of the total premium.

Segal provided an analysis of cost proposals using the following methodology:

- Current costs were calculated using 2018 State Medicare medical rates and State Medicare member counts.
- Current total costs were projected to 2019, 2020, and 2021, using a 4% medical trend.
- UHC submitted rates for 2019 and 2020, with a rate cap range for 2021 based on potential CMS variation in revenue (to be released in April of 2020).
- UHC total costs were also calculated using total State Medicare member counts.

The preliminary bid from United Healthcare (UHC) provided a 20% to 27% savings for Medicare-eligible retirees over 3 years. The variation is due to the rate cap range for 2021.

A final bid was required as part of the bid process. This was subsequent to the CMS release of the 2019 Medicare Advantage and Part D Rate Announcement and Call Letter, April 2, 2018. As required, the final bid was provided by UHC on April 27, 2018.

We have reviewed the final rate submission from UHC. We also discussed the final rates with them to understand the change in rates for each year and their pricing strategy. We find the rates to be reasonable and favorable, as expected with the announcement of favorable CMS funding from the 2019 Call Letter.

Under current law, the Insurer Fee has been eliminated for 2019; however, the Insurer Fee for 2020 and beyond still stands at this point. Therefore, UHC has provided rates for 2020 and 2021 with and without the Insurer Fee. The first 2 years rates are guaranteed, and the third year rate provides a range of guaranteed rates based on the change in CMS funding that will be available

in the April 2020 release of the 2021 MA Rate Announcement and call Letter. Note that these are guarantees and could potentially be lower under favorable experience.

The first year rate is higher than the second year rate based on a couple of factors. CMS payments are based on risk scores for each member, and risk scores are based on claims from the prior year. Risk scores for the first year will be low because of risk score inaccuracies; however, UHC will have a year to work on the accuracy of these scores that will provide for better revenue in the second year. For expenses, UHC will be implementing programs in the first year to better manage member health that will provide for lower costs in the second year. The combination of increased revenue from risk scores and lower claims costs causes the second year premium without the HI fee to drop significantly.

If law is changed in the 2nd year to eliminate the Insurer Fee, the rate will go down. However, if the Insurer Fee remains, the rate including the Insurer Fee will be the same as the 1st year rate.

We have provided an analysis of these final rates using the same methodology as described above. The final bid from UHC provides a 48% to 55% savings for Medicare-eligible retirees over 3 years if the Insurer Fee is applicable in 2020 and 2021. The final bid from UHC provides a 53% to 62% savings for Medicare-eligible retirees over 3 years if the Insurer Fee is applicable in 2020 and 2021.

The final analysis is provided in the following table.

| | | Nationwide Bid (With Health Insurer Fee) | | Nationwide Bid - BAFO (With Health Insurer Fee) | | Nationwide Bid - BAFO (No Health Insurer Fee) | | Health Insurer Fee | |
|---|---|---|---|---|---|---|---|---|---|
| **Members** | **28,733** | **28,733** | | **28,733** | | **28,733** | | | |
| **Counties Covered** | **72** | **72** | | **72** | | **72** | | | |
| | | | | | | | | | |
| | **Current** | **UHC** | | **UHC** | | **UHC** | | | |
| **Bid PMPM** | | **Low** | **High** | **Low** | **High** | **Low** | **High** | | |
| 2019 | $228.76 | $170.00 | | $103.81 | | $103.81 | | $0.00 | |
| 2020 | $232.05 | $170.00 | | $103.81 | | $79.20 | | $24.61 | |
| 2021 | $235.48 | $170.00 | $220.00 | $103.81 | $153.81 | $79.20 | $129.20 | $24.61 | $24.61 |
| | | | | | | | | | |
| **Wtd Avg PMPM** | | | | | | | | | |
| 2019 | $228.76 | $170.00 | | $103.81 | | $103.81 | | $0.00 | |
| 2020 | $232.05 | $170.00 | | $103.81 | | $79.20 | | $24.61 | |
| 2021 | $235.48 | $170.00 | $220.00 | $103.81 | $153.81 | $79.20 | $129.20 | $24.61 | $24.61 |
| | | | | | | | | | |
| **Cost** | | | | | | | | | |
| 2019 | $78,875,405 | $58,614,148 | | $35,793,273 | | $35,793,273 | | | |
| 2020 | $80,011,145 | $58,615,320 | | $35,793,273 | | $27,307,843 | | | |
| 2021 | $81,192,314 | $58,615,320 | $75,855,120 | $35,793,273 | $53,033,073 | $27,307,843 | $44,547,643 | | |
| TOTAL | $240,078,864 | $175,844,788 | $193,084,588 | $107,379,818 | $124,619,618 | $90,408,959 | $107,648,759 | | |
| | | | | | | | | | |
| **Savings** | | | | | | | | | |
| 2019 | | $20,261,257 | | $43,082,132 | | $43,082,132 | | $0 | |
| 2020 | | $21,395,825 | | $44,217,872 | | $52,703,301 | | $8,485,430 | |
| 2021 | | $22,576,994 | $5,337,194 | $45,399,041 | $28,159,241 | $53,884,471 | $36,644,671 | $8,485,430 | $8,485,430 |
| TOTAL | | $64,234,076 | $46,994,276 | $132,699,045 | $115,459,245 | $149,669,904 | $132,430,104 | $16,970,859 | $16,970,859 |
| **% Savings** | | 27% | 20% | 55% | 48% | 62% | 55% | | |
| | | | | | | | | | |
| **Points** | | | | | | | | | |
| **200** | | **200** | | **200** | | **200** | | | |

