WHITE PAPER

Issues in Part D Bids and Reconciliations that Lead to Overestimation of Cost

Drew McStanley, FSA, MAAA
727.259.7466 • drew.mcstanley@wakely.com

Mark Koransky, FSA, MAAA
908.591.0129 • mark.koransky@wakely.com

Julia Lambert, FSA, MAAA
727.259.7474 • julia.lambert@wakely.com

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Earlier this year, a Wall Street Journal (WSJ) article, "The $9 Billion Upcharge: How Insurers Kept Extra Cash From Medicare",[1] reported that Part D plan sponsors have consistently overestimated plan costs leading to plan sponsors keeping more profit than they would have had their estimates been accurate. Based on the Part D settlements for 2006 to 2015, the article suggests that plan sponsors are taking advantage of Part D payment rules and increasing plan profit margin by overestimating the costs of the Part D benefits when determining the required revenue during the bidding process. Part D payment rules provide risk protections where excess profits and losses are shared between plan sponsors and Centers for Medicare and Medicaid Services (CMS) via the risk corridor program. The publicly available, historical risk corridor settlement amounts indicate that actual costs are generally below those costs estimated in the bids, resulting in CMS and Part D plan sponsors sharing in the extra profits. While the article is accurate in reporting the sharing of extra profits of the risk corridor program, it falls short in describing the causes of the settlements and assessing the strategies of Part D sponsors. This paper outlines technical aspects of the Part D payment program that support the following conclusions, challenging those made by the WSJ.

1) Prior to 2019 bids, the prescribed bid pricing tool (BPT) had an issue that resulted in overstating the Part D *basic* costs for certain types of members (i.e. "transfer" members). Even today, the BPTs allow overstatement of Part D basic costs for these members.
2) The risk corridor calculations understate the actual Part D costs for Enhanced Alternative (EA) plans, leading to biases in the risk corridor settlements.
3) Federal reinsurance settlements may be inaccurately understated or overstated for EA plans with risk sharing arrangements covering Part D.
4) Plan sponsors are not incented to overestimate costs in the bids.

[1] https://www.wsj.com/articles/the-9-billion-upcharge-how-insurers-kept-extra-cash-from-medicare-11546617082

This paper provides new insights into the risk corridor program results observed by the WSJ. More importantly, it indicates that the risk corridor program is biased in favor of CMS and against Part D plans, indicating corrections to the Part D reconciliation settlements are warranted in prior years and moving forward.

Part D Bidding Background

Part D plan sponsors annually estimate costs in the "bids" that are submitted to CMS. The bid is an estimate of the required revenue that is needed to provide Part D coverage, pay for administrative services, and maintain a profit margin. Part D plan sponsors submit their annual estimates to CMS via BPT forms provided by CMS. The BPTs provide the basis for the member premiums, CMS revenues, and targets for the risk corridor settlement calculations.

Each plan's standardized Part D bid, or required revenue at a 1.0 risk score for the Defined Standard (or equivalent) benefit, is compared to the National Average Bid amount (NAB)[2] as part of the process to determine member premium.

$$Member\ premium\ =\ the\ plan's\ standardized\ bid\ -\ NAB\ +\ Base\ Beneficiary\ Premium\ (BBP)$$[3]

All else equal, an increase in a plan's standardized bid will result in a similar increase in member premium. If a plan were to inflate their bid amount with overestimated costs, they would be forced to charge a higher member premium than they would have charged otherwise.

To understand the risk sharing programs between plan sponsors and CMS under Part D, it is important to understand the phases in the Defined Standard Part D benefit. The Defined Standard benefit is a specific plan coverage that reflects the lowest level of benefits that any plan must cover. The Defined Standard benefit, as well as other benefit designs that have an equivalent benefit richness to the Defined Standard benefit,[4] are called "basic" benefits. Figure 1 on the following page shows the amount that each stakeholder pays in each benefit phase according to the 2019 Defined Standard benefit for a member without low-income subsidies.

