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## The Medicare Prescription Drug Proposals and Health Insurance Risk

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**OVERVIEW** — *In order to facilitate a better understanding of the complex issues raised by the current Senate and House proposals to establish a prescription drug benefit for Medicare beneficiaries, this paper briefly addresses some fundamentals of the health insurance market, defines key risk-sharing mechanisms, including risk corridors and reinsurance, and identifies the relevant risk provisions in the bills. Other issues related to cost management strategies and program design, which may have an impact on cost and adverse selection, are briefly discussed.*

# The Medicare Prescription Drug Proposals and Health Insurance Risk

Efforts to add a prescription drug benefit to the Medicare program have intensified in recent months. Though many agree on the importance of finding a way to provide what has become a critical component of medical treatment to our nation's seniors, much disagreement remains about how this should be achieved. In late June, the House and Senate passed their respective versions of a Medicare prescription drug benefit plan.<sup>1</sup> Although different in significant and numerous ways, the two bills share a reliance on private entities to provide drug coverage for seniors. These entities include both comprehensive health plans and stand-alone drug plans.

This reliance raises concerns about the appropriate structure of a benefit that will need to appeal to a wide range of seniors, not just those with significant prescription drug needs, and to insurers, who will be wary of offering a new benefit in the face of unknown demand and the risks of adverse selection. What incentives are needed to encourage private plans to participate? How will the risk concerns differ for comprehensive health plans and stand-alone drug plans? What are the likely effects of the various risk arrangements on plans, the government, and Medicare beneficiaries? Will risk corridors, reinsurance, or a combination of both best serve the interests of the various stakeholders? What role will prescription drug cost-management strategies play? Resolving these and other questions will be key to assuring the viability of a meaningful drug benefit for Medicare beneficiaries.

## HEALTH INSURANCE BASICS

The possibility of facing extremely costly medical bills and the financial consequences that could follow lead most individuals to seek the protection offered by some form of health insurance. In addition to protecting individuals from the high cost of health care services, health insurance also assures greater access to such services.<sup>2</sup>

Health coverage is available through a variety of sources, both private and public, including employers, Medicare, Medicaid, federal and state employee plans, the military, and the Veterans Administration. The most significant source of private health insurance is employer-sponsored coverage, which covers more than 160 million people.<sup>3</sup> Small employers offering coverage typically opt to insure through an outside health insurer.

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In contrast, large employers are more likely to self-insure their employees, paying directly for their employees' health care services and assuming the risk for the associated costs. Individuals without access to employer-sponsored coverage may purchase coverage in the individual market, either directly or through a group purchasing arrangement.

By grouping a large number of individuals with different levels of expected health care needs, an arrangement referred to as *risk pooling*, health insurance providers can spread the cost of high-claims cases. This makes premiums more affordable than they would otherwise be.<sup>4</sup> Costs for larger groups tend to have less variation, making them more predictable. This is due, in large part, to the sheer size of these plans and to the high proportion of employees that enroll in a plan. When an insured pool does not reflect the health status of the general population but instead results in one in poorer-than-average health, *adverse selection* has occurred.<sup>5</sup> Pools with sicker individuals will have higher premiums (reflecting their higher costs), which in turn will likely result in healthier individuals seeking lower-cost alternatives. Consequently, insurers try to avoid adverse selection by retaining or attracting low-cost subscribers. In this way, they are able to maintain competitive premiums for the entire pool.

Some experts argue that concerns about adverse selection are even greater for the provision of a prescription drug benefit for the Medicare population because of seniors' ability to predict these costs. Most prescription drug spending by the elderly is for the treatment of chronic diseases, making such spending predictable and persistent.<sup>6</sup> Seniors, armed with this spending information, are better able to make coverage decisions based on their expected costs, which may lead only those with the highest expected costs to seek coverage.

## RISK-SHARING MECHANISMS

The lack of experience private entities have with predicting the costs of this new benefit may lead them to set premiums too low. Such inaccurate rate-setting can result in significant losses for the private entities and/or for the federal government. Various mechanisms can be used to limit the risk or spread the risk between the insurer and/or the government. While insurance shields individuals from the high cost of medical services, risk-sharing mechanisms serve to limit the risk exposure of insurers and government. Discussed below are mechanisms included in the two congressional proposals.

