Medicare Prescription Drugs Through Private Drug-Only Policies:

A Discussion with Actuaries

THE HENRY J. KAISER FAMILY FOUNDATION

Medicare Prescription Drugs Through Private Drug-Only Policies: A Discussion with Actuaries

By

Health Policy Alternatives, Inc.

June 2003

EXECUTIVE SUMMARY

At the heart of the current debate in Congress over Medicare prescription drug coverage is the appropriate role of private insurance plans under contract with the government to provide prescription drug benefits. Although some lawmakers want an outpatient prescription drug benefit to be insured by the government but administered by private sector contractors, other lawmakers want a benefit that is both administered and largely insured by private entities. Differences also exist on how much choice Medicare beneficiaries should have in selecting a prescription drug plan; how much variation should be allowed in the benefit package structure; and whether beneficiary premiums should be uniform nationwide or whether plans should compete on price with enrollee premiums varying according to their choice of plan.

To help inform this debate, the Kaiser Family Foundation contracted with Health Policy Alternatives, Inc. (HPA), to convene a panel of health actuaries familiar with the Medicare program and the prescription drug debate. Given their experience with pricing different health insurance products and working with insurers, employers, and pharmacy benefit managers (PBMs), health actuaries are in a unique position to assess many of the major issues related to the private health plan delivery of a Medicare prescription drug benefit.

With the assistance of the American Academy of Actuaries, HPA identified and invited eight individual actuaries to participate in the project. The objective was to explore the implications of providing prescription drug benefits to Medicare beneficiaries through private, drug-only plans from the perspective of the insurance industry and other potential plan sponsors such as PBMs. Did any consensus exist among the actuaries participating in the project on the major issues involved in structuring such a Medicare prescription drug option?

The views of the actuaries were obtained through structured phone interviews, first with each actuary individually and then in a conference call in which most participated. The findings from these interviews are the basis of this report; no separate data analysis was performed. From these interviews, HPA identified those views on which there was consensus and those views for which there were dissenting opinions. While it was not the intent to critique the details of the bill that was passed by the House of Representatives in 2002 (H.R. 4954), a summary of the provisions contained in that bill was provided to the group to provide context for the discussion.

The actuaries were guardedly optimistic that a drug-only private plan approach to providing Medicare prescription drug benefits could be viable, provided that certain key features were included in an enacted program. Most important were that there be adequate government subsidies of beneficiary premiums, and that, while plans should bear some insurance risk to provide incentives for efficiency, at least in the beginning, insurance risk should be shared between the private plans and the federal government. On the method of risk sharing, most of the actuaries said that risk corridors were better and more attractive than reinsurance. Allowing only a one-time election of the drug

benefit was also regarded as critical. Additional features seen by actuaries for plans as advantageous to offering a drug-only benefit included: the freedom to price premiums without arbitrary government limits; the ability to price premiums for local markets and not nationally; flexibility to exit the market (no guaranteed renewal as exists for Medigap insurers); some benefit flexibility, especially with respect to cost-sharing structures; preemption of most state laws and regulations to reduce the costs of compliance and make it easier to market on a multi-state or national basis; and an active role for the government in marketing and collecting premiums to reduce plans' administrative costs.

The actuaries varied in their level of enthusiasm for a drug-only approach. To some extent, this reflected the differences in market positioning of their respective companies or their actuarial experience. Even the more enthusiastic of our participants had reservations, however, about participating in a government-sponsored program. Based on their experiences with Medicare+Choice and Medigap, they questioned the reliability of the government as a business partner.

It was evident from our discussions that some of the reservations expressed by the actuaries about a Medicare stand-alone drug program would endure whatever the parameters of any enacted legislation. They were of one voice in expressing concern that Congress would likely make mid-course program changes that could impede their ability to accurately price policies or predict program requirements. Given the specifications of a proposal similar to the House-passed bill, however, they expected at least large national PBMs, or large national insurers in partnership with PBMs (or similar entities), to enter the market. Whether a Medicare drug-only product would be sustainable as a line of business would depend on plan experience and future government policy, especially maintenance of adequate government subsidies and limited enrollment opportunities that would promote broad participation by Medicare beneficiaries in the program.

Although our discussion about a Medicare stand-alone drug program centered on the needs and concerns of plans (i.e., insurers and PBMs), we also asked the actuaries to evaluate various program design features from the perspective of beneficiaries. This line of inquiry revealed an inevitable tension between the priorities for plans and the needs and concerns of beneficiaries. Especially obvious were the tradeoffs related to benefit design, the pricing of premiums, and enrollment options. The flexibility desired by plans with respect to benefit design and pricing could result in confusing and unpredictable options that could be difficult for beneficiaries to compare, with the potential for significant premium variability from year to year and area to area. Limits on the ability of beneficiaries to switch policies from year to year could reduce beneficiaries' access to needed drugs and increase their out-of-pocket costs. Participation rules allowing plans to readily withdraw from the Medicare market could undermine beneficiaries' confidence in the stability of their drug coverage. Such observations highlight the importance of striking a balance between plan and beneficiary concerns in the crafting of a Medicare prescription drug program.

Medicare Prescription Drugs Through Private Drug-Only Policies: A Discussion With Actuaries

The increased importance of prescription drugs in the treatment and management of disease, and the resulting rapid increase in prescription drug spending, has brought the lack of outpatient prescription drug benefits in the Medicare program to the forefront of the political agenda. Virtually all members of Congress, as well as the Bush Administration, have indicated their support for some form of outpatient drug coverage for Medicare beneficiaries but no consensus has emerged, however, on how to address the issue. The House of Representatives passed a bill in each of the last two Congresses that would provide Medicare outpatient prescription drug benefits but no bill cleared the closely divided Senate.

The major points of disagreement over Medicare outpatient prescription drug coverage include the amount of federal money that should be committed to a new entitlement, the structure for delivering the benefit, and how such a new benefit would relate to overall changes or reform in the Medicare program. In general, the two opposing camps consist of those who believe the Medicare program is unsustainable in its current form and that drug coverage should be part of an overall Medicare restructuring; and those that believe the current Medicare structure is basically sound, and that a drug benefit should be added within the same basic parameters as benefits in the existing program.