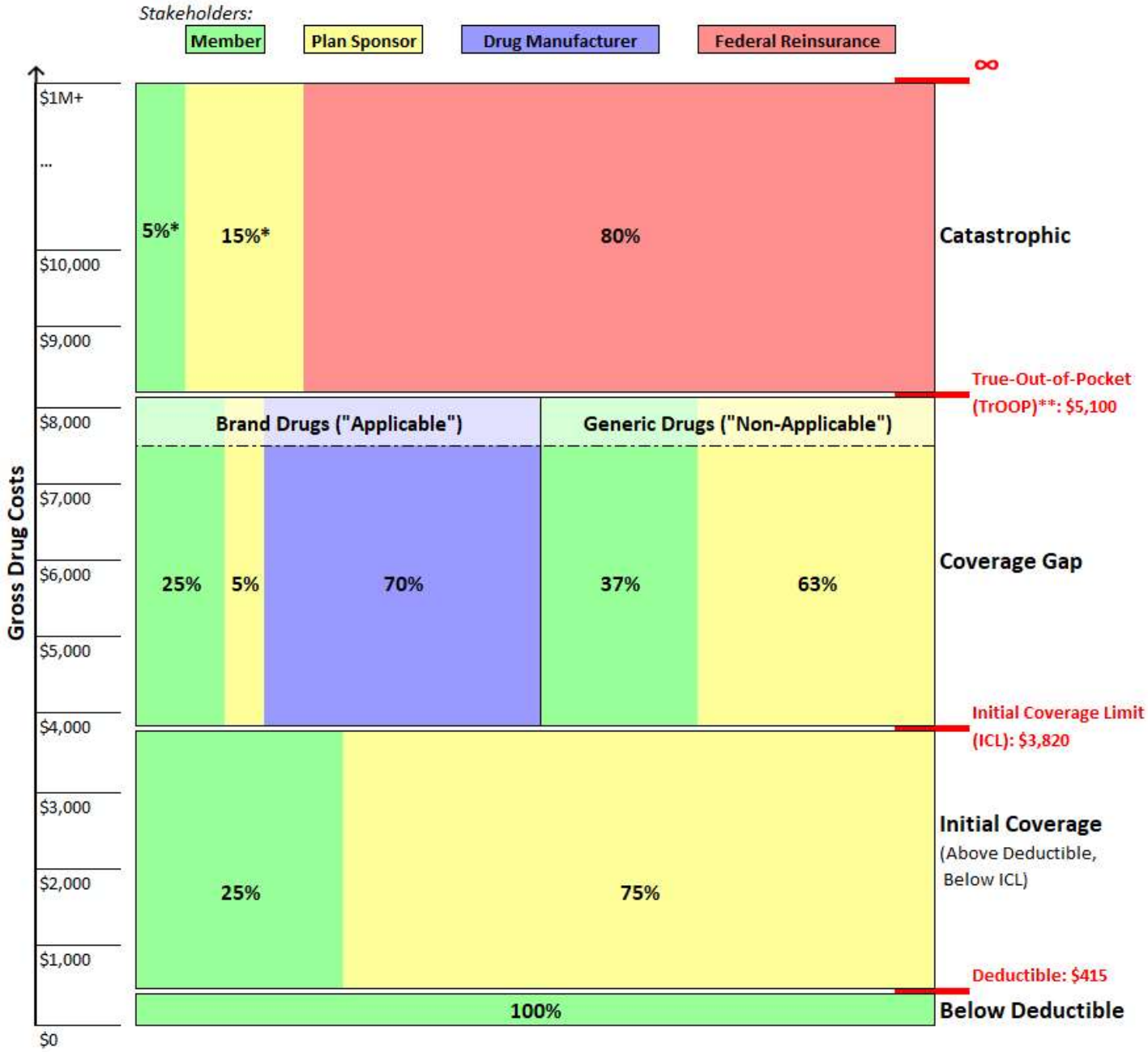
Federal reinsurance (in red) is the portion of the benefit that is fully CMS' risk. The basic benefit (in yellow) is the portion of the benefit for which the plan and CMS share risk through the risk corridor program.

[2] The NAB is a nationwide weighted average of standardized bid amounts for stand-alone prescription drug plans and MA-PD plans. The weights are based on the number of enrollees in each plan.

[3] The BBP is equal to 25.5% of the sum of the NAB and the national average CMS reinsurance amount.

[4] Other benefits include an Actuarial Equivalent benefit or Basic Alternative benefit.

Figure 1. 2019 Defined Standard Benefit for an Individual without Low-Income Subsidies
Portion of Gross Drug Costs Paid by Stakeholder in Each Part D Benefit Phase



* Approximation - in reality the member pays the greater of 5% coinsurance or $3.40 for generic drugs / $8.50 for brand drugs, and the health plan is responsible for 20% less the amount paid by the member.

** The catastrophic phase is reached when the member accumulates $5,100 of "True Out-of-Pocket" spend, which equates to various gross drug costs depending on a member's specific utilization of brand versus generic drugs. For 2019, CMS approximated the accumulated gross drug costs to be about $8,139.54, on average when an individual without low-income subsidies reaches the catastrophic phase.

