MILLIMAN WHITE PAPER

Government Funding for Medicare Part D

Katie Holcomb, FSA, MAAA
Douglas Rodrigues, ASA, MAAA

Milliman

Summary

The Pharmaceutical Research and Manufacturers of America (PhRMA) engaged Milliman to analyze the actual government spending for Medicare Part D as a percentage of total program costs in comparison to the government's legislated subsidy target of 74.5%. The 74.5% target is comprised of direct subsidy payments and reinsurance claims. We draw the following conclusions from our analysis:

- Part D insurers submit best estimate bid projections to CMS. When insurers underestimate the reinsurance component of these bids, the government's share of total program costs increases.
- In past years, the government contribution to Part D has consistently exceeded the 74.5% intended by law.
- We estimate reinsurance costs were underestimated in 2017 by approximately 17%, resulting in a federal contribution rate of about 77%. This resulted in federal spending of $6.8 billion more than intended by statute. Note, our analysis excludes the impact of risk corridors which could partially offset federal spending.

Background

The Medicare Part D program was established in 2006 under the Medicare Modernization Act (MMA). This program was designed to subsidize the cost of prescription drugs, such that Medicare beneficiaries were responsible for 25.5% of the aggregated cost of standard drug coverage while the government funded the remaining 74.5%[1]. Note, this 74.5% funds basic claim coverage for all members, though the government also funds aspects of Part D through other means, such as subsidies for low income members and risk corridor payments for plans who experience greater losses than expected.

Insurers must submit initial Part D bids in June to the Centers for Medicare and Medicaid Services (CMS) for plans they wish to offer in the following calendar year. After reviewing all bid submissions, CMS calculates key metrics needed to determine government and enrollee contributions.

The following equation is used to apply the funding requirements for standard Medicare Part D benefits in a given calendar year:

Total Basic Part D Cost = National Average Bid Amount (NABA) + Federal Reinsurance

where:

NATIONAL AVERAGE BID AMOUNT (NABA)

The NABA represents the expected revenue needed for insurers to provide standard Medicare Part D benefits to beneficiaries. This amount is equal to the sum of the national average member premium and the direct subsidy.

NATIONAL AVERAGE MEMBER PREMIUM (NAMP)

The NAMP represents the average member premium needed to cover 25.5% of the cost for standard Medicare Part D benefits. The actual member premium charged by insurers may vary from this amount to account for any difference between the insurer's bid amount and the NABA, as well as additional premium for supplemental benefits.

DIRECT SUBSIDY

The direct subsidy represents the portion of plan benefits that must be funded by the government. This amount is solved for such that the sum of the direct subsidy and national average projected federal reinsurance subsidy is equal to 74.5% of total basic Part D costs. This amount is risk adjusted when paid to plans to account for health status differences, but the risk adjuster is intended to net back to 1.00 on a program-wide basis.

FEDERAL REINSURANCE

The government covers 80% of costs for members in the catastrophic phase. The government collects a portion of rebates proportionate to this claim funding. CMS pays the projected net reinsurance amount to insurers throughout the benefit period with a reconciliation payment several months after the end of the benefit period for differences between actual and expected reinsurance claims.

Results

The 74.5% government funding is based on projected plan costs, but as noted, the government pays actual reinsurance claims regardless of how they compare to expected costs. The table in Figure 1 shows how final versus expected reinsurance costs cause actual federal funding to exceed 74.5%:

[1] Medicare Prescription Drug, Improvement, and Modernization Act of 2003. 42 U.S.C. § 1395w-115 (2003). The 74.5% funding represents the government share of total bid costs plus reinsurance costs, where bid costs are the total claim and non-claim costs expected to be incurred by the plan sponsor.

Figure 1
Comparison of 2017 Bid to Estimated Final Government Part D Contributions Per Member Per Month (PMPM)

	Part D Metric	Bid Amount	Estimated Final Amount[1]
(a)	NABA	$61.08	$61.08
(b)	NAMP	$35.63	$35.63
(c) = (a) - (b)	Direct Subsidy	$25.45	$25.45
(d)	Reinsurance	$78.65	$94.43
(e) = (a) + (d)	Total Program Cost	$139.73	$155.51
(f) = (c + d) / (e)	Federal Contribution %	**74.5%**	**77.1%**

[1]Excludes employer-sponsored plans. The actual reinsurance amount for 2017 is not publicly available at the time of this report and is estimated based on CMS and Milliman data sources. NABA, NAMP, and the direct subsidy are only reconciled through the risk corridor program, which is not addressed here. As such, we set the final amount equal to the bid amount for these items. Note this also excludes any restatement of NABA / NAMP resulting from changes in actual enrollment.