### Reinsurance

Similar to the protection offered by insurance to individuals, reinsurance provides some level of protection to the primary insurer by taking on some portion of the risk that it has assumed. Primary insurers pay a premium to the reinsurers in exchange for protection against higher-than-expected

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claims.<sup>7</sup> Given the potential for extremely high costs, reinsurance premiums can be quite expensive. These high premiums and some ability to spread the risk enable reinsurers to take on much greater risk. Reinsurance is very prevalent in the commercial market. The most common types of reinsurance are aggregate reinsurance and individual reinsurance.<sup>8</sup>

Aggregate reinsurance protects an insurer from some of the risk associated with an insured group. Reinsurance protection is triggered if total claims for a group exceed a certain threshold. Individual reinsurance limits an insurer's exposure for claims above a certain level for each covered individual.<sup>9</sup> For example, individual reinsurance coverage may reimburse the primary insurer for 80 percent of the claim costs incurred by an individual above \$20,000 for a specified time period. Unlike aggregate reinsurance, however, individual reinsurance does not protect insurers from aggregate losses that occur below the defined threshold. So, while an insurer may not have an individual enrollee who reaches the threshold that would trigger individual reinsurance payments, it may have a large number of enrollees who incur significant expenses below that threshold, creating unexpected aggregate losses.

The ability of primary insurers to reinsure provides a safeguard for greater affordability and availability of insurance coverage. Without protection from claims costs well in excess of premiums, insurers—and self-insured employers—could suffer considerable losses. The threat of such losses could affect insurers' decisions regarding benefit offerings and could discourage employers from self-insuring. Furthermore, reinsurance protects the financial solvency of insurers, particularly those that are smaller or are just starting up. Reinsurance could play a critical role in the establishment of a Medicare prescription drug benefit, given the lack of experience insurers will have in providing a drug benefit to this population. Reinsurance provisions in both the Senate and House proposals are discussed in a later section.

### Risk Corridors

Risk corridors are another mechanism for limiting the losses experienced by an insurer. Risk corridors are centered on a target point that typically represents the total amount of annual premiums paid to an insurer (excluding administrative costs). Gains or losses within a given percentage above or below that target point are assumed by the insurer. Gains or losses beyond that established risk corridor are shared by the insurer and the payer.<sup>10</sup>

For example, if the target amount were set at \$10,000, and a plan assumed full risk for costs 10 percent above or below that amount, a plan would keep the gains if costs totaled \$9,000 to \$10,000 and would assume the losses if they totaled \$10,000 to \$11,000. If costs fell below \$9,000, the gains would be shared between the plan and the payer in defined percentages, and if costs exceeded \$11,000, the losses would be shared.

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## Risk Adjusters

Risk adjusters, while not technically a risk-sharing mechanism, compensate insurers based on the expected health risk of the individuals they enroll, thereby creating a more accurate payment mechanism.<sup>11</sup> Demographic factors, including age, gender, occupation, and Medicaid eligibility, reflect overall health patterns in the general population and may be used to project expected health care costs of an individual.<sup>12</sup> Risk adjustment based on diagnostic information, which looks at a beneficiary's diagnosis in one year and predicts expected costs for the following year, may also be used. Diagnostic information can be determined through the collection of data that document an individual's encounters with the health care system. By compensating plans that have enrollees who are in poorer health and have higher costs, risk adjusters provide some protection against adverse selection. Risk adjusters therefore reduce incentives for plans to avoid high-cost enrollees.

