



AMERICAN ACADEMY *of* ACTUARIES

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Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Medicare Part D – Lessons Learned

Dear Ms. Block -

In December 2003, the passage of the Medicare Modernization Act (MMA) resulted in the addition of a new “Part D” to the Medicare program to provide pharmacy benefits. The MMA reflected many compromises and new ideas for managing Part D, including extensive involvement of the private market. The year 2006 was the first year of operation for Medicare Part D, and the program was successful in attracting health plans and other entities to participate and individuals to enroll. About 90 percent of Medicare beneficiaries had some type of drug coverage in 2006.¹ The program also included many new administrative requirements and features. While some aspects of the program operated smoothly, others did not, leaving areas for improvement and fine-tuning.

On behalf of the American Academy of Actuaries’² Part D Lessons Learned Work Group, I would like to offer the following observations of what has worked well and what has not. Based on those observations, this letter also offers recommendations to improve the overall operation and administration of the Part D program. Specifically, some of the areas needing additional refinement include the bidding process, management of eligibility, and coordination with Medicaid and with the Social Security Administration.

PART D PROGRAM RESULTS

Plan Choices

Medicare Part D has been an overall success in terms of the number of sponsors and level of beneficiary choice. Initial concerns that only a few sponsors would submit bids or that beneficiaries would only be able to select from a limited number of plans have proven to be unfounded. More than 1,400 prescription drug plans were offered in 2006 and most beneficiaries had more than 40 different plans to choose from. For 2007, the total number of plans increased to near 1,900, with most beneficiaries having 50 or more plan choices. The number of Part D sponsors offering nationwide plans increased from 10 in 2006 to 17 in 2007.³

A potential drawback to the vast number of beneficiary plan options was that seniors could have been overwhelmed and opted not to enroll in Part D at all. However, the CMS enrollment figures for 2007 show that:

¹ The Kaiser Family Foundation. “Medicare: Prescription Drug Coverage Among Medicare Beneficiaries,” June 2006.

² The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

³ The Kaiser Family Foundation. “The Medicare Prescription Drug Benefit – An Updated Fact Sheet,” November 2006.

- 24 million Medicare eligible beneficiaries either elected Part D coverage, were auto-enrolled in a Prescription Drug Plan (PDP),⁴ or receive Part D coverage through Medicare Advantage (MA-PD) plans;
- 7 million beneficiaries have creditable drug coverage through employer plans, which receive the retiree drug subsidy mandated in the MMA; and
- 8 million beneficiaries have creditable drug coverage through various other sources such as federal employee and military plans.

In total, CMS announced that more than 39 million or 90 percent of all Medicare beneficiaries had some type of prescription drug coverage in 2007.⁵

During the 2006 bidding process, CMS was concerned with the abundance of plans being submitted and limited each PDP sponsor to no more than three plan options in each region. During the 2007 bid process, CMS initially indicated that it might reduce this to only two plan options for 2007. However, the final requirement for 2007 was that a third plan could be offered, but only if it contained an enhanced benefit with coverage in the gap.

Despite this requirement, few sponsors offer full benefits in the coverage gap in 2007. These plans require significantly higher premiums for several reasons:

- The government catastrophic reinsurance does not become available until a higher level of total drug spending, since the member's true out-of-pocket maximum (TrOOP) is reached later (i.e., the supplemental coverage reduces the government reinsurance cost burden).⁶
- The cost of the additional coverage includes the impact of induced utilization on costs below the coverage gap.
- Adverse selection is likely because drug costs are easier to predict than medical costs, coupled with the fact that beneficiaries may change their plan choice each year. The risk-adjusted payment mechanism does not apply to the supplemental premium and likely does not adequately address the impact of adverse selection.

According to widely reported accounts, given this competitive environment, some seniors have been confused or frustrated with their options. To address this, CMS might consider imposing additional structure around the program. Options may include further limits on the number of plan options a sponsor may offer or restricting plan designs. Also, with many regions not having any plan options with full coverage in the gap, CMS may consider adopting regulations that would encourage such coverage.

Another potential concern is that the program may have been too successful in attracting bidders. Some PDP sponsors may not be adequately prepared to administer the Part D benefit. This could lead to inadequate member services. In a worst-case scenario, ill-prepared sponsors may not enroll adequate membership, which may cause adverse financial results or possible insolvency.

Some of the areas being discussed for potential program modifications include:

- Government price negotiations with pharmaceutical companies and/or pharmacy benefit managers
- Elimination or narrowing of the coverage gap
- Creation of a government-sponsored nationwide PDP to compete with private PDPs

⁴ The term "PDP" will be used throughout this paper if the comment applies only to PDPs. If the comment applies to both PDPs and MA-PDs, the terms "Part D plan" or "Part D sponsor" will be used.

