Sharing risk in Medicare Part D

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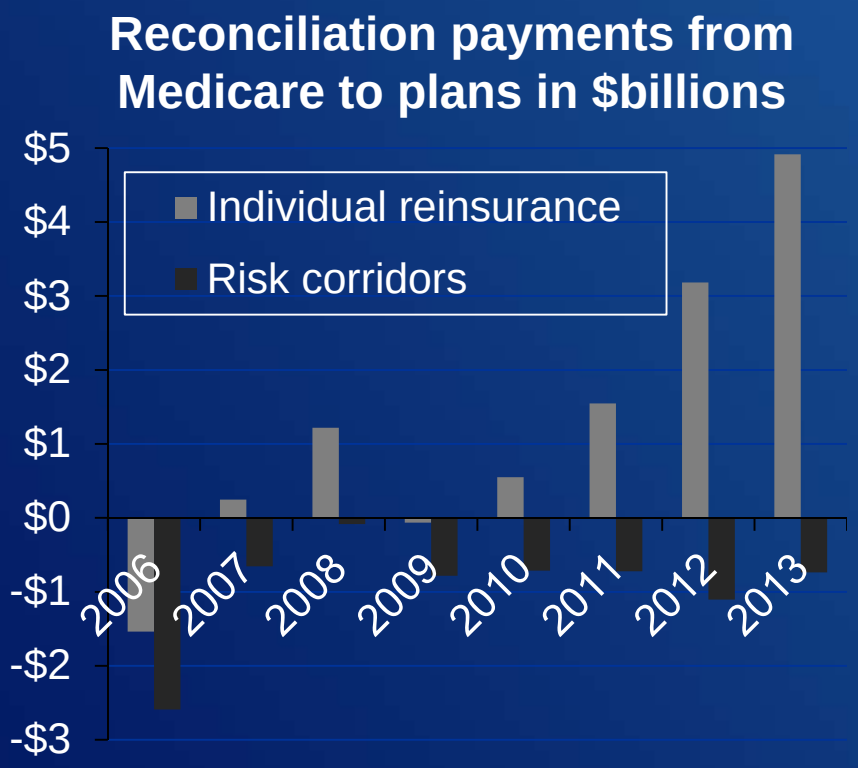
Roadmap

- Recap from March 2015 meeting
- Potential effects of lowering Medicare's individual reinsurance
- Feedback from private reinsurers
- Potential changes to risk corridors
- Medicare's medical loss ratio requirements
- Next steps

Mechanisms for and objectives of risk sharing in Part D

Mechanism	Objective
Direct subsidy: Medicare's subsidy that lowers premiums for all enrollees. Medicare pays plans a monthly capitated amount.	Plan sponsors manage enrollees' benefit spending because the sponsor loses money when spending is higher than payment + enrollee premium.
Risk adjustment	Counters the incentive for sponsors to avoid high-cost enrollees
Individual reinsurance	Counters the incentive for sponsors to avoid high-cost enrollees
Risk corridors	• Initially used to establish the market for stand-alone drug plans • Protection against unanticipated benefit spending (e.g., introduction and wide use of a high-cost drug)

Patterns of reconciliation payments



Source: MedPAC based on data from CMS.

Data are preliminary and subject to change.

- Individual reinsurance
  - Sponsors underbid on catastrophic spending
  - Medicare paid plans
- Risk corridors
  - Sponsors overbid on rest of covered benefits
  - Actual benefits often 90% of bids or lower
  - Plans paid Medicare

