

CHAPTER

6

**Sharing risk in
Medicare Part D**

Sharing risk in Medicare Part D

Chapter summary

In 2013, Medicare spent almost \$65 billion on Part D, which uses private plans to deliver prescription drug benefits. Medicare pays for benefits whether beneficiaries use traditional Medicare and enroll in stand-alone prescription drug plans (PDPs) or they enroll in Medicare Advantage prescription drug plans. Plan sponsors bear insurance risk for the benefit spending of their enrollees. When competing plans bear risk, they have incentives to offer benefits that are attractive to beneficiaries and yet manage spending so that premiums remain affordable. Medicare shares insurance risk with Part D plans to address policy goals. This chapter examines the ways in which Medicare pays Part D plans and shares insurance risk with them.

Mechanisms for sharing risk

Part D plan sponsors submit bids to CMS that represent their revenue requirements (including administrative costs and profit) for delivering basic drug benefits to an enrollee of average health. After reviewing bids, CMS determines Medicare's per member per month prospective payment to plans, called the direct subsidy, which reduces premiums for all Part D enrollees. Because Medicare's direct subsidy is a fixed-dollar amount, plan sponsors risk losing money if their enrollees' drug spending is higher than the combination of direct subsidy payments and enrollee premiums.

However, plan sponsors do not bear all the risk. CMS risk adjusts direct subsidy payments to counteract incentives for sponsors to avoid enrollees

In this chapter

- Introduction
- Part D's mechanisms for sharing risk
- Evaluating today's role for risk-sharing provisions
- Reconciling prospective payments with actual spending
- Hypothetical, simplified examples of bids, payments, and reconciliation
- Potential policy changes to risk sharing

who use more drugs. In addition, Medicare pays plans individual reinsurance equal to 80 percent of covered spending above Part D's catastrophic threshold (in 2015, roughly \$7,000 in total drug spending). Also, risk corridors limit each plan's overall losses or profits if actual spending is much higher or lower than anticipated. Corridors provide a cushion for plans in the event of large, unforeseen aggregate drug spending.

An additional feature is that Medicare pays for most premiums and cost sharing on behalf of enrollees with low incomes and assets through Part D's low-income subsidy (LIS). On average, individuals who receive the LIS tend to have poorer health and use more prescriptions. Unlike other enrollees whose cost sharing is set by plan sponsors as part of a plan's benefit design, cost sharing for LIS enrollees is set by law at nominal amounts and they face no coverage gap.

Today's role for risk sharing

Before the start of Part D, stand-alone PDPs did not exist. Initially, individual reinsurance and risk corridors were included to help ensure plan entry and formation of competitive markets. Today, Medicare beneficiaries have many enrollment options. Although there is variation across plans, competition has kept growth in average Part D premiums fairly low over time.

Now that the market for PDPs is well established, it may be time to reevaluate policy goals for risk sharing in Part D. Changes in risk sharing that provide incentive for plans to manage broader measures of cost may increase the program's efficiency. Between 2007 and 2013, spending for the competitively derived direct subsidy payments to plans—the portion of Medicare's payments on which plans bear the most insurance risk—grew by a cumulative 12 percent. In contrast, benefit spending on which sponsors bear no insurance risk (low-income cost sharing) or limited risk (the catastrophic portion of the benefit, where Medicare provides 80 percent reinsurance) grew much faster over the same period. Program payments for the LIS and individual reinsurance grew by a cumulative 39 percent and 143 percent, respectively. These increases suggest that sponsors have been less successful at cost containment when they faced less risk for benefit spending.

Patterns of reconciliation payments

Medicare makes prospective payments to plans based on sponsors' bids. Six months after the end of each benefit year, CMS begins reconciling prospective payments with actual benefit costs that plans paid. As a final step in reconciliation, CMS applies a statutory formula for risk corridors.

Medicare's reconciliation and risk corridor payments reveal regular patterns. First, many plan sponsors have bid too low on the amount of benefit spending they expected above Part D's catastrophic threshold relative to their enrollees' actual catastrophic spending. In recent years, the majority of plan sponsors received additional money from Medicare at reconciliation because their prospective payments for individual reinsurance were too low. Second, plan sponsors have bid too high on the rest of benefit spending other than catastrophic benefits. Between 2009 and 2013, about three-fourths of parent organizations returned a portion of overpayments to Medicare through risk corridors, with Medicare collecting an aggregate of between \$700 million and \$1.1 billion each year. (Throughout this chapter, we use the term *overpayments* to refer to the differences by which some plans' prospective payments exceeded actual benefit costs.)

Potential reasons for the patterns of payments

Actuaries interviewed by Commission staff suggested that there is significant uncertainty behind the assumptions they make when projecting drug spending by Part D plan enrollees. At the same time, Part D's risk-sharing mechanisms may provide incentives to bid too low on catastrophic spending and too high on spending for the remainder of the Part D benefit. By underestimating catastrophic spending, plan sponsors may be able to charge lower premiums to enrollees and then later get reimbursed by Medicare for 80 percent of actual catastrophic claims through additional reinsurance at reconciliation. As a practical matter, an individual sponsor is only one of many sponsors whose bids collectively affect the amounts that Medicare pays in prospective payments. Still, Medicare's reconciliation payments show consistent patterns rather than the randomness one might expect from projection errors in the actuarial assumptions behind bids.

Potential changes to Part D risk sharing

Policymakers may want to consider changes in Part D's risk-sharing mechanisms that encourage plan sponsors to better manage drug benefits for higher cost enrollees. One option would be to require plans to include more of the costs of catastrophic spending in their covered benefits. Under this option, Medicare's overall subsidy would remain at 74.5 percent, but the makeup of Medicare's subsidy would change—plan sponsors would receive less individual reinsurance and a larger direct subsidy payment. Because a larger share of Medicare's subsidy would take the form of capitated payments, plan sponsors would be at risk for more of covered benefits, and the change would provide stronger incentive to manage drug spending. However, because they would bear more risk, plan sponsors may also need to purchase private reinsurance or build a risk premium into their bids.

A second option would be to change the structure of the risk corridors. For example, the corridors could be widened or eliminated so that sponsors would pay for more or all of plan losses and, because the corridors are symmetric, keep more or all of plan profits. By exposing plan sponsors to greater risk, they would have stronger incentives to manage benefit spending. However, because of the interaction between risk corridors and individual reinsurance, thus far the role of Part D's risk corridors has been primarily to limit the profits that plans have received above those already built into bids. The absence of corridors (with no other changes to the risk-sharing arrangement) would potentially allow sponsors to keep more profits than they do currently, if they did not change how they bid. Another option is to tighten Part D's risk corridors because plan sponsors have returned a portion of overpayments to Medicare each year.

Several program modifications may be necessary at the same time—that is, a package of changes—to balance concerns about cost control and incentives for selection behavior. One concern relates to LIS enrollees, who make up about 80 percent of individuals who reach Part D's catastrophic threshold. If, in isolation, plans were required to shoulder more of covered benefits above the catastrophic threshold, then the policy change could disproportionately affect plans with high shares of LIS enrollment. CMS could counter this effect somewhat by ensuring that Part D's risk adjusters were calibrated to take into account plans' greater degree of risk. At the same time, policymakers might also consider changes in LIS policy that give sponsors greater flexibility to contain costs. ■

Introduction

Since 2006, Medicare has used private plans to deliver prescription drug benefits to beneficiaries who choose to enroll in Part D. The program is considered an ambitious effort to use market mechanisms to deliver a large-scale entitlement benefit (Duggan et al. 2008).

In this chapter, we examine the ways in which Medicare shares insurance risk with Part D plans. When competing plans bear risk, they have an incentive to strike a balance between offering benefits that are attractive to beneficiaries and managing their enrollees' drug spending so that the plans' premiums will be affordable. Medicare shares some of this insurance risk to offset the incentive for plan sponsors to avoid higher cost enrollees and to provide a cushion for plans in the event of large, unforeseen drug spending. With the exception of new national coverage decisions, Medicare does not generally offer similar risk-sharing provisions for the Medicare Advantage program. Along with other factors, one consequence of Part D's existing risk-sharing arrangements is that pharmaceutical manufacturers are able to set high launch prices for certain new medicines.

Some forms of risk sharing were intended to help establish a market that did not exist before Part D—stand-alone prescription drug plans (PDPs). Now that Part D is in its 10th benefit year, the Commission contends that it is time to consider whether the initial design of its risk-sharing mechanisms is structured in a way that addresses current program goals.

Part D provides prescription drug benefits to most Medicare beneficiaries, whether they are in traditional fee-for-service Medicare or in Medicare Advantage (MA) plans. In 2014, 69 percent of beneficiaries were enrolled in Part D plans. Over three-fifths of those enrollees were in PDPs, with the remainder in Medicare Advantage—Prescription Drug plans (MA-PDs) (Medicare Payment Advisory Commission 2015). Under the Part D program, Medicare subsidizes 74.5 percent of the cost of basic drug benefits and enrollees pay the remaining 25.5 percent through premiums. Medicare also pays plans for some or all of enrollees' premiums and cost sharing for those who qualify for and enroll in the program's low-income subsidy (LIS), including beneficiaries dually eligible for Medicare and Medicaid.¹ In 2014, 30 percent of Part D enrollees received the LIS, and just over 70 percent of LIS enrollees were in stand-alone PDPs.

Sponsors of Part D plans must hold valid insurance licenses in the states in which they operate, and they must carry out essential industry functions such as marketing, enrollment, customer support, claims processing, making coverage determinations, and responding to appeals and grievances. Plan sponsors also carry out other specialized functions of pharmacy benefit managers (PBMs), either through firms owned by the same parent organization or through contracts with private PBMs. They develop and maintain formularies—a list of drugs the plans cover and the terms under which they will cover them—to manage the cost and use of prescription drugs. Formularies identify which drugs the plan will cover in each therapeutic class and the cost-sharing tier on which individual products fall. Formularies also list whether the drug is subject to any type of utilization management such as prior authorization, quantity limits, and step therapy. In some respects, CMS's regulations for Part D formularies prevent plan sponsors from using certain management techniques that sponsors apply in other markets.²

Plan sponsors and their PBMs also negotiate with drug manufacturers for rebates—payments from pharmaceutical companies to the plan sponsor for placing the manufacturer's product on a specific cost-sharing tier or for successfully encouraging enrollees to use the manufacturer's drugs. Plan sponsors manage their formularies to structure competition among drug therapies and to shift drug utilization toward certain products to obtain rebates. However, a plan sponsor's ability to negotiate rebates is limited for certain products that have no clear substitutes—for example, many high-cost specialty drugs.

Generally, health insurers seek to enroll a broad set of individuals to spread risk. Under Part D, plan sponsors face several types of risk:

- **Insurance risk**—Included in sponsors' payments for covered benefits is a portion of the cost of prescriptions filled. Sponsors are at risk because, under Medicare's capitated payment system, their plans lose money if their enrollees' drug spending is higher than the combination of capitated payments and enrollee premiums. In addition, sponsors do not have full control over spending because enrollees and prescribers (rather than the sponsor) initiate decisions about how many and what kind of prescriptions are filled.
- **Risk of adverse selection**—Sponsors face risk that their plan will attract a larger proportion of high-cost individuals than their competitors.

- **Trend risk**—Unanticipated changes can occur in the prices of drugs, the quantity of prescriptions filled, or in the mixture of prescriptions taken (e.g., brand-name drugs vs. generics). For example, if a new drug is introduced into the market and the manufacturer is able to set its launch price considerably higher than what a plan sponsor anticipated at the time it submitted its bid for Part D, the sponsor could have higher benefit spending than planned.
- **Other risks of doing business**—Sponsors face risks that their payers (including the Medicare program), other partners, and enrollees may change negotiated business deals, program rules, or behavior in unanticipated ways.

Plan sponsors seek to manage their risk in various ways, such as by influencing enrollee and physician behavior through their formularies and tiered cost sharing to encourage substitution of lower cost drugs for more expensive therapies. Drug plans employ utilization management tools such as prior authorization, quantity limits, and step therapy for drugs that are expensive or subject to misuse, or to encourage use of lower cost therapies.

From the perspective of the Medicare program, some methods that insurers use to manage their risk may not be desirable. For example, Medicare regulations aim to keep sponsors from designing benefit packages, formularies, and marketing materials that would discourage sicker beneficiaries from enrolling.

To manage trend risk, insurers collect market intelligence about the types of drugs in the development pipeline, when those drugs are likely to enter the market, the conditions they will treat, and projections of prices for new and existing drugs. This effort involves keeping abreast of the medical literature, which sometimes finds evidence for using an existing drug in new ways.

