



MEMORANDUM

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To: Senate Committee on Finance
Attn: Stephanie Carlton

From: Kathleen S. Swendiman
Legislative Attorney, ext. 7-9105

Andrew L. Nolan
Legislative Attorney, ext. 7-0602

Paulette C. Morgan
Specialist in Health Care Financing, ext. 7-7317

Subject: Legal Issues Relating to the Secretary's Authority to Set Payment Rates Under the Medicare Advantage Program

This memorandum provides a legal analysis of certain issues relating to the authority of the Secretary of Health and Human Services to make assumptions regarding anticipated congressional legislation affecting the Sustainable Growth Rate formula when setting benchmarks for payments to private health plans under the Medicare Advantage program. This analysis has also been provided to other congressional offices in the form of a general distribution memorandum.

Medicare Advantage Program Reimbursements

Medicare Advantage (MA)¹ is an alternative way for beneficiaries to receive covered benefits under the Medicare program. Under MA, Medicare beneficiaries who are entitled to Part A and enrolled in Part B receive benefits from private health plans rather than from the traditional fee-for-service Medicare program.² MA private health plans are paid a per-person monthly amount to provide all Medicare covered benefits (except hospice) to beneficiaries who enroll in their plans.

The authority of the Secretary of Health and Human Services (Secretary) to make payments to organizations that provide Medicare covered benefits under a Medicare Advantage plan exists in section 1853 of the Social Security Act (SSA).³ The monthly payment is based on a comparison of each plan's

¹ Medicare Part C, Section 1851 *et seq.* of the Social Security Act, 42 U.S.C. § 1395w-21 *et seq.*

² For a summary of the Medicare program and how the various parts (A, B, C and D) provide covered benefits see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

³ 42 U.S.C. § 1395w-23.

estimated cost of providing Medicare covered services (“the bid”) relative to the maximum amount the federal government will pay for the services in the plan’s service area (“the benchmark”).⁴ In general, if a plan’s bid is less than the benchmark, its payment is equal to its bid plus a rebate equal to a percentage of the difference between its bid and the benchmark.⁵ If a plan’s bid is greater than the benchmark, its payment is equal to the benchmark and the plan must make up the difference between its bid and the benchmark by charging a beneficiary premium. The Secretary has the authority to review and negotiate plan bid amounts to ensure that the bid reflects revenue requirements.

Medicare Advantage Reimbursement Formula

Section 1853(j)(1) of the SSA defines the formula for computing the federal MA benchmark as consisting of two possible measurements for the year 2014. **First**, the benchmark for 2014 could be measured as one-twelfth of the annual capitation rate for a plan’s area under section 1853(c)(1).⁶ The annual capitation rate is the greater of one of two numbers.⁷ Specifically, under section 1853(c)(1)(C)(v), the capitation rate for 2014 is the greater of either⁸ (1) the capitation rate for a county for the previous year increased by the national per capita MA growth percentage (NPCMAGP),⁹ or (2) the per capita fee-for-service (FFS) or “average adjusted per capita cost” (AAPCC) for the county for the year involved.¹⁰ The national per capita MA growth percentage is defined under section 1853(c)(6) to be:

“. . . the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, excluding expenditures attributable to subsections (a)(7) and (o) of section 1848 and subsections (b)(3)(B)(ix) and (n) of section 1886 . . .”¹¹

The AAPCC is defined under section 1876(a)(4) to generally be:

⁴ 42 U.S.C. § 1395w-23(a)(1)(B). If a plan’s bid is less than the benchmark, its payment will be the bid plus a rebate. *Id.* at 1395w-23(a)(1)(B)(i). If a plan’s bid equals or exceeds the benchmark, its payment will be the benchmark amount and each enrollee in that plan will pay an additional premium equal to the amount by which the bid exceeds the benchmark. *Id.*

⁵ Rebate percentages are based on a plan’s quality as measured by a 5-star rating system established by CMS. In 2014, a plan with 4.5 or more stars will have a rebate percentage of 70%, a plan with at least a 3.5 but less than a 4.5 star rating will receive a 65% rebate, and a plan with less than 3.5 stars will receive a 50% rebate. *See* 42 U.S.C. § 1395w-23 (b)(1)(c).

⁶ 42 U.S.C. § 1395w-23(j)(1)(A).

⁷ The capitation rate previously could be the greatest of five numbers, but two of the bases were for dates that have since passed. *See* 42 U.S.C. § 1395w-23(c)(1)(A) (for years before 2005) and *Id.* § 1395w-23(c)(1)(B) (for years 1998 – 2004). Moreover, under 42 U.S.C. § 1395w-23(c)(1)(C)(v)(I), the capitation rate could also be measured as 102% of the annual capitation rate for an area for the previous year. However, that section was repealed pursuant to 42 U.S.C. § 1395w-23(k)(1)(B)(ii), which limits the calculation of the benchmark amount to the greater of the two above referenced terms.