As seen in Figure 1, the best estimate bid amounts yield the legislated federal contribution target of 74.5%. However, if the federal contribution is recalculated using the estimated actual reinsurance amount, the federal contribution rate is higher, reaching approximately 77% of total Part D basic coverage. We estimate insurers underestimated the reinsurance amount in their 2017 bids by approximately 17%. **This comparison illustrates the government bears additional costs when actual reinsurance is greater than bid estimates, thereby increasing the overall government contribution to the Part D benefit program. Historical results show a trend of underestimating reinsurance in past years, with 64% to 68% of plans underestimating in 2011-2013[2], causing government funding to consistently exceed the 74.5% intended by law.** We estimate government spending was about $6.8 billion higher in 2017 than originally expected by the 74.5% target.

Final reinsurance amounts can be higher than original bid projections for a number of reasons. For example, when utilization and costs increase by more than anticipated, bid reinsurance estimates may be insufficient. In particular, there has been significant growth in specialty products in recent years, which can be difficult to predict given they are often utilized by a small subset of the population. If reinsurance bid estimates had been closer to final amounts, member premiums would likely have been higher.

Note, Figure 1 does not account for risk corridor payments. Through the risk corridor program, the government shares a portion of plan gains and losses above a certain threshold. Plans have historically projected higher than actual costs resulting in gains shared with the government, so the actual government funding percentage for 2017 could be lower than indicated in Figure 1.

While our analysis excluded the impact of risk corridor payments, we estimate the overall impact of these payments on total government funding is small. Risk corridor payments were $1.1 billion in 2015. While it is difficult to estimate plan-level gains and losses for 2017, if average risk corridor payments are the same as in 2015, this offset would reduce the federal contribution percent to 76.7%. The fact that plans have been more accurate in projecting total costs (evidenced by relatively small risk corridor payments) than the subset of costs for reinsurance may indicate it is easier to accurately project overall cost levels than the distribution of costs by stakeholder.

Methodology / Assumptions

We relied on two data sources in estimating the final 2017 reinsurance amount: 2015 CMS settlement data projected to 2017, and actual 2017 Part D claims from Milliman's Part D Consolidated Database (PDCD). We excluded employer group waiver plan (EGWP) data from our analysis since these plans are not required to submit Part D bids and, therefore, do not contribute to the 74.5% funding calculation. Members in EGWPs are also excluded from our estimate of how total dollar government spending would be impacted. We estimated the final 2017 reinsurance amount as the average of the reinsurance amounts implied by each of the underlying data sources. Each of our sources had certain limitations. Please see the next section below for details and key assumptions used to estimate the 2017 reinsurance amount from each data source.

[2] Medicare Payment Advisory Commission (June 1, 2015). Chapter 6: Sharing Risk in Medicare Part D. Report to the Congress: Medicare and the Health Care Delivery System. Retrieved January 8, 2019, from http://www.medpac.gov/docs/default-source/reports/chapter-6-sharing-risk-in-medicare-part-d-june-2015-report-.pdf.

2015 CMS settlement data

- Most recent CMS settlement data source available to date.
- Comprised of all Medicare Part D plans, but actual reinsurance results are only provided at the contract level. We limited our analysis to only include contracts with less than 5% of membership from EGWPs.
- Trended actual 2015 reinsurance amounts to 2017 using the ratio of the 2017 to 2015 national average bid reinsurance amounts.

2017 Part D Consolidated Database

- Data contains actual Part D claims from calendar year 2017.
- Contains a large number of Medicare Part D lives (approximately 10 million), but does not capture 100% of the market.
- Plan and claim level detail available for detailed calculation of actual reinsurance claims.
- Actual rebate data is not available, so rebates were assumed to be consistent with bid estimates. We assumed rebates were 25% of total claim costs, based on a Milliman survey of 2017 bid assumptions.

Caveats / Limitations / Qualifications

This report was developed to estimate the portion of Part D program costs funded by the federal government. This information may not be appropriate, and should not be used, for other purposes. The information presented in this report is provided for PhRMA. PhRMA may share this information with outside entities with Milliman's permission. Milliman does not intend this information to benefit, and assumes no duty or liability to, other parties who receive this work product. Any third party recipient of this work product who desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

In preparing our analysis, we relied upon public information from CMS and a Milliman claims database of nationwide Medicare claims. Actual results will vary for specific health plans due to differences in trends, discount and rebate arrangements, benefit designs, and formulary structures, among other differences.

We are not attorneys and do not intend to provide any legal advice or expertise related to the topics discussed here. The opinions included here are ours alone and not necessarily those of Milliman.

Katie Holcomb is an actuary for Milliman, a member of the American Academy of Actuaries, and meets the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of her knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices. This information has been prepared under the terms of the consulting services agreement between Milliman and PhRMA, dated January 19, 2016 and extended effective December 19, 2018.

Milliman

CONTACT
Katie Holcomb
katie.holcomb@milliman.com

Douglas Rodrigues
douglas.rodrigues@milliman.com