Plan sponsors may also cover additional benefits above and beyond the Part D basic benefit, called Enhanced Alternative (EA) benefits. In these types of benefits, the member's cost-share (in green) is replaced with amounts covered by the plan. A few important points about EA plans:

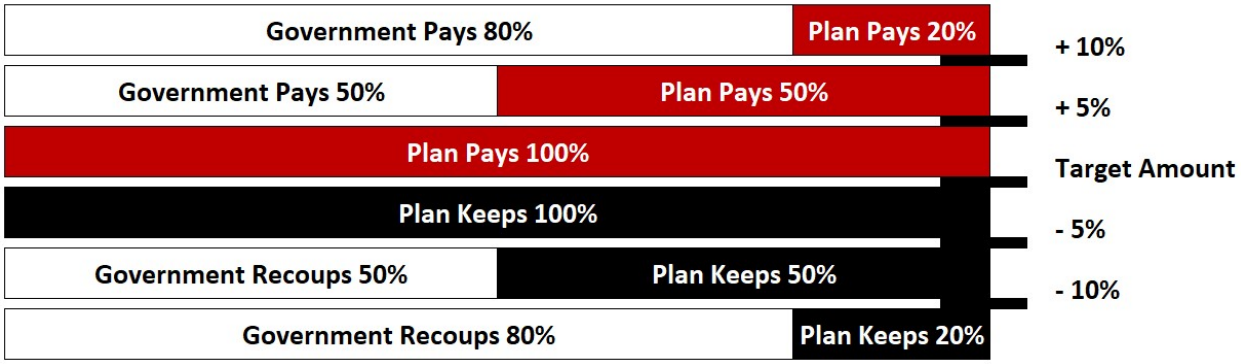
1) Enhanced Alternative benefits result in less federal reinsurance obligations from CMS. As denoted in the figure above, the catastrophic phase of the 2019 Part D benefit is reached at the point when the member accumulates "true out-of-pocket" spend (or TrOOP) equal to $5,100. This catastrophic TrOOP level is the same for all Part D benefit plans in 2019, regardless of whether or not it is a Defined Standard benefit. In an Enhanced Alternative benefit, the member cost-sharing in the early benefit phases is reduced, resulting in less out-of-pocket spend for similar drug costs compared to the less rich Defined Standard benefit. The amount of gross drug cost needed to meet the $5,100 TrOOP is increased, extending the coverage gap period until the TrOOP level is met. This results in lower amounts of drug costs in the catastrophic portion of the benefit and less federal reinsurance, as compared to a basic benefit plan.

2) For an EA plan, the BPTs require plan sponsors to project the Defined Standard benefit costs for the expected population in Worksheet 3 of the BPT.

3) The risk of that enhanced coverage falls solely on the plan sponsor. That is, CMS does not share in the risk of the enhanced portion of the benefit. The risk corridor program, where risk is shared between the plan sponsor and CMS, applies only to the subset of the costs related to the basic benefit.

CMS' risk corridor program mitigates the impact that over- or under-estimating plan costs in the bid has on a plan's profit margin. Under this program, CMS shares in the plan's gains (profits) if basic benefit costs are more than 5% lower than expected; and conversely, CMS shares in the plan's losses if basic benefit costs are more than 5% higher than expected. The table below shows the percentages of losses (at the top of the table) and gains (on the bottom half of the table) that CMS shares with the plan in various corridors around the target claim amount.

Figure 2. Part D Risk Corridors for 2019[5]



[5] Source: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf (Page 48)

The WSJ reported an observed pattern of extra profits in risk corridor settlements, resulting in CMS recouping money from plan sponsors and indicating that health plans' actual costs were lower than what was projected in the bid. That is, actual costs were calculated to be below the target amount. Mechanics of the bids and risk corridor calculations, as outlined below, have contributed to the pattern observed by the WSJ.

Issue #1 – Transfer Members

Prior to a change made to the CMS Part D BPT for payment year 2019, prescribed formulas in the BPT prevented plans from reflecting the appropriate level of expected costs for members who join the plan during the year, transferring in from another plan with a prior accumulated balance (i.e. "transfer" members). Part D rules require the subsequent plan to recognize prior coverage and adjudicate benefits based on the members' accumulated balance to-date. As a result of their prior accumulated balance, transfer members are further along in their benefit than they would have been had they joined the plan at the beginning of the year. However, earlier years' BPTs forced pricing actuaries to incorrectly assume that these members had $0 in accumulated costs when they joined the subsequent plan. If the BPT was not prepared this way, then CMS' validation checks would indicate that the pricing had "failed validation". The Validation Report in the BPT also states, "Please note that BPTs with failed validation errors may be required by CMS to resubmit."