⁸ 42 U.S.C. § 1395w-23(c)(1)(C)(v)(I).

⁹ 42 U.S.C. § 1395w-23(c)(1)(C)(v)(II).

¹⁰ 42 U.S.C. § 1395w-23(c)(1)(D). Pursuant to 42 U.S.C. § 1395w-23(c)(1)(D), because 2014 is a year in which CMS will rebase the capitation rate, section 1853(c)(1)(D)(i) applies. *See* Centers for Medicare & Medicare Services, “Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates,” press release, February 15, 2013, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvTgSpecRateStats/Downloads/Advance2014.pdf>. In a rebasing year, the Secretary recalculates per capita fee-for-service spending in each county using more recent data. The Secretary has authority to determine when to rebase rates, but must rebase at least once every three years. *See* 42 U.S.C. § 1395w-23(c)(1)(D)(ii).

¹¹ 42 U.S.C. § 1395w-23(c)(6).

“ . . . the average per capita amount that the Secretary estimates in advance . . . would be payable in any contract year for services covered under parts A and B, or part B only . . . ”¹²

Section 1876(a)(4) of the SSA counsels that the Secretary’s estimate should be made on the basis of “actual experience” or “retrospective actuarial equivalent.”¹³

Second, pursuant to the Affordable Care Act,¹⁴ starting in 2012, the benchmark can amount to one-twelfth of the “**blended benchmark amount**” as that term is defined in 1853(n)(1).¹⁵ For all years subsequent to 2012, section 1853(n)(1) defines “blended benchmark amount” to mean “the amount specified in” section 1853(n)(2)(A),¹⁶ which, in turn, defines the term as the product of (1) “the **base payment amount**” for a given area and year and (2) the “**applicable percentage for the area for the year specified**.”¹⁷

The “**base payment amount**” for all years subsequent to 2012 is defined in section 1853(n)(2)(E) by reference to the amount specified in section 1853(c)(1)(D), the aforementioned section that defines the MA capitation rate vis-a-vis the per capita FFS amount or AAPCC.¹⁸ The “**applicable percentage for the area for the year specified**” is defined in section 1853(n)(2)(B). The percentage is set at either 95%, 100%, 107.5%, or 115% depending on a ranking provided by the Secretary in which higher percentages are applied to counties with the lowest FFS spending.¹⁹ The 25% of counties with the lowest FFS spending are to receive the highest percentage (115%) of per capita FFS. The 25% of counties with the highest FFS spending are to receive the lowest percentage (95%) of per capita FFS.

The transition to the new methodology is to take place over two to six years, with a larger transition period for areas where the new methodology would result in larger benchmark decreases. The benchmarks are to be further adjusted based on plan quality.²⁰

As **Table 1** (below) illustrates, the discretion of the Secretary to decide the 2014 benchmark calculation ultimately depends on the interpretation of two statutory provisions, sections 1853(c)(6) and 1876(a)(4) of the SSA.

¹² 42 U.S.C. § 1395mm(a)(4).

¹³ 42 U.S.C. § 1395mm(a)(4). Pursuant to section 1853(c)(1)(D)(i), the Secretary may further adjust the rate “as appropriate” for the purpose of “risk adjustment,” for the MA payment area for individuals who are not enrolled in an MA plan for the year, and to exclude the costs attributable for payments for certain services. 42 U.S.C. § 1395w-23(j)(1)(A). The computation in section 1853(j)(1)(A) is with respect to a “service area that is entirely within an MA local area.” *Id.* For a service area that includes more than one MA local area, the statute requires the amount to be determined by a weighted average of the respective local areas. *Id.*

¹⁴ Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

¹⁵ 42 U.S.C. § 1395w-23(j)(1)(A). The benchmark change required by the Affordable Care Act is to be phased in for each county over 2, 4, or 6 years depending on the size of the benchmark reduction, with longer phase-in schedules used for counties with larger benchmark decreases per §§ 1853(n)(1) and 1853(n)(3). In 2014, benchmarks for counties with a 2-year phase-in schedule are to be fully phased in to the ACA calculation. See <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2014Advance.html>.

¹⁶ 42 U.S.C. § 1395w-23(n)(1).

¹⁷ 42 U.S.C. § 1395w-23(n)(2)(A)(i)-(ii).

¹⁸ 42 U.S.C. § 1395w-23(n)(2)(E).