Part D's mechanisms for sharing risk

Part D plan sponsors submit bids to CMS that represent their revenue requirements (including administrative costs and profit) for delivering a basic drug benefit to an enrollee of average health. Part D is different from Part C (the Medicare Advantage program) in that Part D's payment-setting policy does not involve a comparison with an administratively set benchmark amount. Instead, after

reviewing the assumptions of each bid, CMS calculates a nationwide enrollment-weighted average among all bids. CMS applies a statutory formula to that nationwide average bid to determine Medicare's per member per month prospective payment to plans, which is called the *direct subsidy*. This direct subsidy reduces premiums for all Part D enrollees. Because Medicare pays a capitated amount, plan sponsors risk losing money if their enrollees' drug spending is higher than the combination of their direct subsidy payments from Medicare and enrollee premiums. Requiring plan sponsors to bear insurance risk provides incentive for them to manage benefit spending.

At the same time, Part D was designed so that plan sponsors do not bear all the risk.

- CMS risk adjusts the direct subsidy to address incentives that would otherwise exist for sponsors to seek out healthier enrollees and avoid sicker ones.
- Part D pays for 80 percent of covered spending above the basic benefit's catastrophic threshold (called *individual reinsurance*), with the plan responsible for 15 percent and the enrollee paying 5 percent.
- Part D has symmetric *risk corridors*, which enable risk to be shared between plans and the Medicare program; that is, they limit each plan's overall losses or profits if actual spending for basic benefits is much higher or lower than what was anticipated.

Special role of the LIS

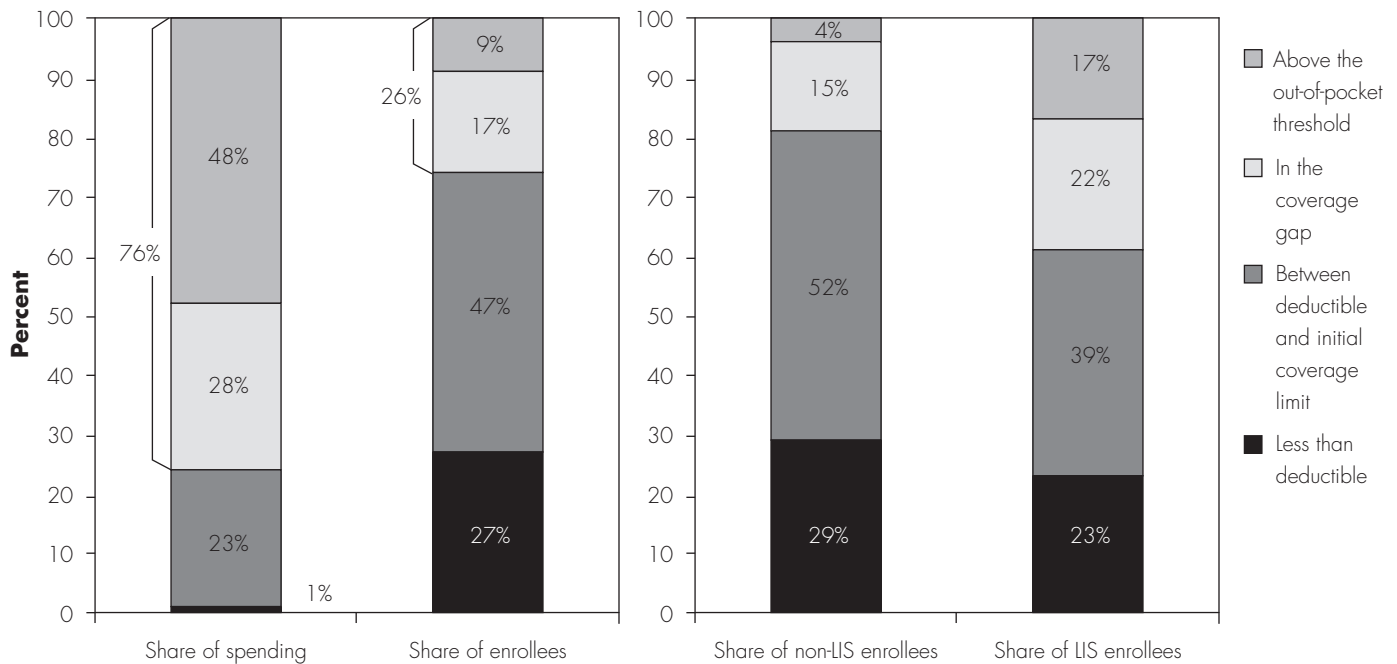
A plan's number of LIS enrollees is an important factor in the context of sharing risk because LIS enrollees tend to have higher than average drug spending and plan sponsors have fewer tools to manage that spending. Unlike other Part D enrollees whose cost-sharing amounts are set by sponsors as part of their plans' benefit designs, cost-sharing amounts for LIS enrollees are set by law at nominal amounts. Similarly, under law, LIS enrollees face no coverage gap. Part D's risk-adjustment system (described in the next section) helps to mitigate the higher benefit spending of LIS enrollees. Plan sponsors also receive monthly prospective payments from Medicare for estimated LIS cost sharing that CMS later reconciles with plans based on actual prescriptions filled.

Risk adjustment of capitated payments

Spending for benefits under Part D is highly skewed. This distribution creates incentives for sponsors to avoid high-cost enrollees. In 2012, 26 percent of enrollees had

FIGURE 6-1

About one-fourth of enrollees incurred three-fourths of Part D spending, 2012



Note: The spending distributions are based on total covered drug spending. The specific amount of total covered spending at each individual's out-of-pocket threshold depends on the mix of brand and generic prescriptions filled while in the coverage gap. The dollar amounts used to show spending thresholds are for an individual not receiving Part D's low-income subsidy who has no other supplemental coverage.

Source: MedPAC analysis of 2012 Part D prescription drug event data from CMS.

gross benefit spending that could put them in the coverage gap or above the standard benefit's out-of-pocket (OOP) threshold (Figure 6-1). Their combined drug spending accounted for 76 percent of total spending for basic benefits. A much larger proportion of LIS enrollees compared with non-LIS enrollees had benefit spending high enough to reach the OOP threshold: 17 percent versus 4 percent, respectively.

To deter selection behavior, Medicare applies a risk score to sponsors' direct subsidy payments—paying more for sicker beneficiaries and less for healthier ones. CMS assigns risk scores to each Part D enrollee using estimates from the prescription drug hierarchical condition category (RxHCC) model. The RxHCC model predicts drug benefit spending based on enrollees' demographic characteristics, diagnoses from their medical claims, and other characteristics.³

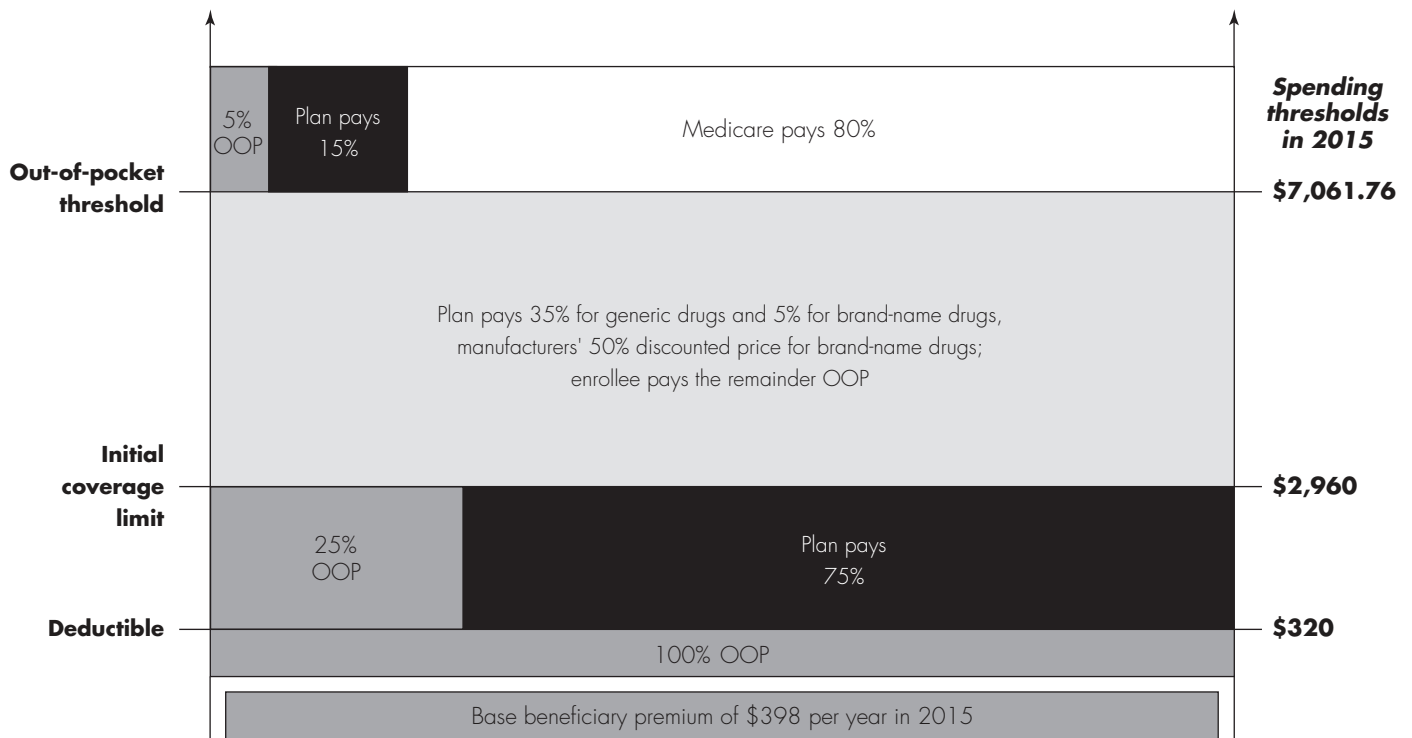
Previously, the Commission raised questions about whether risk scores calculated under an earlier version of RxHCC were effective at overcoming incentives to avoid LIS enrollees (Hsu et al. 2010, Hsu et al. 2009, Medicare

Payment Advisory Commission 2009). However, beginning in 2011, CMS refined the RxHCC model to better capture differences in the mix of prescription drugs taken by categories of enrollees.⁴ For example, among younger disabled enrollees who receive the LIS, there may be a greater prevalence of conditions such as HIV/AIDS or mental illness compared with older nondisabled enrollees, and their drug spending may be costlier on average.

Commission staff asked plan and consulting actuaries with expert knowledge about how the current RxHCC model operates. All interviewees responded that newer models are much improved for equalizing remuneration between LIS and non-LIS enrollees. However, several actuaries also said that the risk adjusters tend to undercompensate for enrollees who use high-cost specialty drugs. CMS may need to modify certain RxHCCs to recognize lags that can occur between the entrance of new high-cost drugs and the point at which claims data become available to recalibrate risk-adjustment models. At the same time, if Medicare were to base plan payments on risk-adjusted amounts that predict actual spending too closely, the result would differ

FIGURE 6-2

Medicare pays 80 percent of benefits above Part D's out-of-pocket threshold through individual reinsurance



Notes: OOP (out-of-pocket). Dollar amounts and benefits between the initial coverage limit and the out-of-pocket threshold (also known as the “coverage gap”) reflect Part D’s defined standard benefit structure in 2015. Most plans with basic benefits modify this defined standard benefit by using different cost-sharing requirements (e.g., copayments rather than coinsurance, often no deductible), while maintaining the same average benefit value. Note that the “coverage gap” is scheduled for elimination by 2020. By that date, enrollees will pay a consistent 25 percent cost sharing up to the out-of-pocket threshold.

Source: MedPAC analysis.

little from using a system of cost-based reimbursement rather than prospective payment.

In CMS’s call letter to plan sponsors for benefit year 2016, the agency stated that it is using an updated version of the RxHCC model that, in addition to basing adjusters on more recent data, adds diagnosis information and prescription drug claims from MA–PDs to estimate risk scores (Centers for Medicare & Medicaid Services 2015). That model also incorporates an actuarial adjustment to spending for treatment of hepatitis C because the 2013 claims data to which the model is calibrated do not reflect the high cost of new therapies.⁵ In prior years, CMS had incomplete diagnosis information from MA–PDs and used only fee-for-service (FFS) diagnoses combined with PDP claims to build risk scores. Now that a more complete set of diagnoses is available from MA–PDs, CMS will use

updated models estimated from pooled PDP and MA–PD drug claims to better represent the Part D population (Centers for Medicare & Medicaid Services 2015)

Individual reinsurance for high-cost enrollees

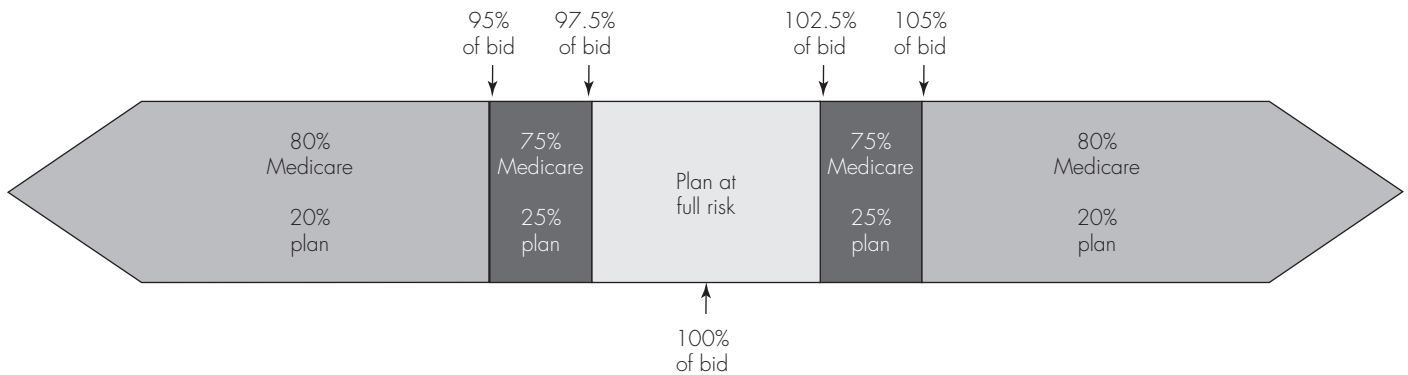
Individual reinsurance is another mechanism that was intended to temper selection behavior among competing plans. For enrollees with very high drug spending, Medicare pays plan sponsors 80 percent of spending on covered benefits above Part D’s OOP threshold (Figure 6-2). The remaining benefit spending is divided between the plan (15 percent) and the enrollee (5 percent).

