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MEDICARE PRESCRIPTION DRUG PLANS: THE DEVIL IS IN THE DETAILS

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Updated April 2003

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MEDICARE PRESCRIPTION DRUG PLANS: THE DEVIL IS IN THE DETAILS

As the debate over a Medicare prescription drug benefit continues in Congress, policy-makers need to consider several issues when drafting and evaluating the various proposals.

- *First, if enrollment in the drug program is voluntary, the program must be designed to minimize adverse selection. That is, actual program enrollment needs to be nearly universal, broad enough to include healthy participants as well as those who would be expected to be high utilizers of the program. Otherwise, per-enrollee costs could become too high, potentially leading to the need for increased beneficiary premium contributions and cost sharing, and discouraging the participation of private entities that administer and/or deliver the benefit.*

- *Second, the plan must include components that will help minimize per script costs, contain drug utilization, and keep total spending to an affordable level. Otherwise, drug spending under the program will grow much faster than projected, further endangering the solvency of the overall Medicare program.*

- *Finally, policymakers may want to add risk-sharing provisions during the first few years after implementation to private sector organizations administering or delivering the benefit. Risk-sharing provisions are especially important in the early years of the program, until pent-up demand levels off and utilization data for previously uninsured beneficiaries becomes available.*

These issues are discussed in more detail below, along with options for addressing them.

Adverse Selection

Adverse selection can be a problem in any voluntary health insurance program. Because people in poor health are more likely to purchase coverage, and to purchase more generous coverage in particular, premiums will increase significantly to cover the impact of this selection. Indeed, in typical private insurance programs in which premiums are paid entirely by participants, the average cost for those who enroll will be well above the average of all potential applicants. As premiums are set higher to reflect the higher costs of enrollees, even fewer applicants are willing to pay them, further increasing selection effects and the average per enrollee cost.

The potential for adverse selection is even greater for a stand-alone Medicare prescription drug program because seniors can better predict their future drug costs than their other health care costs. The key to minimizing adverse selection in a Medicare prescription drug program is to increase participation rates, which can be accomplished through various means, including:

- **Premium subsidies.** When deciding whether to participate in the program, many seniors will evaluate the perceived value of the program and compare their expected out-of-pocket drug costs to the plan's premiums. Those who expect to have covered drug costs that are less than the premium required to participate will be less likely to enroll. Premium subsidies

reduce the direct cost of participation, increasing the number of eligible individuals who will expect their likely benefit from the program to exceed the premium cost, and thus will increase enrollment.

- **"Default" enrollment.** Making enrollment in the drug program the default option (i.e., seniors desiring not to be in the program would have to take a step to opt out) would increase enrollment.

- **Penalty for delay.** Mandating that enrollment in the drug plan be on a guaranteed-issue basis would ensure that all seniors have access to the benefit, regardless of health status. However, these enrollment features could encourage seniors to delay enrollment until they expected to incur significant prescription drug expenses. Limiting guaranteed issue to an initial open enrollment period, or providing some other meaningful penalty for late enrollment, would encourage individuals with low current drug expenditures to consider their future needs and protect themselves by enrolling.

- **Risk Adjustment.** In the absence of universal coverage, some degree of adverse selection is inevitable. Risk adjustment and/or other types of reinsurance arrangements can reduce the incentives an insurer might have to avoid enrolling high-risk individuals. These options are discussed in more detail below.

The combination of these elements would help to reduce adverse selection, thereby increasing the program's long-term stability. In addition, because private insurers would hesitate to offer plans if they feared they would be selected against, reducing adverse selection would also increase the likelihood that insurers or other organizations would participate in the program.

Drug Utilization Management

The CBO estimates that prescription drug spending by the Medicare population will total $95 billion this year and will nearly triple to $284 billion by 2013. The introduction of a Medicare prescription drug program would likely increase drug spending even further due to induced or pent-up demand. In other words, because drug coverage would reduce the out-of-pocket costs of prescription drugs to consumers, they would be able to afford to use more drugs. One-third or more of seniors currently lack prescription drug coverage. Prescription drug spending by this population is very likely to increase dramatically if they obtain comprehensive drug coverage. Utilization could increase even among seniors with drug coverage (e.g., through a retiree health plan, Medigap, Medicare+Choice plan) if the Medicare prescription drug plan is more comprehensive than their current plan.