¹⁹ See 42 U.S.C. § 1395w-23(n)(2)(B)-(C).

²⁰ See 42 U.S.C. § 1395w-23(o).

Table I. The Two Possible Bases for the 2014 MA Benchmark Calculation

	AND/ OR	One Twelfth of the “Blended Benchmark Amount”
1 <i>Capitation Rate for the Previous Year Increased by “National MA Growth Percentage” § 1853(c)(6)</i> <p style="text-align: center;">OR</p>		Product of . . . <i>Base Payment Amount</i> AND <i>Applicable Percentage for the Year Specified</i>
2 <i>“Average Adjusted per Capita Cost” § 1876(a)(4)</i>		<i>“Average Adjusted per Capita Cost”</i> 95%, 100%, 107.5%, or § 1876(a)(4) 115%

Source: Table created by CRS.

Notes: Pursuant to 42 U.S.C. § 1395w-23(n)(3), certain counties are subject to an alternative phase-in of the blended benchmark amount, which results in a benchmark calculation that is a combination of the two bases described in the table.

In its February 15, 2013 announcement,²¹ CMS provided preliminary information on MA payment rates and policies for 2014. This annual announcement included a calculation of the factors described above used to determine MA payments in a particular county for 2014. CMS is to finalize these rates and policies for 2014 on April 1, 2014.

Secretary’s Authority to Make Assumptions Regarding Anticipated Legislative Changes

The Sustainable Growth Rate (SGR) methodology, the statutory method for determining the annual updates to the Medicare physician fee schedule,²² is projected to reduce Medicare reimbursements to physicians by 25% in 2014,²³ limiting the amount of the “expenditures” or “payable[s]” that form the basis of the Secretary’s estimate under sections 1853(c)(6) and 1876(a)(4) of the SSA respectively. However, every year since 2003, Congress has passed bills to override the rate cuts mandated by the SGR.²⁴ The Medicare statute does not provide the Secretary explicit authority to adjust the MA benchmarks after April 1 for the following year. We examine, below, the Secretary’s position that she must base the calculation of the MA benchmarks upon current law as of April 1 for the following year. We then analyze alternative interpretations which may be available to the Secretary, as well as potential legal issues which may arise if the Secretary were to change her interpretation.

The Sustainable Growth Formula

The Sustainable Growth Rate methodology was established under the Balanced Budget Act of 1997, P.L. 105-33, because of the concern that the physician fee schedule itself would not adequately constrain overall increases in spending for physicians’ services. Under the SGR formula, if expenditures over a

²¹ Centers for Medicare & Medicare Services, “Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates,” press release, February 15, 2013, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2014.pdf>.

²² See 42 U.S.C. § 1395w-4(f).

²³ See CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

²⁴ *Id.*

period are less than the cumulative spending target for the period, the annual update is increased. However, if spending exceeds the cumulative spending target over a certain period, future updates are reduced to bring spending back in line with the target.

In the first few years of the SGR system, actual expenditures did not exceed the targets. However, beginning in 2002, actual expenditures exceeded allowed targets, and the discrepancy has grown with each year, resulting in a series of ever-larger required reductions under the formula. With the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the required reductions. Most recently, on January 2, 2013, the President signed H.R. 8, the American Taxpayer Relief Act of 2012, P. L. 112-240, into law. Section 601 of that Act averts the SGR-determined reduction and maintains the Medicare physician fee schedule payments at their current rates through December 31, 2013. The conversion factor for 2014 and afterwards will again be computed as if the modification to the conversion factor in this section had never applied, unless Congress intervenes by enacting legislation that delays or modifies the annual update.

Interpreting the Secretary's Authority

The primary task in interpreting the meaning of any statute is to “ascertain congressional intent and give effect to the legislative will.”²⁵ The starting point to determine legislative intent is the plain language of the statute itself.²⁶ If the statute's terms are “plain,” the law should be enforced “according to its terms.”²⁷ If a statute is ambiguous, the legislative history and the underlying public policy of the statute can guide the interpretation.²⁸ In this case, the text of the MA statute does not specifically compel or preclude the Secretary from taking into account foreseeable future events that may impact MA growth rate estimates. Thus, the question arises whether the statute would permit the Secretary to interpret her authority under the MA statute to include assumptions regarding future congressional activity when calculating estimates of the NPCMAGP.