**Risk adjusters reduce incentives for plans to avoid high-cost enrollees.**

## S. 1 AND H.R. 1 RISK-SHARING APPROACHES

### Senate Approach

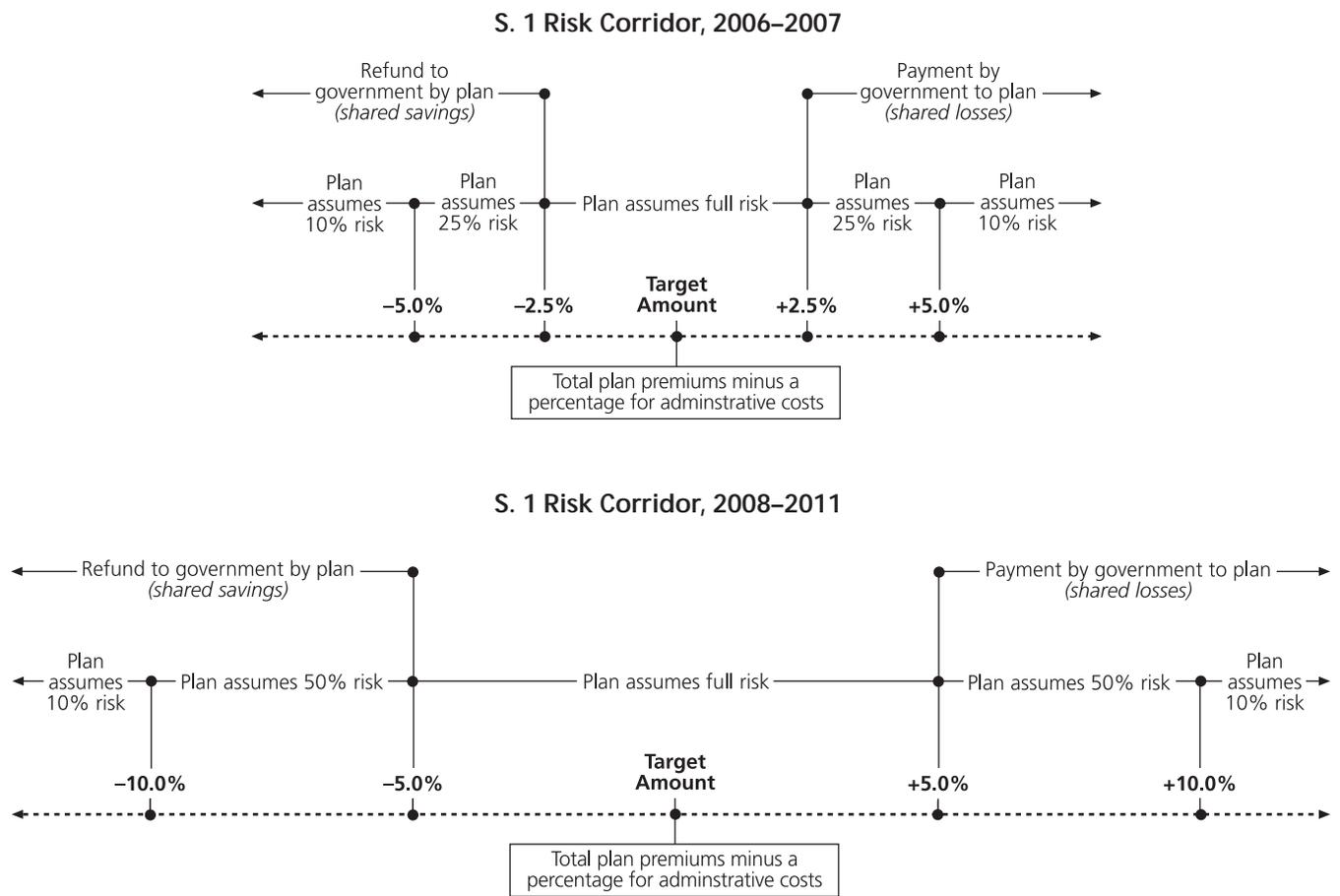
The Senate proposal, the Prescription Drug and Medicare Improvement Act of 2003 (S.1), would combine the use of risk corridors, reinsurance, and risk adjusters to encourage private entities to participate in the Medicare prescription drug market. Risk corridors would be established around a target amount that is based on total plan premiums (less administrative costs). Private entities would assume full risk for costs up to 2.5 percent above the established target amount. They would assume 25 percent risk for costs between 2.5 percent and 5 percent above the target amount, and 10 percent risk for costs exceeding 5 percent above the target amount.<sup>13</sup> (See Figure 1.) While a plan's risk would be limited, so too would its gains if costs were lower than expected. If a plan's costs fell below the target amount, it would be required to share the gains with the government in percentages that mirror the risk sharing.

To compensate for the lack of plan experience in providing a prescription drug benefit to Medicare eligibles, the risk corridors would expose plans to lower levels of risk in the first two years (2006 and 2007). Between 2008 and 2011, however, these corridors would expand, requiring plans to assume more risk. Full risk for costs within 5 percent (above or below) of the established target amount would be borne by the plans (Figure 1). Beginning in 2012, the administrator charged with overseeing the new program would set the risk thresholds, which could not be lower than those in place between 2008 and 2011.<sup>14</sup>

In addition to the protection offered by risk corridors, the Senate proposal includes an individual reinsurance provision. The reinsurance protection offered under the Senate bill (and the House bill), however, is not

traditional reinsurance as described earlier. The federal government would serve as the reinsurer and no premium would be collected in exchange for this protection. Plans would receive payments equal to 80 percent of the costs they incur for providing drug coverage for each individual who exceeds the annual out-of-pocket limit (\$3,700 for 2006).<sup>15</sup> Calculation of these costs would not include administrative costs, the costs of providing additional benefits, or any rebates or other discounts received by a plan.<sup>16</sup> Sponsors of retiree prescription drug plans and states offering pharmaceutical assistance programs would also be eligible for reinsurance payments for covered individuals, provided the coverage met certain requirements, including actuarial equivalence with the standard coverage offered by participating plans.<sup>17</sup>

**FIGURE 1**  
**Risk Corridors from the Prescription Drug and Medicare Improvement Act of 2003 (S. 1),**  
**2006–2007 and 2008–2011**



The Senate proposal would grant to the administrator the authority to create a methodology for adjusting payments to plans to take into account cost variations based on the differences in risk of different enrollees.<sup>18</sup> The administrator would be required to publish risk adjusters on an annual basis.