## *2019 Recommended Agreement Changes following Negotiations*

| Description of Change Requested<br>A&E =(Assumption & Exception negotiations agreement) | 2019 Contract Reference | Original Language | Proposed Change / Language (see underlined and ~~struck out~~) |
|---|---|---|---|
| **Removed references to PBM in definitions** as Board did not approve concept for 2019. | 000 Defintions | | Remove definitions for: COVERED PRODUCTS; EGWP; ELIGIBLE PRODUCT; MEDICARE PART D; PARTICIPATING PHARMACY; PARTICIPATING PROVIDER; PHARMACY BENEFIT PLAN; PRODUCT; REBATE; SPECIALTY DRUGS; WRAP PLAN |
| **Removed references to PBM in remainder of Agreement** as Board did not approve concept for 2019. | 105 Introduction;<br>110 Objectives;<br>115.6 General Requirements;<br>140 B 2) c) IYC Open Enrollment Materials;<br>140 C Required Participant & prescriber outreach for formulary changes;<br>140 D Required Participant Educational Materials;<br>155 D Fraud and Abuse 2) o through r;<br>205 B 4 & 5 Enrollment;<br>220 M & N Benefits;<br>225 1) Quality;<br>235 Claims | | Remove all references to Pharmacy Benefit Manager (PBM) that is not Board's current PBM |
| **Removed references to Alternative Benefit Plan** as Board did not approve concept for 2019. | 000 Definitions;<br>220 A Benefits Overview | | Remove ALTERNATIVE BENEFIT DESIGN as defined in UNIFORM BENEFITS and all other references. |
| **A&E 4** Due to differences between CMS Medicare Advantage regulations and state law, add "if not preempted by federal law". | 115.17 General Requirements- network access standards | Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32. | Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32, if not preempted by federal law. |
| **New policy** that only individuals and families where all are enrolled in Medicare Parts A & B are eligible for Medicare Advantage. | 125A 9) Eligilibity | | ANNUITANTS and CONTINUANTS listed below who are enrolled in MEDICARE PARTS A and B are eligible for enrollment in the MEDICARE ADVANTAGE plan for individual coverage. To enroll in family MEDICARE ADVANTAGE coverage, an ANNUITANT or CONTINUANT and their DEPENDENTS must be enrolled in MEDICARE PARTS A and B. ANNUITANT and CONTINUANT family contracts that include a PARTICIPANT who is not enrolled in MEDICARE PARTS A and B are not eligible to enroll in the MEDICARE ADVANTAGE plan. |