Beginning with section 1853(c)(6), the plain language of the statute appears to provide the Secretary with considerable flexibility in determining the NPCMAGP. The statute generally defines the NPCMAGP as a “reflect[ion of] the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B.”²⁹ The word “reflect” implies, by its very nature, a level of imprecision.³⁰ The imprecision implied by the word “reflect” is magnified as the word is further defined by the term “estimate,” which ordinarily refers to a “general calculation” or “an approximate computation.”³¹ The statute imposes few, if any, non-ambiguous limits on what the reflection of the Secretary's estimate must be. Specifically, section 1853(c)(6) requires that the Secretary's projection be for the “per capita rate of growth in expenditures under this title for individuals entitled to benefits under part A and enrolled under part B.”³² The phrase “under this title for

²⁵ *Philbrook v. Glodgett*, 421 U.S. 707, 713 (1975).

²⁶ *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253 (1992).

²⁷ *Hartford Underwriters Ins. Co. v. Union Planters Bank, N. A.*, 530 U.S. 1, 6 (2000).

²⁸ *Crandon v. United States*, 494 U.S. 152, 160 (1990).

²⁹ 42 U.S.C. § 1395w-23(c)(6).

³⁰ See *Board of Trade v. SEC*, 187 F.3d 713, 719 (7th Cir. 1999) (interpreting the word “reflect” in the Commodity Exchange Act to indicate imprecision).

³¹ See *Horsemen's Benevolent & Protective Assn. v. Valley Racing Assn.*, 4 Cal. App. 4th 1538, 1558 (Cal. App. 5th Dist. 1992); *Indiana Gas & Water Co. v. Williams*, 132 Ind. App. 8, 13-14 (Ct. App. 1961).

³² 42 U.S.C. § 1395w-23(c)(6).

individuals entitled to benefits under part A and enrolled under part B” modifies the word “expenditures,” indicating that the estimate must generally project expenditures made pursuant to Title XVIII of the SSA for the individuals at issue.

The statute, however, is silent as to what constitutes a proper means to calculate the projection of the growth of future FFS expenditures. Generally, the Supreme Court interprets such silence as an implicit delegation of authority to the agency to fill in the gap in the statutory scheme, and an agency’s gap filling rules are given controlling weight unless they are “arbitrary, capricious, or manifestly contrary to the statute.”³³ This broad interpretation of section 1853(c)(6) is confirmed by the legislative history of the NPCMAGP, which assumed that then-titled “national per capita Medicare+Choice growth percentage” would be an imprecise estimate by the Secretary.³⁴

Section 1876(a)(4) defines, in relevant part, the average adjusted per capita cost (AAPCC) as the amount “the Secretary estimates in advance . . . would be payable in any contract year for services covered under Parts A and B, or part B only . . .”³⁵ Unlike section 1853(c)(6), the SSA’s provision defining the AAPCC does provide some basis for the Secretary’s estimate. Specifically, the Secretary’s estimate should be based on “actual experience or retrospective actuarial equivalent . . .”³⁶ If the Secretary decides to base the AAPCC on a retrospective actuarial approach, there must be an “adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence.”³⁷ The specific means by which the Secretary uses either the experiential or actuarial approach to deciding the AAPCC is not defined by the statute, and, like section 1853(c)(6), appears to have been implicitly delegated to the agency, arguably providing the Secretary with considerable latitude in determining the AAPCC. This interpretation appears to be confirmed by the legislative history of the Tax Equity and Fiscal Responsibility Act of 1982, the law that created the AAPCC. Specifically, lawmakers envisioned that the Secretary of Health and Human Services would “develop[] and . . . implement” the “methodology to make appropriate adjustments in the” AAPCC.³⁸

As noted above, nothing in sections 1853(c) or sections 1876(a)(4) provide an explicit, substantive limit on the Secretary’s authority to estimate either the NPCMAGP or the AAPCC other than the general requirement that the estimate not be arbitrary, capricious, or manifestly contrary to the statute. Instead, both provisions that underlie the Secretary’s estimate of the MA benchmark provide the Secretary with considerable discretion to make an accurate projection of either the projected FFS growth rate or the projected per capita FFS.

³³ *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 843-844 (1984).

³⁴ H.R. Rep. No. 105-217, at 619 (1997) (“Calculations of the annual capitation rates for each payment area would have to take into account any adjustment for over or under projecting the national per capita Medicare+Choice [renamed Medicare Advantage in P.L. 108-173, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003] growth percentage and any adjustment for national coverage determinations.”).

³⁵ 42 U.S.C. § 1395mm(a)(4).

³⁶ 42 U.S.C. § 1395mm(a)(4).

³⁷ 42 U.S.C. § 1395mm(a)(4).

³⁸ H.R. 97-757, at 24 (1982) (“Under this bill, the new HMO provisions may not be implemented until the Secretary . . . notifies the Congress that he is reasonably certain that the methodology to make appropriate adjustments in the . . . AAPCC . . . has been developed and can be implemented to assure actuarial equivalence.”)