At the heart of the debate is the appropriate role of private insurance plans under contract with the government to provide prescription drug benefits. In general, the two sides divide over whether the benefit should be structured similar to Medicare Part B, or whether benefits should be provided by competing private sector plan sponsors in a manner similar to Medicare+Choice (M+C). While there is general agreement on having an outpatient prescription drug benefit administered by private sector entities under contract with the government, there is disagreement over how much insurance risk should be assumed by private entities, how much choice beneficiaries should have in selecting a plan; how much variation should be allowed in the benefit package design; and whether beneficiary premiums should be uniform nationwide or whether plans should compete on price with enrollee premiums varying according to their choice of plan.

To help inform this debate, the Kaiser Family Foundation contracted with Health Policy Alternatives, Inc. (HPA), to convene a panel of health actuaries familiar with the Medicare program and the prescription drug debate. Given their experiences with pricing different health insurance products and working with insurers, employers, and pharmacy benefit managers (PBMs), health actuaries are in a unique position to assess many of the major issues related to the private health plan delivery of a Medicare prescription drug benefit.

With the assistance of the American Academy of Actuaries, HPA identified eight practicing actuaries to participate in the project. A list of the participating actuaries is included as Attachment A. The participating actuaries had diverse backgrounds relative to Medicare including experience in traditional health insurance companies, in companies

that market Medicare supplemental insurance policies (Medigap); health maintenance organizations (HMOs) that participate in M+C; Medicare contractors providing administrative services to Medicare; and with companies associated with retiree health benefits, including pharmacy benefit managers (PBMs).

Our objective was to explore the implications of providing prescription drug benefits to Medicare beneficiaries through private, drug-only plans from the perspective of the insurance industry and other potential plan sponsors such as PBMs. While it was not the intent to critique the details of the bill that was passed by the House in 2002 (H.R. 4954), the provisions contained in that bill were provided to the group to provide context for the discussion. (Attachment B is the summary of the H.R. 4954 provisions that was provided to project participants.) The actuaries were also asked for their views on integrating a drug benefit with the existing Medicare benefit package as has been proposed in some competing legislation.

A key concern regarding the private drug-only plan approach is whether benefits would be available to all beneficiaries throughout the United States and be sustained over a period of time. The concern stems from experience to date with the M+C program. M+C plans are not available in many areas, and the number of plans participating in M+C has dropped significantly over the last five years. Plan withdrawals have led to steadily declining enrollment and increased concerns about the sustainability of the program. Therefore, HPA explored with the actuaries the characteristics of a competing, private plan approach to identify what features would be attractive to plans and therefore might make such an approach viable and sustainable, and what features would probably discourage plans from participating.

HPA identified key issue areas to explore with the actuaries on benefit design and cost management techniques; pricing of premiums; bearing of risk; minimum enrollment and reserve requirements; incentives and disincentives for plan participation; and administrative issues. HPA then developed a set of questions around these major issues and conducted individual telephone interviews with each of the participating actuaries. Responses from these structured interviews were then compiled into a document identifying areas of agreement as well as areas where there were divergent views or no apparent consensus. This document was distributed for review to each of the participants. Finally, a telephone conference call with the participating actuaries was conducted to ascertain the group's concurrence with the content of the document and to see if there were any other areas of consensus. No data analysis or other sources of information were relied on to complete this report.

The actuaries participated as experts and spoke for themselves and not their companies. The interviews were not recorded and the actuaries were assured that their remarks would not be attributed by name. This report reflects HPA's best understanding of what was actually said by the participating actuaries.

In this report, "plan" is used to mean an insurer, pharmacy benefit manager, employer or some other entity that contracts with Medicare to offer a stand-alone outpatient

prescription drug-policy. A "drug-only policy" is used as shorthand to mean a stand-alone prescription drug benefit that is offered by a plan to Medicare beneficiaries.

BENEFIT DESIGN AND COST MANAGEMENT TOOLS

The discussion of benefit design issues focused on both specification of a drug benefit itself as well as the management tools available to health plans for use in the administration of the benefit. There was broad agreement among the actuaries that some flexibility in the design of coverage would be desirable to health plans and lead to greater plan participation.

Proposals like H.R. 4544 allow drug-only plans to vary benefits so long as the benefits meet an actuarial equivalence standard. The actuaries believed that imposing an actuarial equivalence standard would likely be viewed favorably by plans so long as the process for certifying the actuarial test was not too burdensome. While benefit flexibility was seen by most of the participating actuaries as positive, if the rules for applying it to the benefit design were complex and the regulatory approval process time consuming, then this flexibility would be considerably less attractive.

For example, several participants observed that rules concerning the treatment of out-of-pocket drug expenses and the existence of a significant band of non-coverage (a "donut hole") prior to triggering stop-loss (catastrophic) protection could complicate the determination of actuarial equivalence. Some actuaries were also concerned that variations in drug formularies and differential cost sharing could raise marketing costs, be a source of confusion for beneficiaries, and drive risk selection. This latter outcome was thought to be especially likely if information on specific drugs included in each plan's formulary were to be disclosed to beneficiaries prior to their purchase of a policy. However, the actuaries did not view these issues alone as a serious threat to plan participation.

If the actuarial equivalence standard is applied narrowly, then there would not be much room for benefit variation. However, there's still a lot of room for variation in formulary design outside of an actuarial equivalence requirement.

Of particular importance to the actuaries was the extent to which plans would be given the flexibility to apply cost management tools to the administration of the benefit. They generally agreed that the most effective management tool would be patient cost sharing (e.g., tiered co-pays tied to generics, preferred brands, and other brands). They also noted the importance to effective cost management of generic substitution policies, pharmacy network restrictions, drug utilization review (DUR) programs, formulary design, mail service, and pharmacy education. Several participants noted differing formularies among the competing policies could prove confusing to some beneficiaries.