⁵ Issue Brief No. 817 by the National Health Policy Forum at http://www.nhpf.org/pdfs_ib/IB817_PDP_11-08-06.pdf has additional background regarding plans offered and enrollment in Part D.

⁶ If the Part D plan participated in the Part D payment demonstration, catastrophic coverage is reached at the same point as the defined standard plan design.

- Lowering the asset test to increase low-income entitlement to coverage

Benchmarks and Member Premiums

Another favorable Part D outcome has been the dollar level of the bids submitted. Competitive bids determine the amount of revenue Part D sponsors receive, using a legislatively prescribed formula to determine the portion paid by the government and the portion paid by individuals. Most initial projections estimated that Part D member premiums in 2006 would be between \$35 and \$40. The actual bids submitted for 2006 were, on average, significantly lower than projected. The national average base beneficiary premium for 2006 was \$32.20, with individual plans varying from \$1.87 to \$104.89.⁷

These lower than expected bids set the stage for sponsors to bid more aggressively in 2007. Aggressive bidding was also contemplated because the MMA called for the 2007 benchmark to be determined using the average of all bids weighted by the enrollment of each sponsor. This differed from the 2006 benchmark calculation methodology, which used the arithmetic average of the bids since no enrollment experience was available.⁸ Since beneficiaries tended to enroll in lower-premium plans, it was expected that the portion paid by CMS would decline from 2006.

Recognizing that this decline would directly translate into higher member premium, CMS mitigated the impact of member premium increases using a demonstration program to transition the national average benchmark calculation from 2006 to 2007. The result was a 2007 base beneficiary premium of \$27.35, based 80 percent on the arithmetic average of the bids and 20 percent on the weighted average of the bids. In 2007, member premiums range from \$9.50 to \$135.70. Without this demonstration, direct subsidy payments from CMS would have been lower and resulting member premium increases from 2006 to 2007 would have been higher by \$2 to \$5 per month. To date, CMS has not indicated the calculation methodology applicable for 2008.

In addition to the Part D national average benchmark demonstration, CMS also announced a demonstration for the calculation of the regional low-income benchmark premium subsidies. Under this demonstration, the low-income benchmarks were calculated using arithmetic averages (as done in 2006), rather than the enrollment-weighted average approach called for in the MMA. If this had not been done, many low income beneficiaries would have had to change PDP plans since many of the plans they were auto-enrolled into in 2006 would have had premiums above the low-income benchmark in 2007. Of course, the disadvantage is that CMS will pay higher low-income premium subsidies in 2007 than it otherwise would have. Again, CMS has not announced whether the demonstration will be continued for 2008.

CMS estimates that the two demonstrations combined will increase payments to Part D sponsors by approximately one billion dollars in 2007.⁹ The relative merits of limiting member premium increases or low-income enrollment disruption versus a higher taxpayer burden should be debated, as a decision should be made soon on whether to continue these demonstrations in 2008. This is critical information that actuaries working on Part D plans need to know when preparing their 2008 bids.

Operational Challenges

Both CMS and Part D plans faced significant challenges in the initial year of the Medicare Part D program. As with any new government program of this magnitude, some issues are to be expected and should be resolved over time. With that said, some of the issues could be readily addressed through guidance from CMS or additional regulations, and Part D plans are expected to push for resolution to these issues sooner rather than later.

⁷ The member premium for a specific Part D plan is equal to the national average base beneficiary premium plus or minus the difference between the bid for that plan and the national average monthly bid amount (referred to as the national benchmark).

⁸ The exception to this approach was for MA-PDs, which were weighted in the calculation using existing MA enrollment.

⁹ See page 247 of the transcript of the MedPac meeting on November 8-9, 2006 at http://www.medpac.gov/public_meetings/transcripts/1108_1109_medpac.final.pdf.

Several issues associated with the statutory and regulatory requirements came to light as the program was implemented in 2006. In addition, there were shortfalls in the execution of a few key areas. A few of the key issues are highlighted below:

- **Timelines** – The timeline established under the Part D program for bidding, enrollment and other functions has been a significant challenge for many Part D plans. Consider the following issues:
 - *Part D bid forms, bid instructions, and benefit parameters, among other items, are not released until the first week of April.* This is a mere two months before the final bids are due. Additionally, CMS has issued guidance regarding bidding very close to, and even after, the final bid due dates in 2006 and 2007. For future years, it will be crucial to set feasible rules of bidding upfront with enough time for Part D plans to analyze and understand the rules in order to make appropriate adjustments.
 - *Employer Group Waiver Plans (EGWPs – also known as 800 series plans) cannot be quoted before the release of the national average bid and premium amounts.* This is a concern for many Part D plans, as large employers demand final premium quotes well in advance of the effective coverage date. The timing of the release of the national averages (August), which dictates the CMS subsidy amounts available under EGWPs, makes this nearly impossible for most large employers with a calendar year plan. A dual effort will be needed to resolve this issue — employers will need to be more patient in getting their final premium quotes and CMS will need to complete its bid review process and calculation of the national averages as promptly as possible.
 - *2006 midyear enrollment worsened financial results for Part D plans.* In 2006, enrollment into the Part D program was allowed through May 15 without penalty. Given the front-loaded nature of the Part D benefit (i.e., Part D plans are responsible for the highest percentage of costs when individuals are in the initial coverage corridor), Part D plans were disadvantaged by having a large portion of enrollees sign on in May, as opposed to January. While some Part D plans anticipated this phenomenon in bidding, many did not and, therefore, had poorer resulting experience (assuming experience matched all other assumptions). This was primarily an issue in 2006 only, as the enrollment extension through May applied only in the initial year of the program.
 - *Limiting marketing and enrollment periods poses staffing challenges for Part D plans.* Under MMA regulations, all PDPs are allowed to market their plans only from October through December and MA-PDs (except Special Needs Plans) are allowed to market their plans only from October through March. Further, open enrollment periods run only from November 15 to December 31 of each year. Part D plans must have staffing and administrative levels that are predicated on the high levels of customer demands during open enrollment. For example, levels of telephone calls typically increase to levels five to 20 times the level outside of the open enrollment period. This is a management challenge, although early experience for the 2007 open enrollment period seems to indicate that communications and enrollment issues were much more manageable than in the 2006 start-up period.
 - *Allowing enrollment through December 31st for coverage taking effect on January 1st is operationally impracticable.* It is unrealistic to expect that a beneficiary enrolling on December 31st will have his/her drug card ready to use at a pharmacy the following day.
- **Lock-in versus pass-through drug pricing** – CMS released guidance on May 19, 2006 stating that all bids must be submitted and all claims must be adjudicated assuming pass-through pricing, which in effect

requires that any pharmacy discount or rebate spreads¹⁰ retained by a pharmacy benefit manager (PBM) or other intermediary be reflected as an administrative cost.

Many PBM arrangements in the marketplace today do contain spreads.¹¹ However, many Part D plans use lock-in pricing for bidding and claim adjudication, meaning that these spreads are ignored. For many Part D plans the lock-in pricing approach provides an advantage¹² in bidding because their administrative costs are lower, more than enough to offset the higher drug costs.

CMS reversed its guidance on June 2, 2006 (three days before 2007 bids were due), allowing Part D plans to utilize either drug pricing approach. This created an uneven playing field for bidding, as noted above, and given the timing, left Part D plans little time to change course if they wanted to.

For 2008 bids, CMS will need to release its final guidance much earlier around this provision and should consider moving to one approach or the other to ensure a level playing field for all Part D bidders.

- **Eligibility and subsidy issues** – Initial enrollment difficulties, especially around automatically enrolled dual eligibles (those eligible for Medicare and Medicaid), left many Part D plans paying for claims on members of other plans, paying claims at the wrong subsidy level, and left some states paying for Part D claims. While some of these issues have diminished, enrollment and subsidy-level discrepancies still exist and may persist into the future. The enrollment timing issue discussed earlier will continue to cause problems. Also, there is typically a three-month lag in determining a person’s eligibility for Medicaid, and the change to the individual’s benefit is always retroactive. While CMS has provided some guidance to Part D plans regarding the reconciliation process for incorrect claims, many Part D plans are still unclear on the guidance and are struggling through the reconciliation process. Clearing up these concerns and ensuring they do not occur going forward should be another critical issue for CMS to address as it seeks broad acceptance of the Part D program from Part D plans and individuals.
- **SSA premium issue** – There were several issues with Part D premium payments from Medicare beneficiaries who elected withdrawals from their Social Security checks, most notably an expensive glitch that led the federal government to mail roughly \$50 million in checks to 230,000 Medicare beneficiaries in August 2006. This highlights the need for the federal government to increase resources and staffing available to CMS to make the Part D program operate more effectively.

Several of these issues have been at the forefront of the publicity that Part D has received at times since it started in 2006. It is important to keep in mind that the shortcomings identified have been largely isolated; overall, seniors are satisfied with the Part D program. Most surveys show that 75 percent or more of seniors are satisfied with their Part D benefit.¹³ It should also be noted that there appears to have been a fairly smooth transition into the second year of the program.