The Secretary's Position

The Secretary has taken the position over the past several years that she is required by the language of the MA statute to base her calculation of the MA payment rate update on the law as in effect on April 1 when the benchmarks are announced for the plan year beginning the following January 1. Most recently this position was articulated in CMS' 2013 announcement of MA benchmarks in the context of a question by a commentator as to why CMS has ignored the consistent repeal of the SGR-legislated fee schedule reductions:

CMS's consistent interpretation and longstanding practice has been to base the projected growth percentage on the law as it exists on the date of the announcement of the payment rate update. The statute requires that the growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title." We believe that the best reading of this statutory language is that the growth percentage should be based on the provisions of "this title" (Title XVIII) as of the date that the rates are announced. As a result, every ratebook to date has been based on a USPPC increase estimated under the then current law. Changes to the Medicare statute are a fairly common occurrence. There have been a number of years where Medicare expenditures were expected to be reduced by pending legislative action. In those years, if we had anticipated the legislative changes in the projections, payments to Medicare Advantage plans would have been reduced. By following current law as the basis for the projection, any judgment regarding the likelihood or implications of unknown possible law changes is removed.³⁹

The MA statute does not address the issue of whether the Secretary should or should not anticipate future congressional action when setting plan benchmarks. Indeed, Congress' repeated delay of the SGR fee schedule reductions over the past several years is, by all accounts, an unusual situation, unanticipated in 1997 when the SGR methodology was first implemented. The Secretary's interpretation of Section 1853(c)(6) and related provisions as requiring her to calculate MA payment rates based solely on the law as of April 1 is one that is within her discretion and appears to be reasonable and likely to be upheld by the courts. It should be noted that the Secretary has the authority to adjust the payment rates each year to account for "errors in the previous year's calculations" of the national per capita MA growth percentage (NPCMAGP).⁴⁰ The Secretary has used this authority to factor the effects of Congress' override of the SGR reductions which occurred after the current year's MA payment rates were set, into the following year's estimate of the NPCMAGP.

Alternative Positions

Since neither the MA statute nor its legislative history address anticipation of foreseeable future congressional actions when setting benchmarks for MA plan payments, a change in the Secretary's position may be considered. In contrast to the Secretary's position, it could be argued that nothing in the plain language of the statute indicates that the phrase "under this title" imposes an independent restriction on the Secretary's discretion such that the estimate cannot reflect potential changes in the law, based on prior experience. From this perspective, viewing the phrase "under the title" in isolation to impose a restriction on the Secretary's discretion may be arguably contrary to a basic canon of statutory interpretation that counsels against construing statutory phrases in isolation.⁴¹ In other words, the phrase

³⁹ Centers for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," press release, April 2, 2012, p. 18 <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2013.pdf>.

⁴⁰ Section 1853(c)(6)(C) of the SSA, 42 U.S.C. § 1395w-23(c)(6)(C).

⁴¹ *United States v. Morton*, 467 U.S. 822, 828 (1984) ("We do not, however, construe statutory phrases in isolation; we read (continued...)

“under this title” could be read in light of the surrounding texts which define the NPCMAGP as a “reflection” of the Secretary’s “estimate” of future expenditures under Title XVIII of the SSA. Additionally, the Secretary’s interpretation may be said to ignore section 1876(a)(4), an independent basis for the MA benchmark, which also provides CMS with considerable discretion in estimating the FFS rates.⁴² Ultimately, the methodology and basis for how the Secretary arrives at the estimates under sections 1853(c)(6) or 1876(a)(4) appears to be a product of the Secretary’s considerable discretion. This discretion could arguably form the basis for an alternative interpretation of the MA statute.

Issues Which Might be Raised If the Secretary Changes Her Interpretation

A question may be raised whether the Secretary has the authority to reverse her current interpretation and take the position that she has the authority to assume Congress will again act legislatively to modify or eliminate the effects of the SGR formula reductions when formulating the current benchmarks. CMS has described its interpretation that it is required by the language of the MA statute to base its calculation of the MA payment rate update on the law as in effect on April 1 as being “consistent” and “long-standing.”⁴³ While an agency may change its interpretation of a statute, the courts generally require, in such circumstances, that the agency articulate a “reasoned analysis for change.”⁴⁴ This ordinarily requires the agency to “display awareness that it is changing position” and to show that “there are good reasons for the new policy.”⁴⁵ If the Secretary articulates a reasoned basis for changing her interpretation of her authority under the Medicare statute regarding the effect of anticipated congressional actions on estimates of the NPCMAGP, it is possible the courts would uphold her authority to change her position.