Plans would also have the ability under the Senate proposal to employ cost-control mechanisms to manage utilization and spending. The proposal states that plans “may use a variety of cost-control mechanisms, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.”<sup>19</sup> The proposal outlines a series of requirements for the development and application of formularies to protect beneficiary access.

### House Approach

The House proposal, the Medicare Prescription Drug and Modernization Act of 2003 (H.R.1), would rely on individual reinsurance (risk corridors are not included) to attract private plans into the Medicare prescription drug arena. (Again, the federal government would provide reinsurance payments and no premium would be collected from plans, distinguishing this approach from traditional reinsurance.) Reinsurance payments would be tiered and would include payments equal to (a) 20 percent of an enrollee’s prescription drug costs between \$1,001 and \$2,000 (in 2006) and (b) 80 percent of costs above the out-of-pocket limit (\$3,500 in 2006).<sup>20</sup> In addition, the House proposal includes a cap on reinsurance payments that would limit payments to 30 percent of a plan’s aggregate spending on prescription drugs for standard coverage.<sup>21</sup> Reinsurance payments would also be available to sponsors of retiree prescription drug plans that are actuarially equivalent to standard coverage.<sup>22</sup>

As noted earlier, individual reinsurance insulates insurers from potentially high-cost enrollees, but it does little to shield them from significant aggregate costs. The 30 percent aggregate cap may only heighten this concern for plans.

The House proposal would give the administrator the authority to risk-adjust plan payments if appropriate to avoid risk selection,<sup>23</sup> but risk adjustment is not required as it is in the Senate proposal. Similar to the Senate bill, the House version permits the use of prescription drug cost-management mechanisms.

### COST-MANAGEMENT AND PROGRAM DESIGN ISSUES

In addition to the risk-sharing mechanisms described above, there are other factors that may play an important role in reducing cost and limiting adverse selection associated with the provision of a prescription drug benefit

**H.R.1 would rely on individual reinsurance to attract private plans into the Medicare prescription drug arena.**

to Medicare beneficiaries. Of particular significance are prescription drug cost-management mechanisms and program design issues.

### Prescription Drug Cost-Management Mechanisms

Private entities' willingness to offer an affordable prescription drug benefit to Medicare beneficiaries will depend, in large part, on their ability to manage beneficiary utilization and spending. Efforts to eliminate, or even limit, this ability may deter plans from assuming the risk associated with this benefit. Both the Senate and House proposals would allow plans to use cost-management mechanisms, among which are formularies, beneficiary cost sharing, and tiered copayments. These strategies are commonly used in the private market and in Medicaid.<sup>24</sup> Consumer advocates have expressed concern about the level of discretion plans would have in designing their coverage under these proposals and the impact this discretion would have on beneficiary access. Below is a brief description of some of the strategies that plans may use.

**Formularies** — A formulary is a list of prescription drugs approved by a plan to be dispensed to patients. Such lists include drugs within each therapeutic class and are used to steer physicians and patients to the most cost-effective drugs.<sup>25</sup> Typically, patients who need access to drugs not listed on a formulary are required to obtain prior authorization or file an appeal to have the drug covered. Beneficiaries may factor a plan's formulary into their decision when looking at which plan to join. If a plan's formulary does not include a drug, or drugs, critical to their care, they may opt to join a plan with a formulary that does.

**Cost Sharing/Tiered Copayments** — Both proposals would grant plans the flexibility to determine beneficiary cost sharing, which may be assessed through deductibles, copayments, or coinsurance. Cost sharing reduces, to some extent, the potential for overutilization and unnecessary use of prescription drugs by placing some financial responsibility on the beneficiary. The appropriate level of cost sharing, however, will likely be the subject of considerable debate.

