AMERICAN ACADEMY *of* ACTUARIES

July 30, 2003

The Honorable William M. Thomas
Chairperson, House-Senate Medicare Conference Committee
2208 Rayburn House Office Building
Washington, DC 20515-0522

Dear Representative Thomas:

This letter presents the comments of the American Academy of Actuaries'[1] Health Practice Council regarding certain aspects of the Prescription Drug and Medicare Improvement Act of 2003 (S. 1) and the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 1). These bills would provide prescription drug coverage to Medicare beneficiaries through private plans. Key provisions in these bills address risk sharing between the government and the private entities participating in the program. These provisions help to limit private insurers' losses, thereby increasing the likelihood that private entities will participate.

In particular, this letter discusses the general risk sharing approaches available, summarizes the risk sharing provisions in the Senate and House bills, and provides specific comments on the risk sharing approaches in the Senate and House bills.

Executive Summary

The Senate and House bills both provide for risk sharing protection as an incentive to private entities to participate in the proposed Medicare prescription drug program. Each bill, however, takes a different route to providing this protection.

The Senate bill (S.1) combines the use of risk corridors in the initial years with individual reinsurance at a relatively high attachment point (the value at which individual reinsurance begins to reimburse the private insurer). The House bill (H.R. 1) relies solely on individual reinsurance, with a relatively low dollar attachment point.

Comments on the Senate approach:

- Risk corridors help protect private plans against underpayments.
- Risk corridors help protect the government from overpaying plans.
- Provisions allow transition to more risk while maintaining the protection offered by risk corridors.
- Aggregate record-keeping under risk corridors will ease administrative burdens (when compared with the provisions of the House bill).

[1] The Academy is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification and practice standards, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of objective analysis. The Academy regularly prepares comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

- Without close management, risk corridors may allow for some potential "gaming" of administrative costs.
- Individual reinsurance will provide additional protection against very high-cost individuals.
- The high individual reinsurance attachment point will ease administrative burdens (relative to a lower attachment point as in the House bill).
- The combination of risk corridors and individual reinsurance could cause administrative complexities.

Comments on the House approach:

- Individual reinsurance will provide protection against unexpectedly high claims from medium and high-cost individuals.
- The relatively low attachment point could cause private insurers and government auditors significant administrative burdens in the calculation of the amounts owed beneficiaries and the private insurers.
- The 30% reinsurance cap will cause volatility and uncertainty in the revenue available to private entities.
- Perverse incentives could result with respect to negotiated prices.
- The low individual reinsurance attachment point could create perverse incentives for the pharmaceutical industry to add new drugs at very high prices.
- The relatively low individual reinsurance attachment point also rewards less efficient private entities. They may reach the attachment point sooner than more efficient entities, thus obtaining extra federal subsidies.

Overall, the Senate bill's higher reinsurance attachment point (which significantly reduces the administrative burden of calculating millions of beneficiaries' reinsurance amounts) combined with the greater revenue stability and lessened exposure through risk corridors is likely to provide a greater incentive for private entities to participate. While the House bill offers some protections through its reinsurance mechanism, the likely greater volume of reinsurance calculations and the uncertainty in revenue from reinsurance appear to make this program somewhat less desirable from an actuarial perspective.

General Risk Sharing Approaches

Both the Senate and House bills provide an incentive to private insurers to participate in the new prescription drug program by including mechanisms to share risk between the insurers and the federal government. Private entities offering a prescription drug benefit to Medicare beneficiaries may find it difficult to estimate the per capita benefit costs and the trends in these costs. This difficulty arises from the lack of comprehensive data on current prescription drug usage by seniors and the uncertainty regarding how utilization will change for those newly covered, especially in the early years of a Medicare prescription drug program. Understating costs could result in large losses to private sector entities. Overstating costs could result in overpayments by the government. Approaches for limiting these risks include risk corridors, aggregate reinsurance, and individual reinsurance.