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|---|---|---|---|
| **A&E 7 & 8** clarify meaning of "day" as "business day". | 125 F Medicare Participants | CONTRACTOR shall ensure that all PARTICIPANTS are enrolled in both MEDICARE PARTS A and B by the PARTICIPANT's coverage EFFECTIVE DATE. If a PARTICIPANT disenrolls from MEDICARE PARTS A or B after the EFFECTIVE DATE, the CONTRACTOR shall notify the DEPARTMENT on the day the CONTRACTOR identifies the PARTICIPANT as having disenrolled from PARTS A or B and the effective date. | The MEDICARE ADVANTAGE CONTRACTOR shall ensure that all PARTICIPANTS are enrolled in both MEDICARE PARTS A and B by the PARTICIPANT's coverage EFFECTIVE DATE. If a PARTICIPANT disenrolls from MEDICARE PARTS A or B after the EFFECTIVE DATE, the CONTRACTOR shall notify the DEPARTMENT on the BUSINESS DAY after the CONTRACTOR identifies the PARTICIPANT as having disenrolled from PARTS A or B and the effective date. |
| **New policy** that if a Medicare Advantage member disenrolls from Part B, the individual or family contract will change to IYC Medicare Plus. | 130 A Medicare Participant Premiums | | Any PARTICIPANT enrolled in MEDICARE ADVANTAGE within an individual or family contract who subsequently cancels Medicare coverage, shall have all covered PARTICIPANTS on their contract disenrolled from the MEDICARE ADVANTAGE plan and enrolled in the IYC Medicare Plus plan effective the date of loss of Medicare coverage. Benefit payments for that PARTICIPANT shall be limited in accordance with UNIFORM BENEFITS. |
| **UHC** request for ETF to notify employers of CMS Uniform Premium Requirements | 130 D Medicare Advantage Uniform Premium Requirements | | The EMPLOYER may determine how much of ANNUITANT'S plan beneficiary premium they will subsidize, subject to the following conditions in determining the plan beneficiary premium subsidy:<br><br>1) The EMPLOYER can subsidize different amounts for different classes of ANNUITANTS in the plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly); and<br><br>2) The EMPLOYER cannot vary the plan beneficiary premium subsidy for individuals within a given class of ANNUITANTS. |
| **UHC request** for UHC review and approval of group Medicare Advantage materials due to CMS Medicare Advantage regulations. | 140 B 5) MA Participant Marketing Materials | | 5) MEDICARE ADVANTAGE PARTICIPANT/Marketing Materials. The DEPARTMENT shall provide the MEDICARE ADVANTAGE CONTRACTOR with copies of any and all materials relating to the coverage available through the MEDICARE ADVANTAGE plan that the DEPARTMENT intends to disseminate to eligible ANNUITANTS and their eligible DEPENDENTS. The DEPARTMENT and the MEDICARE ADVANTAGE CONTRACTOR will work together to approve materials prior to distribution. The DEPARTMENT understands that the MEDICARE ADVANTAGE plan is subject to federal and state regulatory oversight, and that eligible PARTICIPANT materials and marketing materials (including, but not limited to, cover letters accompanying direct mail kits, announcement mailings, etc.) may be required to be filed with, reviewed and approved by, CMS or state regulators prior to use. The DEPARTMENT agrees not to distribute such material prior to mutual agreement of materials. The DEPARTMENT also agrees to comply with all relevant federal and state regulatory requirements regarding the distribution and fulfillment of eligible PARTICIPANT materials and/or marketing materials and applicable timeframes. |

