Possible changes to Medicare Part D reinsurance programs

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On January 16, 2015, members of the Medicare Payment Advisory Commission (MedPAC) announced that they may recommend altering aspects of the risk-sharing protections extended by the Centers for Medicare and Medicaid Services (CMS) to Medicare Part D plan sponsors.

According to Commission Chairman Glenn M. Hackbarth, "The [risk-sharing] structure that's in place now may have been appropriate when it was a new program… We're sort of at the point now where we know there are a lot of people that want to be in this market and maybe we ought to be re-evaluating the approach to risk sharing. I have no sense of how difficult that is, but I guess I feel some urgency about getting on with that work. It really seems time to me."[1]

This is not the first time MedPAC has suggested changes to the risk-sharing programs.[2,3] However, the current state of the Part D market, recent attempts to curtail Medicare spending, and large increases in reinsurance payments may increase the likelihood that MedPAC and CMS will implement changes to the Part D reinsurance programs. Implementing such changes will not necessarily result in decreased program spending and may spur an increase in the prevalence of private-sector reinsurance in the Part D market.

Background

In the Medicare Modernization Act of 2003 (MMA), Congress established the prescription drug component of Medicare (Part D). Congress included the following three mechanisms to mitigate financial risk for Part D prescription drug plans (PDPs):

- **Risk adjustment:** Adjustment of direct subsidy payments from CMS to PDPs to reflect beneficiaries' health status
- **Individual reinsurance:** CMS covers 80% of beneficiaries' costs in excess of an annual drug cost threshold
- **Risk corridors:** Sharing of gains or losses between CMS and PDPs

The last two risk mitigation mechanisms—individual reinsurance and risk corridors—are the subject of MedPAC's remarks and the focus of this paper.

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 for Medicare beneficiaries was fairly limited before the advent of Part D, so data on the potential enrolled population was scarce. Furthermore, the defined standard (DS) benefit design was very different from typical commercial prescription drug benefit designs. Each of these increased the likelihood of pricing error. In addition, Part D prohibits medical underwriting and requires level premiums, which create a risk of anti-selection.

While the risk adjustment and individual reinsurance programs provide protection against selection risk, the risk corridor program provides coverage in the event that a plan is significantly underpriced. Because plans also share profits with CMS, the risk corridor program also provides potential cash flow for CMS and serves as a disincentive for plans to overprice.

There are many similarities between these risk mitigation programs and the "3R" protections offered for qualified individual health plans under the Patient Protection and Affordable Care Act (ACA). In fact, the success of Part D risk protections served as a blueprint for the ACA 3Rs.[4]

1 Medicare Payment Advisory Commission (January 15, 2015). Proceedings of Public Meeting. Retrieved February 13, 2015, from http://www.medpac.gov/documents/january-2015-meeting-transcript.pdf?sfvrsn=0.

2 Schmidt, R. & Suzuki, S. (October 9, 2014). Sharing Risk in Part D. Medicare Payment Advisory Commission. Retrieved February 13, 2015, from http://www.medpac.gov/documents/october-2014-meeting-presentation-sharing-risk-in-medicare-part-d.pdf.

3 Medicare Payment Advisory Commission (March 2014). Chapter 14: Status Report on Part D. Report to the Congress: Medicare Payment Policy. Retrieved February 13, 2015, from http://www.medpac.gov/documents/reports/mar14_ch14.pdf.

4 Leida, H. (August 2013). Learning From Medicare Advantage and Part D: Lessons for the Individual Insurance Market Under ACA. Milliman Healthcare Reform Briefing Paper. Retrieved February 13, 2015, from http://publications.milliman.com/publications/healthreform/pdfs/learning-from-medicare-part-d.pdf.

Individual reinsurance

The Part D individual reinsurance program is often compared to specific stop-loss reinsurance as it mitigates a plan's financial risk for any one beneficiary. Under DS coverage, beneficiary coinsurance is reduced to approximately 5% in the "catastrophic phase," which is triggered when a beneficiary reaches the maximum out-of-pocket (MOOP) amount. CMS assumes responsibility for 80% of costs above the MOOP and plan liability is limited to approximately 15%. The Part D MOOP is $4,700 in 2015, which equates to $6,680 in gross drug costs for a low-income beneficiary and approximately $7,062 in gross drug costs for a non-low-income beneficiary in a DS Part D plan.[5]

While the plan is only liable for 15% of claim costs above the MOOP, the total liability can still be significant. Net plan liability above the MOOP represents approximately 16% of the national average bid amount[6] for 2015.