Risk corridors are contractual safeguards that can limit the downside risk (loss), the upside risk (gain), or both, for an insurance organization. In a typical arrangement, a best estimate of the benefit claim cost (excluding administrative costs) would be made. Gains or losses inside a risk corridor around that estimate would be the full responsibility of the private sector organization. Additional gains or losses

outside the risk corridor would be shared with or borne by the federal government. As a result, an at-risk organization such as an insurance company would be able to offer coverage, but its risk would be limited.

The example below illustrates how risk corridors work:

Estimated annual Medicare prescription drug cost (for illustrative purposes only)	$1000 per year per senior
First-year Medicare prescription drug risk corridor	± 2.5 percent (i.e., the corridor is 5 percent wide around the best estimate)
Dollars at risk per senior in first year	$25 per year per senior possible gain or loss
Federal government responsibility	Losses in excess of $1025 Gains if costs are less than $975 per year per senior

In this example, if the insurance company enrolled 1 million seniors, its maximum loss would be $25 million (1 million seniors times $25 maximum loss per senior), with the government covering any losses over $25 million. Similarly, if cost estimates proved to be conservative, then the federal government would recover any gains that exceeded $25 million.

Risk corridor designs do not always include both an upside and a downside corridor. When both an upside and a downside corridor are present, they are not necessarily uniform. Other risk corridor designs could include some cost sharing (e.g., 10 percent) outside the initial corridor. In other words, the insurer would be responsible for all claims within the first 2.5 percent corridor, then 10 percent outside the corridor.

Risk corridors or other risk sharing arrangements might be essential during the first few years of a Medicare prescription drug program. During the period in which risk corridors are in place, both insurers and the federal government would be able to gather the drug expenditure data needed to make more accurate cost estimates for future years. As a result, this mechanism could be useful as a transition to full-risk contracting. For example, in the second year, the risk corridor could be expanded from ± 2.5 percent (a corridor 5 percent wide) to ± 5.0 percent (a corridor 10 percent wide) to allow for greater incentives for the private sector organization.

Aggregate Reinsurance is another option to limit insurers' downside risk. Under aggregate reinsurance, the federal government would pay all or a percentage of claims once a private plan's aggregate claims paid exceed a pre-determined threshold. This threshold is typically expressed as a percentage of aggregate expected claims (for example, a first-year aggregate limit might be 102 percent of projected paid claims). Insurers would keep all gains if actual claims are lower than expected. However, this unlimited upside potential may make it more attractive for insurers to participate in the program, which would help to foster greater competition. Government-provided aggregate reinsurance protection is similar to a one-sided risk corridor. In other words, the insurer would keep all gains, regardless of the size, if actual spending is less than expected, but would bear the losses only up to a certain point if spending is greater than expected. However, aggregate reinsurance may be easier to administer than risk corridors. Other mechanisms, like premium stabilization reserves, funded by some level of underwriting gains, could be added to limit the possibility of unintended funding windfalls. These funds could then be used to reduce future plan premiums.

Individual Reinsurance can protect a plan from unexpected high claims of individual beneficiaries. Although the variability of prescription drug spending among individual Medicare beneficiaries is less compared to the variability of other health spending, plans can still be at risk for unusually high prescription drug claims among individual enrollees. Under individual reinsurance, the federal government would pay all or a high percentage of claims once an individual enrollee's claims exceed a pre-determined threshold (typically expressed as a dollar amount, such as $5,000). Individual reinsurance, however, would provide very little protection for plans from higher than expected aggregate costs under the threshold, which could occur especially in the first few years of the program due to induced or pent-up demand. In this case, high aggregate costs could be generated by higher than expected average consumption of prescriptions, rather than from very high costs of relatively few beneficiaries.

Side-by-Side Comparison of Senate and House Risk Sharing Provisions

The House and Senate bills each contain risk sharing provisions. The Senate version combines risk corridors with individual reinsurance, and the House version relies solely on individual reinsurance. The table below details the provisions in the two approaches.

