

MedPAC's Proposed Changes to Medicare Part D

Paper 2 of 2: Considerations for Part D Plan Sponsors

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In its June 2016 report, the Medicare Payment Advisory Commission (MedPAC) proposed several changes to the Medicare Part D program. MedPAC advises Congress on policies related to Medicare, and while these recommendations are nonbinding, they often indicate future program changes that could be enacted by Congress. This paper outlines key considerations for plan sponsors as they prepare for the proposed changes. A second Milliman white paper discusses the impact that MedPAC's proposed changes could have on plan sponsors (e.g., insurers or employers), Part D members, and pharmaceutical manufacturers.¹

In its proposal to overhaul the Part D reinsurance program, MedPAC recommended reducing the federal component of reinsurance from 80% of costs in the catastrophic coverage phase to 20%, eliminating enrollee cost sharing above the out-of-pocket threshold, and excluding coverage gap discount amounts from enrollees' true out-of-pocket (TrOOP) accumulation.² This proposal follows more than two years of indications in MedPAC's public meetings and reports to Congress that proposed changes to the risk-sharing programs in Part D were forthcoming.^{3, 4, 5, 6} If implemented, the package of proposed changes would be the most significant change to the structure of the Part D program since the closure of the coverage gap mandated by the Affordable Care Act (ACA) in 2010.

- 1 MedPAC's Proposed Changes to Medicare Part D. Paper 1 of 2: Impacts on Various Part D Stakeholders. Retrieved October 27, 2016, from <http://us.milliman.com/insight/2016/MedPACs-proposed-changes-to-Medicare-Part-D-Impacts-on-various-Part-D-stakeholders/>.
- 2 Medicare Payment Advisory Commission (June 2016). Chapter 6: Improving Medicare Part D. Retrieved July 18, 2016, from <http://www.medpac.gov/docs/default-source/reports/chapter-6-improving-medicare-part-d-june-2016-report-.pdf?sfvrsn=0>.
- 3 Medicare Payment Advisory Commission (November 5, 2015). Proceedings of Public Meeting. Retrieved March 7, 2016, from http://www.medpac.gov/docs/default-source/meeting-materials/nov_2015_meeting_transcript.pdf?sfvrsn=0.
- 4 Medicare Payment Advisory Commission (January 15, 2015). Proceedings of Public Meeting. Retrieved March 7, 2016, from <http://www.medpac.gov/docs/default-source/meeting-materials/january-2015-meeting-transcript.pdf?sfvrsn=0>.
- 5 Schmidt, R. and Suzuki, S. (October 9, 2014). Sharing Risk in Part D. Medicare Payment Advisory Commission. Retrieved March 7, 2016, from <http://www.medpac.gov/docs/default-source/meeting-materials/october-2014-meeting-presentation-sharing-risk-in-medicare-part-d.pdf?sfvrsn=0>.
- 6 Medicare Payment Advisory Commission (March 2014). Chapter 14: Status Report on Part D. Report to the Congress: Medicare Payment Policy. Retrieved March 7, 2016, from http://www.medpac.gov/docs/default-source/reports/mar14_ch14.pdf?sfvrsn=0.

The President's proposed FY2017 budget also included a proposal to incrementally reduce federal reinsurance coverage from 80% to 20% over a six-year timeframe.⁷ The Centers for Medicare and Medicaid Services (CMS) did not make any changes to the reinsurance parameters in the 2017 Rate Announcement and Call Letter.⁸ However, CMS did acknowledge increasing specialty and catastrophic drug costs in its Advance Notice proposal (and subsequent implementation) to pay Employer Group Waiver Plans (EGWPs) a prospective reinsurance payment rather than addressing reinsurance payments only through the end-of-year settlement process. Through MedPAC's reinsurance proposal, the President's budget, and CMS's EGWP reinsurance payment change, it is clear that policymakers are cognizant of the significant increases in federal reinsurance costs in the Part D program.

Medicare Part D plan sponsors should consider the following effects if MedPAC's proposal is implemented:

1. Bid amounts will increase, but national average member premiums may not necessarily change initially.
2. Plan sponsors may need to more effectively manage the cost of high-cost members in order to stay competitive.
3. Risk score maximization may become a more important strategy for Part D plan sponsors.
4. The Part D risk score model will need to be adjusted to prevent disruption in the Part D market.
5. Smaller plan sponsors could be subject to higher variability in costs.
6. Rebates will continue to be the most valuable price concession.