To understand how this can impact pricing, it is essential to understand the Part D basic benefit phases outlined above in Figure 1. Note that the portion of the claim costs paid by the insurer varies at each phase. In the second stage of the Part D benefit (after the member has met their deductible and their Initial Coverage phase begins), plans are liable for 75% of drug costs. This is the peak percentage of drug costs that plans will be responsible for in a particular benefit phase. As spending accumulates and the member reaches the Coverage Gap or Catastrophic phase, the plan's share of spending per dollar of drug costs decreases. Thus, the point at which a member is assumed to fall within their benefit when they joined the plan can impact the amount of cost the plan is expected to incur for the member's claims. In reality, members transferring into the plan with a balance will have already progressed somewhat through their benefit before joining the plan. Prior to CMS' change to the 2019 BPT, plans projected transfer members as if they were in the beginning of the Part D benefit with $0 in accumulated costs (i.e. "at first dollar") in order to avoid failing the BPT's validation checks. This results in an overestimation of plan costs in the basic bid for transfer members. Table 1 below provides a numerical example of this concept.

Assumptions:

- A member has accumulated $3,000 in gross drug costs with a prior plan ("Plan 1")
- That member then transfers into what is now their current plan ("Plan 2") mid-year, and Plan 2 recognizes the accumulated $3,000 of drug costs elsewhere, placing them toward the end of their Initial Coverage phase
- The member is dispensed another $2,500 in gross drug costs for brand drugs covered by Plan 2

- While the member is enrolled in Plan 2, their benefits follow the 2019 Defined Standard benefit for an individual without low-income subsidies as shown in Figure 1 above

Table 1: Impact of Pricing the Transfer Member at First Dollar

		Starting at $0 (i.e. Bid Pricing)		Starting at $3,000 (i.e. Actual)	
Benefit Phase	**Plan Liability as % of Gross Drug Costs**	**Member's Gross Drug Costs Incurred in Plan 2**	**Plan Cost**	**Member's Gross Drug Costs Incurred in Plan 2**	**Plan Cost**
Deductible	0%	$415	$0	N/A	N/A
Initial Coverage	75%	$2,085	$1,564	$820	$615
Coverage Gap	5%	N/A	N/A	$1,680	$84
Total		**$2,500**	**$1,564**	**$2,500**	**$699**

What ultimately allowed plans to price these types of members more accurately in the 2019 Part D BPT without a "failed validation" was CMS' switch from a prescribed set of calculated cells to open input cells, allowing the user to estimate plan liability based on the member's expected accumulated cost when they join the plan (rather than $0). CMS did not announce why they were making this change, so it is possible that some plans may still be projecting costs with an inaccurate treatment of these transfer members as illustrated above.

The prescribed formulas that led to overestimating basic benefit costs disproportionally impacted plans that enroll a high percentage of members eligible to receive a Low-Income Subsidy (LIS) or alternatively eligible to enroll in a Special Needs Plan (SNP, e.g. chronic or institutional). These members can change Part D plans at any time in the year while non-LIS or non-SNP members can generally only change plans during the open enrollment period prior to the upcoming plan year. Thus, most transfer members will be LIS-eligible or SNP-eligible.

Issue #2 – DIR Allocation Bias in the Risk Corridor Calculation for Enhanced Alternative Plans

Another contributing factor to the savings bias in the risk corridor settlement is the treatment of how Part D rebates, or Direct and Indirect Remuneration (DIR), are handled in the risk corridor calculation for EA plans. DIR amounts, including pharmacy and manufacturer rebates, are generally a reduction to pharmacy costs.[6] For purposes of risk corridor calculations, some DIR amount needs to be allocated to Part D basic coverage (which is shared risk between the plan and CMS via the risk corridor mechanism) and federal reinsurance (which is CMS' liability). Due to the inconsistent allocation of DIR used for the target versus the actual costs, actual basic benefit cost experience will appear to be more favorable than

[6] Certain types of DIR can be negative, which would cause an increase (rather than a decrease) to pharmacy costs. For example, amounts paid by the plan as part of a risk sharing arrangement covering Part D would be a form of negative DIR resulting in higher Part D plan costs.

it really is. As a result, plan sponsors can end up paying too much or receiving back too little through the risk corridor, artificially placing the plan at a disadvantage.

As discussed earlier, the risk corridor payment is based on the relationship between the target claim amount (i.e. the level of expected basic claims estimated in the BPT)[7] and the actual basic claim costs, or what CMS refers to as the Adjusted Allowable Risk Corridor Costs (AARCC).[8] If the actual basic claim costs or AARCC comes in at a certain percentage higher or lower than the target, then the government may share in a portion of the plan's gains or losses within each band as shown in Figure 2 above. Both the target claim amount and the AARCC reflect a net liability for basic benefits after applying the portion of DIR that is attributable to the basic benefits. However, there is a material inconsistency between the two approaches used to allocate DIR in the calculation of the target claim amount and the AARCC.