If the Secretary were found to have the authority to change her position, her new interpretation would, if challenged, again be given considerable weight by the courts unless found to be arbitrary, capricious, or otherwise contrary to the statute.⁴⁶ While forward-thinking projections such as budget estimates and revenue assessments routinely consider the possibility of future congressional legislation, it is unusual for an agency to assume that a current statute will not be in effect by a certain date, and to base future federal obligations on such anticipated congressional action. The question may be raised whether the Secretary has the authority to make an assumption that Congress will take a specific legislative action by a certain date.

As noted in the discussion above, the Secretary has considerable discretion in developing the benchmarks for MA payments under the law. The Secretary may argue that, at this point in time, given 11 years of consistent congressional action to override the physician fee schedule reduction, along with the increasing magnitude of the required SGR reduction, the foreseeability of congressional action makes such an assumption both authorized and reasonable. In other words, because of the magnitude of the negative payment trend in the SGR formula and Congress’ past legislative “fixes,” it might be arguably more

(...continued)

statutes as a whole.”)

⁴² *See supra*.

⁴³ Centers for Medicare & Medicaid Services, “Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,” press release, April 2, 2012, p. 18 <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtgSpecRateStats/Downloads/Announcement2013.pdf>.

⁴⁴ *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 41 (1983).

⁴⁵ *FCC v. Fox TV Stations, Inc.*, 556 U.S. 502, 515 (2009).

⁴⁶ *See Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 843-844 (1984).

realistic to assume, this year, that Congress will enact a SGR patch to prevent the required reduction under the SGR formula from taking place than to assume Congress will allow the law to stay in effect as it is. This position, it might be argued, would reasonably ensure that the 2014 MA payment rates reflect, as far as possible, the actual costs of paying providers under Medicare in 2014.⁴⁷ On the other hand, it could also be argued that assuming Congress will take a legislative action that has not yet been taken is “arbitrary and capricious” and not in accordance with the statute as currently in effect.

Another issue which may be raised if the Secretary were to change her interpretation is that if, on April 1, 2013, the Secretary incorporates the assumption that the current SGR reductions will not happen, but they do, then the 2014 MA payment rates would be higher than permitted under the law. The Antideficiency Act, prohibits federal payments from being made in excess of available appropriations. The Act may be implicated if funds are expended for unauthorized purposes, which would arguably be the case if the Secretary’s assumption concerning future legislation ended up being incorrect.⁴⁸ On the other hand, if the Secretary’s interpretation that she has the authority to incorporate assumptions concerning future congressional actions were found by the courts to be reasonable, and not arbitrary or capricious, or contrary to the statute, then the Antideficiency Act may not be implicated.

A number of policy considerations have been suggested as reasons why the Secretary should assume Congress will override the SGR reductions in calculating final payment levels for MA plans in 2014. Some argue that the recent Affordable Care Act changes, the recent slowdown in Medicare costs, and the ever-growing SGR update factor have combined to reduce projected payments to plans more than expected this coming year, and that the Secretary should assume Congress will delay or modify the SGR reductions (which would raise the benchmarks for health plan payments) in order to mitigate possible disruptions for beneficiaries who would likely face “increased premiums, reduced benefits, or plan exits from local areas.”⁴⁹ Such considerations would not be directly relevant to a legal analysis of whether the Secretary has the authority to assume anticipated congressional action in setting payment rates, although they might be relevant in the context of deciding whether or not to phase-in or otherwise lessen the impact of significant plan payment reductions, if such authority were available to the Secretary. In fact, CMS has solicited suggestions for mitigating the effects of projected plan payment reductions in its February 15th Advance Notice: “We appreciate that plans are facing several legislatively mandated changes affecting payment for 2014, and this may present challenges for plans. We solicit comment on suggestions to address these challenges within the parameters of current law.”⁵⁰

⁴⁷ While this appears to be a tenable construction of the Secretary’s authority, we have thus far not identified any instances where agencies have based expenditure obligations on legislative action not yet taken. This dynamic, coupled with the unique nature of the issues raised by the interaction between the SGR methodology and the MA statute, makes it difficult to predict with any degree of certainty what analytical rubric a reviewing court would ultimately employ in its consideration of such agency action.

⁴⁸ See 31 U.S.C. § 1341(a)(1)(B). The principle involved is that the use of appropriated funds for unauthorized purposes violates the Antideficiency Act since no funds are available for the unauthorized purpose. See, e.g., B-302710, (Comp. Gen. May 19, 2004) (use of funds in violation of statutory prohibition against publicity or propaganda) and B-290005, (Comp. Gen. July 1, 2002) (appropriation used to procure unauthorized legal services).