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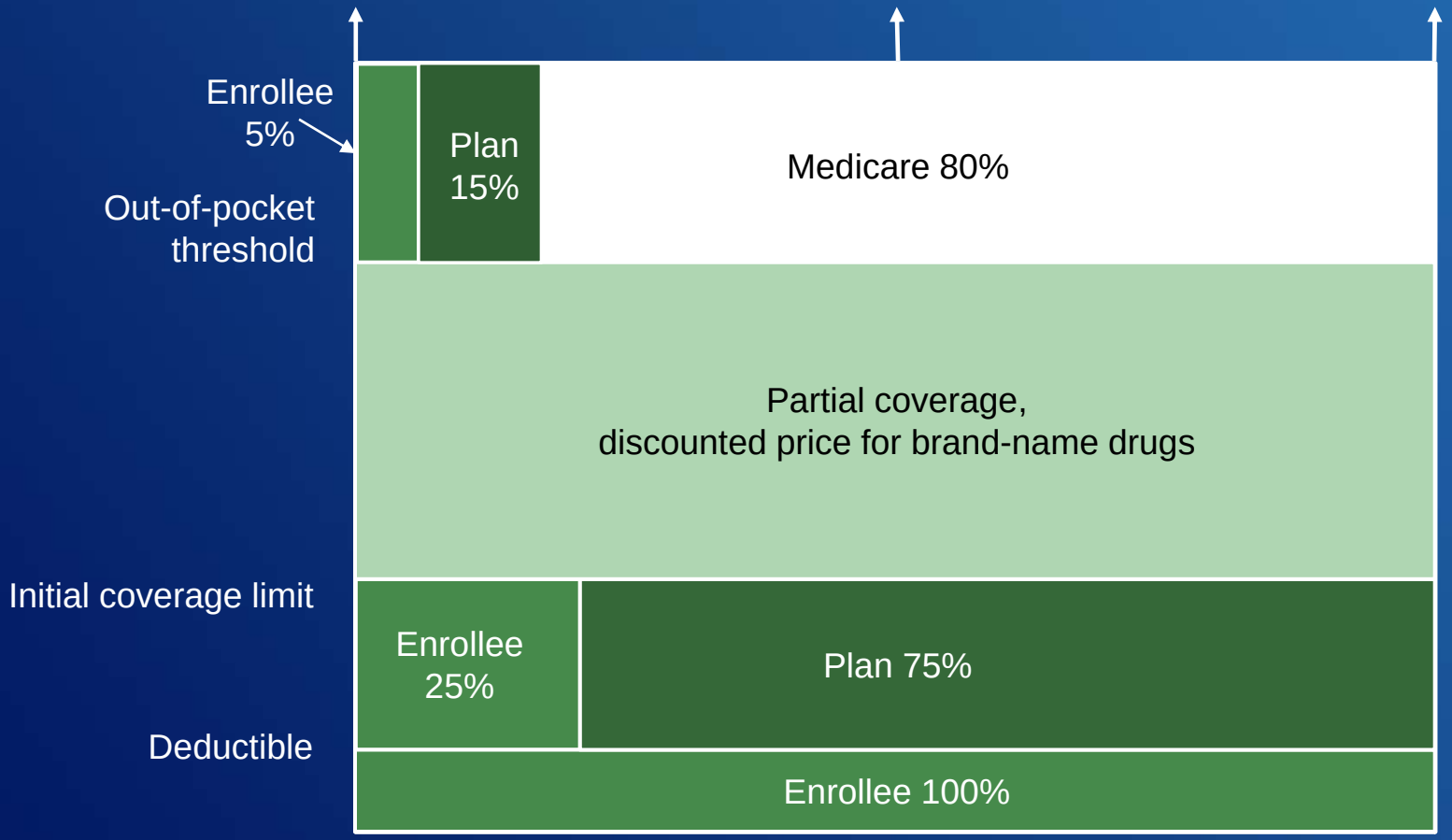
An advantageous way to bid?