Because LIS enrollees tend to have poorer health and higher drug spending than non-LIS enrollees, they reach Part D’s OOP threshold disproportionately. Of the 2.6

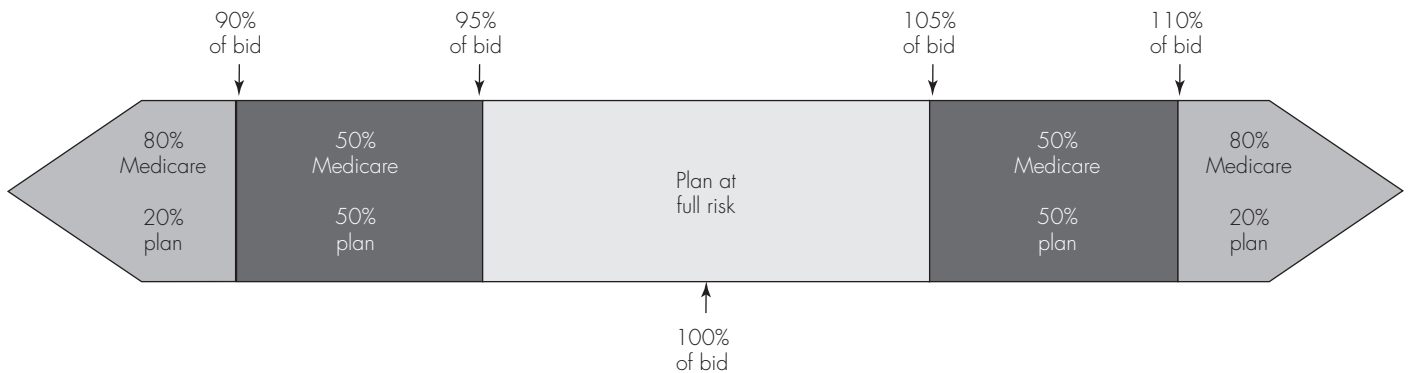
FIGURE 6-3

Part D risk corridors have widened over time

Structure of risk corridors in 2006 and 2007



Structure of risk corridors since 2008



Source: MedPAC depiction of Part D risk corridors as set by law.

million enrollees in 2012 who reached the OOP drug spending threshold, about 80 percent received the LIS (Medicare Payment Advisory Commission 2015).

Risk corridors

Each of the first two methods of Medicare’s risk sharing is applied separately for each enrollee. In contrast, risk corridors seek to limit a plan’s overall losses across all of its enrollees when actual spending for basic benefits is higher than anticipated. Since Part D’s risk corridors are symmetric, they also limit a plan’s unanticipated profits when actual spending for basic benefits is lower than anticipated. Administrative costs and supplemental benefits are not part of the Part D risk corridor calculation.

Plan sponsors submit their bids seven months before the start of a Part D benefit year. If circumstances change

substantially between when a sponsor submits its bid and when it delivers benefits, risk corridors may help provide a safety net. For example, if medical literature suggests that a brand-name drug could be effective treatment for a widely prevalent condition and plan sponsors had not anticipated this news, then benefit spending could be considerably higher than expected.

The law that created Part D required plans to accept certain levels of risk during the first years of the program and then gave the Secretary of Health and Human Services authority to require additional levels of risk. Risk corridor parameters widened in 2008 (creating more plan risk) but have not changed since then (Figure 6-3). Sponsors are now at full risk for average monthly benefits within the range of 95 percent to 105 percent of the plan bid. If actual benefit spending is between 105 percent and 110

**TABLE
6-1**

Medicare's incurred spending for payments to Part D plans

	2007	2008	2009	2010	2011	2012	2013	Average annual rate of growth, 2007-2013	Cumulative growth, 2007-2013
In billions of dollars									
Direct subsidy	\$18.1	\$17.7	\$18.9	\$19.7	\$20.1	\$20.8	\$20.3	1.9%	12.1%
Individual reinsurance	8.0	9.4	10.1	11.2	13.7	15.5	19.5	15.9	142.9
Low-income subsidy	<u>16.7</u>	<u>18.0</u>	<u>19.6</u>	<u>21.0</u>	<u>22.2</u>	<u>22.5</u>	<u>23.3</u>	<u>5.7</u>	<u>39.4</u>
Total*	\$42.8	\$45.2	\$48.5	\$51.9	\$56.0	\$58.8	\$63.1	6.7%	47.2%
Share of total									
Direct subsidy	42%	39%	39%	38%	36%	35%	32%	N/A	N/A
Individual reinsurance	19	21	21	22	24	26	31	N/A	N/A
Low-income subsidy	<u>39</u>	<u>40</u>	<u>40</u>	<u>40</u>	<u>40</u>	<u>38</u>	<u>37</u>	N/A	N/A
Total	100%	100%	100%	100%	100%	100%	100%	N/A	N/A

Note: N/A (not applicable). Numbers reflect reconciliation amounts. Totals may not sum due to rounding.
 *Most enrollees paid premiums directly to Part D plans or had premiums withheld from their Social Security checks, and those amounts are not included in the totals. On a cash basis, the Boards of Trustees estimate premiums of \$4.1 billion in 2007, \$5.0 billion in 2008, \$6.1 billion in 2009, \$6.7 billion in 2010, \$7.3 billion in 2011, \$7.8 billion in 2012, and \$9.3 billion in 2013.

Source: MedPAC based on Table IV.B.9 of the 2014 annual report of the Boards of Trustees of the Medicare trust funds.

percent of the bid (or between 90 percent and 95 percent), Medicare splits the difference with the plan sponsor fifty-fifty. Beyond 110 percent (or below 90 percent), Medicare covers 80 percent of excess benefit costs (or recoups excess profits). Since 2012, the Secretary has had authority to change the structure of Part D's risk corridors as long as it keeps at least the same amount of plan risk as in 2011. Medicare recoups any amounts owed by withholding them from future monthly payments.

Evaluating today's role for risk-sharing provisions

At the start of Part D, risk corridors and individual reinsurance were included in the program to help ensure plan entry and formation of competitive markets across the country. Large numbers of plans were available initially, followed by consolidation within the industry. Yet even after these consolidations, beneficiaries have, in 2015, between 24 and 33 PDPs to choose among, depending on where they live, as well as many MA-PD plans (Medicare

Payment Advisory Commission 2015). Between 12 percent and 15 percent of enrollees have made a voluntary decision to switch plans to lower their premiums, cost sharing, or both (Hoadley et al. 2013, Suzuki 2013). That estimate excludes individuals who must change plans because of plan exits. In addition, CMS reassigns some LIS enrollees each year to plans that have premiums below regional thresholds.

How has this degree of plan rivalry affected Part D premiums? In 2014, monthly beneficiary premiums averaged about \$29 across all plans (Medicare Payment Advisory Commission 2015). Although enrollee premiums vary considerably, the average premium has grown slowly at 3.3 percent per year between 2007 and 2014 and has been especially flat since 2010.

Between 2007 and 2013, per capita program spending for Part D grew at average annual rates slightly below those for combined Part A and Part B FFS spending (Medicare Payment Advisory Commission 2015). However, going forward, both the Medicare Trustees and the Congressional Budget Office project that per capita spending for Part D

will grow at about twice the rate of FFS spending (Boards of Trustees 2014, Congressional Budget Office 2015). That faster growth is due, in part, to the growing use of high-cost specialty drugs among the Medicare population.

Even in the current time frame, it is not clear that strong incentives and tools exist to control all aspects of program costs. Specifically, evidence suggests that plan sponsors have been less successful at managing benefits for high-cost enrollees, including individuals who receive the LIS. For these beneficiaries, Medicare bears the majority of insurance risk. In the case of LIS enrollees, plan sponsors have fewer tools to encourage the use of lower cost medicines.

Program spending shows plans less successful at managing spending of LIS enrollees

Evidence on program spending gives a mixed picture of the success of Part D plans at containing costs. Spending for the competitively derived direct-subsidy payments on which sponsors bear the most insurance risk has grown slowly, while benefit spending for which sponsors bear no insurance risk (low-income cost sharing) or limited risk (the catastrophic portion of the benefit, for which Medicare provides 80 percent reinsurance) has grown much faster. This evidence suggests that sponsors have been less successful at cost containment when they were at less risk for benefit spending.

In 2013, Medicare spent \$63.1 billion on Part D payments to plans (Table 6-1). Program spending on behalf of the 11 million individuals who receive the LIS continued to make up the largest component. About \$23 billion, or 37 percent of total Part D spending, was for premium and cost-sharing assistance for LIS enrollees. Sizable portions of direct subsidy and individual reinsurance payments to Part D plans were also on behalf of LIS enrollees. When combined, spending in 2013 for the LIS, direct subsidy, and individual reinsurance paid for LIS enrollees totaled about two-thirds of total program spending.

Between 2007 and 2013, individual reinsurance payments to plans grew from \$8 billion to \$19.5 billion. This increase amounts to an average annual growth rate of nearly 16 percent, or more than twice the pace of enrollment in Part D plans. By comparison, direct subsidy payments to plans—the portion of Medicare’s payments on which plans bear the most insurance risk—grew by an annual average rate of less than 2 percent.

National average bid shows high growth in individual reinsurance

Changes over time in the national average bid also reflect higher growth in individual reinsurance—the portion of program spending on which plan sponsors do not bear risk. Expected total benefit spending per member per month has grown at a modest rate of 2.4 percent annually between 2007 and 2015, from \$107 to \$130 (Figure 6-4, p. 150). During that period, the monthly amount that plans expect to receive through Medicare’s direct subsidy has declined at an average annual rate of 4.4 percent, from about \$53 to about \$37, while the amount per member per month that sponsors expect to receive in individual reinsurance has grown at an average annual rate of 10.5 percent, from \$27 to about \$60.

Sponsors have been less successful at increasing LIS enrollees’ use of generics

For many therapeutic classes, plan sponsors use cost-sharing differentials along with utilization management tools to encourage generic substitution (a switch from a brand-name drug to the chemically equivalent generic drug) and therapeutic generic substitution (a switch from a brand-name drug to the generic form of a different drug in the same therapeutic class).