The most effective cost-management tool is the patient cost-sharing structure.

A number of other issues related to benefit design were discussed but without achieving consensus about their implications for a drug only insurance policy. With respect to the impact of an actuarial equivalence standard for the

benefit package, some participants felt that there would be a lot of variation in benefit design across available policies. The experience with an actuarial equivalence standard on benefits offered by health plans in the Medicare competitive pricing demonstration was cited as an illustration.[1] In that case, there were very significant differences in benefit designs with the same actuarial value across two planned demonstration sites (Phoenix and Kansas City). As one participant noted, "actuaries can be very creative."

In contrast, it was also observed that the actuarial equivalence standard in H.R. 4954 was relatively tight with respect to equivalence within cost sharing tiers and a uniform catastrophic threshold. As a result, little significant variation in product design would be possible. More likely, in the view of one participant, would be variation around the drug formulary with different plans favoring different brand-name products within the same therapeutic class. It was suggested that some policies might offer generic drug coverage without a copayment requirement in order to keep premiums low and attract enrollment. This discussion led one actuary to speculate that plans with very rich benefit packages were unlikely to be offered because of the risk to plans of adverse selection and less competitive premiums. Others disagreed and felt that there would be a niche market for plans "offering everything to those willing to pay for it." Still others believed that the value of the benefit packages would cluster around a standard package with some plans offering only a modestly richer benefit.

There was also a difference of opinion regarding the impact of using pharmacy network restrictions in the senior market. Some participants expected that most plans offering a Medicare drug benefit would have networks providing reasonable access to pharmacies across the country. One person felt that access was very important to seniors and that regional players without a comprehensive network would be at a substantial disadvantage. If legislation included specific access standards, such as requiring a participating pharmacy be available within 20 miles of every enrollee, it could discourage participation by smaller, regional plans.

One of the points of contention in the debate over a Medicare drug benefit is the degree to which prescription drug coverage should be integrated with other medical benefits. Without exception, all of the actuaries agreed that integration of covered items and services into a broad package of benefits is preferable to a stand-alone drug benefit.

Integrated benefits are preferable because they allow coordinated care management and account for tradeoffs in the use of health services. They also reduce the potential for selection bias based on specific benefits.

Integration reduces or removes much of the selection bias that is in play when individuals are making decisions about participation based on an assessment of their need solely for drug coverage. Integration also allows plans to better manage care by encouraging the most appropriate and cost effective treatments. In addition, integration allows variation in rates of cost increases for individual benefit categories (e.g., physician, hospital, or prescription drugs) to be homogenized into one overall rate of increase. The faster growing medical service costs can be averaged in with

[1] Authorized by the Balanced Budget Act of 1997, the Medicare Competitive Pricing Demonstration was later suspended by Congress before the demonstrations began.

those service costs that are increasing more moderately. Also, the trade-offs among benefits can be taken into account as changes in medical practice evolve. For example, treatment with pharmaceuticals may become preferred over more invasive interventions such as surgery. In such cases, drug spending would rise but may be offset by lower spending for hospital care.

As will be discussed below, premium increases from one year to the next can lead individuals to drop coverage. If benefits were integrated into one broad package, an enrollee's decision to terminate coverage would have greater consequences and, would therefore, discourage disenrollment. However, if a policy covers only one category of health care benefits, such as prescription drugs, premium cost increases may be more likely to cause enrollees, especially those who are not currently taking many drugs, to drop the coverage.

Although the actuaries clearly favored integrated benefits, they recognized the practical and political hurdles that face policymakers regarding the creation of a Medicare drug benefit and changing the underlying structure of the existing program. Said one actuary, "I support transforming Medicare into a coordinated care program and drugs would help that occur. But it has to be done in a way that does not threaten seniors. Practically speaking, you need traditional Medicare as an escape valve, an alternative to private plans."

PRICING A DRUG-ONLY POLICY

A drug-only policy for Medicare beneficiaries poses significant uncertainty with respect to pricing a premium, especially for an entity considering entering the Medicare market for the first time. If a premium is priced too low, the plan will not collect sufficient revenues to pay claims and administrative overhead or provide a margin for profit. If the premium is priced too high, the policy may not be competitive in the marketplace. The participating actuaries were generally in agreement that initially pricing would be problematic, especially if the plan had to assume any insurance risk. For some, this uncertainty could be enough to discourage plan participation. For others, the pricing issue was a concern but would probably not prevent plans from entering the market, at least on a trial basis.

The pricing of a premium for a drug-only policy is a major challenge, especially in the first years of offering because we don't have the data.

One of the pricing challenges results from inadequate prescription drug utilization data. Many insurers and PBMs have prescription drug claims data for seniors with employer-sponsored retiree coverage, or who are enrolled in an M+C plan or a Medigap policy with drug coverage. Some have data on drug use by seniors who have discount drug cards. However, these entities do not have adequate proxy information to allow them to predict with confidence the utilization of seniors (or the disabled) who would become newly insured for prescription drugs under a stand-alone drug policy. Would this group of Medicare beneficiaries have the same or different utilization patterns as seniors who obtain their drug coverage through a plan that is integrated with other medical services?

How much increased drug utilization might result as a consequence of becoming newly insured? Would there be a significant increase in utilization due to pent-up demand? Another challenge in pricing a premium is predicting how many and which beneficiaries would enroll in a specific drug-only plan. Managing the uncertainty of both the risk of pricing adequately in the first place and the adverse selection risk becomes easier to the extent that plans are partially protected from anti-selection by risk-sharing arrangements. Risk-sharing is a critical point because otherwise even a small error in predicting claims experience can result in a significant financial loss for the company selling the policy.

The third pricing issue is whether a plan would be permitted by the rules of the Medicare program to charge a premium for the policy that is sufficient to cover claims and overhead costs (inclusive of an allowance for profit). For the actuaries participating in this discussion, the crucial element is that initial or renewal premiums not be limited by government law or regulation other than requiring that premium rates be actuarially justified. (Several actuaries were concerned that the government would eventually impose limits on premium increases in response to beneficiary concerns about rising premium costs.) Concerns about being able to increase premiums to keep pace with drug cost inflation were also raised and are discussed in the next section.