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|---|---|---|---|
| **A&E 15** Due to differences between CMS Medicare Advantage regulations and state law, add "if not preempted by federal law". | 220 K Coordination / Non-Duplication; also 400 Uniform Benefits- V. Coordination of Benefits | The CONTRACTOR'S administration of BENEFITS provisions must conform to Wis. Adm. Code INS 3.40. | The CONTRACTOR'S administration of BENEFITS provisions must conform to Wis. Adm. Code INS 3.40, if not preempted by federal law. |
| **A&E 16** ETF reserves the right to review provider contracts. Proprietary provisions may be redacted. | 230 Provider Contracts | | The MEDICARE ADVANTAGE CONTRACTOR must certify annually that their provider contracts meet the requirements in Section 230 and Exhibit A. If the Department determines it is necessary, and has exhausted all other reasonable alternatives, it will review provider contracts on a case-by-case basis for the purpose of confirming that the provider contracts meet the requirements in Section 230 and validating reported data regarding provider payments. UHC may be allowed to redact proprietary and confidential information from such Provider Contracts before the Department review, unless such information is imperative to the review. |
| **A&E 17** Clarify that a benefit period equals a calendar year. | 230 B Provider Directory | The CONTRACTOR must make a provider directory available to PARTICIPANTS during the annual IT'S YOUR CHOICE OPEN ENROLLMENT period and throughout the benefit period. Providers listed in these directories are subject to CMS MEDICARE ADVANTAGE access standards and requirements to accept new patients, unless otherwise noted. The CONTRACTOR is required to have a current provider directory easily accessible on their website at all times. The provider directory must include a revision date and all past versions within a benefit period and must be provided to the DEPARTMENT upon request for the purposes of resolving complaints. | 2) The MEDICARE ADVANTAGE CONTRACTOR must make a provider directory available to PARTICIPANTS during the annual IT'S YOUR CHOICE OPEN ENROLLMENT period and throughout the benefit period. Providers listed in these directories are subject to CMS MEDICARE ADVANTAGE access standards and requirements to accept new patients, unless otherwise noted. The CONTRACTOR is required to have a current provider directory easily accessible on their website at all times. The provider directory must include a revision date and all past versions within a benefit period and must be provided to the DEPARTMENT upon request for the purposes of resolving complaints. Past versions within a benefit period may be needed for the purpose of resolving complaints. A benefit period is one calendar year. |
| **A&E 18** Due to differences between CMS Medicare Advantage regulations and state law, add "if not preempted by federal law". | 230 C Continuity of Care | The CONTRACTOR must comply with the continuity of care provisions under Wis. Stat. § 609.24, for providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and listed in the provider data submission. | The CONTRACTOR must comply with the continuity of care provisions under Wis. Stat. § 609.24 if not preempted by federal law, for providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and listed in the provider data submission. DEPARTMENT acknowledges that federal law preempts Wis. Stat. § 609.24(1)(e), which requires that provider contracts contain provisions addressing reimbursement rendered under this section and if provider contracts do not contain such provisions, MEDICARE ADVANTAGE CONTRACTOR is required to reimburse the provider according to the most recent contracted rate. |
| **A&E 19** Due to differences between CMS Medicare Advantage regulations and state law, clarify that interest must be paid at the higher, state mandated rate. | 235 Claims | The CONTRACTOR shall comply with Wis. Stat. § 628.46 with regard to any interest due for late payment of claims submitted by an OUT-OF-NETWORK provider. | In the event MEDICARE ADVANTAGE CONTRACTOR receives a written demand from an affected member or an affected OUT-OF-NETWORK provider with regard to any interest due for late payment of clean claims under Wis. Stat. § 628.46, the MEDICARE ADVANTAGE CONTRACTOR agrees to promptly supplement the Federally required prompt pay interest rate and pay at the 7.5% rate provided for in Wis.Stat. § 628.46. |

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|---|---|---|---|
| **A&E 22** Due to differences between CMS Medicare Advantage regulations and state law, and a thorough, multi-faceted CMS process, ETF willl rely on the CMS grievance process rather than state's for Medicare Advantage members. | 240 A Grievances | | The MEDICARE ADVANTAGE CONTRACTOR will follow CMS rules set forth in 42 CFR part 422, subpart M, and Chapter 13 of the Medicare Managed Care Manual. All of the following provisions in 240 do not apply to the MEDICARE ADVANTAGE CONTRACTOR. |
| **A&E 23 Per** CMS Medicare Advantage regulations, contractor must accept written cancellation from member, but will inform ETF upon receipt. Verbal requests will be directed to ETF. | 245 Cancellation of Participant Coverage | If the ANNUITANT or CONTINUANT contacts the CONTRACTOR directly to cancel coverage, the CONTRACTOR is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT. | If the ANNUITANT or CONTINUANT contacts the MEDICARE ADVANTAGE CONTRACTOR directly to cancel coverage, the MEDICARE ADVANTAGE CONTRACTOR is to reject all non-written cancellation requests and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT. If the ANNUITANT or CONTINUANT contacts the MEDICARE ADVANTAGE CONTRACTOR directly to cancel coverage, the MEDICARE ADVANTAGE CONTRACTOR must approve all written cancellation requests, pursuant to CMS Rules and Regulations. Additionally, the MEDICARE ADVANTAGE CONTRACTOR will immediately notify the DEPARTMENT of the written termination request received. |
| **UHC request** for specific record retention due to CMS Medicare Advantage regulations. | 260 F 2) Record Retention | | MEDICARE ADVANTAGE Enrollment Record Retention: The DEPARTMENT'S record of a PARTICIPANT'S enrollment election must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual PARTICIPANT, the MEDICARE ADVANTAGE CONTRACTOR and/or CMS, as necessary, and be maintained by DEPARTMENT for the term of the CONTRACT and for ten (10) years thereafter.<br><br>MEDICARE ADVANTAGE Disenrollment Record Retention: The DEPARTMENT'S record of PARTICIPANT'S election to disenroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual PARTICIPANT, the MEDICARE ADVANTAGE CONTRACTOR and/or CMS, as necessary, and be maintained by the DEPARTMENT for at least ten (10) years following the effective date of the PARTICIPANT'S disenrollment from the Plan. |