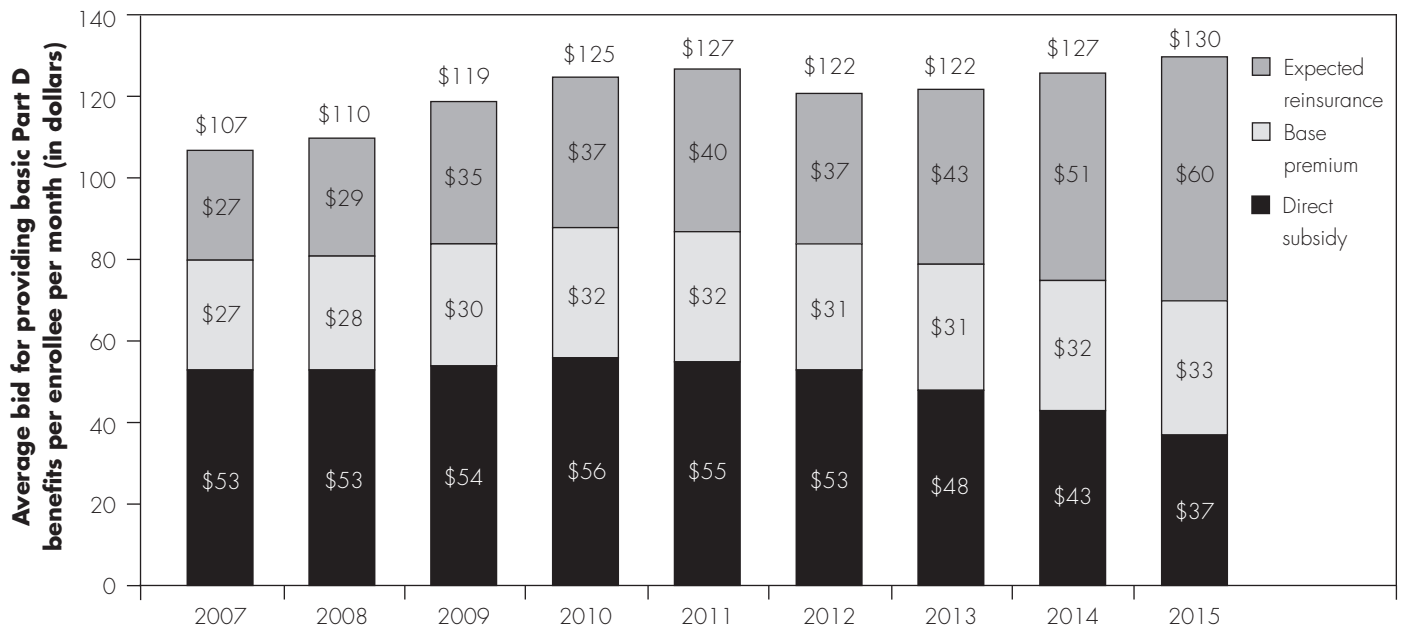
Both types of generic substitution have been key strategies of plan sponsors for managing overall growth in Part D spending. The Commission’s set of volume-weighted indexes shows that, between January 2006 and December 2012, when generic substitution is taken into account, prices for Part D drugs decreased cumulatively by about 4 percent (Medicare Payment Advisory Commission 2015).⁶ However, measured by individual national drug codes, prices rose by an average of 35 percent cumulatively over the same period. This difference suggests that generic substitution has played a key role in keeping down prices for Part D.

Both LIS enrollees and non-LIS enrollees use a greater share of generics than they did at the start of Part D. Still, plan sponsors have had more success at encouraging non-LIS enrollees to use generics than LIS enrollees. Between 2007 and 2012, LIS enrollees had a consistently lower share of prescriptions for generic drugs (generic dispensing rate, or GDR) than did non-LIS enrollees (Table 6-2, p. 150).

Encouraging LIS enrollees to use more generics has been a challenge both for MA–PDs and PDPs. Overall, a higher share of prescriptions filled by MA–PD enrollees are

**FIGURE
6-4**

National average plan bid for basic Part D benefits



Note: The averages shown are weighted by the previous year's plan enrollment. Amounts do not net out subsequent reconciliation amounts with Medicare.

Source: MedPAC analysis based on data from CMS.

for generics compared with prescriptions filled by PDP enrollees. Still, both plan types have been less successful at steering their LIS enrollees to use generic drugs compared with the level of generic use achieved for their non-LIS enrollees. For example, in 2012, the difference in GDRs between non-LIS and LIS enrollees was 3 percentage points and 5 percentage points among enrollees in PDPs and MA-PDs, respectively (Table 6-3).

We observed greater differences in GDRs for some of the most widely used categories of drugs. In 2012, Part D spending on antihyperlipidemics (cholesterol-lowering drugs), peptic ulcer therapies, and diabetic therapies accounted for nearly \$20 billion in gross drug spending combined, or about 22 percent of total spending. Table 6-4 shows percentage point differences in GDRs for the three drug classes in 2012. In the therapeutic class of antihyperlipidemics, the GDR for non-LIS enrollees

**TABLE
6-2**

Generic dispensing rate by LIS status, 2007-2012

	2007	2008	2009	2010	2011	2012
All Part D	61%	67%	70%	74%	77%	81%
By LIS status						
LIS	60	65	68	71	74	78
Non-LIS	62	69	72	76	79	83

Note: LIS (low-income subsidy). Shares are calculated as a percentage of all prescriptions standardized to a 30-day supply. "Generic dispensing rate" is defined as the proportion of total prescriptions dispensed that are generic.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

**TABLE
6-3**

Generic dispensing rate by LIS status and by plan type, 2012

	Generic dispensing rate		Percentage point difference (Non-LIS vs. LIS)
	Non-LIS	LIS	
PDP enrollees	81%	78%	3
MA-PD enrollees	85	80	5
Percentage point difference (PDP vs. MA-PD)	-4	-2	

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Shares are calculated as a percentage of all prescriptions standardized to a 30-day supply. "Generic dispensing rate" is defined as the proportion of total prescriptions dispensed that are generic.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

exceeded that of LIS enrollees by 6 percentage points and 7 percentage points among PDP and MA-PD enrollees, respectively. For peptic ulcer therapies, the differences in GDRs were 8 percentage points for PDP enrollees and 9 percentage points for MA-PD enrollees. Among prescriptions filled for diabetic therapies, the difference in GDRs between non-LIS and LIS enrollees was 13 percentage points for both PDP and MA-PD plan types.

Although generic substitution is not clinically appropriate in every circumstance, the financial implications of not using generic medications when appropriate can be substantial. Among beneficiaries enrolled in PDPs, the difference in the average cost per prescription between LIS and non-LIS enrollees ranged

from \$8 for antihyperlipidemics to \$27 for diabetic therapy (Table 6-4).

Multiple factors contribute to differences in GDRs among groups of beneficiaries. For example, differences in health status can limit the opportunity for clinically appropriate therapeutic substitutions. Since LIS enrollees are more likely to be disabled and tend to have a greater disease burden than non-LIS enrollees, they may have different medication needs. At the same time, because the amount and structure of copayments are set by law, plan sponsors have limited ability to use financial incentives to move LIS enrollees toward generic drugs. Some of the difference in GDRs is likely due to the cost-sharing subsidy that changes the financial incentives faced by LIS enrollees from those faced by non-LIS enrollees.

**TABLE
6-4**

Differences in average cost per prescription between LIS and non-LIS enrollees for selected therapeutic classes, 2012

	Percentage point difference in GDR	PDP			Percentage point difference in GDR	MA-PD		
		Average cost per prescription				Average cost per prescription		
		LIS	Non-LIS	Dollar difference		LIS	Non-LIS	Dollar difference
Antihyperlipidemics	6	\$56	\$48	\$8	7	\$46	\$34	\$12
Peptic ulcer therapy	8	57	42	15	9	45	28	16
Diabetic therapy	13	105	78	27	13	94	64	30

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), GDR (generic dispensing rate). Prescriptions are standardized to a 30-day supply. GDR is the proportion of total prescriptions dispensed that are generic.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

**TABLE
6-5**

Amounts paid by Medicare to Part D plan sponsors resulting from payment reconciliations

Amounts in millions of dollars by benefit year

Reconciliation category	2006	2007	2008	2009	2010	2011	2012	2013
Low-income cost sharing	\$90	\$471	\$1,250	\$379	\$332	\$342	\$633	\$1,559
Individual reinsurance	-1,537	247	1,219	-64	549	1,547	3,182	4,915
Risk corridors*	-2,590	-654	-82	-783	-713	-721	-1,105	-737
Total	-\$4,049	\$52	\$2,342	-\$485	\$151	\$1,168	\$2,710	\$5,736

Note: Negative amounts reflect aggregate payments to Medicare from plan sponsors. Totals for the years 2006 through 2010 include amounts for reinsurance demonstrations.

*Excludes amounts for Humana Limited Income Net contract.

Source: MedPAC analysis based on plan payment data from CMS.

Reconciling prospective payments with actual spending

Part D plans receive several types of prospective payments from Medicare:

- direct subsidies (modified by risk adjusters) that lower premiums for all plan enrollees,
- an average amount of individual reinsurance based on how much a plan sponsor expects the benefit spending of its enrollees to exceed the catastrophic threshold, and
- an average amount of cost sharing that the plan sponsor expects LIS enrollees will incur.⁷

Each prospective payment category is based on the bids that plan sponsors submit to CMS seven months before the start of the benefit year.

Six months after the end of each benefit year, CMS begins a reconciliation process—a comparison of prospective payments from Medicare with the actual benefit costs that plans paid. CMS and sponsors go through the following sequence of reconciliation steps:

- Review actual levels of enrollment and risk scores to reconcile the amounts of direct subsidy that plans should have received.

- Review drug claims for LIS enrollees to compare what plans should have received for low-income cost sharing through prospective payments.
- In the case of enhanced plans, estimate the amount of benefit spending associated with coverage that is more generous than basic benefits to remove that amount from the calculations.⁸
- Review drug claims to determine actual levels of drug spending net of rebates and discounts to reconcile prospective individual reinsurance with actual payments due.
- Calculate risk corridor payments as the last step of the reconciliation process.

The first steps in this sequence pertain to cash flows; in particular, they involve reconciling Medicare’s prospective payments to plans with actual spending. The final step of calculating risk corridors directly affects how much of those payments sponsors may keep to offset plan losses or to augment profits beyond those already included in plan bids.

Table 6-5 shows aggregate reconciliation payments between 2006 and 2013. Positive amounts indicate that Medicare paid more to sponsors on net, while negative amounts indicate that in the aggregate, plan sponsors returned a portion of overpayments to Medicare. (Throughout this chapter, we use the term *overpayments* to

**TABLE
6-6**

Flow of individual reinsurance payments, 2006–2013

Percent of parent organizations

	2006	2007	2008	2009	2010	2011	2012	2013
Sponsor paid Medicare	76%	58%	38%	50%	42%	36%	36%	32%
Medicare paid sponsor	21	40	59	49	58	64	64	68
No payments	4	2	3	1	0	0	0	0
Total	100	100	100	100	100	100	100	100

Note: Reinsurance payments are made at the plan level. Calculations for this table are based on the sum of reinsurance payments across all plans offered by the same parent organization. The shaded row shows that over time, an increasing share of parent organizations has received additional payments from Medicare Part D at reconciliation because amounts due based on actual claims experience were higher than prospective payments (that were based on plans' bids). Columns may not sum to 100 percent due to rounding.

Source: MedPAC analysis based on plan payment data from CMS.

refer to the differences by which some plans' prospective payments exceeded actual benefit costs.)

Individual reinsurance

In recent years, reconciliation payments for reinsurance show a pattern: Bids from plan sponsors have tended to underestimate spending above the catastrophic threshold. In 2008 and in 2010 through 2013, a majority of parent organizations received money from Medicare because their prospective payments for reinsurance were too low (Table 6-6). Since 2009, the share of plan sponsors receiving additional reinsurance payments from Medicare has increased.

This pattern means that plan sponsors missed out on some of the prospective payments that ultimately were due to them for reinsurance, potentially limiting their cash flow. However, underestimating catastrophic spending may provide a financial advantage to plan sponsors: They may be able to charge lower premiums to enrollees and later get reimbursed for 80 percent of actual catastrophic claims through additional reinsurance from Medicare at reconciliation.

The pattern of underestimating reinsurance was not so evident in the early years of the Part D program. Table 6-7 (p. 154) shows the sponsors of plans that are among those with the largest Part D enrollment. The gray-shaded values show payments from plan sponsors to Medicare, while the unshaded amounts reflect payments from Medicare to plan sponsors. Many of the largest sponsors had to return

reinsurance overpayments to Medicare in 2006 and 2007, but by 2011, nearly all of the large sponsors received reconciliation payments from Medicare.

Risk corridors

Once CMS completes reconciliation of individual reinsurance, it determines whether any risk corridor payments are due by comparing plans' bids for basic benefits with actual spending. In each year between 2006 and 2013, most plan sponsors returned a portion of overpayments to Medicare because of the risk corridors (Table 6-8, p. 154). In other words, plan sponsors had profits beyond the margins already included in their bids. Since 2008, the share of parent organizations returning a portion of overpayments has increased. Between 2009 and 2013, about three-fourths of parent organizations made risk corridor payments to Medicare because their reconciled benefit costs were at least 5 percent lower than their bids. Detailed data show that most parent organizations had actual costs beyond the second risk corridor threshold (data not shown).⁹

This pattern of risk corridor payments means that plan sponsors made substantially more in profits beyond the margins that were already built into their bids. If risk corridors had not been in place, profits would have been even larger. Aggregate reimbursements through the risk corridors were at their highest in 2006 (\$2.6 billion), when plan sponsors had little information on which to base bids (Table 6-5). Yet sponsors were still, in the aggregate,

**TABLE
6-7**
Reconciliation payments for individual reinsurance from Medicare to Part D plan sponsors with the largest enrollment, 2006-2013

Amounts in millions of dollars by benefit year

Parent organization	2006	2007	2008	2009	2010	2011	2012	2013
UnitedHealth Group	-\$765	-\$99	\$84	\$51	-\$255	\$54	\$335	\$912
Humana	-180	-148	325	-290	-46	293	469	541
CVS Caremark	45	-32	139	141	166	285	544	1,013
Universal American	-17	110	313	62	184	5	3	10
Health Net	75	22	19	-2	25	92	15	21
Medco	-10	-29	39	1	130	46	N/A	N/A
Express Scripts	N/A	*	1	1	3	6	456	927
Aetna	8	20	6	35	66	75	180	147
Coventry	-278	41	-39	-132	-19	111	262	163
CIGNA	64	54	60	17	10	-15	170	194
HealthSpring/NewQuest	-39	-40	14	-9	29	133	N/A	N/A
WellCare	-116	39	77	12	30	127	93	18
Munich American/Sterling	1	-3	-11	10	6	15	21	34
Windsor	-4	-2	-20	-1	5	N/A	N/A	N/A
Kaiser	-19	-23	1	10	3	21	19	88
WellPoint	28	-44	32	-90	9	28	62	74
Subtotal for the above parent organizations	-\$1,207	-\$134	\$1,042	-\$182	\$346	\$1,274	\$2,629	\$4,142
Total reconciliation payments for all parent organizations	-\$1,537	\$247	\$1,219	-\$64	\$549	\$1,547	\$3,182	\$4,915

Note: N/A (not applicable). Data may be "not applicable" typically because the organization had not yet entered the market or because it merged with or was acquired by another organization. Shaded amounts reflect years in which the plan sponsor paid Medicare. Reinsurance payments are made at the plan level. This table aggregates payments across all plans offered by the same parent organization. Columns may not sum to stated total.
*Less than \$0.5 million.