PART D PROGRAM FEATURES AND LESSONS LEARNED

Lesson 1: Market-Driven Benchmarks

The statutory requirement to use a market-driven national average benchmark to determine Part D member premiums has driven intense competition among Part D bidders. There were two main factors generating this

¹⁰ An example of a pharmacy discount spread is when the PBM and pharmacy agree to average wholesale price (AWP) less a 16 percent discount on brand name drugs, the PBM and Part D plan agree to AWP less 14 percent discount, and the PBM keeps the 2 percent spread.

¹¹ Spreads exist most commonly when a Part D plan contracts with an external PBM, as opposed to when the Part D plan owns or is affiliated with the PBM.

¹² This advantage arises since the impact on a bid from higher drug costs is mitigated by member cost sharing, which is roughly 50 percent for a defined standard or equivalent Part D plan.

¹³ The Kaiser Family Foundation. “Kaiser Health Poll Report Survey: Seniors Early Experiences with their New Medicare Drug Plans,” June 2006.

competition: (a) low member premiums attract more price-conscious seniors and (b) dual and low-income beneficiaries¹⁴ are auto-enrolled to PDPs bidding below the low-income benchmark for the region. For 2006, there was a wide range of bids from insurers uncertain of the costs of the market. By the time of submission for 2007 bids, Part D sponsors recognized that low bids were necessary to attract membership and retain auto-enrollees, and this higher membership would generate efficiencies. Though minimal, there was also some early indication of emerging experience. These factors combined led to a greatly compressed range of submitted bids. This lowered the national average benchmark and regional low-income benchmarks and reduced government outlays for the Medicare Part D program.

However, the benchmark calculation mechanism had the somewhat negative, but short-term, consequence of *raising* member premiums for the *lowest* bidding plans in 2007. In 2007, many Part D plans reduced their bids, thus lowering the National Average Monthly Bid Amount. As a result, the average CMS subsidy was reduced. In turn, the residual member premiums were increased for some bidders that originally had low premiums in 2006. As noted above, this effect was somewhat mitigated when CMS used its demonstration authority to postpone full use of membership-weighted average calculations for the national-average benchmark and low-income benchmarks for 2007.

Whether in 2008 or some future year, CMS may ultimately move to the statutory requirement of full-membership weighting in the calculation of both the national and low-income benchmarks. If this is done in 2008 (rather than continuing a gradual phase-in), the national benchmark may drop again as membership weighting fully recognizes that the vast majority of members enroll in the lowest cost plans. Under that scenario, 2008 member premiums may again jump more than expected from trends in cost and utilization due to the effect of re-weighting the national benchmark.

If CMS decides to reflect full membership-weighted values for the 2008 regional low-income benchmarks, then somewhere between 3 million and 4 million dual/low-income members may need to be re-allocated to the low bidding plans. There may be more pressure for the higher-cost plans to reduce their bids, which would further reduce the regional low-income benchmarks. As a result, it appears that CMS, Part D plans, policymakers and dual/low-income beneficiaries should be prepared for a major migration to low-bidding plans. A positive consequence of this action would be another round of savings for the U.S. Treasury.

Lesson 2: Annual Enrollment Period

As written into statute, CMS must hold a single 45-day open enrollment period running from November 15 to December 31 each year for most enrollees. While a single open enrollment period means there can be intensive communication efforts between CMS and Part D plans and beneficiaries, there have been unintended consequences of this particular feature of the MMA:

- Unlike annual open enrollment in most under-65 situations, the last day of the Part D open enrollment is literally midnight before the effective date of new coverage. In contrast, most employers, including the federal government, hold open enrollment periods that end perhaps two weeks to a month before the effective date of new coverage. One of the key challenges for Part D plans is to provide evidence of coverage (ID cards or letters) from the Part D plan that could be used the next day (e.g., January 1). Although likely requiring a change in statute to provide CMS regulatory flexibility, there are at least two solutions:
 - Start and end the open enrollment period two weeks earlier (i.e., from November 1 through December 15 each year); or

¹⁴ Dual and low-income beneficiaries compose over one-third of all Part D enrollment.

- Make new coverage for beneficiaries with an election after, for example, December 24 effective on February 1 rather than January 1.
- The significance of the annual open enrollment period is enhanced because of the MMA’s enrollment lock-in provision:
 - Beneficiaries who are only allowed to enroll during the annual enrollment period are either “locked in” to coverage with their current Part D plan until the end of the year or are “locked out” if they decided to not enroll.¹⁵ This has the positive effect of providing a strong incentive for beneficiaries to enroll. It also limits adverse selection since it prevents beneficiaries from enrolling, or staying enrolled, only when the expected plan payments exceed the member’s expected out-of-pocket costs including premiums. If this were not the case, average premiums would increase, reducing affordability of coverage.
 - Beneficiaries and their advocates must pay attention to potential changes in their current Part D plan. If they miss their opportunity to change Part D plans, they become subject to any formulary or cost-sharing changes made by their current Part D plan. Since Part D plans typically change cost-sharing (because of the indexing of benefit levels) and make formulary or utilization management changes from year to year, this can have cost consequences for beneficiaries.
 - The single open enrollment period and bidding rules create powerful economic incentives to design low-cost plans (encourage use of low-cost drugs, negotiate favorable contracts and maximize rebates), to manage plans efficiently and to bid aggressively. A successful strategy is rewarded by high membership. An overly conservative bid strategy may be penalized by low membership, which may result in higher overhead and reduced ability to offer a competitive plan in subsequent years. This incentive has likely been a major factor in reducing the costs for the Part D Medicare program.