	S. 1 as passed in Senate June 27, 2003	**H.R. 1 as passed in House June 27, 2003**
	Risk Corridors	
Risk Corridors	Plans would be eligible for risk sharing within certain corridors. Years 2006-2007: • Plans bear full risk for spending within ± 2.5% of target. • Government would bear 75% of spending incurred (government share would increase to 90% if 60% or more of all participating plans representing at least 60% of covered beneficiaries had allowable costs exceeding 2.5% above target) when spending exceeds ± 2.5% but less than ± 5% of the target. • Government would bear 90% of spending exceeding ± 5% of target. Years 2008-2011: • Plans bear full risk for spending within ± 5% of target. • Government would bear 50% of spending incurred between ± 5% and ± 10% of target. • Government would bear 90% of spending incurred ± 10% of target. Years 2012 and beyond: • Risk thresholds would be set by Administrator, at not less than those in years 2008-2011.	No Provision

	S. 1 as passed in Senate June 27, 2003	H.R. 1 as passed in House June 27, 2003
Allowable Costs	Target amount = Plan premium less administrative expenses (negotiated on a plan-by-plan basis with administrator). Allowable costs are based on actual costs reported by the plan.	
Stabilization Reserve Fund	Payments to fund in 2006-2010 would be any target amounts that exceed applicable costs by more than 3 percent. Beginning in 2008, funds could be used to stabilize or reduce plan premiums. Applicable costs = Allowable costs plus the amount by which payments were reduced through application of the risk corridor provisions.	
Reporting Requirements	Plans would be required to provide information regarding total actual costs for providing standard coverage and a breakdown of the aggregate payments made and the aggregate amount of discounts.	
Individual Reinsurance Provisions		
Reinsurance payment	80% of an individual's allowable drug costs that exceed the out-of-pocket limit	• 20% of an individual's allowable drug costs between $1000-$2000. (Thresholds indexed by average per capita spending for outpatient drugs by Medicare beneficiaries.) • 80% of an individual's allowable drug costs over the individual's maximum out-of-pocket threshold. Reinsurance payments are adjusted so that they do not exceed 30% of the total payments made by plans for standard coverage.
Allowable costs	Allowable costs are based on actual costs reported by the plan.	Allowable costs = The part of gross covered prescription drug costs that is actually paid (net of discounts, chargebacks, and average percentage rebates), but no more than the part of such costs that would have been paid under the plan if it provided standard coverage. Gross costs = Costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

	S. 1 as passed in Senate June 27, 2003	H.R. 1 as passed in House June 27, 2003
Reporting requirements	For each individual exceeding the out-of-pocket threshold, the plan must provide the total actual costs incurred in providing prescription drug coverage over the out-of-pocket threshold, and a breakdown of the aggregate payments made and the aggregate amount of discounts.	Not specified.

Specific Comments on the Senate Approach

The Senate bill combines the use of risk corridors in the initial years with individual reinsurance at a relatively high attachment point (the value at which individual reinsurance begins to reimburse the private insurer).

Risk corridors help protect plans against underpayments. The risk corridor approach helps to mitigate pricing risk by protecting plans against underpayments, thereby reducing barriers to plan participation. In contrast to the implementation of other Medicare programs that used demonstrations to find the likely range of experience, it appears that a Medicare stand-alone drug program will be implemented without testing beginning January 1, 2006. Because of the potentially large enrollment into a stand-alone drug program, the need for insurance company surplus will be significant. The risk corridor approach will help greatly in managing that risk.

For example, for one mid-sized state, there may be 1 million stand-alone drug program enrollees. If the average target cost per enrollee for the program is $1500 per year in 2006, then the total target cost would be $1.5 billion in that state. As discussed earlier, there is significant uncertainty regarding the calculation of the target cost levels and the amount of downside risk (the risk that costs exceed the target) to participating plans inside the 2.5% corridor will be $37.5 million, with additional risk outside the corridor. With as many as 40 million beneficiaries, the downside risk within the corridor could amount to $1.5 billion in total first year losses across all insurers. Without risk corridors, potential losses could far exceed these amounts, if induced and pent-up demand for prescription drugs is unexpectedly high. Although the private insurance industry may be willing to assume in aggregate a $1.5 billion risk, it may be less likely to participate as the risk level increases.

