MILLIMAN BRIEF

Are Medicare Part D risk corridors working as expected?

Considerations with the induced utilization adjustment in the Part D Bid Pricing Tools

Adam Barnhart, FSA, MAAA
Kevin Pierce, FSA, MAAA

Milliman

Medicare Part D risk corridors may not be working as expected. An induced utilization adjustment in the Part D Bid Pricing Tools shifts Part D risk-sharing for some enhanced alternative plans. This article highlights the importance and impact of this consideration, along with details on how it could occur.

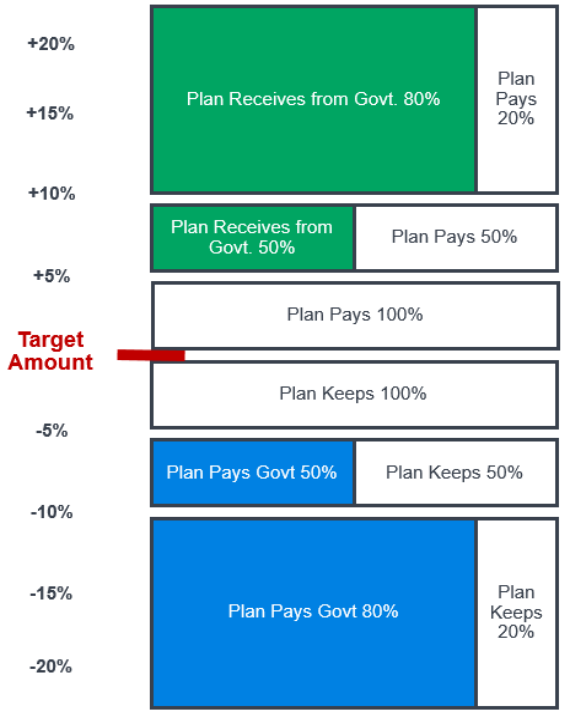
What are risk corridors?

Medicare Part D plans share excess gains and losses with the federal government through risk corridors. The risk corridor program puts the federal government at risk for some of the variance between actual claims experience and what is projected in the annual Part D bid. This risk includes both upside and downside risk and is designed to be symmetric.

Part D risk corridors are based on a target amount reported in the Bid Pricing Tools (BPT). Actual basic claims are compared against the target amount to determine savings or losses. The federal government shares a defined proportion of savings and losses at fixed thresholds. Figure 1 illustrates the 2021 Medicare Part D risk corridor distribution.

For enhanced alternative (EA) plans, actual claims are divided by an induced utilization (IU) adjustment from the Part D BPT before calculating risk corridors. The BPT IU adjustment calibrates actual basic claims to be in line with the target amount. The Part D BPT sets a "floor" for this adjustment at 1.0, causing a shift in the risk corridor distribution.

FIGURE 1: 2021 MEDICARE PART D RISK CORRIDOR DISTRIBUTION



RISK CORRIDOR OVERVIEW

Savings and losses for risk corridors are determined based on the following formula:

$$Target\ Amount - \frac{Actual\ Basic\ Claims}{Max(BPT\ IU\ Adjustment, 1.0)}$$

The federal government shares in the following proportions of savings and losses:

- 0% of savings and losses between 0% to ±5% around the target amount
- 50% of savings and losses between ±5% to ±10% around the target amount
- 80% of savings and losses between ±5% to ±10% around the target amount

Why does this IU Floor matter?

The target amount reflects a plan's estimated cost under the defined standard (DS) benefit with expected utilization on the DS benefit. For EA plans, basic claims reflect plan liability under the DS benefit but with actual utilization on the EA benefit. These two values are expected to be different, with the BPT IU adjustment used to measure this difference. However, the 1.0 floor for this adjustment shifts the risk corridor distribution, potentially putting plans in an immediate risk-sharing position.

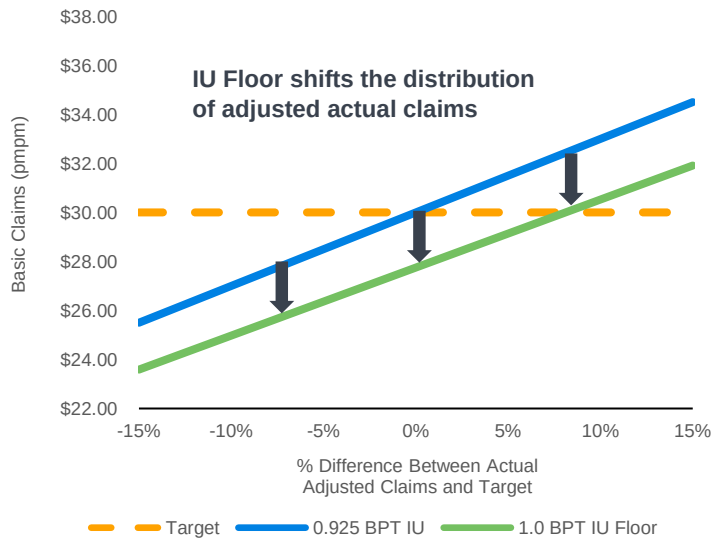
Figure 2 below illustrates a potential shift in the actual adjusted claims and how this compares to the target amount due to the 1.0 floor for the BPT IU adjustment. The 1.0 floor shifts the distribution such that the target is not equal to adjusted claims when claims emerge exactly as expected. This creates a nonsymmetric distribution for risk corridors around expected claims. The plan would need claims to emerge 12.5% higher than expected to receive risk corridor payments compared to the 5% threshold with standard risk corridors.