The long-term sustainability of a Medicare prescription drug plan depends in part on the extent to which the plan can manage drug utilization and spending. Many tools are available to help contain utilization and costs, including patient cost sharing, limiting the range of drugs covered, and drug utilization management mechanisms.

- **Patient cost sharing.** Patient cost sharing through deductibles, copayments, and/or coinsurance will reduce the overall cost of the program in two ways. First, it directly reduces

the share of the costs borne by the insurance program. Second, and equally important, cost sharing will also make patients more sensitive to prescription drug costs, thereby reducing utilization to that which is medically necessary and, ultimately, overall costs.

Deductibles are amounts that must be paid out-of-pocket before drug coverage begins. Aside from lowering the cost of benefits paid, low or modest deductibles help hold down administrative costs by eliminating claims processing for small amounts. Large deductibles in effect result in catastrophic coverage, which provides coverage for those most in financial need of assistance at a relatively low cost.

With *coinsurance*, the patient is responsible for a percentage of the drug cost. *Copayments*, on the other hand, are a fixed amount per prescription and have the advantage of being more predictable to patients. However, copayments might not make patients as sensitive to the costs of drugs as does coinsurance. Also, whereas coinsurance automatically adjusts for increases in drug costs, copayments (and deductibles) need to be increased periodically as drug costs rise, or overall program costs will increase faster than drug costs.

By making patients more sensitive to costs, cost sharing will decrease prescription drug utilization. Although the goal of cost sharing is to reduce unnecessary utilization, it will likely reduce necessary utilization to some extent as well. Reducing the cost-sharing requirements for lower-income seniors will help minimize the extent to which cost sharing discourages needed care. However, some minimal level of cost sharing should be present for even the lowest income levels to deter unnecessary utilization.

- **Formularies.** Formularies are lists of a plan's preferred medications and are used to encourage the use of less costly drugs. There are three types of formularies — open, closed, and incentive. Under *open formularies*, all drugs are available with no incentive to choose one over the other, although programs can be designed to encourage use of preferred medications (e.g. therapeutic interchange programs). In contrast, *closed formularies* limit the drugs available under the plan to those listed in the formulary. *Incentive-based formularies* contain cost-sharing differentials for preferred and non-preferred brand name drugs, and generic drugs, thereby giving patients a financial incentive to request preferred or generic medications. Nevertheless a non-preferred drug may be the only drug that is fully effective for a particular person, leaving the beneficiary paying more unless exceptions are available.

  Merck-Medco, a pharmacy benefit manager (PBM), has estimated that the cost savings that derive from formularies can range from 2 percent to 3 percent for an open formulary with compliance interventions to 5 percent to 9 percent for a three-tier incentive-based formulary. It is important, however, that any formulary be broad enough to include drugs in each therapeutic category and class of covered outpatient drugs. In addition, the formulary must be periodically reviewed and modified to reflect new drugs being introduced and updated clinical information.

- **Drug Management Mechanisms.** Insurers and/or pharmacy benefit managers have several mechanisms they can use to help contain drug costs:

Prior authorization requires physicians to receive authorization that the drug is appropriate for the medical condition and could save from 1 percent to 2 percent of drug spending. Because it is expensive to administer, prior authorization is typically reserved for expensive drugs that have potential for excessive use or misuse.

Maximum dispensing limits restrict the quantity of medication a patient receives over time or per fill, and could also save about 1 percent to 2 percent of drug spending. This technique may be appropriate for therapies in which the potential for excessive use affects either cost or clinical outcomes.

Step therapies are used to check the medical appropriateness of using a newer, more expensive medication (i.e. a second-line drug) rather than a traditional medication (i.e. a first-line drug) for the same condition. This technique encourages the use of traditional therapies if they are more cost-effective than newer therapies and the new therapies offer minimal to no additional clinical benefit. Step therapies could save from 1 percent to 3 percent of drug spending.