Risk corridors protect the government from overpaying plans. Because the risk corridors are symmetrical, they also protect the federal government from the risk of windfall profits to the private sector. Symmetrical risk corridors have an advantage over individual or aggregate reinsurance in that they automatically capture any unexpectedly large profits. It is likely that competition among private plans will drive down premiums and costs, but the first two to three years (at least) of the program will have volatile experience. Symmetrical risk corridors protect the federal government from overpaying plans while also protecting private insurers from underpayments. The risk corridors will be combined with a stabilization reserve fund to stabilize or reduce plan premiums.

Risk corridors allow transition to more risk. Risk corridors can allow a relatively quick transition to transferring more risk to the private sector over a period of several years. By gradually increasing the risk corridors over time, the Senate plan gradually transfers increasing risk to insurers. Because the 2.5% initial risk corridor is quite large in terms of risk for an individual insurer, most plans will bid as accurately as possible to keep premiums to the right level.

Aggregate record-keeping under risk corridors will ease administrative burdens. Compared with reinsurance calculations and reporting that might involve millions of individual beneficiary calculations, risk corridors are inherently simpler because calculations and reporting can be done on an aggregate basis. Private insurance actuaries are currently familiar with these risk corridor calculations from the current Private FFS and PPO demonstrations. CMS staff (if they have oversight responsibility) are also familiar with risk corridor methodology and calculations. In addition, audits by CMS can be done on a spot-check basis and then on a computerized basis in the aggregate.

There is some potential for "gaming" administrative costs. There may be issues related to potential "gaming" of the administrative costs in any risk corridor calculation. In short, the "gaming" could occur if a private insurer chose to overstate its administrative costs, with the goal of achieving a profit while bidding low on the claims cost in order to gain a large number of enrolled beneficiaries and reimbursement for claims above the risk corridor. However, the size of the risk corridor (2.5% of claims in the initial years) is large enough to make it difficult to "game" the administrative costs so high as to overcome the risk corridor losses. In addition, these administrative costs would soon be transparent to the stand-alone drug program manager (the agency administering the bidding process), because the agency will be able to compare 50 or more administrative bids for exactly the same type of prescription drug adjudication and delivery work.

Individual reinsurance will provide additional protection against high-cost individuals. The individual reinsurance provision will provide additional protection if an insurer has enrolled particularly high-cost seniors.

The individual reinsurance high attachment point will ease administrative burdens.
The individual reinsurance would begin when an individual exceeds the out-of-pocket maximum ($3700 in 2006), that is when the individual's total prescription drug spending exceeds $5800. Relatively few beneficiaries are likely to exceed that level of spending. According to CBO projections, about 12 percent of Medicare enrollees are expected to exceed $6000 in prescription drug spending in 2005.[2] Because individual reinsurance typically requires detailed record-keeping and reporting for each individual with spending exceeding the attachment point, higher attachment points lessen the administrative burdens.[3]

Combination of risk corridors and individual reinsurance could cause administrative complexities.
Removing the reinsurance payment from the risk corridor will be complex, but this is similar to current commercial stop-loss calculations. Many smaller private sector insurers and many employers use a combined individual and aggregate reinsurance approach, which is very similar. In addition, private health insurers with capitation contracts have considerable experience with complex risk sharing provisions. Although many risk sharing contracts now run smoothly, there was considerable disagreement over payment under these provisions in earlier years. Adding to the complexity, private health insurers were often administering a number of different risk sharing models. If the federal government were to implement a single risk sharing model, it would greatly minimize the administrative complexity.

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[2] Congressional Budget Office, "Issues in Designing a Prescription Drug Benefit for Medicare," October 2002.