Specific stop-loss coverage differs from Part D individual reinsurance in two ways: Specific stop-loss coverage does not take effect until a beneficiary exceeds an attachment point typically much higher than the beneficiary's MOOP, and the reinsurer often assumes all liability once that attachment point is exceeded.

Risk corridors

The Part D risk corridor program is often compared to aggregate stop-loss reinsurance as the risk corridor program serves as a protection for total loss across entire plans. The total cost for DS coverage is compared to costs that were predicted in their bids (and used to develop premium rates). If a plan's actual costs associated with DS coverage differ from expected by more than 5%, then half of the losses (or profits) between 5% and 10% are shared with CMS. If actual costs differ from expected by more than 10%, then 80% of the losses (or profits) in excess of 10% are absorbed by CMS. Note that these parameters have remained unchanged since 2008 despite authority granted to CMS by the MMA to change the parameters.

Aggregate stop-loss coverage differs from Part D risk corridors in two ways: aggregate stop-loss coverage typically only has a single attachment point and is typically only one-sided (i.e., no sharing of gains).

Relevance of initial risk mitigation program goals in current Part D environment

As we enter the 10th year of the Part D program, MedPAC has publicly questioned whether the initial program risks addressed by the risk corridor and individual reinsurance programs are still relevant.

Concern about lack of data and unusual benefit design is less significant for current plan sponsors than in the early years of Part D. The program now has nine years of data and many carriers have been involved in the market since the beginning. Carriers and consulting firms have developed sophisticated models to summarize historical data and adjust for anticipated changes such as benefit design, drug cost inflation, formulary changes, emerging therapies, generic launches, and contractual changes with pharmacies or pharmacy benefit managers. Small and new plan sponsors would still face these risks, though to a lesser degree than the initial entrants faced in 2006.

Fear of anti-selection is also less significant due to the popularity of the program and current enrollment rates. According to MedPAC's most recent data book, almost 90% of Medicare beneficiaries are enrolled in either a Part D plan or some other form of creditable coverage (coverage at least as rich as DS, often provided by an employer or government program).[7] Individual plans may still experience anti-selection, but the impact of systematic anti-selection is minimal with such a high participation rate.

Indicative of plans' historical ability to manage costs relative to expected is the fact that the risk corridor program has been a net receivable for CMS most years since the inception of Part D.[8] That is, in aggregate, costs are frequently near or lower than plans' expectations. Not only did the Part D risk mitigation mechanisms moderation of certain risks result in a robust marketplace, they also continue to encourage new plan participation. Federal risk mitigation is an attractive feature for potential new entrants.

Concern about costs associated with catastrophic individuals is still relevant in the current Part D environment, especially in light of recently released Hepatitis C drugs (Sovaldi and Harvoni).[9] However, the current individual federal reinsurance program covers much more than catastrophic costs. No standard definition of catastrophic individual exists, but commercial specific stop-loss policies serve as a reasonable benchmark. A typical commercial specific stop-loss

5 Centers for Medicare and Medicaid Services (April 7, 2014). Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Retrieved February 13, 2015, from http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2015.pdf.

6 Centers for Medicare and Medicaid Services (July 31, 2014). Annual Release of Part D National Average Bid Amount and other Part C & D Bid Information. Retrieved February 13, 2015, from http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2015.pdf

7 Medicare Payment Advisory Commission (June 2014). Section 10: Prescription Drugs. A Data Book: Health Care Spending and the Medicare Program. Retrieved February 13, 2015, from http://www.medpac.gov/documents/publications/jun14databooksec10.pdf?sfvrsn=1.