⁴⁹ Report commissioned by the Association of Health Insurance Plans, Oliver Wyman, “Proposed changes to 2014 Medicare Advantage payment methodology and the effect on Medicare Advantage organizations and beneficiaries,” at 4, (February 26, 2013), available at http://www.medicarechoices.org/pdf/Proposed_Changes_to_Medicare_Advantage.pdf.

⁵⁰ Centers for Medicare & Medicare Services, “Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates,” press release, February 15, 2013, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2014.pdf>.

SGR Assumptions In Other Contexts

The Secretary has taken note of Congress' actions in recent years to prevent the required SGR physician fee schedule reductions from occurring in several contexts related to the Medicare Advantage program. The question has been raised whether the Secretary's assumption that Congress may enact future legislation overriding the SGR reduction in the contexts discussed below clarifies or supports the argument that the Secretary has the authority to assume Congress will override the required SGR reductions in physician payments before they go into effect this year when calculating the MA benchmarks.

Contingency Margin for the Medicare Part B Premium

Section 1839(a)(1) of the SSA⁵¹ provides that the monthly Part B premium be based upon the projected costs of benefits and associated administrative costs, plus a contingency margin. Specifically the statute provides that "(i)n calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin." The premiums paid by Medicare Part B beneficiaries represent revenue to the program which will be used to finance program costs. In setting Part B premiums for 2013, the Secretary set forth the actuarial assumptions and bases used to determine the current premium rates in its notice on November 21, 2012.⁵² These assumptions included "the likelihood and potential magnitude of expenditure changes resulting from enactment of legislation affecting Part B costs in a year subsequent to the establishment of financing for that year."⁵³ This assumption and others are used in order to ensure that income to the program will be sufficient to cover program costs by accounting for possible variations between actual and projected costs. Thus, the Secretary included in the actuarial assumptions governing the size of the contingency margin the possibility of congressional legislation affecting both the anticipated SGR reductions and sequestration reductions in federal outlays that would affect the Medicare program.

The size of the contingency margin for 2013 is affected by several factors. The largest factor involves the current law formula for physician fees, which is scheduled to result in a reduction in physician fees of nearly 30 percent in 2013. For each year from 2003 through 2012, Congress has acted to prevent physician fee reductions from occurring. In recognition of the strong possibility of substantial increase in Part B expenditures that would result from similar legislation to override the decreases in physician fees in 2013, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary. The asset level projected for the end of 2012 is not adequate to accommodate this contingency. . . .

Another factor affecting the size of the contingency margin comes from section 302 of The Budget Control Act of 2011 (Pub. L. 112-25), which mandates a government-wide sequestration process to reduce Federal outlays . . . (t)here is a possibility that the sequestration requirements will be modified or postponed before taking effect. The contingency margin has been adjusted to accommodate this possibility.⁵⁴

⁵¹ 42 U.S.C. § 1395r(a)(1).

⁵² Centers for Medicare & Medicaid Services, "Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2013," 77 Fed. Reg. 69850-69859 (November 21, 2012).

⁵³ *Id.* at 69853.

⁵⁴ *Id.* at 69854. *See also* Medicare Premiums and Deductibles for 2012, Fact Sheet, October 27, 2011 available on the CMS website: "For each year from 2003 through 2011, Congress has acted to prevent smaller physician fee reductions from occurring. The 2012 reduction is almost certain to be overridden by legislation enacted after Part B financing has been set for 2012. In recognition of the strong possibility of increases in Part B expenditures that would result from similar legislation to override the (continued...)"

The Secretary's assumptions under Section 1839 of the SSA relating to possible future legislative actions which could affect program costs are clearly supported by the statute's specific requirement that the Secretary include in the Medicare Part B premium calculation "an appropriate amount for a contingency margin." There is no analogous provision in the Medicare Advantage formula which would accommodate similar assumptions, therefore, the Secretary's actuarial assumptions concerning possible future legislation in setting Part B premiums are not directly relevant to the Secretary's authority to make similar assumptions regarding possible SGR changes in calculating the payment rates for plans under the Medicare Advantage program. In addition, the purposes of these two provisions are quite different. The Part B premium constitutes **revenue** to the federal government, and, as such, should include assumptions appropriate to ensure that total revenue is sufficient to cover anticipated expenses. The MA payment rates, on the other hand, constitute **costs** to the federal government, and, as such, should include assumptions appropriate to ensure that payments reflect appropriate conservation of taxpayer funds within the requirements of statutory authorities.