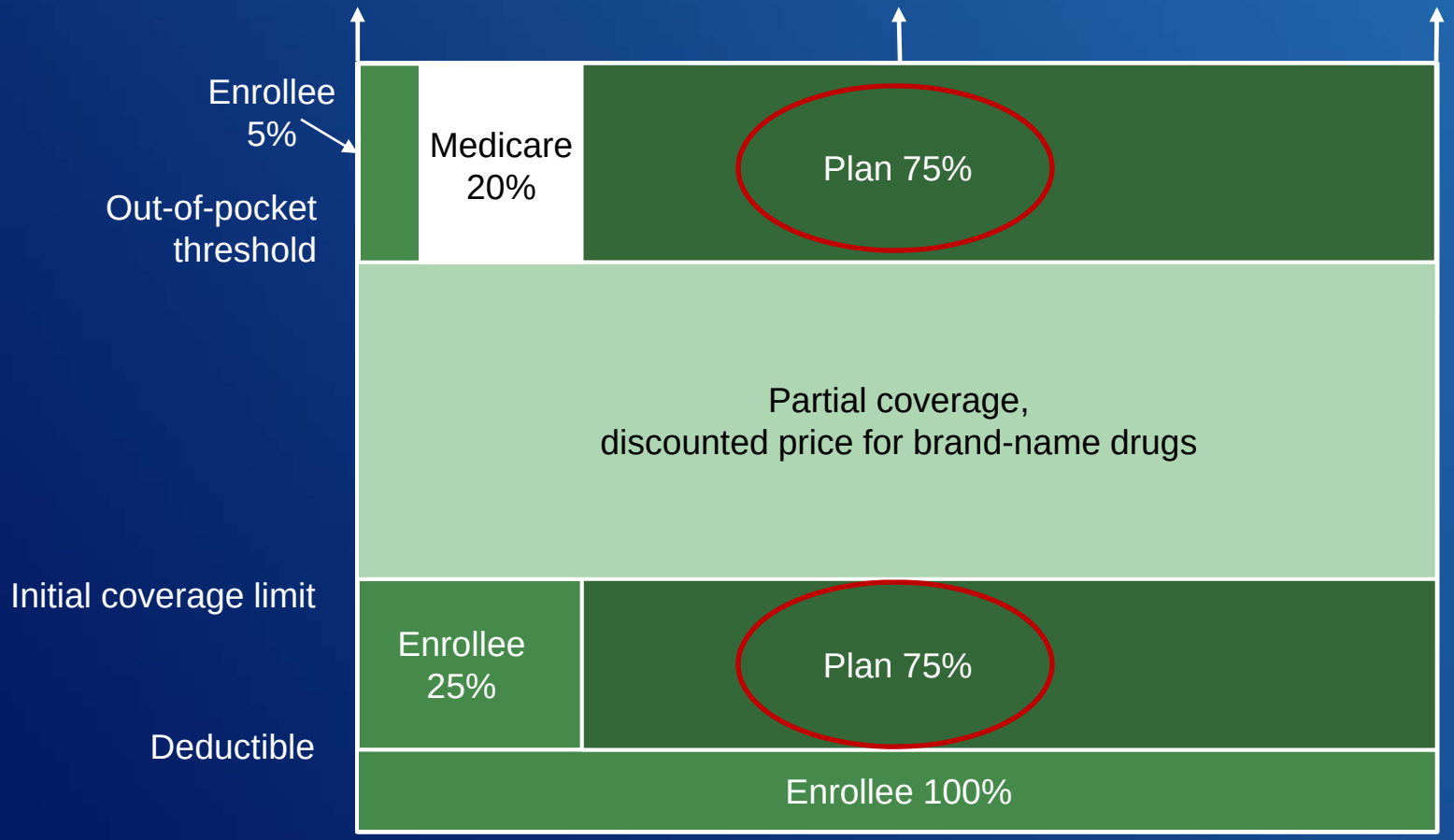
- Underestimate catastrophic spending
- Overestimate rest of benefit spending
  - ✓ Competitive premium
  - ✓ Recoup most of the cost "over-runs" above catastrophic threshold at reconciliation
  - ✓ Retain some "excess" profits above those already in bid
  - ✗ Lower cash flow due to lower prospective reinsurance payments

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



Note: OOP (out of pocket).

One option: Medicare pays for 20% of benefits above the OOP threshold



Note: OOP (out of pocket).

Example of effects of lower Medicare individual reinsurance on premiums

Hypothetical example assuming no behavioral changes	Medicare's reinsurance above catastrophic limit	
	80% above the limit	20% above the limit
Medicare reinsurance	$40.00	$10.00
Plan's at-risk benefits:		
Above the limit	$7.50	$37.50
Rest of benefit	$52.50	$52.50
Total	$60.00	$90.00
Total benefit cost	$100.00	$100.00
Enrollee premium	$25.50	$25.50
Medicare subsidy:		
Direct subsidy	$34.50	$64.50
Reinsurance	$40.00	$10.00
Total	$74.50	$74.50

- Same 74.5% Medicare subsidy, but more through capitated payments
- Potential behavioral effects:
  - Downward pressure on cost because of greater incentive to manage benefit spending
  - Upward pressure on cost because plans may need to reflect a risk premium or buy private reinsurance

