Sharing risk in Part D

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Roadmap

- Quick review of Part D's approach
- Mechanisms for sharing risk
- Experience with risk sharing
- Issues related to low-income subsidy
- Potential approaches to changes in risk sharing

Part D's approach

- Private plans deliver drug benefits
  - Compete for enrollees
  - Drug-only plans or part of Medicare Advantage
- Medicare pays for nearly 75% of basic benefits, enrollees pay 25%
  - Monthly capitated payments to plans
  - Plan premiums vary depending on their bids
  - Medicare has other subsidies that offset risk

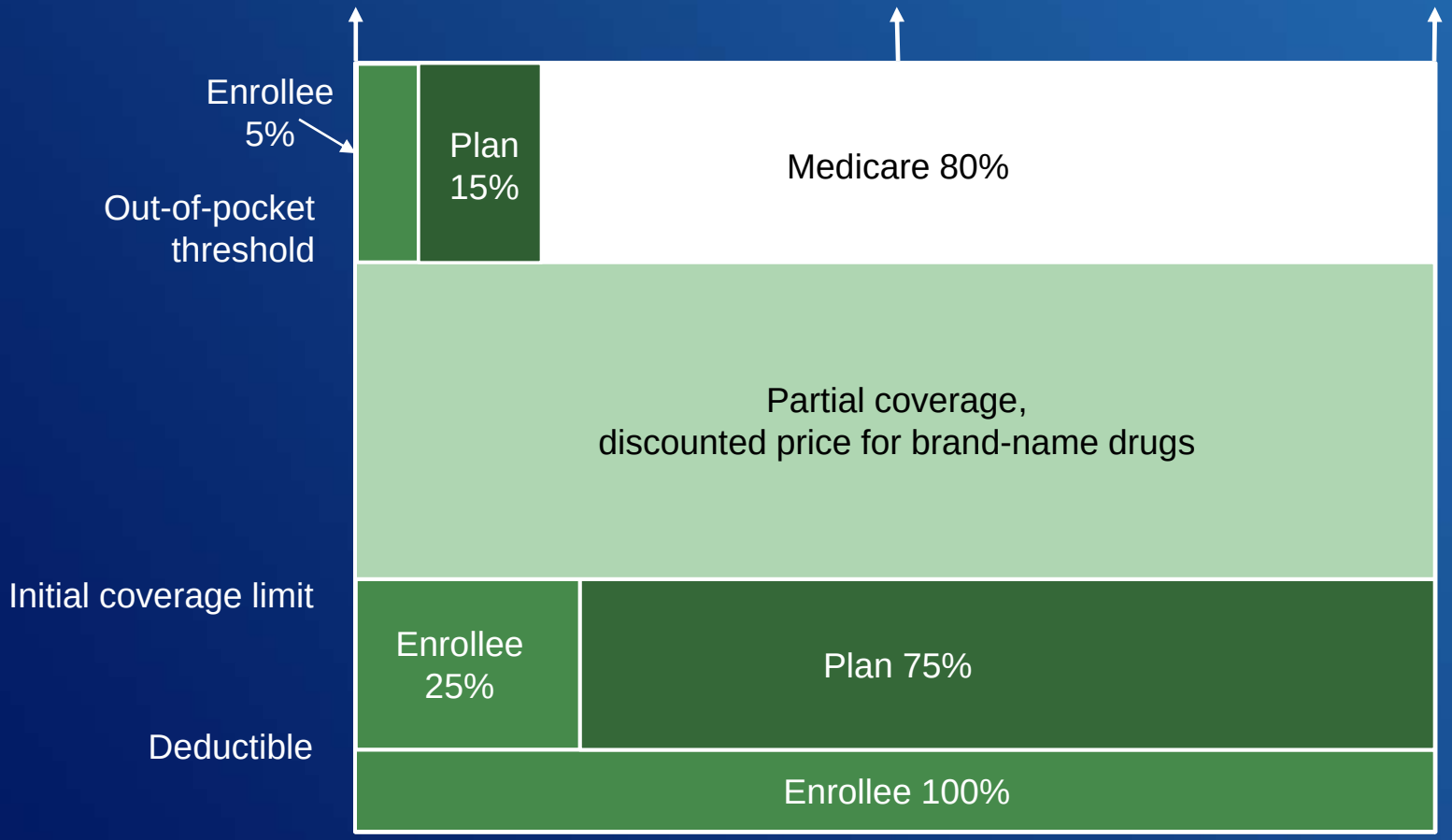
Part D's low-income subsidy (LIS)

- Beneficiaries at or below 150% of poverty
- Extra help with premiums
  - Regional threshold—maximum amount Medicare will pay for an LIS premium
  - CMS randomly assigns LIS enrollees to basic plans with premiums at/below threshold
- Extra help with cost sharing
  - Nominal copay amounts set in law
  - No coverage gap