The target claim amount used in the risk corridor formula is based on the Defined Standard cost projection in Worksheet 3 of the BPT for each EA plan. This is what the target would be based on regardless of whether a Defined Standard or an EA plan is actually offered. Formulas in Worksheet 3 allocate a portion of the total DIR to federal reinsurance based on the proportion of gross drug costs covered by the reinsurance program (i.e. the red-shaded region shown in Figure 1 above). The remaining DIR is then allocated to the basic benefits. Thus, when DIR is allocated between federal reinsurance and the basic benefits on Worksheet 3 of the BPT, it is done consistent with the catastrophic and non-catastrophic costs adjudicated under the *Defined Standard benefit.*

When calculating the actual basic coverage for EA plans for risk corridor purposes, the development of AARCC still calculates plan liability as if the plan's drug claims were adjudicated under the Defined Standard benefit design,[9] rather than the plan's richer benefit design.[10] The DIR allocation between federal reinsurance and the plan, however, is based on the actual catastrophic and non-catastrophic costs under the *EA benefit*. As indicated earlier, the portion of catastrophic and federal reinsurance costs will be lower under the EA benefit since members generally take longer to accumulate TrOOP spend. Compared to the Defined Standard benefit allocation of DIR on Worksheet 3 for the target, less DIR will be allocated to federal reinsurance and more will be allocated to the plan under an EA benefit. This allocation artificially lowers the plan's AARCC, resulting in the pattern observed by the WSJ.

Table 2 below shows an example of how the allocation of DIR of in the risk corridor calculation (in Column D) creates a bias that puts EA plans at an unfair disadvantage compared to the target amount (in Column

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[7] The basic claim amount from the BPT is adjusted to account for differences between the "expected" risk score in the BPT and the actual risk score of the membership to develop the target claims used in the risk corridor calculation.

[8] For EA plans, the actual basic claim costs (or AARCC) are calculated from a combination of claim values from Prescription Drug Event (PDE) data that the plan submits to CMS and adjustments from BPTs (i.e. Induced Utilization Adjustment from Worksheet 5 of the BPT). CMS discusses the methodology used to calculate AARCC and risk corridor settlement amounts in the PDE Participant Guide (pages 1-21 to 1-24 in the following link): https://www.csscoperations.com/internet/Cssc.nsf/files/PDEParticipantGuide%20cameraready%20081811.pdf/$File/PDEParticipantGuide%20cameraready%20081811.pdf

[9] Risk corridor is designed to apply to the "basic" portion of the Part D benefit only – that is, the portion that is Defined Standard benefit.

[10] The basic coverage calculations are performed using specific fields from the PDE data (i.e. Covered Plan Paid or "CPP" and Gross Drug Costs Above Out-of-Pocket Threshold or "GDCA") that were created for this purpose. This would exclude any supplemental portion of the benefit for Enhanced Alternative plans, which offer benefits that are richer than a Defined Standard benefit.

A). Each of the four columns reflects per member per month costs for an applied benefit (i.e. DS for Defined Standard or EA for Enhanced Alternative) and level of induced utilization (IU). The IU level is used to reflect that members in a richer benefit plan (e.g. EA) may utilize their benefit and fill their prescriptions more so than they might under a less rich benefit (e.g. DS) due to the lower out-of-pocket spend they would incur. Columns A through C reflect estimated amounts developed for a BPT. Column D reflects the AARCC calculation for actual costs assuming the actual drug costs and DIR come in exactly as estimated in the BPT. Under this assumption, the AARCC should equal the target. However, as explained below, the DIR allocation results in an AARCC *below* the target.

Table 2: Example of DIR Allocation Bias for EA Plans

		A	B	C	D
		Worksheet 3 Basis or Target Amount	Used for Worksheet 5 IU Calculation	Worksheet 5 or Actual EA Basis	Actual Basic or AARCC Basis
		↓	↓	↓	↓
	Benefit:	**DS**	**DS**	**EA**	**DS**
Line	**IU Level:**	**DS**	**EA**	**EA**	**EA**
1	Gross Drug Costs	$269.18	$276.44	$276.44	$276.44
2	Federal Reinsurance	$62.82	$78.72	$60.62	$60.62
3	Total DIR	$47.61	$49.75	$49.75	$49.75
4	Reinsurance DIR = [3] x [2] / [1]	$11.11	$14.17	$10.91	$10.91
5	Plan DIR = [3] – [4]	$36.50	$35.59	$38.84	$38.84
6	Plan Liability before DIR	$106.33	$109.80	$163.75	$109.80
7	**Plan Liability after DIR** = [6] – [5]	**$69.83**	**$74.21**	**$124.91**	**$70.95**
8	= [7 from Column B] / [7 from Column A]			Bid IU Impact (Cell F75 WS5)	1.0628
9	= [7] / [8]			**AARCC Used in Risk Corridor Calculation**	**$66.76**
10	= [7 from Column A]			**Target Claim Amount**	**$69.83**
11	= [9] / [10]			**Risk Corridor Ratio**	**95.6%**

Column A reflects an expected level of drug costs ($269.18) consistent with the benefit richness of a DS benefit and furthermore applies a DS benefit to those costs to get a plan liability before DIR allocation of $106.33. After DIR is applied, the net basic plan liability is $69.83. This is consistent with Worksheet 3 of the BPT and what will be used as the basis for the target amount in the risk corridor formula.