Plans should be given the flexibility to adequately price premiums without arbitrary government interference.

A related concern of the actuaries was that sponsors of drug-only policies be permitted to price their products locally. They agreed that locally or at most regionally-specific premiums are necessary to reflect the significant geographic variations in prescription drug utilization. In the actuaries' experience, prescription drug utilization varies significantly from one community to another even within a state, let alone within a region or across the nation. The overall mix of medications and the quantity of their use would likely vary due to differing physician prescribing patterns, patient health status, and other factors; drug prices also vary somewhat by area. For many plans, a requirement that they price on a national or regional basis could discourage their participation in the program.

Prescription drug utilization varies significantly by geography. Patterns vary even within a state.

On a few issues of pricing, the views of the participating actuaries differed. Similar to the discussion over benefit variation, there were different opinions on whether premiums would tend toward the average or whether some policies would be offered at the extremes: either at significantly higher than average premiums or at significantly below average premiums. It was suggested that some drug-only policies might attract higher-income beneficiaries with a high premium policy providing an open formulary and low cost-sharing requirements. Such plans might also attract fully subsidized (i.e., low-income) beneficiaries, especially if there were an attractive reinsurance mechanism for the insurer. Other plans might target beneficiaries who would be attracted to low premiums, either because they have low prescription drug needs or have limited resources yet do not qualify for the low-income subsidies.

BENEFICIARY PARTICIPATION AND ADVERSE SELECTION

A critical element in evaluating the viability of a Medicare prescription drug proposal that provides for voluntary participation on the part of beneficiaries is whether the benefit will attract a broad enough pool of beneficiaries to be sustainable. To be attractive to beneficiaries, the new drug insurance option would have to be readily available, affordable, and offer equivalent or better coverage at a lower price than other available sources. The "participation" or "take up" rates would be strongly influenced by the cost to the beneficiary of enrolling in the policy, which is largely viewed in terms of the premium. Another key factor is the enrollment and premium collection rules.

The participating actuaries were told to assume that the average premium for a beneficiary would be about $33 per month, based on the subsidy structure in H.R. 4954.[2] Beneficiaries with very low incomes would pay no premium as a result of the federal subsidies. Premiums would be collected by the government through automatic deduction from beneficiaries' Social Security checks or other forms of automatic payment. Beneficiaries would generally have a one-time only enrollment option in the Medicare drug program, although they would be able to switch among available drug-only policies during annual open enrollment periods.

The participating actuaries agreed that an average beneficiary premium at the start of the program of about $33 per month was low enough to achieve adequate beneficiary participation rates. The subsidies, together with the one time enrollment requirement, would encourage take-up by most beneficiaries, possibly with the exception of very high income seniors, who the actuaries thought might be more likely to self-insure for prescription drug costs. They noted, however, that even some low-income beneficiaries who could enroll for no premium might fail to do so because of the eligibility determination process and the stigma attached to means-tested provisions.

Government subsidies must be sufficient to keep beneficiary premiums affordable.

As noted above, there was a common concern among the actuaries that plans be given the flexibility to raise premiums from year to year to keep up with the annual increases in the spending for prescription drugs, referred to by actuaries as "drug trend." Given the actuaries' experience with drug trend to date, everyone expected that premiums for drug-only policies would have to go up steadily and significantly to cover claims costs. For plans to retain enrollees, it would therefore be necessary for the government premium subsidies to keep pace with drug expenditures. Otherwise, the premiums would become so high that only the beneficiaries with the highest drug costs would retain coverage while those with lower drug costs would elect instead to go without coverage, creating what is known as a death spiral. This deterioration of the risk pool would be moderated, however, if for beneficiaries who drop their coverage and then later apply to reenroll, plans could charge higher premiums and medically underwrite their applications. This is, in fact, a provision

[2] The subsidy structure in the House-passed bill included both the direct federal subsidies of the beneficiary premium and the indirect subsidies to the plans provided through the reinsurance mechanism.

of H.R. 4954.[3] It should be added that the actuaries expressed skepticism that a one-time enrollment opportunity would be a lasting rule anticipating that eventually Congress would change the rules, as it has done with Medigap and M+C.

Another concern of the actuaries was allowing beneficiaries to switch drug plans each year. Some of the actuaries said that this would increase plan adverse selection because beneficiaries would use the opportunity to switch to the plan with the formulary and cost-sharing structure that best met their needs at the time. Although there was some support for locking in beneficiaries to a specific plan for more than one year, the participating actuaries noted both practical and political problems in doing this. Would beneficiaries be protected from significant increases in premiums? What if they needed to take a drug that was not covered by their policy's formulary? No consensus was reached on this issue.

There was a consensus, however, among the participating actuaries that existing employer-sponsored retiree drug benefits would be eliminated or redesigned to supplement Medicare benefits. This would be a likely result of any Medicare drug benefit, not just one that was structured around private drug-only plans, largely because employers are looking to reduce their liabilities for retiree health benefits anyway. The actuaries did feel that the feature in H.R. 4954, referred to as "true out-of-pocket costs" would discourage employers from sponsoring Medicare drug plans or providing wrap-around benefits. This provision would prohibit claims payments from third party payers, including employer-sponsored health plans, from counting toward the Medicare policy's out-of-pocket (i.e., catastrophic) limit.

RISK ARRANGEMENTS

One of the major areas of disagreement among policymakers in the structuring of Medicare prescription drug proposals is in the treatment of risk. Under H.R. 4954, Medicare drug-only plans would be required to bear most of the risk for benefit costs (what is called insurance, claims or benefit risk).[4] The federal government would share some of the risk through a reinsurance mechanism. In some competing proposals being considered by Congress, the government would contract with private entities to administer a prescription drug benefit for the Medicare program, but the entities would bear performance risk only. Whereas the insurance risk would be shouldered entirely by the federal government, the private entity would agree in its contract to meet certain objectives with respect to the administration of the benefit, and the management of its costs and quality.[5]

The actuaries were asked their views on different types of risk-sharing arrangements, judged from a plan perspective. We asked them to consider first sharing risk through

[3] Beneficiaries who fail to maintain continuous coverage under a qualified drug policy could be charged higher premiums and be subject to medical underwriting.