Source: MedPAC analysis based on plan payment data from CMS.

**TABLE
6-8**
Flow of risk corridor payments, 2006-2013

Share of parent organizations

	2006	2007	2008	2009	2010	2011	2012	2013
Sponsor paid Medicare	86%	71%	60%	72%	74%	77%	78%	78%
Medicare paid sponsor	9	24	30	19	15	16	16	14
No payments	5	5	10	8	11	7	6	8
Total	100	100	100	100	100	100	100	100

Note: Risk corridor payments are made at the plan level. This table aggregates risk corridor payments across all plans offered by the same parent organization. The shaded row shows that, after 2009, about three-quarters of parent organizations returned overpayments to Medicare Part D at reconciliation because the actual benefits that plans paid were considerably lower than prospective payments. Columns may not sum to 100 percent due to rounding.

Source: MedPAC analysis based on plan payment data from CMS.

**TABLE
6-9**

Risk corridor payments for plan sponsors with the largest enrollment, 2006-2013

Amounts in millions of dollars by benefit year

Parent organization	2006	2007	2008	2009	2010	2011	2012	2013
UnitedHealth Group	-\$618	-\$200	-\$43	-\$275	-\$262	-\$169	-\$467	-\$250
Humana*	-712	-107	49	-183	-177	-105	-186	-28
CVS Caremark	-67	-44	46	2	24	-126	-127	-261
Universal American	-91	-26	8	-44	-32	-5	-7	**
Health Net	-45	-14	-3	-36	-9	-3	-1	**
Medco	**	-7	4	7	6	N/A	N/A	N/A
Express Scripts	N/A	**	0	0	0	0	-2	-1
Aetna	-40	-4	-6	2	7	-14	9	-3
Coventry	-80	-70	-35	-4	-46	-8	1	56
CIGNA	-8	40	13	-2	-2	-5	-65	-75
HealthSpring/NewQuest	-34	-25	-3	-3	-7	-25	N/A	N/A
WellCare	-104	-54	14	-5	-40	-85	-63	-38
Munich American/Sterling	**	-1	5	2	**	**	-2	-5
Windsor	-1	-1	-3	-2	-4	N/A	N/A	N/A
Kaiser	-63	-11	-29	-10	-14	-14	-11	-12
WellPoint	-126	-73	-28	-70	-39	-9	-45	-16
Subtotal for the above parent organizations	-\$1,988	-\$598	-\$9	-\$620	-\$594	-\$568	-\$966	-\$633
Total reconciliation payments for risk corridors for all parent organizations	-\$2,590	-\$654	-\$82	-\$783	-\$713	-\$721	-\$1,105	-\$737

Note: N/A (not applicable). Data are typically “not applicable” because the organization had not yet entered the market or because it merged with or was acquired by another organization. Shaded amounts reflect years in which the plan sponsor paid Medicare. Risk corridor payments are made at the plan level. This table aggregates payments across all plans offered by the same parent organization. Columns may not sum to stated total.

*Excludes Humana Limited Income Net program.

** Less than plus or minus \$0.5 million.

Source: MedPAC analysis based on plan payment data from CMS.

making \$700 million to more than \$1 billion in risk corridor payments to Medicare each year since 2009.

Plan sponsors with the largest Part D enrollment have been fairly consistent in returning a portion of overpayments to Medicare each year because of the risk corridors. In Table 6-9, gray-shaded areas show payments from plan sponsors to Medicare, while unshaded amounts reflect payments from Medicare to plan sponsors. Many of the largest plan sponsors made risk corridor payments to Medicare in most of the years between 2006 and 2013.

Feedback from plan actuaries

One might expect the flow of reconciliation payments to vary from year to year—with plan sponsors returning

overpayments to Medicare in some years and receiving underpayments from Medicare in other years. Instead, payments have shown fairly regular patterns:

- Many plan sponsors have bid too low on the amount of benefit spending above Part D’s catastrophic threshold relative to actual spending, resulting at reconciliation in additional reinsurance payments from Medicare to plans; and
- Plan sponsors have bid too high on the rest of (noncatastrophic) benefit spending relative to actual spending, resulting in risk corridor payments from plans to Medicare.

Does drug spending vary more than medical spending?

Some actuaries interviewed for this analysis suggested that per capita Part D drug spending is inherently more variable than medical spending because of uncertainties about the drugs that will enter the market and their prices. If true, such a factor might lend support to continuing risk-sharing arrangements in Part D.

As a simple test of that hypothesis, we compared the variation over time in combined Part A and Part B fee-for-service (FFS) spending across individual beneficiaries in the United States with the variation in individuals' Part D spending. (We measured variation as the coefficient of variation (CV), or the standard deviation of individuals' spending divided by mean spending) (Table 6-10). (For comparability to the FFS population, we used only enrollees in stand-alone drugs plans.) Mean FFS spending has grown modestly

between 2008 and 2012 by an annual average of 1.1 percent. The distribution of FFS spending has remained relatively stable as measured by its CV, growing slightly from 212 percent in 2008 to 217 percent in 2012.

In 2012, Part D spending had nearly the same CV as FFS spending—211 percent compared with 217 percent. However, the distribution of Part D spending has changed dramatically over time. Mean spending grew by 1.9 percent between 2008 and 2012, and median spending fell as enrollees began using more generic drugs. As measured by its CV, Part D's spending distribution widened significantly between 2008 and 2012—from 155 percent to 211 percent. Spending levels at the top end of the distribution (the 99th percentile) grew at a faster pace than spending for FFS Part A and Part B services. ■

**TABLE
6-10**

Coefficient of variation for Part D spending per beneficiary has grown while that for FFS Part A and Part B spending has remained the same

	FFS Part A and Part B			Part D (PDPs)		
	2008	2012	Annual average change	2008	2012	Annual average change
Population size (in millions)	32.3	34.0	1.3%	15.9	18.3	3.5%
Mean spending	\$10,584	\$11,057	1.1	\$3,013	\$3,248	1.9
Median spending	2,695	2,765	0.6	1,814	1,531	-4.1
Standard deviation	22,474	24,029	1.7	4,664	6,840	10.0
Coefficient of variation (in percent)	212%	217%	0.6	155%	211%	8.0
Spending at the 99th percentile	105,336	113,762	1.9	20,801	27,758	7.5

Note: FFS (fee-for-service), PDP (prescription drug plan). Coefficient of variation is the standard deviation divided by the mean. The values include beneficiary cost sharing as well as covered benefit spending. Values include enrollees who had no claims. The shaded row shows that while the coefficient of variation of the sum of each FFS beneficiary's Part A and Part B spending has remained stable over time, the coefficient of variation of enrollees in stand-alone Part D plans has grown.

Source: MedPAC analysis based on Master Beneficiary Summary File data and prescription drug event claims.

These patterns have persisted over several years even though CMS reviews each bid submission closely for inaccuracies.¹⁰ To better understand these patterns,

Commission staff conducted interviews with actuaries from nine organizations who have detailed knowledge about developing Part D bids.

Timing of bid development and key uncertainties

Plan sponsors submit their bids each June—seven months before the start of the benefit year for which the bid is prepared. As part of their bids, sponsors provide information to CMS about their expected number of enrollees, how many will receive the LIS, the average cost of benefits net of rebates and discounts from drug manufacturers and pharmacies, and how much the plan expects to receive in individual reinsurance from Medicare. CMS uses this information to set prospective payments to plans.

The actuaries we spoke with all described difficulty in making key assumptions that affect drug benefit spending so far in advance. Many of the interviewees believed that drug spending is more difficult to predict than medical spending (see text box). They attributed this difficulty to unknown timing in the entry of new drugs into the market (including new specialty drugs, but also new generics whose entries are sometimes delayed) and to uncertainty about price inflation for brand-name drugs and changes in utilization. According to our interviewees, sponsors tend to “lock down” many assumptions in May before bids are due in June. Those assumptions include which drugs will enter the market and at what price; the amount of rebates and discounts that pharmaceutical manufacturers and pharmacies will provide; and trends in the price growth, utilization levels, and mix of drugs used by enrollees.

Homogeneous assumptions about spending growth

The key uncertainties and timing of the bid process reflect how difficult actuaries believe it is to bid accurately. Still, those factors do not by themselves explain the systematic patterns of payments we observed. Several interviewees’ remarks regarding how plans develop their spending projections may help explain the patterns. In the process of developing bids, some sponsors use “smooth,” homogeneous assumptions about trend. *Trend* refers to growth in monthly spending per enrollee associated with price inflation, changes in numbers of prescriptions filled, and changes in the mix of medications used. Sponsor actuaries must submit historical data on their plan’s Part D spending, along with assumptions about future spending trends, to support their bids. Plan sponsors that project a smooth trend across all spending assume that expenditures by members who are at the lower end of their plan’s spending distribution will grow at the same rate as individuals at the upper end.

However, a homogeneous trend assumption—the same projected spending growth for those at the lower and upper ends of the spending distribution—may not be appropriate. Several interviewees noted that low-spending enrollees tend to use more generic medications with relatively lower price inflation, while high-spending enrollees tend to use more brand-name and specialty drugs with higher price growth. This pattern corresponds with a previous Commission analysis of enrollees who reached the catastrophic phase of Part D, which showed that most of their spending was driven by the volume of traditional prescriptions filled and by a tendency to use brand-name medications (Medicare Payment Advisory Commission 2013). For this reason, it might be better to use different sets of trend assumptions for different therapeutic classes or for different categories of enrollees; several of the actuaries we interviewed confirmed that they take this approach. For plan sponsors who use smooth assumptions about trend, that approach might tend to overestimate spending at the lower phases of Part D’s benefit structure and underestimate spending above the catastrophic threshold—where Medicare pays for individual reinsurance.

Entrance into the market of high-priced specialty drugs

Most of the actuaries we interviewed said that the entrance in December 2013 of Sovaldi, a new treatment for hepatitis C, was one explanation for underestimating individual reinsurance in Part D bids. However, the pattern of reconciliation payments that we observed predates the market entrance of Sovaldi. At an average wholesale price of \$1,000 per pill, or \$84,000 per treatment regimen, Sovaldi (and, more recently, other new hepatitis C therapies) appears to be an effective treatment that could be used by a potentially large population of patients. Manufacturers are introducing therapies for other conditions at similar launch prices. Insofar as plan sponsors are unable to predict the timing of FDA approval for marketing those therapies, launch prices, or the extent of use among plan enrollees, the introduction of new high-priced drugs could be one explanation for underestimating individual reinsurance, particularly after 2014.

Manufacturers’ rebates

The actuaries with whom we spoke identified manufacturer rebates as another factor that may contribute to underestimation of individual reinsurance in plan bids. Manufacturers provide rebates to plan

sponsors for including their drugs on the plan’s formulary or for successfully encouraging plan enrollees to use the manufacturers’ medications. According to the CMS Office of the Actuary, rebates from manufacturers reduce spending for brand-name drugs in Part D by 20 percent to 30 percent (Boards of Trustees 2014).

Manufacturers provide price concessions after enrollees have filled prescriptions rather than at the time that the sponsor is developing its bid. CMS calls these types of price concessions *direct and indirect remuneration (DIR)*. Another source of DIR is price discounts offered by pharmacies for having “preferred” status in a sponsor’s pharmacy network. When a plan sponsor submits its bid, actuaries must net out DIR from gross benefit spending, including spending above Part D’s catastrophic threshold.

The magnitude of DIR can be difficult for plan sponsors to predict. For example, one interviewee noted that his firm (a plan sponsor) had an especially contentious relationship with a major pharmaceutical manufacturer over rebates. At the time that bid submissions were due, the actuary believed there was only a fifty-fifty chance that the two sides could reach any agreement. In this situation, he used actuarial standards of practice—a conservative assumption about the magnitude of DIR in the sponsor’s bid.