Column B reflects a higher level of drug costs ($276.44) expected due to IU resulting from the benefit richness of this example EA plan's benefit (reflected in Worksheet 5 of the BPT). However, the DS benefit is applied to the costs similar to Column A. Column B also allocates DIR (now a bit higher due to IU) between federal reinsurance and the basic plan coverage based on the level of catastrophic costs from its *DS benefit* adjudication. This column is needed to determine the Bid IU Impact in row 8, which is used in the risk corridor calculation.

Column C reflects the same higher level of drug costs associated with the EA plan benefit ($276.44), but costs now reflect the EA benefit richness, so plan liability is higher and federal reinsurance is lower than in Columns A and B.

Column D illustrates how the actual basic claim costs or AARCC is calculated, assuming that actual drug costs and DIR are identical to estimations in the BPT. The actual gross drug costs, DIR, and federal reinsurance match the expected amount from the EA benefit adjudication in Column C. In calculating the AARCC, the allocation of DIR is based on that actual federal reinsurance amount from the EA plan. However, the target amount is calculated using a DIR allocation to federal reinsurance based on the DS plan (Column A).

This difference in DIR allocation drives the AARCC amount ($66.76 in Column D) to be lower than the target ($69.83). That is, the calculated actual AARCC appears artificially more favorable than the target simply because of the government's inconsistent allocation of DIR for EA plans. In this example, the ratio of the actual AARCC to the target is 95.6% when it should be 100% if actual costs came in as expected in the BPT. This understatement in the AARCC leads to biases in the risk corridor settlements, where:

- plan gains are overstated resulting in the government over-recoupments from the plan sponsors, or
- plan losses are understated resulting in government underpayments to plan sponsors.

This issue directly impacts all EA plans; and in 2019, about 79% of all plans eligible to participate in the risk corridor program are EA plans. Those EA plans cover over 23 million members, which represent about 62% of the enrollment in plans eligible to participate in the risk corridor programs.

To correct this bias, CMS should adjust the allocation of DIR used in the calculation of AARCC to be consistent with federal reinsurance costs under a Defined Standard benefit.[11] Doing so will make the expected risk corridor ratio (i.e. AARCC / Target) = 100% at the time the BPT is prepared. Separately, CMS should reopen and correct historical years' risk corridor settlement calculations, which can be easily quantified using existing data available to CMS and plan sponsors.

Issue #3 – The DIR Used to Calculate Reinsurance Settlements Is Incomplete for EA Plans with Risk Sharing Arrangements Covering Part D

Every year, plan sponsors report their DIR amounts, for various types of DIR,[12] to CMS in June or July following the plan year when the actual DIR amounts are known. CMS uses this information for two purposes:

[11] While we believe this the correct thing to do both actuarially and mathematically, we have not reviewed whether it would be permissible to correct this issue from a statutory or legal standpoint.

[12] Types of DIR include: 1) PBM retained rebates, 2) rebates expected but not yet received, 3) all other rebates, 4) administrative service fees reported as DIR, 5) price concessions for administrative services, 6) legal settlement amounts, 7) all other price concessions from manufacturers, 8) amounts received from pharmacies, 9) amounts paid to pharmacies, 10) risk sharing arrangement payments and adjustments, and 11) all other DIR.

1) To calculate risk corridor settlements
2) To calculate federal reinsurance settlements

As discussed previously, the risk corridor focuses entirely on amounts attributable to the "basic" Part D benefit. However, the amount of federal reinsurance that the government pays each plan is based on the level of catastrophic costs resulting from the actual benefits offered by the plan. For EA plans, the benefit includes both the basic and supplemental (or enhanced) portions. The actual amounts of federal reinsurance for EA plans are calculated in a similar manner as that outlined in Column C of Table 2. That is, the reported DIR is allocated to federal reinsurance based on the ratio of actual federal reinsurance drug costs compared to gross drug costs.

Using the reported DIR for both risk corridor and federal reinsurance purposes presents a problem because CMS' DIR reporting structure does not distinguish between amounts attributable to the basic and supplemental portions of the Part D benefit. For most types of DIR, this is not a problem. However, for one type of DIR in particular, i.e. "risk sharing arrangement payments and adjustments" (or "risk sharing DIR"), this presents an issue for EA plans that have risk sharing arrangements involving Part D.