Online drug utilization review can be performed electronically at the point of sale to ensure that the patient is eligible for the plan and that the prescription has not been refilled too soon. It can also screen for any drug interactions and perform other systematic checks. This concurrent review can save up to 4 percent of drug spending.

Risk Sharing

Many of the recent Medicare prescription drug coverage proposals suggest not only using private sector organizations to deliver the benefits, but also having these organizations share in the financial risk. Although private sector organizations have some experience with the risks associated with providing prescription drug coverage, either through employment-based, Medicare+Choice, or Medigap plans, these organizations lack experience with the overall senior market and there are increased risks associated with a new Medicare prescription drug benefit. In addition to adverse selection risks related to the program's overall participation rates, a Medicare prescription drug plan is also subject to risks associated with the difficulty in pricing the benefit adequately and plan-specific adverse selection. Each of these risks is discussed below, along with potential methods of addressing these risks.

Pricing Risk

It will likely be difficult for private sector organizations to estimate the per capita costs of a stand-alone prescription drug program for several reasons. First, the costs for seniors who are currently without drug coverage are uncertain. About one-third of current Medicare beneficiaries lack any prescription drug coverage. Their future prescription drug consumption will likely increase under a Medicare prescription drug benefit, but it is unclear how large that increase will be. Understating these costs could result in large losses to private sector entities. Overstating these costs could result in overpayments by the government.

Moreover, the lack of comprehensive data on current prescription drug usage by seniors makes it difficult to estimate costs under the program, even for those seniors who currently have

prescription drug coverage. For instance, using cost estimates derived from Medigap plans could be unreliable. On one hand, these estimates could overstate costs due to the likely adverse selection from seniors who choose these plans. On the other hand, using spending data for seniors with relatively limited Medigap prescription drug coverage could understate costs under a more comprehensive prescription drug program. Because of the potentially enormous volume of senior drug spending, even a 10 percent misestimate in a single large state could cause a $100 million loss (or unexpected gain).

Not only is it difficult to accurately estimate initial levels of prescription drug spending, it is difficult to estimate the trends in spending. Drug spending among the nonelderly with employment-based coverage has grown recently, as much as 15 to 20 percent per year, due to a combination of higher drug prices, increased utilization, and the introduction of new and expensive drugs. On one hand, a Medicare prescription drug program that provides near-full coverage may have cost increases of that magnitude. On the other hand, drug utilization may not increase as quickly among the senior population if they are already using many drugs.

In order to mitigate the pricing risk issue, policymakers may wish to consider shared risk arrangements that protect the government from over-paying and provide protection for those organizations willing to participate. Risk corridors provide a mechanism to limit an organization's potential losses and gains to a more acceptable level. Reinsurance could also limit an organization's potential losses. In addition, using performance standards for administrative tasks in the first several years of a new Medicare prescription drug program could ease the transition to an insurance risk-based system. Each of these is discussed in more detail below.

- **Risk corridors** are contractual safeguards that can limit both the downside risk and upside gain for an insurance organization.[1] In a typical arrangement, a best estimate of the claims and administrative cost of a benefit would be made. Gains or losses inside a risk corridor around that estimated level would be the full responsibility of the private sector organization. Additional gains or losses beyond 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.

[1] The federal government has large-scale experience with the use of risk corridors through its TriCare contracts, which provide health benefits to military personnel, their dependents, and military retirees. In addition, there are other risk corridors now being used in Medicare Private Fee For Service and PPO demonstrations.

The example below illustrates how risk corridors work:

Best estimate of annual Medicare prescription drug premium	$1000 per year per senior
First-year Medicare prescription drug risk corridor	± 1 percent (i.e., the corridor is 2 percent wide around the best estimate)
Dollars at risk per senior in first year	$10 per year per senior possible gain or loss
Federal government responsibility	Losses in excess of $1010 Gains if costs are less than $990 per year per senior

In this example, if the insurance company enrolled 1 million seniors, its maximum loss would be $10 million (1 million seniors times $10 maximum loss per senior), with the government covering any losses over $10 million. Similarly, if cost estimates proved to be conservative, then the federal government would recover any gains that exceeded $10 million.