Medicare Advantage Plan Bids

It has been suggested that the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plan sponsors to incorporate into their bids the possibility of congressional legislation changing or modifying the anticipated SGR reductions in the physician fee schedule. We are not aware of such a requirement. However, we understand that CMS has provided advice to plan sponsors who have submitted questions in advance of bid submissions under the Medicare Advantage program related to this issue. Such advice includes the following two 2010 MA bid questions and answers:

Question: Our physician contracts are tied directly to the RBRVS [resource-based relative value scale] conversion factor, thus under current law we would expect physician fees to be reduced by 21.3% from 2009 to 2010. Since CMS has assumed a 21.3% physician cut in its calculation of the benchmarks and thus is assuming that the rate cut will go into effect, would it be acceptable for us to assume that our physician reimbursement trend for 2009 to 2010 will be negative 21.3%?

Answer: Projections should be based on the actuary's best estimate of CY 2010 plan expenses. Of course, the estimate should take into account the possibility that Congress will ultimately modify the -21 percent physician update for CY 2010.

Question: The 21% cut to Medicare physician payment rates required under the SGR formula called for in current law is significant and requires organizations to anticipate whether there will be legislative intervention and if so, to what extent. Will organizations have an opportunity to resubmit bids to reflect any legislative intervention? If not, does CMS have any suggestions?

Answer: As with the response to the prior question, the projection of physician spending is to reflect the actuaries' best estimate of plan expenditures for CY 2010. Absent explicit statutory authority, there will be no opportunity to change your pricing assumption after June 1, 2009.⁵⁵

(...continued)

decrease in physician fees in 2012, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary."

⁵⁵ Centers for Medicare & Medicaid Services, Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls, April 23, 2009, p. 8, available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/ActuarialBidQuestions2010.pdf>.

Thus, it appears that CMS suggests that plan sponsors include in their plan bids their best assessments of possible legislative actions which may affect their expenses in the coming year. Plan bids constitute the plan sponsors' revenue requirement for the coming year, and since bids cannot be revised, it would appear to be prudent for the plans to include the possibility of congressional legislation that might increase plan costs in their calculation of their bid amounts.⁵⁶ This assumption does not, however, appear to be a requirement of the plan sponsors' bid process.

Conclusion

The Medicare Advantage (MA) formula for setting benchmarks for payments to plan sponsors, as set forth in Section 1853 of the Social Security Act and related provisions, does not specifically address inclusion or exclusion of the effects of the Sustainable Growth Rate formula on the Medicare physician fee schedule when congressional action may be anticipated at a later date. The Secretary has taken the position over the past several years that she is required by the language of the statute to base her calculations on the law as in effect on April 1 when the benchmarks are announced for the plan year beginning January 1 of the following year. "We believe that the best reading of this statutory language is that the growth percentage should be based on the provisions of 'this title' (Title XVIII) as of the date that the rates are announced."⁵⁷ The Medicare statute does not provide the Secretary with authority to adjust the MA benchmarks after April 1 unless so required by Congress, although the statute does provide authority for the Secretary to adjust the benchmarks the following year.

Because the statute does not directly address the question at hand, the Secretary has considerable discretion to interpret the law, and courts are likely to defer to the Secretary's interpretation and give it controlling weight unless it is "arbitrary, capricious, or manifestly contrary to the statute."⁵⁸ There is nothing in the text of the Medicare statute, particularly sections 1853 and 1876 of the Social Security Act that specifically requires the Secretary to assume Congress will take a particular legislative action in the future. The Secretary's interpretation that she should not assume that current law will necessarily be changed by Congress by a certain date appears to be within her discretion and would likely be upheld by the courts.

A different question is whether the Secretary has the authority to reverse her current interpretation and take the position that she can assume Congress will act legislatively to modify or eliminate the effects of the SGR formula when formulating the current benchmarks. While an agency may change its interpretation of a statute, the courts generally require, in such circumstances, that the agency articulate a reasoned basis for the change. If the Secretary articulates a reasoned basis for changing her interpretation of her authority under the Medicare statute to include the assumption that Congress will take a specific legislative action by a certain date, and if such an assumption were found to be both within her authority under the Medicare Advantage statute, and reasonable, not arbitrary or capricious, then it is possible the courts would defer to such a revised interpretation of the statute.

⁵⁶ Plan contract provisions clearly state that the contract "is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions." Art. II, Coordinated Care Plan, 2012 Final Contracts (model), available at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html>.

⁵⁷ Centers for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," press release, April 2, 2012, p. 18 <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtgSpecRateStats/Downloads/Announcement2013.pdf>.

⁵⁸ *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 843-844 (1984).