In CMS' latest memo regarding DIR Reporting Requirements,[13] there is also no indication as to whether plans should report DIR amounts attributable to the basic portion, supplemental portion, or total. The only available guidance addressing which basis of DIR plans should choose, when they prepare their DIR reports for CMS, is buried in the 2016 release of CMS' DIR reporting guidance for contract year 2015.[14] That guidance was as follows:

> *"COMMENT: One commenter asked for clarification regarding how to report certain risk arrangements between providers and Part D plans. Specifically, the commenter asked whether a reporting plan need only report the provider risk arrangement associated with the defined standard benefit as DIR for the purposes of payment reconciliation, as opposed to also reporting the amount associated with enhanced benefits.*
>
> *RESPONSE: Yes. Only the provider risk arrangement impact for performance with respect to the defined standard benefit should be reported as DIR."* (pg. 5)

For risk sharing DIR, the guidance indicates that plans should only report risk sharing DIR amounts attributable to the *basic* portion of the benefit, which is a subset of the total benefit for EA plans. This is correct for risk corridor purposes, as the risk corridor is only focused on costs related to the basic benefit plan. However, reporting only the basic portion of the risk sharing DIR is not correct for purposes of calculating federal reinsurance settlements for EA plans. For federal reinsurance, using only the basic

[13] Link: https://www.npaonline.org/sites/default/files/PDFs/Final%202018%20DIR%20Reporting%20Requirements.pdf

[14] Link: https://www.npaonline.org/sites/default/files/PDFs/Final%20Medicare%20Part%20D%20DIR%20Reporting%20Requirements%20for%202015_1.pdf

portion of risk sharing DIR ignores the risk sharing DIR related to supplemental benefits. Reporting *all* DIR related to risk sharing for Part D covered drugs, including DIR attributable to the supplemental portion of the benefit, is necessary in order to accurately calculate federal reinsurance settlements.

The basic portion of the benefit is only a subset of the total benefit for EA plans, so the amount of risk sharing attributable to the basic portion of the benefit may differ from the total risk sharing amount for these plans. CMS recognizes this in their response above.

The directional impact this has on federal reinsurance settlements will vary depending on whether the risk sharing arrangement resulted in a payable amount from the plan to providers (thus decreasing DIR and increasing Part D costs) or a receivable amount from providers to the plan (thus increasing DIR and decreasing Part D costs). If an EA plan only reported the basic portion of risk sharing DIR to CMS, then the impact would be as follows:

1. If the risk sharing attributable to the supplemental portion of the benefit is a plan *payable*, then DIR would be overstated in the DIR report and CMS would underpay plans for the "actual" federal reinsurance (net of DIR).
2. Conversely, if the risk sharing attributable to the supplemental portion of the benefit is a plan *receivable*, then DIR would be understated in the DIR report and CMS would overpay plans for the "actual" federal reinsurance (net of DIR).

Ultimately, the remedy for this is to expand the structure of the DIR report that plans submit to CMS to separately identify amounts attributable to the basic and supplemental portions of the benefit for Part D covered drugs and to use different DIR amounts for the risk corridor and federal reinsurance calculations. Furthermore, CMS should ask plans to resubmit DIR reports for affected years with this expanded reporting structure, and correct historical years' federal reinsurance settlement calculations.

Issue #4 – Part D Bid Incentives

A key decision for Part D health insurers is how to balance the tradeoff between competiveness and profitability. All else equal, for a plan to increase profit margin, it will have to sacrifice a level of competitiveness (i.e. charge higher member premiums or offer lower supplemental benefits). Insurers strive to maximize both elements as much as possible. The following scenarios will show that overestimating Part D plan cost will not help plans achieve this goal for the reasons listed below:

Reason #1

Overestimating Part D costs will increase a plan's profit margin, but will come at the expense of higher member premiums and a disadvantaged risk corridor position.

Based on plan characteristics and goals, plan sponsors may increase member premium and sacrifice a competitive market position in order to target a higher margin. Scenario 1 below shows that when a higher profit is the plan's goal, it is more advantageous for the plan to execute a strategy that achieves this by

increasing the bid's profit margin, rather than by overestimating claim costs. By including the additional margin in the bid, the plan would not be subject to any risk corridor remittance payments back to CMS, resulting in a higher achieved profit (i.e. option 1.C vs. 1.B below).

Scenario 1 – PDP Sponsor Wants to Increase Margin at the Expense of Increasing Member Premium

		1.A: Lower Level of Margin		1.B: Overestimate Plan Costs in Bid		1.C: Increase Bid Margin	
		Bid	Actual	Bid	Actual	Bid	Actual
A	Part D Net Claims	$70	$70	$80	$70	$70	$70
B	Part D Admin	$10	$10	$10	$10	$10	$10
C	Part D Profit Margin	$5	$5	$5	$15	$15	$15
D = A + B + C	Part D Bid (Revenue)	$85	$85	$95	$95	$95	$95
E	Member Premium[1]	$55	$55	$65	$65	$65	$65
F	Risk Corridor Transfer[2]		$0		($3)		$0
G = C + F	**Margin PMPM**	**$5**	**$5**	**$5**	**$12**	**$15**	**$15**

[1]Assumes no change to the National Average Bid from scenario to scenario

[2]A (negative) transfer indicates a plan payment to the government

The illustration in Scenario 1 above shows the options for a plan that offers standalone Part D benefits only.