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. (In the past, the federal government has had the time to conduct pilots or demonstrations on a small scale to gather the necessary beneficiary data, before implementing a new program. That time may not be available for a new Medicare prescription drug program.)

For example, in the second year, the risk corridor could be expanded from ± 1.0 percent (a corridor 2 percent wide) to ± 2.5 percent (a corridor 5 percent wide) to allow for greater incentives for the private sector organization. Other provisions could include some cost sharing (e.g., 10 percent) outside the corridor. In other words, the insurer would be responsible for all claims within the first 2.5 percent corridor, then 10 percent within an additional 5 percent corridor.

- **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. 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.

- **Individual Reinsurance** can protect a plan from unexpected high claims from individual beneficiaries. Although there is much less variation in prescription drug spending among Medicare beneficiaries compared to other health spending, plans can still be at risk for unusually high claims among individual enrollees. Under individual reinsurance, the federal government would pay all or a percentage of claims once an individual enrollee's claims exceed a pre-determined threshold (typically expressed as a dollar amount, such as $7,500). Individual reinsurance, however, would not provide much 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.

- **Performance standards** are another approach that can be used to encourage cost containment. These measure plan administrators against certain criteria and require them to put a certain amount of administrative fees at risk for their performance. For example, a plan could have a negotiated goal that a certain percentage of prescription drug scripts be generic (e.g., 50 percent) in order to hold down costs. If this goal is met, then the federal government would provide the organization with its full administrative fee payment. Otherwise, a portion of the administrative fee payment would be forfeited. Again, such incentives might be particularly important during the first few years of program operation. After two or more years in this pilot state, the contract could be converted into a full-risk contract, in which the organization would bear the insurance risk.

An important issue is the required duration of a risk corridor or reinsurance stage. Although prescription drug claims are typically paid much more quickly than other medical claims, sometimes within two to four weeks of being incurred, it is likely that any bidding process would require a pilot stage for the first two years. In year one, no data would be available to determine the best estimate of claim costs. Bidding for year two would begin almost immediately during the first year, so, once again, very little data would be available. By the second year of a contract, a full first year of data would be available and bidding for the third program year could proceed on an at-risk basis, or with a wider corridor.

Plan-Specific Adverse Selection

Even if adverse selection is minimized in the program as a whole, a particular plan could end up with a disproportionate share of seniors with high prescription drug expenditures. If payments to the plan do not reflect this, then the plan could be at risk for large losses. *Risk adjustment* could be used to adjust the payments to the plans to take into account the health status of the beneficiaries who participate in the program. Risk adjustment helps to make payments to competing plans more equitable and can reduce the incentives for competing plans to avoid beneficiaries with higher than average prescription drug needs. Risk adjustment may also help stabilize experience among private plans, causing less disruption for plan participants.

Several risk adjustment mechanisms for acute care services have been developed using pharmacy data. Pharmacy-based models can also be used as risk adjustment mechanisms for prescription drug utilization. Although risk adjustment can help account for the differences in participant

health status across plans, no current risk adjustment system is designed to compensate each competitor for the full financial effects of adverse selection.

Conclusion

Proposals to add a prescription drug benefit to Medicare need to address issues related to adverse selection, drug utilization management, and risk sharing. Adverse selection will be minimized to the extent that participation is nearly universal. This can be accomplished through high premium subsidies, default enrollment, and penalties for delayed enrollment.

The long-term sustainability of a Medicare prescription drug program also depends on the extent to which the program manages drug utilization and spending. Patient cost sharing, formularies, and other drug management mechanisms can each help contain costs.

Finally, policymakers may want to provide provisions to minimize the financial risk of private sector organizations administering or delivering the benefit in the first few years of the program. Risk corridors, reinsurance, and performance standards could be used in the initial years of a prescription drug program while organizations collect important data. Risk adjustment could provide additional protection to private organizations, thereby increasing their willingness to participate.