113TH CONGRESS
1ST SESSION

S. 1787

To require a medical loss ratio of 85 percent for Medicaid managed care plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 10, 2013

Mr. ROCKEFELLER introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To require a medical loss ratio of 85 percent for Medicaid managed care plans, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the ''Medicaid Managed
5 Care Responsibility and Equity Act''.

6 **SEC. 2. MINIMUM MEDICAL LOSS RATIO REQUIREMENTS**
7 **FOR MEDICAID AND CHIP MANAGED CARE**
8 **PLANS.**

9 (a) MINIMUM MEDICAL LOSS RATIO REQUIREMENTS
10 FOR MEDICAID AND CHIP MANAGED CARE PLANS.—Sec-

1 tion 1903(m) of the Social Security Act (42 U.S.C.
2 1396b(m)) is amended—
3 (1) in paragraph (2)(A)—
4 (A) by striking ''and'' at the end of clause
5 (xii);
6 (B) by realigning the left margin of clause
7 (xiii) so as to align with the left margin of
8 clause (xii) and by striking the period at the
9 end of clause (xiii) and inserting ''; and''; and
10 (C) by adding at the end the following new
11 clause:
12 ''(xiv) such contract provides that if the Sec-
13 retary determines for a contract year (beginning on
14 or after October 1, 2017) that the entity has failed
15 to have a medical loss ratio, as determined in ac-
16 cordance with paragraph (3), of at least .85 (.80 in
17 the case of an entity in which at least 10 percent of
18 the individuals enrolled in the plan are optional tar-
19 geted low-income children described in section
20 1905(u)(2)(B))—
21 ''(I) the entity shall remit (not later than
22 January 1 of the first calendar year that begins
23 on or after the first day of the contract year)
24 to the State an amount equal to the product of
25 the total revenue of the entity under the State

1 plan under this title (or under a waiver of such
2 plan) for the contract year and the difference
3 between .85 (or .80, if applicable) and the med-
4 ical loss ratio (as so determined) and that any
5 such remittances paid by an entity shall be
6 treated as an overpayment under section
7 1903(d)(3)(A);

8 ''(II) for 3 consecutive contract years, the
9 State shall not permit the enrollment of new en-
10 rollees with the entity for coverage during the
11 second succeeding contract year; and

12 ''(III) the State shall terminate the con-
13 tract if the entity fails to have such a medical
14 loss ratio for 5 consecutive contract years.'';
15 and

16 (2) by inserting after paragraph (2), the fol-
17 lowing:

18 ''(3)(A) For purposes of paragraph (2)(A)(xiv), the
19 medical loss ratio for an entity with a contract under this
20 subsection shall be equal to the ratio of—

21 ''(i) the sum of the amount of contract revenue
22 (as determined in accordance with subparagraph
23 (B)) expended by the entity—

24 ''(I) for providing medical assistance to in-
25 dividuals who are eligible under the State plan

1 under this title or under a waiver of such plan
2 and who are enrolled with the entity; and
3 ''(II) for quality improvement activities (as
4 determined in accordance with subparagraph
5 (C)); to
6 ''(ii) the total amount of contract revenue (as
7 determined in accordance with subparagraph (B)).
8 ''(B) For purposes of subparagraph (A), the Sec-
9 retary shall by regulation specify how contract revenue
10 shall be determined with respect to an entity with a con-
11 tract with the State under this subsection and a contract
12 year. The regulations shall provide that the following shall
13 be disregarded from the determination of contract revenue
14 for a contract year:
15 ''(i)(I) Only in the case of an entity that is ex-
16 empt from Federal income tax, community benefit
17 expenditures made by the entity (not to exceed the
18 limit described in subclause (II)) and reserve funds
19 (not to exceed the limit described in subclause (IV)).
20 ''(II) The limit described in this subclause is
21 the amount equal to 3 percent of the contract rev-
22 enue for the contract year or the amount equal to
23 the product of the highest premium tax rate in the
24 State and the contract revenue, whichever is greater.

1 "(III) In this clause, the term 'community ben-
2 efit expenditures' means expenditures for activities
3 or programs that seek to achieve the objectives of
4 improving access to health services, enhancing public
5 health, and relieving government burden.

6 "(IV) The limit described in this subclause is
7 the amount equal to 3 percent of the contract rev-
8 enue for the contract year except that an entity that
9 is exempt from Federal income tax may increase the
10 amount of reserve funds to be disregarded for a con-
11 tract year up to a limit that does not exceed the
12 amount equal to the sum of 3 percent of the con-
13 tract revenue for the contract year and the total
14 amount of the reserve funds disregarded for the 2
15 preceding contract years or 9 percent of the contract
16 revenues during such 3-year period, whichever is
17 greater.

18 "(ii) Expenditures for providing medical assist-
19 ance to a new beneficiary population enrolled with
20 the entity for the first 2 contract years of such pop-
21 ulation's enrollment.