- 7 U.S. Department of Health and Human Services. Fiscal Year 2017 Budget in Brief. Retrieved March 7, 2016, from <http://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf>.
- 8 Centers for Medicare and Medicaid Services (February 19, 2016). Advance Notice of Methodological Changes for Calendar Year 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter. Retrieved March 7, 2016, from <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Advance2017.pdf>.

Background

The Medicare Modernization Act of 2003 (MMA) established the prescription drug component of Medicare (Part D) with three mechanisms to mitigate financial risk for Part D plan sponsors:

- **Risk adjustment:** The capitated monthly payments, known as the direct subsidy, from CMS to plan sponsors are adjusted to reflect members' health status.
- **Individual reinsurance:** CMS covers 80% of costs in the catastrophic coverage phase, which begins when a member's annual out-of-pocket costs exceed a predetermined threshold (\$4,950 in 2017). Members are generally responsible for approximately 5% of drug costs in the catastrophic coverage phase, with the plan sponsors paying the remaining 15%.
- **Risk corridors:** Plan sponsors share large Part D gains and losses with CMS.

The initial intent of the risk mitigation programs was to encourage plan participation in a market that was relatively unknown at the time. Prescription drug coverage through Medicare was fairly limited before the Part D benefit was introduced in 2006, so existing data on the potential enrolled population was limited. Furthermore, the defined standard (DS) benefit design was different than commercial prescription drug benefit designs typically offered at the time. Both of these factors increased the degree of pricing uncertainty. In addition, Part D rules prohibit medical underwriting and require level premiums, which creates a risk of anti-selection. With the program now in its 11th year, MedPAC has argued that many of the initial Part D risks have been significantly reduced and there is no longer a need for the full extent of the risk-sharing mechanisms as originally designed.⁹

MedPAC's proposal

MedPAC's June 2016 report to Congress included three sets of policy recommendations that would significantly change the structure of the Part D program.

The first set of recommendations advocates a major overhaul of the federal reinsurance program. Recommendations include the following:

1. Reduce the federal share of costs above the TrOOP limit from 80% to 20%.
2. Eliminate enrollee cost sharing above the TrOOP.
3. Exclude coverage gap discount amounts from TrOOP accumulation.

This set of recommendations has the most significant and direct impact on plan sponsors and is the primary focus of the remainder of the paper.

The second set of recommendations targets low income (LI) enrollee cost sharing. Recommendations include the following:

1. Modify copayments for LI members to incentivize generic usage.
2. Reduce cost sharing for generic, preferred multi-source brands and biosimilar drugs
3. Direct the Secretary of the Department of Health and Human Services (HHS) to determine appropriate drugs for which this policy should apply.

The final set of recommendations is intended to provide additional flexibility for plan sponsors to manage high-cost individuals. It includes the following recommendations:

1. Provide more flexibility in the formulary update process.
2. Require additional support for formulary exceptions.
3. Add unspecified flexibility for plan sponsors to manage specialty drug spend.
4. Remove antidepressants and immunosuppressants for transplant rejection from the six protected drug classes.

Plan sponsor considerations

Below is a discussion of six implications that Part D plan sponsors should consider as they prepare for the potential change to the Part D reinsurance program. Readers should consult MedPAC's report to Congress for a quantification of its proposal.

1. BID AMOUNTS WILL INCREASE, BUT NATIONAL AVERAGE MEMBER PREMIUMS MAY NOT NECESSARILY CHANGE INITIALLY.

Basic member premium for a plan is calculated as the sum of the base beneficiary premium (BBP) and the difference between the plan's bid and the national average bid amount (NABA). That is,

$$\text{basic member premium} = \text{BBP} + (\text{standardized plan bid} - \text{NABA})$$

BBP is calculated by CMS as 25.5% of the sum of the NABA and the national average reinsurance amount. Conceptually, BBP is set such that members pay 25.5% of program costs (excluding LI subsidies) in the form of premiums. Formulaically, BBP is calculated as follows:

$$\text{BBP} = 25.5\% \times (\text{NABA} + \text{national average federal reinsurance})$$

The reduction in federal liability and corresponding increase in plan liability for members reaching the catastrophic coverage phase will certainly increase the NABA and decrease the national average reinsurance. Because costs are shifted from one component of the BBP formula to the other, BBP should not be materially impacted in the absence of changes in plan sponsor or member behavior. MedPAC anticipates plan sponsor behavior may change as a result of its proposal. MedPAC stated that lower reinsurance coverage "would provide stronger incentive to manage drug spending."¹⁰ If plans are better able to manage drug spending, BBP could decrease.