[4] In essence, an insurer incurs a risk that premiums may not be sufficient to cover the claims for covered benefits. In this instance, the risk is that the premium may be insufficient to pay the claims costs for covered drugs.

[5] Performance risk may also be referred to as administrative risk.

reinsurance, as called for in H.R. 4954. We then asked about the desirability of transitioning to a requirement that private drug-only plans bear 100% of the insurance risk for the policy. Finally, we asked them to consider whether plans would be willing to assume either partial or full risk in all areas of the country. Not surprisingly, opinions differed on these issues, but they were in basic agreement that the larger, national health plans and perhaps some of the large PBMs would be far more comfortable assuming insurance risk than the smaller, regional players.

Insurance Risk vs. Performance Risk. It was posited above that insurance risk is measured in terms of whether premiums (and subsidies) cover claims costs. Performance risk is measured in terms of whether the plan has sufficient skill and capacity to administer the benefit according to contractual standards. The performance risk may be greater for some entities than others, depending on whether they are already engaged in an insurance business that markets directly to individuals (as would be required under a Medicare drug-only policy), or have the infrastructure in place (or are readily able to partner with a PBM or, perhaps, a chain drug store) to administer a drug benefit.

On the question of insurance risk, the actuaries agreed that given the significant uncertainties involved in selling a drug-only policy to Medicare beneficiaries, the government should share some of the risk with the private drug-only plans, at least over the near term. These uncertainties, described earlier, relate to the extent of beneficiary participation, their utilization of prescription drugs, and which policies they select. However, the actuaries agreed that the plans needed to "have some skin in the game" in order to have incentives to manage the drug benefit efficiently.

Risk-Sharing Arrangements. Risk-sharing between the government and private plans could be done through reinsurance or risk corridors.[6] Each approach comes with certain drawbacks. Some actuaries were concerned that reinsurance reduces the incentives for plans to manage high-cost users. Since the plan knows that the government bears the cost once the reinsurance thresholds are reached, it has less incentive to use restrictive formularies, and aggressive cost-management techniques. Others judged the reinsurance provisions such as those in H.R. 4954 to be appropriate and thought them a major reason why some plans would elect to participate.

Most of the participants, however, preferred that risk-sharing be accomplished through the use of risk corridors, at least in the early years of the program or, for new plans

[6] Under aggregate reinsurance, "the federal government would pay all or a percentage of claims once a private plan's aggregate claims exceed a pre-determined threshold." Under individual or specific reinsurance, "the federal government would pay all or a percentage of claims once an individual enrollee's claims exceed a pre-determined . . . threshold." Risk corridors are contractual safeguards that limit the insuring entity's risk of losing money but also its gain (profit). In a typical risk-corridor 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." Cori Uccello and John Bertko, *MedicarePrescription Drug Plans: The Devil is in the Details,* American Academy of Actuaries, Washington, D.C., Updated April 2003. www.actuary.org/briefings/medicare_may03.htm. Note that H.R. 4954 included both types of reinsurance.

wishing to enter the market, during their first few years of involvement with Medicare. Most are familiar with risk corridors, either in connection with employer plans or in the context of PBM performance clauses in client contracts. The major appeal of risk corridors, especially in the first years of offering a stand-alone drug policy, is that the plan's financial exposure would be limited at a time when they were acquiring claims experience and becoming familiar with the administration of a stand-alone drug benefit. Risk corridors would thus encourage plans to participate.

The principal drawback identified with this risk-sharing approach is the complexity in establishing the corridors (and possibly with the collection of the data needed by the government to make its payments to the plans), especially before adequate information is available. One actuary also expressed a concern that risk corridors might encourage plans to "low-ball their premiums" as a strategy to obtain market share in the initial years. A more skeptical respondent observed, however, that even risk corridors exposed plans to losses and "a loss is a loss." Finally, some actuaries thought that if the risk corridor approach was adopted, there needed to be a way of isolating a plan's administrative costs from its claims costs to assure a fair accounting of those costs assumed by the government.

There was also discussion about the feasibility of compensating plans for adverse selections by means of risk-adjustment. Risk-adjustment is a means by which to protect an individual plan from being disadvantaged in its competition with other plans as a result of enrolling a disproportionate share of enrollees with above-average prescription drug expenditures. There was disagreement on whether risk adjustment was necessary if the plans were already being protected from the effects of adverse selection through reinsurance or risk corridors. In addition, some skepticism emerged about the availability of an adequate tool to apply risk adjustment and concern about the cost to plans of the requisite data collection. However, one actuary asserted that risk adjustment is simpler for prescription drugs than for other medical services because of the widespread availability of electronic prescription drug claims data. At least one person preferred a combination of risk corridors and risk adjustment to reinsurance.

Phase-in to Full-Risk. We also asked for the actuaries' views on whether plans should eventually be required to bear full risk for drug-only policies by phasing in full risk over several years. A few of the participants indicated that over the long run, entities should be required to take full risk while there was hesitation on the part of others in moving to full risk. One actuary said that if plans were eventually required to take full risk, then they should be given the broad discretion to manage risk through such tools as benefit design, underwriting (e,g., rating for health status and age within certain limits), and premium pricing. They also should be allowed the leave the market.

Enrollment Requirements for Assuming Full Insurance Risk. In response to how much enrollment is required to enable a private drug-only plan to bear risk, the actuaries generally agreed that as risk exposure increased, so too does the number of enrollees needed to spread those risks. It was suggested by several actuaries that the minimum number of covered lives required to bear full risk is 10,000 but a larger number would be

better. One respondent said that the number of lives "is the amount that makes the insurer comfortable enough."