Medicare shares risk with private plans

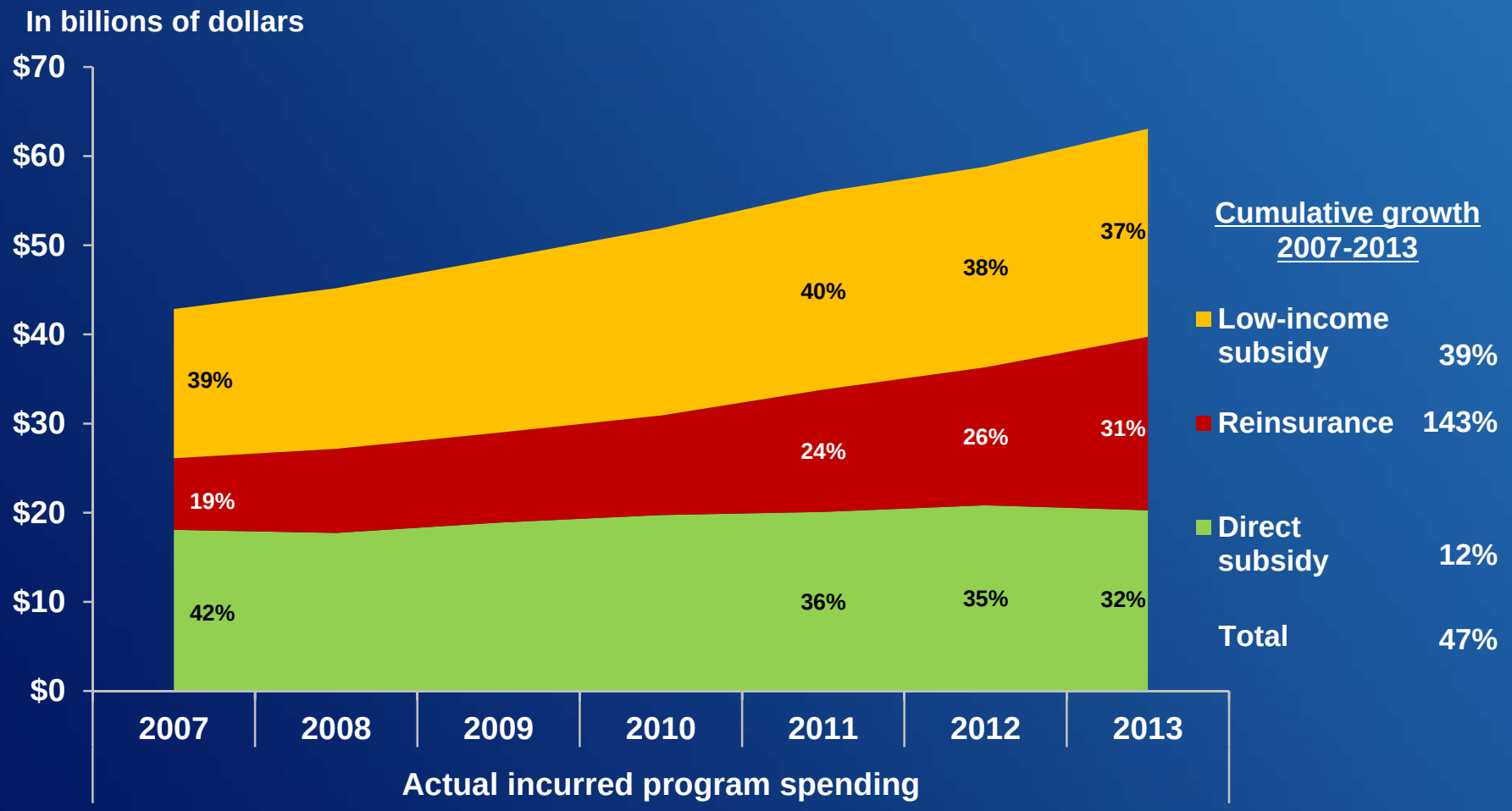
- Mechanisms for sharing risk
  - Capitated payments
  - Risk adjustment
  - Individual reinsurance
  - Risk corridors
- Objectives for sharing risk may have changed
  - Less concern about plan entry and rivalry
  - More concern about managing benefits of high-cost enrollees

Individual reinsurance: Medicare pays for 80% of benefits above the OOP threshold



Note: OOP (out of pocket).

Reinsurance has grown 143% since 2007



MEDPAC Source: MedPAC based on Table IV.B.10 of the Medicare Board of Trustees' report for 2014.

Current structure of risk corridors: actual costs relative to bids

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Objectives of and experience with risk corridors

- Initial objective was to establish market for stand-alone drug plans
  - Risk of attracting high-cost enrollees
  - Little early information on which to base bids
- Sponsors have consistently bid too high
  - Have paid back Medicare each year
  - Portion of enrollee premiums not paid back

LIS enrollees not distributed equally

- About one third of Part D enrollees get LIS
  - 75% in PDPs
  - 25% in MA-PDs
- Among top 20 PDP plans in 2012:
  - 8 had 25% or fewer enrollees with LIS
  - 9 had 75% or more enrollees with LIS
- Changes to risk sharing could affect incentives to enroll individuals with LIS

Managing Part D benefits for LIS enrollees is a major concern

- Higher average disease burden
- Higher average prescription use
- Lower use of generics
- More likely to reach OOP threshold
- On the order of two-thirds of Part D program spending for LIS enrollees

Data for 2012	LIS	Non-LIS
Average risk score	1.195	0.894
Average number of prescriptions per month	5.2	3.8
Average generic dispensing rate	78%	83%
Percent with spending high enough to reach OOP threshold	17%	4%

Source: MedPAC based on 2012 Part D prescription drug event data.

Note: OOP (out of pocket).

Analysis is preliminary and subject to change.

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Market segmentation through minimally enhanced plans

- LIS enrollees who do not choose a plan can only be assigned to plans with basic benefits
- Enhanced plans have higher actuarial value than basic plans
  - Actuarial value of minimally enhanced not much higher than basic benefit
  - Often have lower premium than basic plan offered by same sponsor
- LIS enrollees cannot be assigned to enhanced plans

Potential policy approaches

- Risk sharing
  - Widen or remove corridors
  - Plans pay more than 15% above OOP threshold
- LIS policies
  - 2012 recommendation on LIS cost sharing
  - Consider premiums and average low-income cost sharing when setting regional thresholds
  - Reassign LIS enrollees to basic and enhanced plans if premium at/below regional threshold
- May need to combine policy approaches to balance competing goals