Tiered copayments would be permitted under both the Senate and House proposals. These copayments are typically linked to a plan's formulary and are structured to tie lower cost sharing to preferred drugs and higher cost sharing to nonpreferred drugs. Tiered copayments may also be tied to generic and brand name drugs, with higher cost sharing for the more costly brand name drugs. Tiering serves to make beneficiaries more aware of the true cost of prescription drugs and therefore encourages the use of less costly alternatives.

**Mail Order Pharmacy** — By eliminating the costs associated with retail pharmacies and achieving savings through negotiated prices with wholesalers and manufacturers, the use of mail order programs can be an effective cost-management tool.<sup>26</sup> Mail order can be used only for medications

for chronic conditions. However, given the large percentage of Medicare beneficiaries with one or more chronic conditions, mail order may offer a convenient and cost-effective alternative for seniors. Both proposals would allow the use of mail order pharmacies.

**Pharmacy Networks** — These are groups of pharmacies with which the entity providing coverage has entered a contract. By contracting with a more limited number of pharmacies, greater discounts can be negotiated in exchange for volume.<sup>27</sup> Beneficiaries purchasing their prescription drugs from an in-network, or “preferred” pharmacy, will typically pay a smaller copayment. Both proposals would place limits on the use of networks. The House bill includes “any willing pharmacy” language that would require entities offering prescription drug coverage to permit the participation of any pharmacy that meets the plan’s terms.<sup>28</sup>

### Program Design Issues

Many features of the program’s design are likely to play a role in increasing or decreasing adverse selection.

**Plan Enrollment** — The process by which seniors will have to enroll in a new prescription drug program will be important. The more administratively burdensome the process becomes for seniors, the less likely they are to participate; this is particularly true for those with lower expected prescription drug costs. Automatic enrollment, as occurs for Medicare Part B, would increase the number of participants, thereby reducing the risk of adverse selection.

**Penalties for Delayed Enrollment** — Such penalties would create an incentive for seniors to enroll during their initial enrollment period. Failure to enroll during this time would result in financial penalties for individuals who enroll at a later time (unless they have had creditable drug coverage in the interim). These penalties entice beneficiaries to enroll while they are still in good health rather than waiting until their need for prescription drugs is greater. Both proposals would include penalties for delayed enrollment.<sup>29</sup>

**Administrative Costs** — Inherent in any calculation of the risk of providing a new benefit will be the administrative costs. A new Medicare prescription drug benefit will likely involve a new federal agency, a new administrator, and a new set of regulations. Plans are likely to assess these costs, which could include maintaining and reporting detailed information related to benefits, costs, and drug prices (including all discounts and/or rebates); providing consumer education materials; and internal processes, such as appeals.

These design issues, and others, will need to be well thought out to ensure the appropriate mix of enrolled beneficiaries. If the offered plans appeal only to those in the greatest need of prescription drugs, healthier beneficiaries, as well as insurers, will be hesitant to participate.

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The design of the benefit to reduce the risk of adverse selection, coupled with plans' flexibility to use cost-management tools, will be important in determining the willingness of beneficiaries in good health to enroll in the program. If the premium amount and the various cost-sharing requirements are too high, those beneficiaries who expect to be low utilizers of prescription drugs may forgo coverage and instead continue to pay out-of-pocket for their drug needs. Conversely, those beneficiaries with expected prescription drug costs greater than the cost of the prescription drug benefit will enroll.

## CONCLUSION

The proposals that have emerged in the past two months have prompted significant discussion and debate about the many complex issues involved in creating a Medicare prescription drug benefit. Beneficiaries await a program that will ensure them access to and affordability of prescription drugs. Private entities seek protection from adverse selection and the potential consequences of providing this new benefit to the Medicare population. How these goals should be achieved, however, remains elusive as policymakers are faced with more questions than answers.

Among the critical questions facing policymakers are the following:

- What are the likely effects of the various risk arrangements on plans, the government, and Medicare beneficiaries?
- How should the benefit be designed in order to reduce the risk of adverse selection?
- How much risk might be eliminated by each of the mechanisms used in S. 1 and H.R. 1, including risk corridors, reinsurance, and risk adjusters?
- How will the risk concerns differ for comprehensive health plans and stand-alone drug plans? Are risk concerns heightened when drug-only plans compete against plans that provide more comprehensive coverage? How can these concerns be alleviated?
- What is the administrative burden associated with each of these risk arrangements? How will this burden factor into a plan's assessment of whether or not to participate in the Medicare prescription drug program?
- How effective will prescription drug cost-saving mechanisms (for example, formularies and mail order) be in controlling utilization and spending?
- What will be the impact of increased demand induced by the availability of new coverage?
- What will be the long-term government costs?

## ENDNOTES

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