Plan Solvency Requirements. We asked about whether there should be specific solvency and reserve requirements for drug-only policies. It was observed that such requirements do not currently exist but that the structure adopted by the National Association of Insurance Commissioners to establish risk-based capital standards could be drawn upon, although an appropriate formula for prescription drug plans would still have to be developed.[7]

Market Area Considerations. A final risk-related issue discussed with the actuaries is whether plans would be willing to assume partial or full risk for all areas of the country. Although this issue is discussed more below (see Plan Participation), it should be noted here that there was agreement that smaller plans especially would be reluctant to bear risk (partial or full) for all parts of the country. This, in part, has to do with the fact that they may not currently operate in all market areas and would, therefore, have to increase capacity (e.g., build new networks or collaborate with another entity, such as a PBM or chain drugstore that has the networks). However, it also has to do with adverse selection and the concern that any risk-sharing mechanism may not be sufficient to offset plan losses. For some actuaries, a requirement to market in all areas would add to their level of discomfort in predicting their pool of insureds.

A one-time enrollment rule does not mitigate concerns about adverse selection in a specific market area. It is hard to assess how beneficiaries in an area will sort out among available plans.

ADMINISTRATIVE ISSUES

The actuaries were asked about several issues related to the administration of drug-only policies. One concerned the role of the federal government versus private plans in marketing the new drug benefit and in providing information about the different policies to beneficiaries. They agreed that the government needs to play an active role in communicating with beneficiaries about the existence of the drug benefit and in providing information about the differing policy options in order to achieve maximum beneficiary participation.

Another issue related to whether the plans or the federal government should be responsible for collecting beneficiary premiums. There was agreement that the government should bear this responsibility. This too would help to maximize participation and policy retention. In addition, if the government collected premiums, there would be more "consistency of treatment" in the event that a beneficiary failed to

[7] These standards, which states may elect to adopt, provide a means of setting minimum capital standards as part of overall solvency requirements to support an insurer's operations given its specific size and risk profile. A company's risk-based capital is calculated by applying factors to various asset, premium and reserve items, where the factor is higher for those with greater underlying risk and lower for less risk items. American Academy of Actuaries, *Insurance Terminology*, unpublished document.

pay the premium. (In H.R. 4954, an enrollee would have the option of having their premium contributions withheld from their Social Security check or some other automatic form of payment.) Finally, this would help to reduce the collection costs of plans.

There was some discussion of "member acquisition costs" and how enrollment procedures could reduce these costs. Some type of automatic enrollment was seen as superior to a system requiring affirmative enrollment by beneficiaries. One participant suggested that "default enrollment" could help to reduce administrative costs so long as the benefits and premiums of competing plans do not vary significantly. "If individuals felt they made a mistake, they could change their plan selection the next year."

There was considerable discussion about the timing of annual open enrollment periods. Some participants recommended against a single, annual enrollment period effective on a calendar year basis. There was concern about the difficulty plans would have handling the administrative burden associated with large shifts in enrollment at the end of the year. As an alternative, it was suggested that enrollment periods could be timed to the birth date of beneficiaries, or, at a minimum, the effective date for coordinated enrollment periods could be moved from January 1 to September or October because of the existing burden of group renewals in the commercial market at the beginning of the calendar year. However, it was also noted that staggered enrollment periods would raise issues about whether premium rates would apply for the whole year or be re-determined more frequently.

Finally, one participant raised a concern about the need to include in any Medicare drug proposal specific assurances that plans would be able to exit this line of business in a timely manner. The origin of this concern is a requirement imposed on insurers to provide guaranteed renewal of Medigap policies. While Medigap insurers can close new enrollment in a policy, this standard effectively requires those plans to operate until all covered beneficiaries elect other coverage or the plan sells the product to another insurer. This participant felt some plans would want the opportunity to assess their continuing participation in a drug-only policy market at least on an annual basis, similar to the way M+C works.

Recognizing that a Medicare drug benefit offered through competing private drug-only insurance policies would involve a set of national requirements, several actuaries noted that it would be desirable to pre-empt overlapping or conflicting state insurance laws and regulations. Specifically, state laws relating to rate regulation, benefits, and market conduct should be consistent with related federal requirements. On the other hand, it was noted that if Medicare drug policies were offered through agents and brokers, it would be important to retain state oversight of these agents since oversight by the federal government would not be feasible. It was noted that while agents and brokers can increase enrollment, their fees add to administrative costs. Finally, they suggested that market conduct rules similar to those imposed on M+C plans and the employer group market also be applied to the sale of drug-only policies.

Another concern raised by some of the actuaries was the overall administrative burden involved in bringing a Medicare qualified drug-only policy to market. Obtaining policy approval from the government could be time consuming and expensive, at least if the process is anything like that for M+C plans. This burden was largely attributed to the provision in H.R. 4954 allowing for actuarial equivalence. As discussed earlier, its complexity could result in an administratively burdensome process for both the entities applying to offer policies and the federal government. Experience under the M+C program was cited by several actuaries as the basis for these concerns.

Complex actuarial equivalence requirements could result in a time consuming and administratively burdensome process for both the plans and the government.

PLAN PARTICIPATION

As health actuaries, our participants may be in the position of advising insurance companies, PBMs, or other entities on whether to contract with the Medicare program on an at-risk basis to offer a drug-only policy. As discussed above, there were certain elements contained in H.R. 4954 relating to benefit flexibility, pricing, beneficiary participation, risk sharing, and administrative requirements that the actuaries regarded as encouraging plan participation. However, the discussion also identified areas of concern and uncertainty that could discourage plan participation.

There was a lot of discussion and broad agreement that the "federal government is not a reliable business partner." A number of participants had experience with plans participating in the M+C program and in the Medigap market where, they observed, rules changed, payments were limited, and administrative requirements were found to be burdensome and costly. Thus, entering this new market involved considerable risk that the "rules of game" could change significantly over time. Since future Congresses are not bound by laws enacted by previous ones, the participants emphasized that this uncertainty was a major disincentive for entering this market.

