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Proposed Rule to Update Medicare Advantage and Part D Benefits

OVERVIEW

On November 16th, the Centers for Medicare and Medicaid Services (CMS) issued a rule that proposes significant regulatory changes for Medicare Advantage (MA) and Prescription Drug Benefit (Part D) plans, beginning in contract year 2019. For both MA and Part D plans, the rule would generally ease reporting requirements, update the Medicare Star Rating methodology, remove the meaningful difference requirement, and redefine marketing materials. The rule also includes many provisions that are specific to MA or Part D plans. CMS estimates that the rule would result in approximately $195 million in net savings for Medicare between 2019 and 2023. Selected major provisions of the rule are described below.

CMS will accept comments on the proposed rule until January 16th. The rule is available here.

MA AND PART D PROVISIONS

Medical Loss Ratio (MLR)

MA and Part D plans are currently required to report their MLRs and are subject to penalties if their MLR is below 85 percent. To better align Medicare MLR reporting requirements with commercial MLR requirements under the Affordable Care Act, the proposed rule would limit MA and Part D MLR reporting requirements to the plan's adjusted MLR percentage and remittance amount. Plans would still be required to submit supporting documentation for their MLR calculation if the validity of their MLR were to come under review.

The rule would also allow expenditures for fraud detection, reduction, and recovery activities to be included in the MLR numerator.

Star Ratings

CMS would update MA and Part D Star Rating measures and the methodology. CMS is proposing a more codified rule-making process for Star Rating changes. To reduce rating inflation, CMS is proposing scaled reductions for incomplete data reporting and a new methodology that accounts for contract consolidations. When a product is consolidated into another (typically higher scoring), the Star Rating for the remaining plan would reflect the weighted average of the scores received by the two pre-consolidation products.

CMS is seeking comment on numerous Star Rating topics, including how to: improve the measures; better account for regional differences and market characteristics; level the playing field for new MA plans; include survey measures of physician experience with the health or drug plan; and add measures that evaluate the adoption of new technology.

The list of proposed measures for 2019 is available on page 209 of the proposed rule.

Preclusion List

MA and Part D benefits are currently only covered if they are ordered or prescribed by a provider who is enrolled in or has validly opted-out of Medicare. Under the proposed rule, CMS would instead distribute a preclusion list containing prescribers and providers who have been revoked from the Medicare program. CMS

would provide this preclusion list to plans on a monthly basis and plans would be required to deny any claims from individuals on the list. To avoid the disruption of access to medically necessary drugs, beneficiaries who request reimbursement for a drug that was prescribed by a provider on the preclusion list would be offered a 90-day supply and notified that the drug is only being covered on a provisional basis.

The preclusion list would also apply to Programs of All-Inclusive Care for the Elderly (PACE). PACE organizations would be prohibited from employing or contracting with individuals or entities on the preclusion list.

Meaningful Difference Requirement

Under current law, insurers may submit bids for multiple MA or Part D plans in the same service area as long as those plans are deemed substantially different according to CMS' meaningful difference standards. Under the proposed rule, the meaningful difference requirement would be fully eliminated for MA plans and partially eliminated for Part D plans in 2019. The requirement would not apply when comparing enhanced Part D plans in the same service area, but Part D sponsors would still be required to ensure that enhanced plans are meaningfully different from basic plans.

Marketing Requirements

CMS currently defines marketing materials for MA and Part D plans as those that: promote the plan organization, inform beneficiaries that they may enroll in a plan offered by that organization, explain plan benefits, and explain how Medicare services are covered by a MA or Part D plan. The proposed rule would distinguish "communications" from "marketing" and would define marketing as the use of materials or activities that are intended to encourage enrollment. Such materials and activities would be subject to more stringent requirements, while other communication would be subject to less oversight.

The rule also proposes that unsolicited marketing and mailing marketing materials be prohibited during the MA open enrollment period (OEP), as directed by the 21st Century Cures Act. CMS seeks comments on whether marketing should be suspended entirely during the OEP or only prohibited to MA enrollees who are eligible to participate in the OEP.

MA-SPECIFIC PROVISIONS

Enrollment

As directed by the 21st Century Cures Act, the rule would eliminate the existing MA disenrollment period (MADP) and replace it with a new MA OEP in 2019. During the MADP, which currently runs between January 1st through February 14th each year, individuals may disenroll from MA and enroll in traditional Medicare and Part D. During the fall OEP, which runs from October 15th to December 7th each year, individuals can change from traditional Medicare to MA, or vice versa, and enroll/disenroll from Part D.