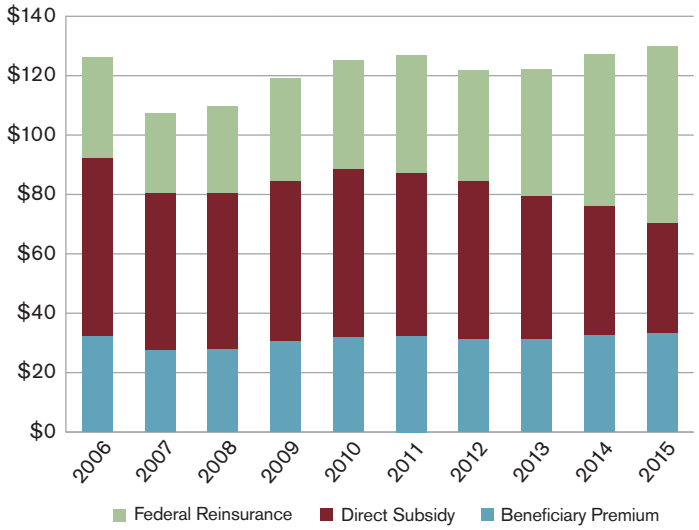
8 Medicare Payment Advisory Commission (March 2014). Chapter 14: Status Report on Part D. Report to the Congress: Medicare Payment Policy.

9 Kaczmarek, S. (July 2014). The Impact of New Hepatitis C Drug Therapy on individual Medicare Part D Spending. Milliman Client Report prepared for Pharmaceutical Care Management Association. Retrieved 18 February, 2015, from http://www.pcmanet.org/images/stories/uploads/2014/partdpremiumstudymilliman.pdf.

attachment point would be expected to capture less than 1% of beneficiaries and 10% of total spending. Contrast this with the Part D individual reinsurance threshold, which even back in 2012 captured about 8% of Part D beneficiaries[10] and 20% of gross drug costs.[11]

As shown in Figure 1, reinsurance costs have trended substantially higher than total spending. According to MedPAC, expenditures for individual reinsurance have grown by 143% between 2007 and 2013.[12] Direct subsidy payments have only increased by 12% over the same time period.[13]

FIGURE 1: NATIONAL AVERAGE BID AMOUNTS



Potential changes

Before discussing potential changes to the risk corridor or individual reinsurance programs, it is important to understand Part D payment mechanics. In early June, each plan submits a bid to CMS for the following plan year. The bid contains projected costs for DS coverage for an average risk population and costs expected to be reimbursed through the individual reinsurance program. CMS computes the national average bid amount (NABA) as well as the national average projected reinsurance amount. CMS then sets the national average member premium (NAMP) at 25.5% of the sum of these two averages. Basic beneficiary premium for a plan is set as the sum of NAMP and the difference in the plan's bid and the NABA. CMS subsidizes plans via a direct subsidy that is equal to the plan's bid, adjusted for the risk profile of the plan's enrolled beneficiaries, less basic beneficiary premium.

MedPAC has suggested two potential changes to the risk corridor program: reducing the sharing percentages or increasing the size of the corridors.[14] Given that the risk corridor program has historically been a source of revenue for CMS, one might assume elimination of or reductions to risk-sharing parameters would result in increased Part D expenditures. But there is no guarantee that this trend of over-projecting costs will continue.

Conventional wisdom says that plans would increase margins (and therefore premiums) to account for the added risk of large losses. Plans could retain the added risk or seek similar protection in the private reinsurance sector. Unlike the federal risk-sharing program, private reinsurance coverage would not be free. But it would also allow plans the ability to retain large profits.

CMS has a few options for revising the individual reinsurance program. It could increase plans' liability of claims in excess of the MOOP, an option proposed in MedPAC's October 2014 meeting.[15] CMS could also establish an attachment point for individual reinsurance that is separate from and higher than the MOOP. Neither of these program changes would impact beneficiaries' cost sharing as the changes would merely shift liability from the individual reinsurance program to basic coverage provided by the plan. Furthermore, neither change would necessarily result in savings for the Part D program as a whole because the reduction in individual reinsurance would be offset by an increase in direct subsidy payments to plans.