Reason #2

For MA-PD plan sponsors, overestimating Part D costs and increasing Part D premium buy-down to maintain the same total member premium level will result in an aggregate profit margin decrease.

Plan sponsors that combine Medicare Advantage Part C benefits with Part D (MA-PDs) have the choice allocate MA rebate dollars to "buy down", or reduce, the Part D premium. While using MA rebates to buy down Part D premium is a useful tool to attract members, it comes at an expensive price to the health plan. MA rebate dollars are the portion of savings that the plan receives if its MA bid is lower than the MA benchmark. The plan will retain 50%-70% of savings as rebates, which varies based on the plan's star rating. As a result, for a plan with a 4.0 star rating to generate an additional $1.00 of MA rebates with no other changes, the plan must decrease the margin component of its MA bid by $1.54 (= $1.00 / 65%[15]).

Scenario 2 below illustrates that overestimating Part D costs will require a higher allocation of MA rebates in order to buy down the Part D premium to the same amount (i.e. option 2.B vs. 2.A below). This is not a practical strategy for MA-PD plan sponsors. In option 2.B, the aggregate margin decreases while the level of competitiveness stays the same.

[15] Rebate % for plans with 4.0 rating = 65%

Scenario 2 – MA-PD Sponsor Overestimates Part D Cost and Allocates MA Rebates to Buy Down Part D Premium

		2.A: Status Quo, Best Estimate Costs in Part D Bid		2.B: Overestimate Plan Costs in Part D Bid	
		Bid	Actual	Bid	Actual
A	Part D Net Claims	$70	$70	$80	$70
B	Part D Admin	$10	$10	$10	$10
C	Part D Profit Margin	$5	$5	$5	$15
D = A + B + C	Part D Bid (Revenue)	$85	$85	$95	$95
E	Part D Member Premium[1]	$55	$55	$65	$65
F	Risk Corridor Transfer[2]		$0		($3)
G	MA Net Claims	$700	$700	$700	$700
H	MA Admin	$90	$90	$90	$90
I	MA Bid Profit Margin	$60	$60	$45	$45
J = G + H + I	MA Bid	$850	$850	$835	$835
K	Benchmark	$1050	$1050	$1050	$1050
L	Rebate %	65%	65%	65%	65%
M = (K – J)*L	Rebates	$130	$130	$140	$140
N	MA Rebates for MA Benefit Enhancements	$75	$75	$75	$75
O	Part D Buy-Down to Reach Target Premium	$55	$55	$65	$65
P = E	**Member Premium After Buy-Down**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Q = C + I + N*I/J	**Total Margin PMPM**	**$70**	**$70**	**$54**	**$64**

[1]Assumes no change to the National Average Bid from scenario to scenario

[2]A (negative) transfer indicates a plan payment to the government

Conclusion

While historical risk corridor calculations indicate that Part D plans' actual costs are lower than their target claim amounts and have led to shared savings between plans and the government, this paper has outlined multiple factors in addition to overestimation of costs that contribute to that outcome. Part D payment mechanics do not incentivize plan sponsors to overestimate costs. Doing so will either put a plan at a competitive disadvantage or reduce the potential profit margin for a plan compared to a plan with accurately predicted costs.

Instead, factors in the Part D bidding and risk corridor settlement processes that are outside of the plan's control, including the handling of transfer members and DIR allocation bias for EA plans, have contributed to the high risk corridor payments from plan sponsors.

Part D pricing actuaries and other professionals should ensure that the bid reflects the best expectation of costs as much as possible in order to minimize risk corridor settlements, and CMS should take

measures to ensure actual and expected values are measured consistently when calculating risk corridor and federal reinsurance settlements.

While additional DIR reporting would be needed to correct federal reinsurance settlements for Issue #3 identified above, no additional information is needed to correct risk corridor settlements for Issue #2. CMS currently has all of the data needed to correct risk corridor settlements for historical years 2006-2018;[11] and Wakely has developed code to recalculate plan sponsors' corrected risk corridor settlements, correcting for the DIR allocation bias identified in Issue #2 above.

If you have any questions on this paper, or would like assistance in estimating a corrected risk corridor settlement or impact of transfer members, please reach out to Drew.McStanley@wakely.com or your Wakely consultant.