The new MA OEP, which will run between January 1st and March 31st, would allow individuals enrolled in MA to change MA plans, switch from a MA plan to traditional Medicare, and enroll or disenroll from Part D coverage. Individuals enrolled in traditional Medicare would not be able to use the MA OEP to enroll in a MA or Part D plan, but would continue to use the fall OEP if they wish to switch from traditional Medicare to MA or Part D. Individuals newly eligible for Medicare Part A and B could enroll in MA during the fall OEP and then make a one-time election to switch MA plans during the immediately following MA OEP. In subsequent years they would make changes only during the MA OEP.

The rule also proposes changes to the default and passive enrollment processes:

- *Default Enrollment* - Subject to state approval, the rule would allow Medicaid managed care enrollees who are newly eligible for Medicare to be defaulted into a Dual Eligible Special Seeds Plan (D-SNP) that is offered by the same parent organization as the Medicaid managed care plan. The plan would be required notify the individual of the default enrollment and the individual would have the opportunity to opt out.
- *Passive Enrollment* – Currently, passive enrollment is restricted to situations in which an MA contract is immediately terminated or when CMS determines that enrollment in a plan poses potential harm to the beneficiary. Subject to state approval, the rule would allow passive enrollment for full-benefit dually-eligible beneficiaries from a non-renewing integrated D-SNP into another highly integrated D-SNP. The D-SNP receiving passive enrollees would have to meet continuity of care standards and operate as a Fully Integrated Dual Eligible SNP or a highly-integrated D-SNP that has a minimum of three stars under the MA Star Rating System. Individuals who are passively enrolled would still be offered a two-month special election period (SEP) to enroll in different Medicare coverage.

Maximum Out-of-Pocket and Cost Sharing Limits

CMS currently sets maximum out-of-pocket and cost sharing limits based on Medicare fee-for-service data. CMS is soliciting comments on other data sources, including MA encounter data, that could be used to better reflect beneficiary health care costs in the MA program.

Uniformity Requirements

MA plans have historically been required to satisfy uniformity requirements by offering all enrollees access to the same benefits at the same level of cost sharing. The proposed rule would allow plans to create benefit packages for groups of individuals with specific health statuses, as long as the cost sharing and supplemental benefits are appropriate for the specific disease conditions. The uniformity requirement would be satisfied as long as all similarly situated individuals were being treated uniformly. MA plans would still be prohibited from denying, limiting, or conditioning coverage based on health status.

The more flexible uniformity requirements would not apply to Part D plans.

PART D-SPECIFIC PROVISIONS

Tiering Exceptions

Part D beneficiaries are entitled to request an exception to the plan's tiered cost-sharing structure for prescription drugs that are medically necessary. It has become standard practice for Part D plans to consider any tier that is labeled "generic" to be exempt from tiering exceptions, even if that tier also contains brand name drugs. Under the proposed rule, plans would be prohibited from excluding a tier containing drugs with lower cost-sharing from tiering exceptions just because that tier is labeled generic.

Follow-On Biological Products

Under current Part D regulations, biosimilar products do not meet CMS' definition of a generic drug and are subject to higher maximum co-payments for low income subsidy (LIS) eligible individuals and non-LIS beneficiaries in the Part D catastrophic coverage phase. CMS proposes to treat follow-on biological products as

generics for purposes of cost-sharing for LIS beneficiaries and non-LIS beneficiaries in the Part D catastrophic coverage phase.

Drug Management Program for At-Risk Beneficiaries

As directed by the Comprehensive Addiction and Recovery Act, CMS proposes to allow Part D plans to implement drug management programs that limit at-risk beneficiaries from accessing frequently abused drugs and prevent at-risk dual or LIS-eligible beneficiaries from using SEPs to change Part D coverage. Under the proposed rule, frequently abused drugs would include most opioids. Part D plans that intend to limit access of a frequently abused drug to an at-risk beneficiary would be required to provide written notice to the beneficiary and, if possible, the beneficiary's prescriber. Beneficiaries who have cancer or are in hospice or long-term care would be exempt from the drug management program.