What is the impact of the IU Floor?

Figure 3 on page 3 illustrates a plan's estimated risk corridors if claims emerge differently from expected. This example assumes the target amount is $30 per member per month (PMPM) and illustrates risk corridors when using a BPT IU adjustment of 0.925 versus the "floored" adjustment of 1.0. The 0.925 BPT IU results in a symmetric distribution, while the 1.000 BPT IU "floor" does not. A few highlights from this example:

1. **-10% claims change**: If claims emerge 10% (or $2.80 PMPM) lower than expected, the plan sponsor pays $0.75 PMPM for risk corridors and keeps $2.05 PMPM, with the 0.925 IU adjustment. With the 1.0 adjustment, the plan sponsor pays $2.35 PMPM for risk corridors, accounting for 84% of the total claims decrease.
2. **No claims change**: If claims emerge as expected, the plan sponsor must pay $0.40 PMPM for risk corridors when using the 1.0 "floored" IU adjustment. The plan sponsor has no gain or loss with the 0.925 IU adjustment.
3. **+10% claims change**: If claims emerge 10% higher than expected (or $2.80 PMPM), the plan sponsor receives $0.75 PMPM for risk corridors and retains $2.05 PMPM of the loss, with the 0.925 IU adjustment. With the 1.0 adjustment, the plan sponsor receives no risk corridors, retaining the full $2.80 PMPM loss.

FIGURE 2: COMPARISON OF ACTUAL ADJUSTED CLAIMS TO TARGET AMOUNT FOR 0.925 BPT IU VS. 1.0 BPT IU FLOOR

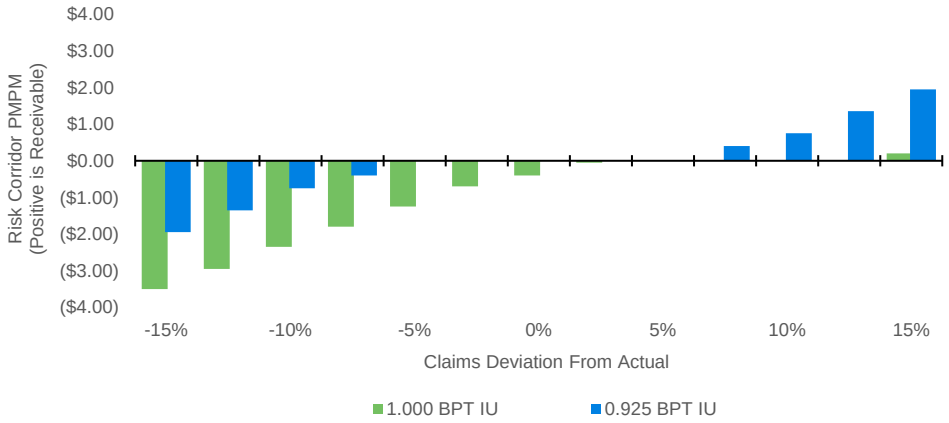


1.0 BPT IU FLOOR SHIFT

This exhibit illustrates a shift in adjusted actual claims compared to the target amount. In this example:

- The target amount is $30.00 (PMPM)
- Expected basic claims are $27.75 PMPM, 7.5% lower than the target amount
- The calculated BPT IU adjustment would be 0.925 (= $27.75 / $30.00)
- Actual claims are divided by the BPT IU adjustment to compare against the target
- Adjusted claims are nonsymmetric about the target amount with the 1.0 BPT IU "floor"

FIGURE 3: PMPM RISK CORRIDORS FOR PLAN WITH $30 TARGET AMOUNT AND 0.925 VS. 1.000 BPT IU ADJUSTMENT



A plan could pay $0.40 PMPM for risk corridors if claims emerge exactly as expected due to the 1.0 Floor for the BPT IU adjustment.

How can this IU Floor occur?