For purposes of netting out rebates from plans’ benefit spending during reconciliation, CMS requires plans to allocate DIR proportionately to the total distribution of claims. However, for some brand-name and specialty drugs that do not have therapeutic substitutes, manufacturers are much less likely to give rebates. Thus, plan sponsors are required to apportion DIR evenly across spending, even if this allocation does not reflect how rebates are generated. This approach may contribute to underestimates of spending above Part D’s catastrophic threshold. The extent to which sponsors underestimate the magnitude of total rebates in bids may lead them to overstate benefit spending on the noncatastrophic portion of the Part D benefit.

For the future, it would be useful to understand more about the organizational level at which plan sponsors negotiate and allocate rebates—for example, whether by individual Part D plans, by contracts, or for a company’s entire book of business. The ways in which plan sponsors allocate rebate dollars across lines of business may provide large plan sponsors with flexibility as they develop bids and determine actual plan costs.

Uncertainty about numbers of LIS enrollees

Several interviewees noted that it can be difficult to estimate the share of their plan’s enrollees who receive the LIS. This difficulty occurs because CMS sets benchmarks for the maximum amount that Medicare will pay in monthly premiums on behalf of LIS enrollees, based on the LIS enrollment–weighted average of plan bids. If a plan sponsor misses that benchmark (i.e., comes out of the bidding process with a plan premium higher than the benchmark), the sponsor stands to have its LIS enrollees reassigned by CMS to other benchmark plans.

Because LIS enrollees are much more likely to reach the catastrophic threshold, misestimating a plan’s share of members who receive the LIS can also lead to misestimates of catastrophic spending and the amount of individual reinsurance that the plan will receive.

Hypothetical, simplified examples of bids, payments, and reconciliation

Our interviews with actuaries suggest there may be consistent issues in how sponsors prepare bids that lead to the patterns of plan payments we observed. However, the observed patterns may also suggest that Part D’s risk-sharing mechanisms provide incentives to bid in certain consistent ways. By tending to underestimate catastrophic spending, plan sponsors may be able to charge lower premiums to enrollees and later get reimbursed for 80 percent of actual catastrophic claims through additional reinsurance from Medicare at reconciliation.

We have constructed hypothetical examples to help explain possible incentives driving sponsors’ behavior in developing Part D bids, in view of their effect on payments and reconciliation. For simplicity, we show a single plan rather than multiple competing plans, which Part D uses. Although the example lacks the dynamic market-wide effects that may result from having multiple plans, it may still be useful for understanding the relationship between a plan’s bid, payments from Medicare, and the financial implications of reconciliation on the plan’s revenue. It can also be viewed as representing the average financial implications for plan sponsors participating in the Part D program as a whole, with the extreme assumption that all plan bids follow the same pattern. As a practical matter, an individual sponsor is only one of many sponsors whose bids collectively affect the amounts that Medicare pays in prospective payments. Still, Medicare’s reconciliation

FIGURE 6-5

Hypothetical example of a simplified Part D bid

Total spending per member per month = \$120



Note: This figure depicts a simplified, hypothetical benefit structure. Part D's actual defined standard benefit structure is shown in Figure 6-2, p. 146.

payments show consistent patterns rather than the randomness one might expect from projection errors in the actuarial assumptions behind bids.

For these examples, we simplified the Part D benefit structure so that there are only two phases of coverage: below and above the catastrophic threshold (Figure 6-5). For spending below the catastrophic threshold, the enrollee pays 25 percent in cost sharing, while the Medicare program covers the remaining 75 percent. The enrollee's plan is fully at risk in this part of the benefit. For spending above the threshold, the enrollee must pay 5 percent cost sharing, while Medicare and the plan cover the remaining 95 percent. Individual reinsurance, paid for by Medicare, covers 80 percent of the cost above the catastrophic threshold, while the plan is at risk for 15 percent of the cost.

A hypothetical plan bid

The bid reflects the plan sponsor's estimate of per member per month (PMPM) costs of providing benefits to an enrollee of average health. When developing the bid, plan sponsors must determine how much of that total PMPM spending will be above the catastrophic threshold (where Medicare picks up 80 percent of the cost) versus below the catastrophic threshold (where plans bear more of the insurance risk).

In this hypothetical example, the plan sponsor bids \$52.50 as the cost of providing benefits below the catastrophic limit, \$7.50 for benefits above the catastrophic limit, and \$40 as its prospective payment for individual reinsurance (Figure 6-5). To estimate these costs, the plan first estimates the benefit's total cost (\$120 PMPM) and, of that total, estimates that \$50 would be above and \$70 below the catastrophic limit.

Medicare program's spending for this example consists of three parts (Figure 6-6, p. 160): 15 percent of plan-covered benefit above the catastrophic limit (\$7.50); 75 percent of plan-covered benefit below the catastrophic limit (\$52.50); and 80 percent individual reinsurance (\$40). The total cost of providing the benefit is \$100 (\$7.50 + \$52.50 + \$40.00). (The beneficiary pays \$20 of the \$120 in total benefit spending through cost sharing: \$2.50 + \$17.50.) Assuming this bid is from an average plan, Medicare's subsidy covers 74.5 percent of benefit costs and enrollees pay the remaining 25.5 percent in monthly premiums. In this example, the beneficiary premium is \$25.50, while Medicare's premium subsidy covers \$40.00 in expected reinsurance and \$34.50 of the plan's covered benefits as the direct subsidy.

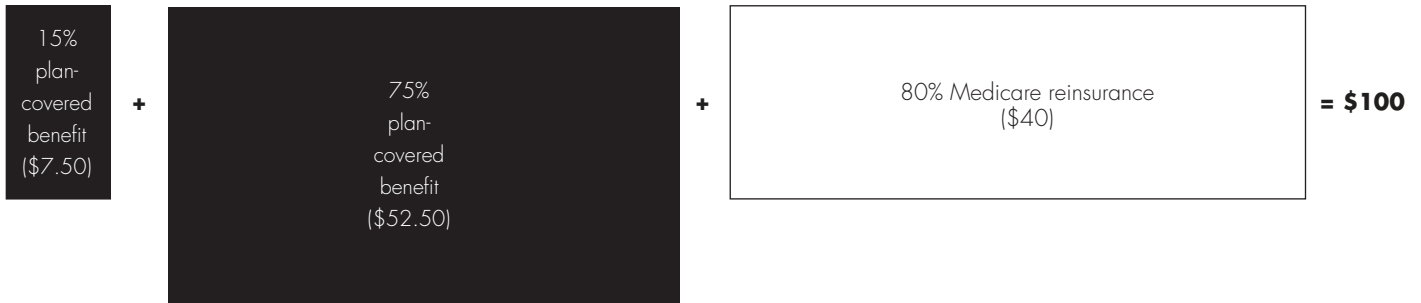
Risk corridors

For this example, we use a simplified risk corridor with just one threshold of payments set at plus or minus 10

**FIGURE
6-6**

Covered benefits in our hypothetical example

Covered benefit financed by enrollee premium (25.5%) and Medicare's subsidy (74.5%)



Beneficiary premium = 25.5% x \$100 = \$25.50 per month

Medicare subsidy = 74.5% x \$100 = \$74.50 per month (\$40.00 in prospective reinsurance and \$34.50 direct subsidy)

(Beneficiary cost sharing = \$17.50 + \$2.50 = \$20.00 per month)

Note: This figure depicts covered benefits in a simplified, hypothetical benefit structure. Part D's actual defined standard benefit structure is shown in Figure 6-2, p. 146.

percent of the plan's bid. If actual costs for benefits (net of rebates and discounts) are beyond these limits (90 percent or less of the plan's bid or 110 percent or more of the plan's bid), then the sponsor and Medicare split the plan's profits or losses fifty-fifty. That is, the plan is fully at risk for up to 10 percent above (profit) or below (loss) its bid. These hypothetical risk corridors operate more simply than Part D's actual risk corridors, in which Medicare shares profits or losses beginning at 95 percent and 105 percent of the plan's bid (Figure 6-3, p. 147).

Reinsurance

Although the plan receives a monthly prospective payment for individual reinsurance based on what it assumed in its bid about the amount of spending above the catastrophic threshold (\$40), CMS later reconciles prospective payments with actual spending. If the sponsor overestimates its plan's prospective payments for individual reinsurance in its bid, then the sponsor has to repay Medicare, and if it underestimates individual reinsurance, then Medicare pays back the sponsor.

Interaction between reinsurance and risk corridors

When bids are submitted to CMS, one of the key pieces of information that plan sponsors provide is how much of the total benefit spending will be above the catastrophic threshold (where Medicare pays for 80 percent of costs) versus below the catastrophic threshold (where the plan

bears more of the insurance risk). If a sponsor were to underestimate spending above the catastrophic threshold, it would have offsetting effects:

- The plan's cash flow would be lower, since Medicare's prospective payments for reinsurance would be less than actual reinsurance costs.
- There would be a loss of 15 percent of the underestimated amount for which the plan is liable above the catastrophic threshold.
- However, Medicare would pay the plan fully for 80 percent of actual costs above the catastrophic threshold at reconciliation.
- Enrollee premiums would be lower than otherwise.

Given these pros and cons, it is not immediately apparent how Part D's risk-sharing mechanisms provide incentives to underestimate catastrophic spending. However, this bidding approach makes more sense when the risk corridors are taken into account.

The risk corridors provide plans with protection from costs that are higher than expected. At the same time, they provide incentives for plan sponsors to keep benefit costs as low as possible relative to bids because sponsors keep some or all of the difference as additional profits (beyond those already included in their bids). Sponsors can achieve

this result by managing their enrollees' drug spending, by bidding conservatively (high) on expected benefit spending, or some combination of both.

A disadvantage of bidding conservatively on benefit costs is that it can lead to higher enrollee premiums. However, higher premium amounts could be offset somewhat by underestimating benefit spending above the catastrophic threshold. As long as the financial advantages of overestimating benefit costs exceed the financial disadvantages of underestimating catastrophic benefits, this approach to bidding makes sense. Further, if other plans are using this bidding approach, a plan that does not bid in this way may be put at competitive disadvantage.

Three cases of reconciled spending

We provide three scenarios for the point at which a plan reconciles payments with CMS to show the ramifications of the bid's development:

- **Case 1:** The plan's estimate of individual reinsurance is lower than actual spending, and Medicare pays the difference to the plan after reconciliation.
- **Case 2:** The plan's estimate of individual reinsurance is higher than actual spending, and the plan pays the difference to Medicare after reconciliation.
- **Case 3:** The plan's estimate of the individual reinsurance is lower than actual spending, and its estimate of the total benefit for which it is at risk is low enough to trigger a risk corridor payment. Medicare pays the difference between expected and actual reinsurance to the plan at the point of reconciliation, and the plan pays Medicare 50 percent of the profit above the 10 percent risk corridor threshold.

Case 1 and Case 3 are similar to actual patterns of Part D payments that we observed because, in both scenarios, the plan has underestimated individual reinsurance in its bid compared with actual spending. We offer Case 2 to illustrate why it is financially advantageous to plan sponsors to follow the approach in Case 1.

Table 6-11 (p. 163) shows the bid for the hypothetical plan described in Figure 6-5 (p. 159) and Figure 6-6. Of the \$120 PMPM in total drug spending, the plan expects the Part D benefit will cover \$100, with the plan at full risk for \$60 of that \$100 and the remaining \$40 to be paid for by Medicare in individual reinsurance. The monthly premium for the beneficiary is \$25.50, and Medicare's

premium subsidy (the combination of the direct subsidy and individual reinsurance) pays for the remaining \$74.50.

In Case 1, the plan's estimate of the total cost was correct in its bid (\$120), but actual spending below the catastrophic limit was lower than the amount assumed in the bid (\$60 instead of \$70), and spending above the catastrophic limit was higher than the amount assumed in the bid (\$60 instead of \$50). As a result, actual costs for the portion of the benefit on which the plan was at risk were lower (\$54) than the \$60 assumed in the bid. Still, the plan's actual costs were within 10 percent of the \$60 bid, so risk corridor payments were not triggered and the plan keeps the \$6 difference as profit. Higher than expected spending above the catastrophic limit increases the amount of individual reinsurance from \$40 to \$48. Therefore, Medicare retroactively pays the plan for the difference (\$8). In Case 1, if the plan sponsor had known ahead of time what actual spending would be, had bid accordingly, and reflected the average costs of all competing plans, the beneficiary's share of the premiums would have been higher: \$26.01 instead of \$25.50.

In Case 2, the plan's estimate of the total cost was correct in its bid, but actual spending below the catastrophic limit was higher than what the plan assumed (\$80 instead of \$70), and spending above the catastrophic limit was lower than the amount in its bid (\$40 instead of \$50). That is, the actual cost of providing the benefit was lower than the amount assumed in the bid (\$98 instead of \$100).