Lesson 3: Risk Corridors

To provide protection and encourage competitive bidding, the MMA provided symmetrical risk corridor protection. For 2006 and 2007, CMS shares first-level risk at 75 percent for results outside a risk corridor that is 5 percent wide around a risk target level.¹⁶ This protection appears to have been a significant reason for the large number of bidders and plans offered. While there are no CMS published results on the financial effects of the risk corridor, anecdotal reports from individual plans indicate that both “loss” and “surplus” risk-corridor payments have been accrued. There were many unknown factors in a new program of this magnitude, and risk corridors appear to have succeeded in providing incentives to participate. They also prevented windfall profits or excessive losses, which may have occurred with a new, innovative program and a paucity of reliable actuarial data on which to base cost estimates.

For 2008 and 2009, the risk corridor widens to 10 percent,¹⁷ and CMS’ share reduces to 50 percent. The bidding rules provide significant incentives to have accurate bids in the risk corridor; otherwise, surpluses are returned to CMS without the benefit of lower premiums. Observers might speculate that this risk corridor protection will become a redundant feature that will not be used by major plan bidders. Some analysts and actuaries believe that bids may possibly become less aggressive since there is less down-side protection. The risk corridors might still be useful if there are new Part D entrants without experience, but the impact on the Part D program and Medicare funding would be minimal if enrollment in new plans is small.

¹⁵ Special enrollment periods at other times of the year are granted to certain beneficiaries (e.g., newly eligible beneficiaries and duals).

¹⁶ The Part D plan is 100 percent at risk for results within +/- 2.5 percent of the target, which is measured based on defined standard benefit costs. The plan’s risk share is reduced to 25 percent (CMS 75 percent) for results in the next 2.5 percent and 20 percent (CMS 80 percent) for experience more than +/- 5.0 percent from the target.

¹⁷ The Part D plan is 100 percent at risk for results within +/- 5.0 percent of the target, which is measured based on defined standard benefit costs. The plan’s risk share is reduced to 50 percent (CMS 50 percent) for results in the next 5.0 percent and 20 percent (CMS 80 percent) for experience more than +/- 10 percent from the target.

Lesson 4: Formularies

A major innovative feature of the Part D program are the incentives to provide formularies that encourage generic and therapeutic substitution and give sponsors bargaining power with pharmaceutical manufacturers for inclusion of their products in preferred tiers (or to cover them at all). Many plan sponsors have used this authority, usually through PBMs, which have responded by designing different levels of formulary restrictions with corresponding levels of rebates. Most sponsors, however, incorporated only moderate restrictions on access to non-preferred products, and usually through charging a higher co-payment rather than exclusion or requiring step therapy. This approach has enabled Part D plans to negotiate higher rebates from manufacturers and achieve much higher utilization of generic drugs.

Greater use of formularies has, however, made an already complex program still more complex. While there were problems explaining the new rules to beneficiaries and ensuring consistent drug therapy when the program began, it is our observation that CMS anticipated and acted on most problems. It required a detailed review of formularies and how they were advertised. CMS reacted quickly to reported difficulties by requiring plans to continue to honor existing prescriptions through March 2006 for beneficiaries who enrolled at the beginning of 2006. CMS and several public-interest groups designed computer programs that determined whether a given plan's formulary included the drugs a prospective enrollee used. Some states also intervened to assure continuity of coverage for low-income individuals. Given the sheer complexity of the new plan designs, the formularies, the major problems in auto and choice assignments, etc., it is remarkable that in our assessment so few instances of patients not being able to obtain needed therapy were reported.