Induced utilization typically reflects the impact of benefit changes on overall utilization. The IU adjustment on Worksheet 5 of the Part D BPT measures something different: the ratio of plan sponsor cost with IU applied to plan sponsor cost without IU applied, all evaluated under the DS benefit. Because this metric is net of Part D subsidies, Coverage Gap Discount Program payments, and rebates, it is possible for this factor to be less than 1.0, even if utilization is higher after IU is applied. In recent years, it has become more common for the BPT IU adjustment to be below 1.0, with a few key drivers:

1. **Enriched DS gap coverage**: The coinsurance in the coverage gap for non-low-income members has decreased from 100% in 2012 to 25% in 2019 under the DS benefit. Manufacturers also contribute 70% of the applicable cost in the gap, drastically changing a plan's liability in this phase.
2. **Increased rebate retention**: Plans may retain greater rebates with the induced utilization from an enhanced plan design. The increased rebates may result in an adjustment that is less than 1.0.

The bid instructions require the BPT IU adjustment to be greater than or equal to 1.0. While the calculated value may be less than 1.0, plans are required to "floor" the adjustment at 1.0. This "floor" shifts the risk corridor distribution.

ENRICHED DS GAP COVERAGE

Plan sponsors cover a lower portion of gross costs in the coverage gap than the catastrophic phase under the DS benefit. This dynamic has existed since the coverage gap discount increased from 50% to 70% of applicable drug costs. For a non-low-income member taking brand drugs, plan sponsor costs are 5% in the coverage gap, one-third of the approximate 15% liability in the catastrophic phase.

The EA utilization portion of the BPT IU adjustment is calculated assuming DS cost sharing, but with a member's true out-of-pocket (TrOOP) cost from the EA benefit to be consistent with Prescription Drug Event (PDE) claims adjudication. A plan offering enhanced cost sharing in any phase before TrOOP may see a shift in allowed cost from the catastrophic phase to the coverage gap. Under the DS benefit, this leads to the plan sharing in a lower proportion of gross cost. Increases in utilization due to IU can offset this impact, but may not be significant enough to increase the IU adjustment above 1.0.

Figure 4 illustrates a potential distribution of costs by phase under the DS plan and an EA plan. This example assumes the increase in member TrOOP shifts 2% of allowed costs from the catastrophic phase to the coverage gap, and no change in aggregate utilization occurs. In this example, the plan sponsor's cost is 0.2% lower under the EA utilization, forcing the IU adjustment by formula to be below 1.0.

FIGURE 4: PLAN SPONSOR COST AND ESTIMATED DISTRIBUTION BY PHASE UNDER THE DS AND EA UTILIZATION SCENARIOS

	PLAN SPONSOR	DISTRIBUTION BY PHASE	
PART D PHASE	COST % OF TOTAL	DS UTILIZATION	EA UTILIZATION
Deductible	0%	10%	10%
ICL	75%	30%	30%
Gap	5%	20%	22%
Catastrophic	15%	40%	38%
Plan Sponsor Cost % of Total		**29.5%**	**29.3%**

INCREASED REBATE RETENTION

As we stated earlier, the IU calculation is net of rebates. A reduction in catastrophic claims also decreases the portion of rebates shared with the government. Because the EA utilization portion of the IU calculation may shift claims away from the catastrophic phase and into the coverage gap (compared to the DS utilization), this may also lead to plans retaining a larger share of rebate dollars and thus reducing plan cost. The reduced plan cost under the EA utilization can further contribute to a BPT IU adjustment below 1.0.

Figure 5 expands upon Figure 4 to illustrate this dynamic of rebate retention. In this context, total direct and indirect remuneration (DIR) and rebates are synonymous. Assuming total DIR is equal to 30% of gross cost, net plan liability is 7.5% lower with the EA utilization than with the DS utilization. The primary driver is rebate retention, as reinsurance decreases by 1.6% of gross cost between the DS utilization and EA utilization scenarios. This scenario would lead to an IU adjustment of 0.925, if the BPT did not set a minimum of 1.0. This scenario does not consider the potential impact of modifying the safe harbor protection for manufacturer rebates under the anti-kickback statute.[1]

This impact becomes more important as rebates continue to increase. The 2020 Medicare Trustees Report estimates DIR at 29.2% of Part D gross cost in 2021, 7% higher than from 21.9% in 2017. Increasing rebates create a leveraging effect, as the larger the rebates, the lower the plan's share of gross cost, and thus the lower the BPT IU adjustment.