As a result, the actual costs for the portion of the benefit on which the plan was at risk were higher (\$66) than the \$60 assumed in the bid, but within 10 percent of the \$60 so that risk corridor payment was not triggered and the plan loses the difference (\$6). Lower than expected spending above the catastrophic limit reduces the amount from \$40 to \$32 for the individual reinsurance that the plan is eligible to receive, and the plan pays back Medicare \$8 at reconciliation. The plan revenue after reconciliation totals \$92 PMPM, \$6 lower than the actual cost of providing the benefit (\$98).

In Case 3, the plan's estimate of total cost was too high: it bid \$120 PMPM, but actual costs were \$110 PMPM. Of the \$110, actual spending below the catastrophic limit was \$50 (far lower than the \$70 the plan assumed in its bid), and actual spending above the catastrophic limit was \$60 (higher than the \$50 in its bid). As a result, actual costs for the portion of the benefit on which the plan was at risk were much lower than what it assumed in its bid: \$46.50

instead of \$60. Total costs of covered benefits were \$94.50 rather than \$100.

Because the plan underestimated individual reinsurance in its bids relative to actual catastrophic spending, Medicare pays the plan an additional \$8. However, the actual costs of benefits for which the plan was at risk were more than 10 percent lower than its bid, and under the risk corridor policy, it must return 50 percent of its profits above the 10 percent threshold ($\$3.75 = 0.5 \times ((0.9 \times \$60) - \$46.50)$). On net, the plan keeps \$9.75 in profits because its revenues after reconciliation were \$104.25 compared with benefit costs of \$94.50.

Case 3 lends particular insight into the real-world patterns of payments we observed. In the example, the plan underestimates spending above the catastrophic limit in its bid: \$50 PMPM instead of \$60. This leads to an underestimate of the amount of individual reinsurance the plan will receive. As in recent real-world payment patterns, Medicare would pay the plan additional amounts (\$8 PMPM) for reinsurance at reconciliation. In addition, in Case 3, the plan's bid overestimates plan-covered benefit spending (\$60 PMPM compared with \$46.50 PMPM in actual claims experience). This overestimate is large enough to trigger a risk corridor payment to Medicare ($-\$3.75$ PMPM) and is similar to what has happened consistently in the Part D program. This could reflect a situation with conservative assumptions about the degree to which the plan could encourage its enrollees to use generic rather than brand-name drugs or fill their prescriptions at preferred pharmacies. Whether due to difficulty in actuarial estimation or other reasons, by underestimating individual reinsurance in its bid, plan sponsors have been able to keep part of catastrophic benefit spending out of enrollee premiums and receive the full reinsurance amounts due to them at reconciliation. Even though the plan must return some of its profit to Medicare through risk corridors, it still nets a portion of profits.

Potential policy changes to risk sharing

Options exist for refining the design of Part D's risk-sharing mechanisms that might better address today's policy goals for the program. For example, given that Medicare appears to have developed a robust market for stand-alone drug plans, it may be time for the program to emphasize policy approaches that encourage closer management of benefits for high-cost enrollees rather

than policies designed to encourage or sustain plan entry. Optimally, a package of changes would be considered to balance concerns about ensuring beneficiaries' access to appropriate therapies, program cost control, and offsetting sponsors' incentives to engage in selection behavior.

LIS enrollees are not distributed evenly among plans

In the aggregate, about one-third of Part D enrollees receive the LIS and two-thirds do not, but few plans have enrollment that tracks these averages. Plans follow a bimodal distribution: They tend to have either a smaller than average share or a larger than average share of LIS enrollment. Average risk scores of plans correlate very closely with the share of their enrollment that receives the LIS.

This distribution of plans has been consistent over time and can be explained by both program design and sponsor behavior. By design, some plans offer enhanced benefits (higher average benefit value than the basic benefit), but LIS enrollees can be assigned only to plans with basic benefits. Unless an LIS enrollee selects a plan herself, CMS follows a policy of random, automatic assignment among the Part D region's qualifying plans (Medicare Payment Advisory Commission 2015). In some regions, relatively few plans qualify, resulting in sizable numbers of assignees and likely leading to these plans' enrollment of a high proportion of LIS enrollees.

Potential changes to Part D's risk-sharing provisions need to be considered in the context of this market segmentation. For example, changes to risk sharing could adjust the parameters that determine the level of benefit spending at which Medicare begins to pay individual reinsurance or ask private plans to shoulder more of covered benefits above Part D's out-of-pocket threshold. However, policymakers would also want to consider how such measures would affect incentives to attract LIS enrollees and other high-cost enrollees. Today, individuals who receive the LIS tend to be concentrated among plans (primarily PDPs) that have a high overall proportion of LIS enrollment. Without other measures, changes to Part D's individual reinsurance could increase incentives for plan sponsors to avoid high-cost enrollees. It would be important to counter those incentives somewhat by ensuring that Part D's risk adjusters were calibrated to take plans' greater degree of risk into account.

At the same time, if policymakers required Part D plans to shoulder more risk, they would also need to give sponsors greater flexibility to contain costs. Because LIS enrollees

**TABLE
6-11**
Potential effects of risk sharing under three hypothetical scenarios
Actual claims experience

	Plan bid	Case 1	Case 2	Case 3
Total cost PMPM (cost sharing and covered benefit)				
Below catastrophic limit	\$70	\$60	\$80	\$50
Above catastrophic limit	<u>\$50</u>	<u>\$60</u>	<u>\$40</u>	<u>\$60</u>
Total	\$120	\$120	\$120	\$110
Part D-covered benefit				
Plan-covered benefit				
Below catastrophic limit (75%)	\$52.50	\$45.00	\$60.00	\$37.50
Above catastrophic limit (15%)	<u>\$7.50</u>	<u>\$9.00</u>	<u>\$6.00</u>	<u>\$9.00</u>
Subtotal, plan-covered benefit	\$60.00	\$54.00	\$66.00	\$46.50
Medicare reinsurance				
Above catastrophic limit (80%)	<u>\$40.00</u>	<u>\$48.00</u>	<u>\$32.00</u>	<u>\$48.00</u>
Total expected/actual benefit costs	\$100.00	\$102.00	\$98.00	\$94.50
	Premium based on bids	What premiums would have been, using actual spending		
Plan premium				
Beneficiary share (25.5%)	\$25.50	\$26.01	\$24.99	\$24.10
Medicare premium subsidy (74.5%)				
Direct subsidy	\$34.50	\$27.99	\$41.01	\$22.40
Individual reinsurance	<u>\$40.00</u>	<u>\$48.00</u>	<u>\$32.00</u>	<u>\$48.00</u>
Subtotal	\$74.50	\$75.99	\$73.01	\$70.40
Total plan revenue PMPM before reconciliation	\$100.00			
Reconciliation				
Risk corridor payment		\$0	\$0	-\$3.75
Individual reinsurance		\$8.00	-\$8.00	\$8.00
Plan revenue after reconciliation				
Beneficiary premium		\$25.50	\$25.50	\$25.50
Medicare premium subsidy				
Direct subsidy		\$34.50	\$34.50	\$30.75
Individual reinsurance		<u>\$48.00</u>	<u>\$32.00</u>	<u>\$48.00</u>
Total		\$108.00	\$92.00	\$104.25
Plan revenue minus benefit costs		\$6.00	-\$6.00	\$9.75

Note: PMPM (per member per month).

incur a disproportionate share of catastrophic benefits, it would be especially important to consider changes in LIS policy. Copayment amounts for LIS enrollees are set by law, and plans cannot use differential copayments for preferred medicines and pharmacies as they do for

non-LIS enrollees. For this reason, the Commission has recommended that the Congress give the Secretary authority to provide stronger financial incentives to use lower cost generics when they are available (Medicare Payment Advisory Commission 2012).

Reduce Medicare's individual reinsurance payments to plans

By law, Medicare subsidizes 74.5 percent of the expected cost of basic drug benefits, with enrollees paying the remainder through premiums.¹¹ Medicare's 74.5 percent subsidy is made up of two components: monthly direct subsidy payments and expected individual reinsurance payments to plans, with Medicare paying the latter mechanism by covering 80 percent of catastrophic spending. One option to reduce these payments would be to keep Medicare's overall subsidy at 74.5 percent of expected costs, but change the structure of individual reinsurance so that plans include more of the costs of catastrophic spending in their covered benefits.

Discussions with plan executives and academic economists confirmed that Medicare's 80 percent reinsurance subsidy likely takes away the urgency for sponsors to manage prescription use among high-cost enrollees. One commenter pointed out that the rebates sponsors receive from manufacturers for all brand-name drugs dispensed to enrollees who reach Part D's catastrophic threshold (including rebates in the coverage gap phase) can more than offset plans' 15 percent share of payments for spending that exceeds the Part D catastrophic threshold. Thus, requiring plans to pay a share larger than 15 percent could provide greater incentive for sponsors to negotiate larger rebates with manufacturers or design formularies in ways that encourage greater use of lower cost drugs.

Policymakers could increase the amount of risk that plans are subject to above the catastrophic threshold to equal that for the benefit during the initial coverage phase. For example, instead of the current 80 percent individual reinsurance provided by Medicare, plans could be at risk for 75 percent of the spending above the catastrophic threshold, and Medicare's individual reinsurance would be reduced to 20 percent. Enrollee cost sharing would continue to be 5 percent of spending above the catastrophic threshold.

Table 6-12 shows that, in our hypothetical example, plans under this option would receive \$10 per month in individual reinsurance instead of \$40 per month, increasing plan-covered benefits from \$60 to \$90 per month. Medicare's overall subsidy would remain at 74.5 percent, keeping average enrollee premiums at \$25.50 per month (assuming no behavioral changes that would affect the costs of providing the benefit). However, the makeup of Medicare's subsidy would change: Plan sponsors would receive the lower amount of individual reinsurance

and a larger monthly direct subsidy payment (\$64.50 per month rather than \$34.50 per month). Because more of Medicare's subsidy would take the form of a capitated payment rather than an open-ended individual reinsurance reconciliation payment made at the end of the year, plan sponsors would be at risk for more of covered benefits than they are today, providing a stronger incentive to manage drug spending.

Such an approach would temper but not eliminate incentives to bid in a financially advantageous way. The same incentives apply here as in Cases 1 and 3 (Table 6-11, p. 163): If a sponsor underestimates catastrophic spending, the plan could still receive a higher direct subsidy and have a somewhat lower premium than it would otherwise. Medicare would still make the plan whole for the actual costs of individual reinsurance (20 percent of the spending above the catastrophic threshold) at reconciliation. However, since the plan would be at risk for significantly more covered-benefit spending, the financial advantage of bidding in this way would be smaller.

Other approaches could be used to lower Medicare's individual reinsurance. Policymakers could raise the catastrophic threshold at which Medicare pays individual reinsurance.¹² Medicare could pay plans individual reinsurance that is below today's 80 percent rate but higher than the 20 percent used in the example above. Or policymakers could eliminate Medicare's individual reinsurance altogether; plan sponsors could choose to purchase private reinsurance if needed. All of these options would increase the risk that sponsors bear, which, in turn, would give greater incentive to manage enrollees' drug spending.

Although we assumed no behavioral change in our hypothetical example, assuming greater risk for high-spending enrollees would likely require plans to reevaluate their overall strategy. For example, plan sponsors could expend greater effort to manage drug use and spending, which could lower the costs of providing the benefit. Other behavioral changes could result in higher costs of providing the benefit. For example, because they would be bearing more risk, plan sponsors might build in a risk premium or decide to purchase private reinsurance to protect themselves from large losses (and the cost of the private reinsurance would be reflected in a higher bid). Thus, the net effect on benefit costs and the premiums enrollees pay would depend on how sponsors responded and on the specific parameters and combinations of policy changes.

**TABLE
6-12**

Alternative approach to Medicare’s individual reinsurance

Part D–covered benefit	Current structure: Medicare individual reinsurance at 80 percent	Option: Medicare individual reinsurance at 20 percent
Medicare reinsurance above catastrophic limit	\$40.00	\$10.00
Benefits covered by the plan		
Below catastrophic limit	\$52.50	\$52.50
Above catastrophic limit	<u>\$7.50</u>	<u>\$37.50</u>
Subtotal, plan-covered benefits	\$60.00	\$90.00
Total benefit costs	\$100.00	\$100.00
Enrollee share (25.5%)	\$25.50	\$25.50
Medicare subsidy (74.5%)		
Direct subsidy	\$34.50	\$64.50
Individual reinsurance	<u>\$40.00</u>	<u>\$10.00</u>
Subtotal, Medicare subsidy	\$74.50	\$74.50
Plan total revenue	\$100.00	\$100.00

Note: The option example presented assumes no behavioral changes that would affect benefit costs. The “current structure” column is consistent with the “plan bid” column shown in Table 6-11 on p. 163.