Lesson 5: Plan Choice

One criticism of the Part D program has been that the significant variety of Part D plans offered in each region (averaging approximately 50 per region in 2007) confuses seniors and their facilitators. As noted above, CMS limited the number of plans a PDP could offer in 2007. However, high levels of beneficiary satisfaction may indicate that this high level of choice is not a significant problem for seniors.¹⁸

To the extent that this criticism is valid, however, there may be some options to standardize parts of the Part D benefit structure and thereby reduce the level of confusion. There are several categories of plan benefit features that could be considered for setting standards, including:

- *Cost-sharing amounts* – The defined standard benefit already establishes the required deductible and coinsurance. For all other plans, cost-sharing levels by formulary tier might be restricted to certain ranges (e.g., generic levels between \$0 and \$10, etc.)
- *Number of cost-share tiers in formulary* – As many as seven tiers have been offered. Perhaps a guideline that allows no more than three or four tiers should be adopted.
- *Formulary size* – This is already highly regulated through the required CMS formulary approval process. Further standardization would reduce the leverage that Part D plans use to extract discounts and rebates from drug manufacturers. In fact, the most effective way to reduce the net prices that Part D plans pay for drugs could be to permit more flexibility, especially where close therapeutic substitutes are involved or a drug is heavily advertised.
- *Utilization management techniques* – The MMA explicitly encourages Part D sponsors to use all practical utilization management techniques (prior authorization, step therapy, quantity limits, etc.). While standard descriptions of these techniques might prove useful to beneficiaries, any further restriction might prevent robust cost control of drug costs.

¹⁸ The Kaiser Family Foundation. "Kaiser Health Poll Report Survey: Seniors Early Experiences with their New Medicare Drug Plans," June 2006.

Lesson 6: Coverage Gap

Some observers have suggested that the unusual structure of the Part D coverage, with the large coverage gap, needs to be addressed. Although the coverage gap was designed to help manage the costs of the Part D program, there may be alternatives that Congress, CMS, and other policymakers might consider. There currently are many Part D plans that offer generic drugs only in the coverage gap. While a few regions have Part D plans offering brand drugs in the coverage gap, no national PDP in 2007 offers brand coverage in all regions. (There are two plans that offer brand coverage in 37 states.)

There are budget neutral options for addressing some or the entire coverage gap. For example, one option may be to completely eliminate the coverage gap by using the savings from:

- Raising the current defined-standard deductible significantly (now at \$265 in 2007) to perhaps double that level;
- Reducing the Part D sponsor's coinsurance percentage below the initial coverage limit from 75 percent to perhaps 50 percent (similar to the old Medigap H, I and J plans); and
- Increasing the point at which catastrophic coverage is provided (from the current level of \$5,451.25 in 2007 to perhaps \$7,500) at the current 5 percent member coinsurance.

Other combinations of changes could likely also achieve this budget-neutral objective of eliminating the coverage gap. The major issue is whether beneficiaries would prefer the current "plan that they know" (albeit unique) to one that would have significantly different benefits.

Lesson 7: SNP Premiums

The MMA introduced Special Needs Plans (SNPs) to address the issues of special populations — the frail elderly, dual beneficiaries and certain disease-specific populations. SNPs can limit their membership to only these defined populations, and offer a combination of medical and Part D benefits. Most plan sponsors and their actuaries believe that SNPs, especially dual SNPs, are unlikely to attract a significant enrollment if they charge a premium. However, due to the national and low-income benchmark mechanism, plans cannot know during their planning and bidding period what the resulting premiums will be.

This dilemma can be illustrated using dual SNPs as an example. In developing the bids, the organization projects a best estimate of medical and pharmacy costs, as well as its requirements for administrative costs and gain/loss margin. The organization also makes its own estimate of the national benchmark, probably using various modeling scenarios, in order to project the expected member premium. If the modeling shows that the expected member premium is above the low-income benchmark, the product is likely deemed to be unmarketable and the bid would not be filed.

If the modeling indicates that the product is feasible, a bid would be submitted. However, the submitted bid would probably differ from the preliminary cost projections since there can be no guarantee that the modeling assumptions and resulting expected premiums will be fully achieved. If the final member premiums are actually above the low-income benchmark, even by a couple dollars, the SNP plan is less viable given that very few dual beneficiaries are likely to enroll. Many plans would likely submit a lower bid with a smaller margin in order to mitigate the risk of small, unintended member premiums while still maintaining marketability.

Another reason that the bidding approach is challenging for dual SNPs in particular is that the filed benefits are often intended to complement Medicaid benefits. Therefore, dual SNPs often file Medicare covered benefits and cost-sharing levels or, perhaps, supplemental benefits that are not already covered by Medicaid. During the rebate reallocation process, non-SNP plans may increase member cost sharing or remove supplemental benefits in order to get to the original targeted premium level. There is often less opportunity for the dual SNPs to do this since the

bid was filed at, or close to, the traditional Medicare level. Further, there is no Part D coverage gap for these members and under current rules, plans are not allowed to cover the low-income cost-sharing amounts for these dual members without becoming the primary party for drug coverage in the gap.