FIGURE 5: ESTIMATED IMPACT OF REBATE RETENTION ON NET PLAN LIABILITY UNDER THE DS AND EA UTILIZATION SCENARIOS

	DS UTILIZATION	EA UTILIZATION	CALCULATION
Gross Plan Liability	29.5%	29.3%	(a) From Figure 4
Total DIR % of Allowed	30.0%	30.0%	(b) Assumption
Reinsurance % of Allowed	32.0%	30.4%	(c) Based on Figure 4
Plan Retained DIR %	20.4%	20.9%	(d) = (b) * (1 – (c))
Net Plan Liability	9.1%	8.4%	(e) = (a) – (d)
PD Worksheet 5 IU Adjustment	**0.925**		**(f) = 8.4% / 9.1% (from (e))**

Which plans are impacted?

Plans with the largest impact will be those that exacerbate the drivers of a lower BPT IU adjustment. At a minimum, plans must have these qualities:

1. Improved cost sharing. Plans that are minimally enhanced, above the defined standard benefit, are unlikely to be impacted.
2. High rebates. Any plans that have rebates that are lower than the market average are less likely to be impacted.
3. A high non-low-income percentage. Low-income (LI) members are priced as having 100% coinsurance in the gap, and therefore they do not create the same IU dynamic as non-low-income members. In addition, a smaller portion of LI members are enrolled in enhanced alternative plans, the only plans affected by the IU Floor.

   Only plans with calculated IU adjustments below 1.0 (and not just low) will see an impact. Many plans have a sufficient amount of increased use to offset the net liability impact of the induced utilization adjustment.

Assuming plans meet the criteria above, those in the 2021 landscape that are most likely to have a factor less than 1.0 include the following:

1. Chronic disease special needs plans (C-SNPs) that target diseases treated with drugs that have high rebates. Many C-SNP beneficiaries have conditions that are treated with highly rebated drugs, but diabetic SNPs in particular will likely have an IU adjustment below 1.0 due to the high rebates on insulins.
2. Any plans that cause members to stay in the gap longer than usual. As shown on Figure 4 on page 3, the longer members stay in the gap, the lower the IU factor will be. This typically happens with two types of benefit enhancements:
   a. Plans with coverage in the gap, especially for brands.
   b. Plans offering reduced cost sharing on insulins under the Senior Savings Model (SSM). Cost sharing under this model is capped in all phases before catastrophic at $35.
   c. Plans with significantly reduced cost sharing in the initial coverage phase. Defined standard cost sharing in the initial coverage phase is 25%, and plans that improve cost sharing to 10% or less on average may potentially have IU significantly less than 1.0. Note that the impact for these plans is somewhat muted because of real increases in utilization due to the benefit improvement.

[1] HHS (November 20, 2020). Final Rule to Bring Drug Discounts Directly to Seniors at the Pharmacy Counter - RIN 0936-AA08. Retrieved November 23, 2020, from: https://www.hhs.gov/sites/default/files/rebate-rule-discount-and-pbm-service-fee-final-rule.pdf

Figure 6 illustrates the plans that may have induced utilization below 1.0 based on the 2021 plan landscape. This figure reflects plan counts and percentages for both Medicare Advantage Prescription Drug (MAPD) plans, and standalone Prescription Drug Plans (PDPs).

FIGURE 6: 2021 MEDICARE PLANS THAT MEET CRITERIA THAT MAY DRIVE INDUCED UTILIZATION BELOW 1.0

PLAN TYPE	MAPD PLAN COUNT	PERCENTAGE OF MAPD PLANS	PDP COUNT	PERCENTAGE OF PDPS
C-SNPs with high rebates	211	5%	0	0%
Plans with gap coverage	1,876	42%	134	13%
Plans with SSM	1,308	29%	310	30%
Plans with low ICL CS	137	3%	0	0%

Any Medicare Advantage organizations (MAOs) that have plans with these attributes should closely review the induced utilization they are reporting on Worksheet 5 of the Part D bid form. In particular, many more plans are potentially impacted in 2021 than prior years due to the introduction and large uptake of the SSM. Given the potential financial impact of the shifted risk corridors, MAOs need to understand the impact of how induced utilization could impact Part D reconciliation.

This analysis highlights the impact under standard risk corridors. This issue may be more pronounced for plans participating in narrower risk corridors, such as:

1. Plans participating in the SSM. These plans may have opted into a narrower first risk corridor threshold of ± 2.5% about the target amount.
2. Risk corridor demonstration programs. In 2019, CMS proposed a risk corridor demonstration program covering 95% of claim deviations more than ± 0.5% about the target amount.[2]

It is unclear if CMS will offer a similar demonstration program for 2022. This program was mentioned after the release of the proposed rule affecting safe harbor protection for manufacturer rebates under the anti-kickback statute.

[2] CMS (April 5, 2019). Guidance Regarding Part D Bids. Retrieved November 23, 2020, from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Downloads/HPMS-Memos/Weekly/SysHPMS-Memo-2019-Apr-5th.pdf

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CONTACT

Adam Barnhart
adam.barnhart@milliman.com

Kevin Pierce
kevin.pierce@milliman.com