Of critical importance to all the participating actuaries was the potential for some key provisions included in H.R. 4954 to be modified over time. For example, the bill's provision for a one-time enrollment period in private drug plans at the time of Medicare eligibility is viewed as an important incentive for broad participation that helps to reduce adverse selection. Similarly, maintaining adequate premium subsidies over time and assuring that competition and increases in drug costs determine premium amounts rather than government-imposed maximums would be important to the stability of plan participation.

Overall, there was a general concern about the potential for adverse risk selection across plans as a result of the voluntary nature of the enrollment decision. In a voluntary market, participants agreed that adequate premium subsidies and one-time enrollment options take on greater importance as means of generating a high degree of participation among Medicare beneficiaries. Because of uncertainties surrounding initial participation, there was a concern that smaller, regional plans would be hesitant to enter this market. It was suggested that offering extra subsidies to smaller plans with significant adverse selection

in the first year could help to increase the number of regional plans that would enter the market.

To conclude our discussions with the actuaries, we asked them to evaluate the desirability of including certain other features in a Medicare stand-alone prescription drug proposal that have been part of the Congressional debate. For example, it was generally agreed that a requirement for plans to enter into multi-year contracts with Medicare that "lock them in" to participation would reduce the number of plans willing to market this product. Whether some type of multi-year contract would be acceptable, the participants observed, would depend in part on the government guarantees, and whether plans would have some flexibility to modify their formularies or pharmacy networks at least on an annual basis and adequately price their premiums. Participants agreed that a lock in provision would make all plans "nervous" because "the government has not proved its reliability as a business partner."

Participants also discussed the impact of having government policy determine plan service areas rather than permitting plans the discretion to define their market areas. Whether multi-state service areas would be a barrier for plan participation would depend to some extent on pharmacy access standards[8] and on the flexibility of state licensure requirements. In addition, one participant observed that it is difficult to enforce requirements that plans "actively market" across a large service area. Another participant noted that, in the case of some Blue Cross plans, coordination of risk and reserve requirements across state lines would be necessary in a multi-state service area.

The actuaries also considered the implications for plan participation of having a government operated 'fall-back' drug plan in areas inadequately served by private plans. There was general agreement that private plans could compete effectively with a government sponsored plan, so long as "there was a level playing field" with regard to plan requirements. Especially critical would be how the government would determine a premium for the fall-back plan and whether the benefit design of the fall-back plan would result in selection effects that undermined fair competition with private plans.

Finally, several actuaries thought that plan participation could be discouraged because of potentially high start-up costs associated with building an infrastructure for marketing and administering a drug-only plan. Related to this concern was a view that plans would have to have confidence that they could stay in this market for a period sufficient to permit recovery of their start-up investments. Uncertainty about the stability of this market and the likelihood of recovering start-up costs could limit participation. Others felt such costs would be marginal because most plans already had the infrastructure and only needed to expand existing capacity.

[8] Some pharmacy access requirements might stipulate, for example, that a pharmacy be within five or ten miles of each enrollee, regardless of where they live in the service area. A more flexible requirement would allow for greater distances in rural areas.

SUMMARY AND FINAL OBSERVATIONS

The actuaries who participated in this project were guardedly optimistic that a drug-only private plan approach to providing Medicare prescription drug benefits could be viable, provided that certain key features were included in an enacted program. As individuals, however, their varying levels of enthusiasm for such an approach reflected the differences in the market positions of their respective companies or their actuarial experience. Even the more enthusiastic of our participants had reservations, however, about participating in a government sponsored program. Based on their experiences with M+C and Medigap, they regarded the government as an unreliable business partner and worried that they could not count on "the rules of the game" remaining constant.

That said, there was consensus among the actuaries interviewed for this project that certain features of a Medicare stand-alone prescription drug proposal would be important to attracting the participation of insurers or PBMs. In sum, these were:

1. Freedom to set premiums without arbitrary government limits.
2. Government subsidies of beneficiary premiums that do not erode over time.
3. A one-time beneficiary enrollment opportunity, with aggressive government marketing and beneficiary information efforts to achieve maximum beneficiary participation.
4. Shared risk with the government, at least in the initial years, preferably through risk-corridors.
5. Ability to price premiums locally and not nationally.
6. Flexibility to exit the market (no guaranteed renewal as exists for Medigap insurers).
7. Some benefit flexibility, especially with respect to cost-sharing.
8. Flexibility to use cost containment measures, including formularies.
9. Preemption of most state laws and regulations to reduce the costs of compliance and make it easier to market on a multi-state or national basis.
10. Government collection and distribution of premiums to reduce the administrative burden on plans, and maximize retention of enrollees.

It was evident from our discussions that some of the reservations expressed by the actuaries about a Medicare stand-alone drug program would endure whatever the parameters of any enacted legislation. They were of one voice in expressing concern that Congress would make mid-course program changes that could impede their ability to accurately price policies or predict program requirements. Given the specifications of a proposal similar to the House-passed bill, however, they expected at least large national insurers in partnership with PBMs or similar entities to enter the market. Whether a Medicare drug-only product would be sustainable as a line of business would depend on plan experience and future government policy, especially maintenance of adequate government subsidies and limited enrollment opportunities.

Although our discussion about a Medicare stand-alone drug program centered on the needs and concerns of plans (i.e., insurers and PBMs), we also asked the actuaries to evaluate various program design features from the perspective of beneficiaries. This line

of inquiry revealed an inevitable tension between the priorities for plans and the needs and concerns of beneficiaries. Especially obvious were the tradeoffs related to benefit design, the pricing of premiums, and enrollment options. The flexibility desired by plans with respect to benefit design and pricing could result in confusing and unpredictable options that could be difficult for beneficiaries to compare, with the potential for significant premium variability from year to year and area to area. Limits on the ability of beneficiaries to switch policies from year to year could reduce beneficiaries' access to needed drugs and increase their out-of-pocket costs. Participation rules allowing plans to readily withdraw from the Medicare market could undermine beneficiaries' confidence in the stability of their drug coverage. Such observations highlight the importance of striking a balance between plan and beneficiary concerns in the crafting of a Medicare prescription drug program.