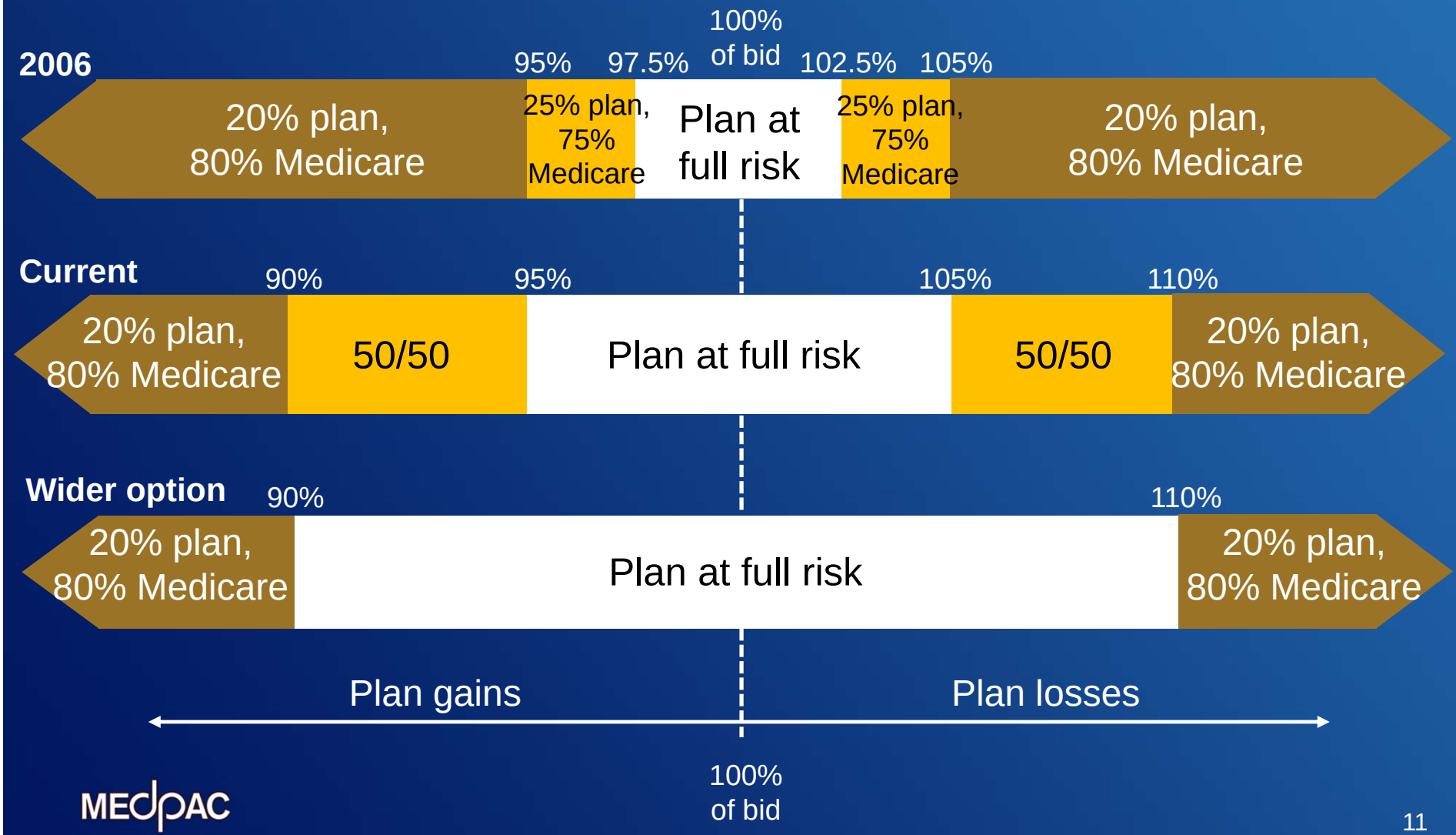
Effects on bidding incentives?

- Lower Medicare reinsurance would not eliminate incentives to underestimate catastrophic spending in bids
- But dollar amount of Medicare's reinsurance would be smaller, so financial advantage of underestimating reinsurance would be smaller too

Could plan sponsors purchase private reinsurance?

- Most Part D sponsors are large insurers that can likely reinsure themselves
- Conversations with private reinsurers:
  - Already have contracts in place with smaller regional Medicare Advantage sponsors
  - Reinsurance for drug spending could be included with coverage of medical spending or stand-alone
  - Individual reinsurance used more commonly than aggregate reinsurance (one-sided risk corridor to protect against losses)
  - Would likely use higher threshold for individual reinsurance or wider corridors than Medicare

Part D risk corridors could be removed or restructured



Potential changes to risk corridors

- In isolation, removing risk corridors would mean sponsors bear more risk, have greater incentive to manage benefits
- In practice, effects of risk corridors and individual reinsurance are interrelated
  - Corridors have constrained overpayments and profits
  - Removing corridors would be considered a cost in legislative scoring
- Might want to keep corridors in the near term, consider widening or removing them in the long term

Medical loss ratio (MLR) requirements

- As of benefit year 2014, CMS evaluates Part D and Medicare Advantage MLRs
  - Benefit claims and quality-improving activities must be greater than or equal 85% of revenues
  - If MLR < 85%:
    - Sponsor must return the difference to Medicare
    - If not in compliance over consecutive years, contract subject to sanctions or termination
- Similar role as a one-sided risk corridor: constraint on administrative costs and profits
- Definition of MLR affects how binding it will be

LIS enrollees not distributed equally

- About 30% of Part D enrollees get LIS
- Among top 20 PDP plans in 2014:
  - 10 had 25% or fewer enrollees with LIS
  - 6 had 75% or more enrollees with LIS
- Changes to risk sharing could affect incentives to enroll individuals with LIS
- Calibration of risk adjusters is very important

Next steps

- Your comments on this work
- June 2015 chapter
- For the Fall 2015 – Spring 2016 cycle:
  - Continued discussion of policy options for sharing risk
  - Revisit 2012 recommendation on LIS cost sharing