[3] Lower attachment points increase the number of claimants above the threshold, which increases the volume of data that must be captured, tracked, reported, audited, etc. In addition, the "cost of care" can include some items that are not generally considered "claims," such as capitations or drug rebates, which may require non-standard or manual processing adjustments to individual claimant records. Insurers and HMOs that currently lack the ability to combine this non-claim data with their claim data will face additional administrative burdens.

Specific Comments on the House Approach

The House bill relies solely on individual reinsurance, with a relatively low attachment point. In addition, reinsurance payments are capped at 30 percent of total plan spending.

Individual reinsurance will provide protection against high-cost individuals. The individual reinsurance will help to mitigate the pricing risk by providing plans protection against high-cost beneficiaries, thus reducing barriers to plan participation.

Relatively low attachment point could cause significant administrative burdens. The individual reinsurance would begin when an individual's drug spending exceeds $1,000. Because this is a relatively low attachment point, many beneficiaries are likely to exceed that level of spending. According to CBO projections, about 64 percent of Medicare enrollees are expected to exceed $1000 in prescription drug spending in 2005.[4] Because individual reinsurance typically requires detailed record-keeping and reporting for each individual with spending exceeding the attachment point, the low attachment point implies great administrative burdens for the participating insurers, with reinsurance calculations for many as 25 million beneficiaries annually.[5]

30% reinsurance cap will cause volatility and uncertainty. The provision that reinsurance payments are capped at 30 percent of total payments will mean reinsurance payments could fluctuate. In addition, this provision increases the uncertainty regarding plan payments and therefore exposes plans to more risk, thereby decreasing the incentives for plans to participate.

Perverse incentives could result with respect to negotiated prices. Plans that have negotiated better prescription drug discounts or rebates will be at a disadvantage in terms of individual reinsurance. Given the same population and prescription drug utilization, plans that have negotiated deep discounts or rebates will reach the $1000 attachment point later than plans without such discounts or rebates. Therefore, they will have a lower share of their plan costs subsidized than will other plans.

The low attachment point could create perverse incentives for the pharmaceutical industry to add new drugs at very high prices. A low individual reinsurance attachment point may provide a perverse incentive for the pharmaceutical industry or other parts of the delivery system to price new drugs at high levels. Although reinsurance covers only 20 percent of spending between the first and second attachment points, this still may be enough to cause perverse incentives for pricing new drugs.

The relatively low individual reinsurance attachment point also rewards less efficient private entities. Less efficient private entities (e.g., those with less strict utilization management mechanisms) may reach the attachment point sooner than more efficient entities, thus providing them with additional federal subsidies.

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[4] Congressional Budget Office, "Issues in Designing a Prescription Drug Benefit for Medicare," October 2002.

[5] Lower attachment points increase the number of claimants above the threshold, which increases the volume of data that must be captured, tracked, reported, audited, etc. In addition, the "cost of care" can include some items that are not generally considered "claims," such as capitations or drug rebates, which may require non-standard or manual processing adjustments to individual claimant records. Insurers and HMOs that currently lack the ability to combine this non-claim data with their claim data will face additional administrative burdens.

Other Comments

Treatment of rebates must be considered. For purposes of risk sharing (risk corridors, aggregate reinsurance, or individual reinsurance), how rebates are incorporated into the calculation is very significant. At this time, rebates can take many forms, including retrospective payments to pharmacy benefit managers (PBMs), private insurers, or other entities based on volume used during the year or other contractual arrangements. In most instances, it is impossible to determine the amount of rebate for a particular prescription at the point of sale. These arrangements may be appropriate for private sector employers offering prescription drug coverage with copayments, because rebates have no direct financial effect on the individual consumer, but instead reduce employer premiums as rebates are recognized. However, the net cost of the drug, including the effects of rebates, is needed for determining both the beneficiary's coinsurance requirements and out-of-pocket maximum and the private insurer's risk sharing reimbursement. The Academy recommends that the Committee members consider whether and how rebates and discounts are applied to both beneficiary and private insurer reinsurance calculations.

Sincerely,

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