9 Medicare Payment Advisory Commission (November 5, 2015), *ibid*.

10 Centers for Medicare and Medicaid Services (February 19, 2016), *ibid*.

MedPAC has also hypothesized that plan sponsors have been systematically under-projecting reinsurance amounts in recent bid years.¹¹ Currently, federal reinsurance amounts are tried up through a settlement process after year end. Thus, the only negative consequence of under-projecting federal reinsurance is delayed cash flow. If MedPAC's hypothesis is true, then recent BBPs have also been understated. BBP could increase if plan sponsors more accurately or more conservatively project catastrophic costs due to plans being at risk for those costs under the proposal.

2. PLAN SPONSORS WILL NEED TO EFFECTIVELY MANAGE THE COST OF HIGH-COST MEMBERS IN ORDER TO STAY COMPETITIVE.

As discussed above, average basic member premiums may not be significantly impacted by the proposed change in federal reinsurance. However, individual plan sponsors may experience changes in basic member premium due to the second half of the basic member premium calculation, which reflects the difference between a plan's bid and the NABA.

All else being equal, a plan that can manage the costs of high-cost members better than the national average will experience a smaller increase in the plan bid than the NABA increase, which will result in decreased premiums for the plan.

Rebates are an effective cost-reduction mechanism for high-cost enrollees. However, plan sponsors may have little bargaining power in negotiating rebates for some high-cost specialty drugs, particularly when drugs have no therapeutic substitutes. Currently, plan sponsors share a portion of their rebates with CMS to reflect rebates received for drugs covered by the reinsurance program. If approved, MedPAC's proposal will reduce the amount of rebates that plan sponsors share with CMS consistent with the reduced federal reinsurance subsidy.

Step therapy, prior authorization, and quantity limits are also used by plan sponsors to ensure utilization of the most effective, but least costly drug therapies. MedPAC's proposal includes additional flexibility around formulary changes and tools to manage specialty drug spend, but it is unclear how much the additional flexibility could reduce average bid amounts.

3. RISK SCORE MAXIMIZATION MAY BECOME A MORE IMPORTANT STRATEGY FOR PART D PLAN SPONSORS.

Another strategy for mitigating the impact of high-cost enrollees is maximizing risk scores (and therefore direct subsidy revenue) for these members through coding improvement initiatives. Medicare Advantage Part D (MA-PD) plan sponsors have an advantage over standalone prescription drug plans (PDPs) with risk score coding initiatives. Both Part C and Part D risk scores are based on medical diagnoses. MA-PD plan sponsors coordinate medical and pharmacy benefits and therefore are better able to engage providers in optimizing diagnosis capture. MA-PDs have historically focused efforts on maximizing Part C risk scores, but may consider investigating efforts that specifically target Part D risk scores. PDPs, on the other hand, do not have access to medical diagnoses and thus cannot engage in similar efforts.

11 Medicare Payment Advisory Commission (June 2016), *ibid*.

The MedPAC proposal to reduce federal reinsurance subsidy payments would shift funding from the reinsurance component, which is ultimately paid to plans based on actual claims, to the direct subsidy, which is paid prospectively on a risk-adjusted capitated basis. If the MedPAC proposal is approved, MA-PD plan sponsors will have a greater opportunity to increase direct subsidy revenue for enrollees through risk score maximization.

4. A CORRESPONDING CHANGE TO THE RISK SCORE MODEL IS NEEDED TO PREVENT DISRUPTION IN THE PART D MARKET.

The CMS RxHCC risk score model is based on expected plan costs under the DS benefit and is calibrated using prior years' claims data. The current risk score model assumes approximately 15% plan liability in the catastrophic phase. If the reinsurance subsidy is modified, a corresponding change in the Part D risk score model would be required to align risk scores with plan liability under the revised reinsurance parameters.