While an increase in plan liability above the MOOP might not directly impact CMS Part D expenditures, MedPAC has hypothesized that such a change could incentivize plans to better manage the costs of high-cost beneficiaries. This is especially relevant in the current Part D environment, where high-cost specialty drugs have rapidly become a large portion of total drug spend. Some specialty drugs such as Sovaldi can catapult beneficiaries above the MOOP in just one month.[16]

Alternatively, CMS could substantially increase the MOOP and increase the size of the so-called coverage gap. Because of provisions in the ACA, beneficiaries' coverage in the gap is actually much richer than it has been historically and will be equivalent to pre-gap benefit levels (25% coinsurance) by 2020. Substantially increasing the MOOP would increase cost sharing between the old and new MOOP values for high-cost non-low-income beneficiaries. The difference in coinsurance would be 20% in 2020 when the ACA coverage gap closure is fully phased in (25% in the gap compared to 5% in the catastrophic phase). It would also increase the pharmaceutical industry's liability for brand drug discounts under the coverage gap discount program. In the short term, each of those could directly reduce Part D expenditures by shifting the liability to beneficiaries and pharmaceutical manufacturers that fund the coverage gap discount program.

10 Medicare Payment Advisory Commission (June 2014). Section 10: Prescription Drugs. A Data Book: Health Care Spending and the Medicare Program.
11 Medicare Payment Advisory Commission (March 2014). Chapter 14: Status Report on Part D. Report to the Congress: Medicare Payment Policy.
12 Schmidt, R. & Suzuki, S. (October 9, 2014). Sharing Risk in Part D. Medicare Payment Advisory Commission.
13 Ibid.
14 Ibid.
15 Ibid.
16 Kaczmarek, S. (July 2014). The Impact of New Hepatitis C Drug Therapy on individual Medicare Part D Spending.

Low-income beneficiaries would not be meaningfully impacted by an increase to the MOOP, as their copays are limited regardless of coverage phase. Reductions in individual reinsurance for these beneficiaries would likely be offset by additional low-income cost-sharing subsidy or direct subsidy payments.

Private reinsurance options

Modest increases in the individual reinsurance attachment point are unlikely to cause plans to seek private specific stop-loss coverage. As discussed above, the current individual reinsurance program covers much more than catastrophic costs. Plan sponsors are unlikely to require coverage for this risk and will likely be unwilling to pay margin on risk that is mostly predictable.

Elimination of the individual reinsurance program or an increase in plan liability in the catastrophic coverage phase may prompt plan sponsors to consider private reinsurance options, particularly if federal risk corridor protection is also reduced.

Private sector specific coverage could take many forms. Some plans may seek traditional specific stop-loss coverage to protect against extremely high-cost individuals. Attachment points would likely be set much higher than the current federal threshold, as low attachment points would likely be prohibitively expensive. Other plans may opt for a less expensive variation of specific stop-loss coverage that includes an aggregating specific deductible. This type of coverage works like specific coverage, except that the reinsurer only reimburses the plan after total specific recoveries exceed the aggregating specific deductible. It provides a plan with protection against many high-cost individuals without charging them for unneeded coverage of a few high-cost individuals.

Elimination of the risk corridor program may also prompt some Part D plan sponsors to seek aggregate coverage in the private sector. Aggregate stop-loss coverage is an option that would limit total losses. Unlike the federal risk corridor program, aggregate stop-loss coverage typically only transfers negative risk (reinsurers protect plans from losses, but do not share profits), so plans would need to pay a premium for the coverage. Premiums would be higher for small and new plans, which could be a detriment for small plans or new plans entering the market.

An alternative to aggregate stop-loss coverage is quota share reinsurance. Standard quota share arrangements split profits and losses pro rata between carriers and reinsurers. Because of the potential upside for reinsurers, quota share reinsurance doesn't charge a separate premium like aggregate stop-loss coverage. The downside for carriers is forfeiting a portion of profits.

Reinsurers may also be amenable to arrangements that combine elements of aggregate stop-loss and quota share coverage to mimic current federal risk corridors. Such coverage would not necessarily be free like the current federal program, but has the potential to be less costly than traditional aggregate stop-loss coverage.

Conclusion

It is yet to be determined whether MedPAC will recommend changes to the structure of the risk corridor or individual reinsurance programs and if CMS would act on any recommendations. What is clear is that the initial goals of the programs have been met and costs associated with providing them (particularly the individual reinsurance program) are increasing drastically. Only an increase in the MOOP would be guaranteed to reduce federal Part D expenditures. Other changes would shift the risk of high-cost individuals from CMS to plans, but only seem likely to reduce federal Part D expenditures if plans react by more actively managing costs of high-cost beneficiaries. Plans may seek reinsurance coverage in the private market if CMS eliminates or scales back its risk mitigation programs.

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