Finally, enrollment assumptions are a key factor in estimating administrative costs and therefore impact premium. If the organization cannot achieve the assumed enrollment level because its premium is higher than anticipated (exceeding the low income benchmark for duals in particular), the bid itself is likely no longer adequate.

There has been a large expansion in the number of SNPs offered for 2007,¹⁹ and CMS could consider how to adjust the bidding process to meet the unique needs of SNPs. The current process has the very real possibility that unintended member premiums may undermine an organization's ability to garner sufficient enrollment upon which to build adequate care management programs to meet the needs of these special populations. This environment does not promote CMS's policy goal of bringing these populations under the managed care umbrella.

ACTUARIAL BIDDING ISSUES

Bid Pricing Tool

Part D bids are submitted to CMS using the Bid Pricing Tool (BPT). The BPT is an Excel© spreadsheet that presents various views of experience data, projection assumptions, and projected costs. The complexity of Part D is reflected in the BPT, making it difficult to work with at times. It must present costs based both on the cost sharing tiers of the defined standard plan (even if the proposed plan is not defined standard) and typical drug pricing criteria (generic/brand and retail/mail usage), as well as illustrate compliance with actuarial equivalence tests and the expectation that utilization may shift between defined standard plans and other plans. Due to these complex needs, it may not be possible for CMS to design a BPT in the typical actuarial format where historical experience is adjusted by a series of factors that result in the projected costs. However, CMS should continue to seek ways to make the BPT easier to populate and audit from an actuarial perspective.

After seeking feedback following the 2006 bid process, CMS revised the BPT for 2007. Many improvements were made, but others are still needed. Some suggested areas for further improvement in the 2008 BPT are summarized below:

- The 2007 BPT was modified to allow only administrative expenses to be entered for basic and supplemental costs combined. It then automatically allocates these costs on a pro rata basis. This change should be reversed to allow the user to determine the allocation. For example, CMS user fees would only apply to basic benefits. Or, indirect administrative costs may be more heavily weighted toward basic benefits since these costs would exist whether or not the benefits were enhanced.
- Similar to administrative costs, the 2007 BPT was modified to only allow the gain/loss margin to be entered in total and automatically allocated to basic/supplemental on a pro rata basis. This modification should also be reversed to allow the user to determine the allocation.
- The 2007 BPT required fewer corrections via updated versions than was true in 2006, but still had a number of these. In 2007, CMS also provided a mechanism to more easily update bids from one version to the next, which was a great improvement. But there still were cases of confusion about which version to use, especially those that occurred after the bid submission date. CMS should continue to improve testing of the BPT before release and communication of BPT updates.

¹⁹ There were 276 SNP plans in 2006, and there are 470 in 2007. The Kaiser Family Foundation. "Medicare Fact Sheet: Medicare Advantage," February 2007.

- CMS should also continue to improve technical problems such as rounding errors, which require manual adjustments to get the BPT to pass its internal edit checks before submission.

Historical Data Quality and Limitations

The 2008 bid submission will be the first time CMS expects Part D plans to include historical experience data in the BPT. The historical 2006 data probably will not be used *directly* in the BPT to project future costs, but it is likely that this data will be the basis for the actuarial projection. Although it seems that having experience data available should simplify the actuary's work, the unique circumstances of the 2006 start-up year produce concerns about the quality and appropriateness of that data. Some of the areas where adjustments may be appropriate are:

- The extended 2006 enrollment period (through May) results in a different seasonality pattern than is expected for 2008. The shorter covered time period for those who delayed enrollment in 2006 resulted in fewer members reaching the coverage gap. If a Part D bidder experienced significant enrollment between January 2006 and May 2006, it will be crucial to take this into consideration or projected costs will be misstated.
- The relative risk profile of early versus later entrants should also be considered.
- Part D plans are required to submit Prescription Drug Event (PDE) experience claim data to CMS. The PDE data for 2006 does not need to be finalized until May 2007. If the PDE data is not sufficiently cleaned up early enough to use for the 2008 bid development, an alternative source (or appropriate adjustments) should be made.
- As noted above, there were significant problems in member enrollment issues and the experience claim data may not correctly match revenues. The claims that were subsequently *reimbursed* by other Part D plans should be removed from the experience data. Likewise, missing claim data that was later *paid to* other Part D plans (or states) should be accounted for.
- One of the features of Part D is to allow a transition period from current drug use to the Part D plan's formulary. The magnitude of such claims is likely to be much smaller in subsequent years, and appropriate adjustments should be made.