The risk score model may also need to be updated to better reflect emerging high-cost treatments. Such treatments have contributed to the recent increase in federal reinsurance and are expected to continue to drive trends in the near future. If new high-cost treatments are not reflected in the risk score model, then risk scores will understate the cost of members using high-cost treatments. This is a more significant risk to plan sponsors under the proposed reinsurance parameters, where plan sponsors would be responsible for the majority of costs in the catastrophic coverage phase.

If the risk score model is not updated appropriately, plan sponsors with a disproportionate share of members requiring high-cost treatments could be disadvantaged either through higher-than-expected costs, higher premiums than competitors, or financial losses. This development could create an incentive for plan sponsors to avoid low-income members or other potentially high-cost members. MedPAC recognized this risk in its June 2015 report to Congress.¹²

5. SMALLER PLAN SPONSORS COULD BE SUBJECT TO HIGHER VARIABILITY IN COSTS.

As mentioned previously, plan sponsors are currently responsible for approximately 15% of gross costs after members reach the catastrophic coverage phase, and manufacturer rebates may offset a portion of those costs. Because of the current federal reinsurance protection, moderately adverse selection in the form of individual high-cost members is unlikely to have serious negative financial implications, even for smaller plan sponsors. However, the proposed increase in plan liability for catastrophic costs could change that dynamic.

12 Medicare Payment Advisory Commission (June 2015). Report to the Congress: Medicare and the Health Care Delivery System. Retrieved March 7, 2016, from <http://www.medpac.gov/docs/default-source/reports/chapter-6-sharing-risk-in-medicare-part-d-june-2015-report.pdf?sfvrsn=0>.

If plan liability increases significantly for high-cost members, smaller plan sponsors may not have the ability or appetite to absorb the risk without additional protection. Plan sponsors may want to seek reinsurance protection through private reinsurance options similar to medical stop-loss coverage or may need to increase margin to provide the capital necessary to protect against greater variability of costs. Either change could increase member premiums. This dynamic is also considered in MedPAC's June 2015 report to Congress.

6. REBATES WILL CONTINUE TO BE THE MOST VALUABLE PRICE CONCESSION.

Many factors are considered in Part D contract negotiations and we do not intend to cover each factor in this paper. One key principle relevant to these negotiations that could be affected by MedPAC's proposal is that rebates are more valuable than an equal amount of discounts.

A major driver of this principle is that plan sponsors are not liable for the bulk of costs in the later phases of the Part D benefit (i.e., gap and catastrophic). The federal government, drug manufacturers, and member cost sharing fund most of the benefit, particularly for brand drugs. Thus, plan liability (and therefore member premium) in these phases is not significantly reduced from lower drug costs at the point of sale. On the other hand, rebates for drugs in the later benefit phases are paid directly to plans and therefore serve to reduce total plan liability and member premiums. Note that a portion of rebates are recouped by the federal government for the federal portion of costs in the catastrophic phase, though as noted above, this portion will be reduced as a result of MedPAC's proposed changes.

The dynamic is especially true in the coverage gap where plan sponsors have little or no liability for brand drugs but retain all

rebates. Excluding coverage gap discounts from TrOOP serves to strengthen the rebate/discount inequality by effectively widening the benefit phase in which rebates are most valuable relative to discounts. Note that the rebate/discount inequality is partially reduced each year until 2020, due to the gradual increase in plan liability (closure of the coverage gap) mandated by the ACA, though there will always be some disconnect because rebates are not shared with members at the point of sale.

Shifting more liability to plan sponsors in the catastrophic phase through federal reinsurance reduction and eliminating member cost sharing could mitigate the rebate/discount inequality in that phase. In total, we expect rebates to continue to be a more effective price concession than discounts if the MedPAC proposal is implemented. However, plan sponsors should consider the changing dynamics of rebates and discounts when evaluating and negotiating contracts.

Conclusion

MedPAC's proposed modifications to the Part D federal reinsurance program could change the financial dynamics for Part D plan sponsors, particularly if appropriate updates are not made to the risk score model. Plan sponsors should prepare for these changes by considering ways to effectively manage costs and maximize revenue for high-cost enrollees.

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