Change Part D’s risk corridors

A different approach to Part D risk sharing would involve making changes to the current risk corridor structure so that sponsors bear more of the aggregate risk for the benefit spending of all plan enrollees. For example, the corridors could be widened: Unlike today’s corridors in which sponsors cover all costs (or keep all extra profits) until actual plan benefits reach 105 percent (95 percent) of plan bids, sponsors could cover all costs (or keep all profits) up to 110 percent (90 percent) of their bids. Alternatively, Medicare could eliminate the corridors altogether, making Part D plans operate similarly to Medicare Advantage plans.¹³ These options are based on the notion that by exposing plan sponsors to greater risk, they would have stronger incentives to manage benefit spending.

In discussions with Commission staff, plan executives and academic economists thought that removing the risk corridors would not substantially affect sponsors’ decisions about whether to stay in the market. The consensus was weaker regarding the effects of removing the risk corridors on sponsors’ incentives to contain costs. In theory, risk corridors reduce the insurance risk sponsors face by limiting potential profits or losses. However, because of the interaction between spending subject to

risk corridors and spending that is paid for by Medicare through individual reinsurance, in reality, the role of risk corridors has been to limit profits that are above those profits that are already built into bids. The absence of corridors (with no other changes to the risk-sharing arrangement) would potentially allow sponsors to keep more profits than they do currently, if they did not change how they bid. However, we do not know how sponsors would bid if the corridors were not in place.

In interviews with plan actuaries knowledgeable about Part D, we asked them whether plan sponsors would bid differently if Medicare no longer provided risk corridors. Most of the actuaries made arguments in favor of retaining corridors. One interviewee contended that without risk corridors, plan sponsors would bid more conservatively than they do today, which would tend to raise premiums. Another interviewee said that although some plan sponsors are large enough to insure themselves against unforeseen risks, smaller sponsors would have to buy private reinsurance, the cost of which could deter entry of new plans. Two interviewees suggested that the presence of Medicare’s risk corridors gives plan sponsors room to bid more aggressively (lower) or to try innovations (e.g., provide supplemental benefits during the gap phase) that they would not pursue otherwise. One actuary foresaw competing incentives if risk corridors were removed. On

the one hand, sponsors might bid conservatively (higher); on the other hand, the degree of competition in the Part D marketplace would mean that sponsors would still have strong incentives to bid low.

Given that Medicare has consistently collected a portion of overpayments to plans through Part D's risk corridors, some might argue in favor of narrowing the corridors. For example, Medicare could return to the corridors it used at the start of Part D, sharing profits (or losses) when actual benefits paid are less than 97.5 percent (or 102.5 percent) of bids, followed by another risk-sharing threshold at 95 percent (or 105 percent) of bids (Figure 6-3, p. 147). This option would ensure that plans returned a greater portion of overpayments to Medicare. However, the potential to earn higher profits through the structure of today's corridors may provide general incentives for plans to manage enrollees' drug spending. Narrower corridors could reduce incentives for cost control.

The role of medical loss ratio requirements

Under provisions of the Patient Protection and Affordable Care Act of 2010, Part C and Part D contracts (which often cover a number of specific plans) are subject to minimum medical loss ratio requirements (MLRs). As of 2014, if CMS determines that a Medicare contract's medical claims and quality-improving activities are less than 85 percent of revenues, the sponsor must return to Medicare the amount above 85 percent. A Medicare contract with an MLR lower than 85 percent for three or more consecutive years is subject to enrollment sanctions. If a contract's MLR is lower than 85 percent for five consecutive years, CMS will terminate the contract (Centers for Medicare & Medicaid Services 2013). Because CMS will evaluate MLRs using reconciled payments, it is unclear when MLR information will be made public.

MLR regulations serve a role similar to a one-sided risk corridor in that they limit a plan sponsor's profits. They do not, however, help pay for a drug plan's unforeseen losses. Unlike with risk corridors, in which plan profits are potentially unlimited, the MLR approach aims to set an upper bound on profits. However, costs that count as quality improving are open to interpretation and difficult to monitor. Another issue that could keep MLRs from constraining profits as much as intended is that the rules for calculating MLRs include Medicare's individual reinsurance payments. Thus, a portion of the allowable 15 percent for administrative expense and profits is based on benefit costs on which Medicare bears the risk. Some analysts might argue that, if MLR requirements are

effective at limiting Medicare contract profits, the approach could also reduce plan sponsors' incentives to control costs.

Issues of concern

Overall, options to reduce individual reinsurance and widen or eliminate risk corridors are designed to require Part D plan sponsors to shoulder more risk. Greater risk may provide plan sponsors with stronger incentives to manage benefit spending, but it also raises the question of whether plans could or would be more effective at managing their enrollees' spending than they are today.

Incentive to avoid high-cost enrollees

Another open question is how adjustments to Part D risk sharing would affect the willingness of plan sponsors to enroll high-cost beneficiaries. Policymakers could have particular concerns about coverage for LIS enrollees because such a high proportion of enrollees who reach Part D's catastrophic threshold receive the LIS.

One mechanism to counter the incentive to avoid high-cost enrollees is the RxHCC risk-adjustment system. CMS updates Part D's risk adjusters each year using newer claims information. Less frequently, the agency recalibrates the combinations of diagnoses that RxHCC uses to predict drug benefit spending. If policymakers were to make changes to Part D's risk sharing such that plan sponsors bore more risk (e.g., if Medicare paid less individual reinsurance), CMS might need to recalibrate the RxHCC model or make some actuarial adjustments to it. Over the longer term, claims data would reflect new patterns of benefit spending on which plans bear risk, and CMS would use those claims to update the risk-adjustment model.

Would more risk deter entry of new plan sponsors?

An initial justification for Part D's risk corridors was that it encouraged the creation of a market for stand-alone prescription drug benefits. One might argue that some form of risk protection is still needed to help new sponsors enter a market that is dominated by large insurers. However, a counterargument is that with so many plans available in the Part D marketplace, deterring new entry may be less of a policy priority.

Sponsors' capacity to bear risk and the availability of private reinsurance

If Medicare reduced its risk-sharing subsidies in Part D, could plan sponsors purchase private reinsurance

if needed? To answer this question, Commission staff spoke with actuaries and consultants within the private reinsurance industry.

The respondents noted that, while they have held exploratory talks with a small number of employers and insurers that offer Medicare drug benefits, private reinsurers currently do not have contracts in place. However, it is common for smaller sponsors of Medicare Advantage plans to purchase private reinsurance that covers all medical benefits, sometimes with and sometimes without prescription drug spending. One consulting actuary noted that large insurance companies have sufficient capital and cash flow on hand to set up systems of cross-subsidies among their business lines to reinsure themselves. The interviewee believed that since most of Part D's enrollment is concentrated among large insurers, those companies could incorporate their Part D plans into these self-insurance systems.

The actuaries we spoke with noted that health insurance makes up a smaller proportion of their business today than life and casualty insurance.¹⁴ For that reason, private reinsurers may be less familiar with Part D and the claims experience of its enrollees. However, interviewees thought private reinsurance could be made available to Part D sponsors because the reinsurers would expect no more variation in drug benefit spending than in medical benefits.

When we described the current structure of Medicare's risk-sharing mechanisms, our interviewees told us that they sell similar types of products: specific stop-loss coverage that operates like Medicare's individual reinsurance and aggregate stop-loss coverage that acts as a one-sided risk corridor (insuring against losses). However, the actuaries thought that if private reinsurers were to provide coverage to Part D plan sponsors, their contracts would take forms different from Medicare's subsidies: a higher catastrophic cap and wider risk corridors. Plan sponsors would be unable to offload as much benefit risk through private reinsurance as Medicare now provides. For example, a private contract for specific stop loss might cover only the top 1 percent or 2 percent of enrollees as ranked by spending. (By comparison, in 2012, 8 percent of Part D enrollees reached the catastrophic threshold.) As another example, a private contract for aggregate stop-loss coverage could be effective if a plan's actual benefit costs averaged 110 percent or 115 percent of the plan's bid rather than 105 percent, as in Medicare's corridors. Interviewees said that the premium for such coverage would incorporate administrative costs and profits on

the order of about 20 percent to 25 percent of covered benefits. However, such spending covered by private reinsurance would be considerably smaller than the amount of risk sharing Medicare provides currently.

Could Part D sponsors negotiate better prices?

Medicare introduced the Part D program in 2006—a time when large numbers of brand-name drugs used widely by the beneficiary population had patent protection. More recently, a record number of blockbuster drugs went off patent and generic versions entered the market. As a result, Part D enrollees and other consumers have made dramatic shifts toward generics in the mix of drugs they use. However, fewer patent expirations are on the horizon, and the pipeline of new drugs under development is much more heavily dominated by biologics and specialty drugs. Many stakeholders expect these drugs to have high prices, perhaps in a range similar to new treatments for hepatitis C. Among PBMs, growth in price and use of specialty drugs is now beginning to drive the overall trend in benefit spending and, for the future, poses a big challenge to the Part D program (Medicare Payment Advisory Commission 2015).

One question to consider relates to the growing influence of higher priced specialty drugs. Even if Medicare required plan sponsors to bear more risk in Part D, would sponsors have sufficient market power to negotiate larger price discounts with pharmaceutical manufacturers? For some drug therapies with limited therapeutic substitutes, the answer is likely no. However, for others, even the prospect of potential competing drugs or biosimilars in the development pipeline has given PBMs bargaining leverage. For example, actuaries told us that a few plan sponsors were able to negotiate rebates from pharmaceutical manufacturers for new hepatitis C therapies because competing therapies were reaching the stage of obtaining FDA approval.

A further question is whether the structure of Medicare's risk-sharing subsidies—especially for individual reinsurance—facilitates a climate in which manufacturers are able to charge very high launch prices for certain drugs. Medicare's 80 percent reinsurance subsidy takes away the urgency for sponsors to manage prescription use among high-cost enrollees and might also be a factor influencing the level at which manufacturers set launch prices for new drugs. ■

Endnotes

- 1 Part D enrollees may qualify for the low-income subsidy (LIS) if they have low income and assets. Of the 11 million beneficiaries with the LIS in 2014, 7 million were dually eligible for Medicare and Medicaid. Another 4 million qualified for the LIS either because they received benefits through the Medicare Savings Programs or the Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration.
- 2 For example, Part D sponsors may not make midyear formulary changes (other than formulary additions) without prior approval from CMS.
- 3 CMS's RxHCC model uses age, sex, disability status, and diagnosis codes to predict the Part D drug benefit spending. The model uses about 5,000 diagnoses and groups them into disease categories based on drugs used to treat those diseases. The version of RxHCC that has been used since 2011 was calibrated using Part D claims data from the early years of the program. Beginning in 2016, CMS will use models that are calibrated from 2012 diagnoses data and 2013 claims data.
- 4 Beginning in 2011, CMS replaced its single RxHCC model with five sets of model coefficients for long-term institutional enrollees, aged low-income enrollees, aged non-low-income enrollees, disabled low-income enrollees, and disabled non-low-income enrollees (Centers for Medicare & Medicaid Services 2010).
- 5 The claims data from 2013 that were used for recalibration do not show spending for drugs introduced in later years. CMS actuaries used more recent years of claims as a proxy to estimate what spending for the new drugs would have been if those medicines had been available in 2013.
- 6 Based on analysis conducted by Acumen LLC for the Commission, the indexes reflect the prices plan sponsors and beneficiaries paid to pharmacies at the point of sale and do not reflect retrospective rebates from manufacturers (Medicare Payment Advisory Commission 2015).
- 7 Beginning in 2011, Medicare also began providing a prospective payment to sponsors for the 50 percent discount that drug manufacturers provide on brand-name drugs for enrollees who reach the coverage gap. Medicare is later reimbursed for providing this up-front cash flow once sponsors and manufacturers know the actual numbers of enrollees who were eligible to receive the discount.
- 8 This estimate includes an assumption about how much basic benefit spending is induced by supplemental coverage.
- 9 In 2006 and 2007, this finding means that costs were 95 percent or less of their bids. In 2008 through 2010, costs for the majority of parent organizations were 90 percent or less of their bids.
- 10 In the agency's call letter to plan sponsors, CMS notes that sponsors submitting clearly inaccurate bids that fail to meet requirements will receive compliance notices, may receive a corrective action plan, and might not be permitted to revise their bids (Centers for Medicare & Medicaid Services 2015).
- 11 Medicare's 74.5 percent subsidy is based on expected benefit costs. When compared with actual benefit costs, Medicare's subsidy may be different from (and likely higher than) 74.5 percent.
- 12 This action could be achieved by extending the "partial" coverage gap phase (scheduled to close by 2020) or by reintroducing a gap in covered benefits.
- 13 Medicare Advantage plans are not subject to risk corridors. However, if CMS makes a national coverage decision that would permit payment for a new therapy or procedure in traditional Medicare, MA plans may receive additional Medicare payment if they provide those services.
- 14 They noted there has been an uptick in reinsurance contracts for stop-loss coverage of medical benefits because of the elimination of maximum lifetime benefits after implementation of the Patient Protection and Affordable Care Act of 2010.

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