CMS Guidance for Bid Development

CMS rarely provides explicit guidance concerning assumptions and methodologies in preparing bids. It is inconsistent with the paradigm of competitive bidding to provide ranges of assumptions. The guidance that is provided comes via several formats:

- The CMS website contains the bid instructions and formal announcements of supplemental guidance. Some of these announcements are also released through email alerts on CMS's HPMS system.
- CMS holds regular conference calls for several weeks leading up to the bid submission deadline to communicate its latest decisions and guidelines and to provide a forum for bidders to raise questions. The user calls have been widely praised for providing access to CMS staff.
- An email mailbox is set up for bidders to submit questions, which are then addressed during the user-group calls. (The submitter ultimately receives a response as well.)

This entire process for CMS providing bid guidance could be improved even further as noted below:

- Some guidance provided in the user-group calls is not documented anywhere until the next year's bid instructions, and it is sometimes difficult for actuaries to be sure they are up to date. CMS should provide a written summary of each conference call within a reasonable period.
- There is so much information and data available on the website that the indexing is complicated, making it very difficult to find the information. CMS should continue to work on improving its website.

- A frequent response to questions (either to the email box or in a user-group call) is that “further guidance is forthcoming.” This was perhaps unavoidable in the initial start-up of Part D, but CMS should try to improve on its response time.
- Sometimes questions of an actuarial nature are answered by non-actuaries, and it does not seem that the question has been addressed. CMS should ensure appropriate staff drafts the responses.

There are also a few key areas where actuaries would appreciate clearer guidance:

- The CMS guidance for gain/loss margins states that it will “allow varied gain/loss margins for separate bids offered by an organization, under certain circumstances. The margin variability must be based on bid-specific factors such as risk margins, surplus requirements, taxes, and other key factors used in the development of the organization’s aggregate gain/loss requirement.” There has been much confusion over and varying interpretation of this guidance. Additional clarification is needed, especially on how market positioning and business goals are allowed to be factored into the bid.
- Certain plan designs are expected to affect utilization changes relative to the defined standard plan. For example, enhanced alternative plans may attract higher utilizers of prescription drugs or greater use of higher-cost drugs. Or, plans that do not have a deductible or use co-pays instead of coinsurance may have a different utilization pattern. CMS does not provide guidance on how to determine the shift in drug utilization or cost, and there is very little experience to use as the basis for an actuarial projection. Actuaries have a good idea on the direction of the shifts, but not the magnitude. As part of the desk review process, CMS identifies outliers and requires further justification of the adjustment that was made. Additional guidance is needed on the parameters CMS uses in these reviews.

CMS Rule Changes Following Bid Submissions

In some cases, as noted earlier, CMS made changes after the 2007 bids were submitted. The most crucial changes were on allowed drug pricing methods (lock-in versus pass-through) and the calculation methodology for the national and low-income benchmarks. In some cases, CMS allowed bids to be re-submitted within a very short timeframe. At a minimum, these changes created practical difficulties for actuaries in complying with the short timeframes allowed.

Of most concern, however, is that had the information been known at the time bids were submitted, the bids might have been different. Actuarial projections are not an exact science, whereby there is a single *right value* for each assumption. Rather, “the assumptions should be reasonable in the aggregate and for each assumption individually. The support for reasonableness should be determined based on the actuary’s professional judgment, using relevant information available to the actuary.”²⁰ There is prevailing recognition that there is a valid range for establishing a reasonable assumption and the desired aggressiveness of a bid may determine where on that spectrum to set the assumption. The calculation methodology for the benchmarks would be relevant information that may affect the level of aggressiveness in bid assumptions.

For strategic planning and cost efficiency, it is crucial to have all the rules specified before the bid submission. CMS should commit to full disclosure of all aspects affecting the bids at least one month before the bid submission deadline.

SUMMARY

Despite some start-up issues, in our assessment, Part D appears to have been successfully launched and seniors are generally satisfied with the program. CMS should continue to address remaining operational issues. There have generally been positive lessons learned during Part D’s first year of operation with regard to insurer and

²⁰ ASOP 8: Regulatory Filings for Health Plan Entities, section 3.2.9.

beneficiary participation in the program. The competitive bidding mechanism and rules surrounding formularies appear to have been key factors in holding down costs and member premiums.

Areas where future improvements may be appropriate are timing problems such as providing EGWP premium quotes and issues related to the annual open-enrollment period. CMS may also want to consider restricting plan design features or addressing coverage in the gap. If SNP plans are to continue to be a viable option, it may be necessary to revise how bidding rules apply to them. Most important, it is crucial that all bidding rules be known well in advance of the bid submission deadline.

The Part D program has been successful in gaining beneficiary interest, beneficiary coverage, and providing choice. Its lessons might be useful in the current debate of reform efforts to address the issue of high numbers of Americans without health insurance benefits.

We appreciate your consideration of these comments. If you have any questions or would like to discuss our recommendations/observations further, please contact Heather Jerbi, the Academy's senior federal health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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