Appendix A -- Participating Actuaries

John M. Bertko
Chief Actuary
Humana Inc.

Cecil D. Bykerk
Executive Vice President and Chief Actuary
Mutual of Omaha Insurance Co.

Mike Carstens
AVP and Actuary
Physicians Mutual Insurance Co.

Ed C. Hustead
Senior Vice President and Director
Hay Group

Jim Swenson
Vice President and Chief Actuary
Blue Cross/Blue Shield of Florida

Thomas S. Tomczyk
Principal
Mercer Human Resource Consulting

Bill Weller
President
Omega Squared of Sedona Inc.

Margaret Wear
Vice President and Chief Actuary
AdvancePCS

APPENDIX B

Provision	House-Passed Plan (H.R. 4954)
General approach	Voluntary benefit under Medicare Part D delivered by competing, risk-bearing plans and administered by new Department of Health & Human Services (DHHS) agency.
Effective date	1/1/2005
Beneficiary participation/ Enrollment	Voluntary participation. One-time program opt-in except for special circumstances (e.g., involuntarily losing drug coverage under an employer's plan). Beneficiaries select from among private drug plans (or M+C, retiree plans) annually.
Benefit package	Standard package defined in law but plans can offer an actuarially equivalent or richer package with the same out-of-pocket limit, the same actuarial value within each coinsurance range, and the same value of unsubsidized coverage. Plans may offer more generous drug coverage.
Deductible	$250 in 2005 under standard benefit, indexed to annual growth in average per capita spending for Medicare beneficiaries for covered outpatient drugs. (Different deductibles permitted if they meet actuarial equivalence requirements -- see "benefit package.")
Beneficiary cost-sharing applied to total drug spending	Under standard benefit: Rx spending level — Coinsurance 0-$250 — 100% $251-$1,000*: — 20% $1,001-$2,000*: — 50% $2,001-$4,800*: — 100% (“gap”) $4,800+ — 0 * Range values indexed to the annual growth in average per capita spending for Medicare beneficiaries for covered outpatient drugs.
Stop-loss threshold applied to out-of-pocket drug spending	$3,700, indexed to the annual growth in average per capita spending for Medicare beneficiaries for covered outpatient drugs (excludes payments from supplemental coverage except Medicaid).
Monthly premium, premium subsidies, and plan reinsurance	Premium is $33 in 2005 (estimate) depending on enrollee’s choice of plan. Plans must charge uniform, community-rated premiums to all in the same service area who have enrolled during open-election periods and have maintained continuous drug coverage. Premiums are subsidized by federal government through direct premium subsidies and through reinsurance. Reinsurance payments to plans would cover 30% of each individual's claims cost that fall in the second copayment range, and 80% of claims costs in the catastrophic range. Direct premium subsidies would equal 37% of expected aggregate benefit payments; reinsurance subsidies would equal 30% of aggregate benefit payments.
Low-income subsidies Note: “Duals” refers to Medicare beneficiaries also eligible for full Medicaid benefits (including drug coverage)	Full premium subsidy and reduced coinsurance ($5 brand, $2 generic copayment) for those up to 150% of poverty. Sliding-scale premium subsidy and reduced coinsurance ($5 brand, $2 generic) for those between 150-175% of poverty. “Gap” in benefit covered for duals through Medicaid wrap-

Provision	House-Passed Plan (H.R. 4954)
	around benefits. Bill provides no assistance with spending within "gap" for other low-income beneficiaries below 175% of poverty.
Asset test	Yes ($4,000individual/$6,000 couple, after exclusions).
Role of private plans/traditional Medicare	Benefits provided through private risk-bearing plans (shared risk with government through reinsurance)
Eligible plans	Must be licensed as risk-bearing entities in each state in which they would provide coverage. Private reinsurance would be permitted. Unlicensed entities could participate with approval of government if they meet specific requirements related to such things as solvency and capital adequacy. The Government would contract with all eligible entities that meet standard with at least two plan contracts serving each area (one plan contract could be with a Medicare+Choice plan. Contracts would be for one-year periods. To ensure all areas have choice of plans, Government may provide financial incentives (including partial underwriting of up to 99% of risk) to plan sponsors.
Role of Medicaid/ state financing Note: "duals" refers to Medicare beneficiaries also eligible for full Medicaid benefits (including drug coverage)	Duals: Premiums and cost-sharing subsidies provided through Medicare (but with state maintenance of effort, phased down to zero by 2014); Medicaid wrap-around coverage (i.e., expenses in the "gap") subject to the current Federal Medical Assistance Percentage (FMAP). Non-duals below 175% of poverty: Premiums and cost-sharing subsidies 100% federally financed through Medicare. Medicaid programs (or the Social Security Administration) determine eligibility for low-income subsidies.
Formularies	Plans may have a formulary so long as the formulary meets standards. Formularies must include drugs within each therapeutic category and class. Nonformulary drugs may be excluded from coverage. Beneficiaries could appeal for coverage of nonformulary drugs if the prescribing physician determines formulary drug is not effective for the patient or has significant adverse effects for the patient.
Other allowable cost management tools	Plans are free to use cost management tools (e.g., drug utilization review, prior authorization, etc). Must have appropriate incentive to use generic drugs and therapeutic interchange.
Medicare+Choice plans	If M+C plan offers Rx coverage, it must offer at least standard Rx benefit equivalent and would receive subsidies.
Employer-sponsored retiree plans	Employer-sponsored retiree plans could qualify for subsidies for Medicare enrollees if Rx coverage meets the minimum requirements. However, third party payments do not count towards catastrophic out-of-pocket limit.
Medigap coverage	Coverage of deductibles is prohibited but could cover copayments.

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

Washington Office:
1330 G Street, NW
Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

www.kff.org

Additional copies of this report (#6086)
are available on the Kaiser Family Foundation's website at
www.kff.org.