22 "(C)(i) For purposes of subparagraph (A), quality
23 improvement activities are activities designed to do any
24 of the following:

1 "(I) To improve health outcomes by implementing activities such as effective case management, care coordination, quality reporting, chronic disease management or medication and care compliance activities.

6 "(II) To prevent hospital readmissions, including a comprehensive program for hospital discharge that includes patient education and counseling, discharge planning, and post-discharge follow-up by an appropriate health care professional.

11 "(III) To improve patient safety and reduce medical errors through the use of best clinical practices, evidence-based medicine, and health information technology.

15 "(IV) To implement a significant investment (as defined by the Secretary and based on a 2-year average of expenditures) in technology improvements such as through electronic medical records, telemedicine, and smart phone or tablet technology.

20 "(V) To implement wellness and health promotion activities, including programs designed to address the social determinants of health (as defined in clause (iii)(I)) or to promote patient engagement (as defined in clause (iii)(II)).

1 ''(ii) For purposes of subparagraph (A), an expendi-
2 ture only shall be considered to be an expenditure for a
3 quality improvement activity if the expenditure satisfies
4 1 or more of the following requirements:

5 ''(I) The expenditure is designed to improve
6 healthcare quality.

7 ''(II) The expenditure is designed to increase
8 the likelihood of desired health outcomes in ways
9 that can be objectively measured, and that can
10 produce verifiable results and achievements.

11 ''(III) The expenditure is directed toward indi-
12 vidual enrollees, incurred for specific segments of en-
13 rollees, or provides health improvements to a popu-
14 lation beyond the population enrolled in coverage
15 with the entity so long as no additional costs are in-
16 curred due to the non-enrollees.

17 ''(IV) The expenditure is grounded in evidence
18 based medicine (including promising practices which,
19 with documented justification, go beyond the exist-
20 ing evidence base), or widely accepted best clinical
21 practice, or criteria issued by recognized professional
22 medical associations, accreditation bodies, govern-
23 ment agencies, or other nationally recognized health
24 care quality or health improvement organizations.

1 "(iii)(I) For purposes of clause (i)(IV), the term 'so-
2 cial determinants of health' means conditions in the envi-
3 ronments in which people are born, live, learn, work, play,
4 worship, and age; that affect a wide range of health, func-
5 tioning, and quality-of-life outcomes, risks, patterns of so-
6 cial engagement and sense of security and well-being, and
7 have a significant influence on population health out-
8 comes. These conditions include, but are not limited to,
9 safe and affordable housing, access to education, public
10 safety, availability of healthy foods, local emergency and
11 local health services, and environments free of life-threat-
12 ening toxins.

13 "(II) For purposes of clause (i)(IV), the term 'patient
14 engagement' means actions individuals must take to ob-
15 tain the greatest benefit for the health care services avail-
16 able to them, and through which process an individual
17 harmonizes robust information and professional advice
18 with the individual's own needs, preferences and abilities
19 in order to prevent, manage and cure disease.

20 "(D) The Secretary may waive the application of a
21 requirement of this paragraph or of paragraph (2)(A)(xiv)
22 to a Medicaid managed care organization for not more
23 than 2 years, based on the following:

24 "(i) The extent to which the organization is
25 likely to cease offering coverage without the waiver.

1 ''(ii) The number of individuals in the plan like-
2 ly to be affected by loss of coverage.
3 ''(iii) The impact of the loss of coverage on the
4 ability of the beneficiaries to receive coverage under
5 another plan and to have continuity of care.
6 ''(iv) The impact on the rates calculated for
7 other Medicaid managed care organizations that
8 would provide coverage for the beneficiaries that
9 would be affected by the termination of coverage.
10 ''(v) Upon the request of a Medicaid managed
11 care organization, to permit implementation of
12 major plan changes (but only for 1 contract year).
13 ''(vi) Any other relevant information submitted
14 by the Medicaid managed care organization or the
15 State.''.
16 (b) APPLICATION TO MANAGED CARE PLANS UNDER
17 CHIP.—Section 2103(f)(3) of such Act (42 U.S.C.
18 1397cc(f)(3)) is amended—
19 (1) by inserting ''subsection (m)(2)(A)(xiv) of
20 section 1903 (relating to minimum medical loss ratio
21 requirements, except that the minimum medical loss
22 ratio applicable to managed care organizations under
23 this title shall be .80) and'' after ''application of'';
24 and

1 (2) by inserting ''other'' before ''requirements
2 for''.
3 (c) REGULATIONS.—Not later than October 1, 2015,
4 the Secretary of Health and Human Services shall promul-
5 gate regulations implementing the amendments made by
6 this section. The regulations shall require that initial test
7 reporting of medical loss ratios by Medicaid managed care
8 organizations be made not later than October 1, 2016.

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