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# LICS and Reinsurance—Are They Really Risk-Free?

By Timothy J. Adams

Timothy J. Adams, FSA, MAAA, is an independent contractor based in Allen, TX. He can be reached at *TimothyXAdams@yahoo.com.*

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 created a new tier within the Medicare insurance program specifically designed to provide for pharmaceutical expenses. This new benefit, often called Medicare Part D (or Med D), is provided by independent health plans, called pharmacy benefit plans (PBPs). These plans are supervised by the Centers for Medicare & Medicaid Services (CMS). While some entities that provide Med D insurance only offer one PBP, it is not uncommon for an entity to provide multiple PBPs. For purposes of this article, any type of entity that provides Med D insurance will be referred to as a plan.

Claims incurred under Medicare Part D progress through four zones over the course of one year. These zones, and their ranges, are:

- Zone 1, the front-end deductible, includes all covered claims up to a preset deductible.
- Zone 2, the initial coverage zone, starts when the deductible is met and comprises covered claims up to another preset amount, called the initial coverage limit.
- Zone 3, often called the donut hole, encompasses all covered claims in excess of the initial coverage limit up until the beneficiary incurs a preset amount of out-of-pocket expenses, which is called TROOP.
- Zone 4, the catastrophic zone, begins when a participant attains the maximum TROOP amount.

Four major classifications of pharmaceutical benefits were defined under Medicare Part D. The standard benefit provides coinsurance benefits in zone 2, along with a smaller coinsurance in zone 4. Most plans do not provide the exact standard benefit as defined in the regulations, but instead provide an actuarial equivalent benefit.

Benefits provided by the plans in excess of standard are often called supplemental benefits or non-covered plan payments (NPPs). CMS provides no assistance with these claims. Any supplemental premiums are paid by the beneficiary, and are strictly the responsibility of the plan to collect with no help from CMS. Likewise, supplemental claims are solely the responsibility of the plan, which assumes the entire risk for adverse experience.

A third type of benefit provided under Med D is the low-income cost subsidy, or LICS, claim. Participants with incomes beneath the low-income thresholds under Med D qualify for claims assistance that is provided indirectly by CMS through the participating plans. All LICS claims are applied to the beneficiary's TROOP.

The fourth and final type of prescription benefit provided under Med D occurs whenever a beneficiary reaches zone 4. From that point onward, the great majority of approved pharmacy claims paid will be classified as reinsurance claims. The funding for these claims is the same as LICS, with CMS providing the benefit indirectly through the participating plans.

In order to provide the LICS and reinsurance benefits to covered beneficiaries, each plan receives premiums from CMS. The rates for these premiums are submitted by the plans and are approved by CMS. The plan then pays LICS and reinsurance claims from its own funds, regardless of the adequacy of the premiums.

During the second half of the following year, CMS performs a settlement based upon the plan's experience. Unlike the standard benefit, which is settled using a type of coinsurance arrangement, the LICS and reinsurance benefits are settled at 100 percent of the difference between premiums and claims. If LICS and reinsurance premiums exceed claims, the plan remits the difference back to CMS. Likewise, if claims exceed premiums, CMS reimburses the plan for the difference.

While this arrangement suggests that CMS bears the entire risk for both LICS and reinsurance, both claim types actually entail substantive risks. For example, the cost of administering the two benefits is not considered in the settlement. This cost is implicitly embedded within the administrative factors that are a component of the standard benefit premium. To the extent that cost for administering these benefits comes out higher than assumed, it becomes a loss to the plan.

One of the more visible risks in writing LICS and reinsurance regards cash flow. If a plan pays out more in LICS and reinsurance claims than it collects in premiums, it must front the difference until it receives the settlement. This is not a particularly big risk if the plan has sufficient cash available to cover the entire shortfall, especially considering current interest rates. But this risk becomes much bigger if the plan does not have sufficient liquidity. At that point, it would be forced to sell assets or borrow money to cover the shortfall. The following table provides a good example:

Notice how the cash flow starts positive. This is because reinsurance claims are always light early in the year. Cash flow turns negative later in the year, caused by the sharply rising reinsurance claims late in the year. Had the settlement been performed right at year-end, the company's interest loss would have been relatively minor. But other considerations, such as lags, plan-to-plan (P2P) and retroactivity, render such early settlement impossible. The plan must therefore continue with this shortfall until the more likely time of settlement, either parting with whatever interest the cash shortfall would have earned during this time, or paying interest on money borrowed during this time to cover the shortfall.

It should also be noted that even though low reinsurance claims early in the year provide the plan with a chance to build up a cash reserve for later reinsurance claims, this advantage is offset by the fact that standard Part D claims typically exceed premiums early in the year, thereby negating much of the positive cash flow from reinsurance.

P2P claims present another risk. Frequently the Med D claims-paying process will cause plans to pay benefits on behalf of beneficiaries who are actually covered by other plans. Through the P2P process, CMS redirects such claims to the correct plan. With CMS as an intermediary, this plan then reimburses the plan that originally made the payment. While most P2P claims ultimately end up being paid by their correct plans, some P2P claims fall through the cracks. When a plan pays a P2P claim for which it is not reimbursed, the entire amount becomes a cost for the plan, as none of the amount will be credited back to it during the settlement process.

The settlement process raises risks as well. If CMS recognizes fewer LICS and reinsurance claims than the plan actually paid, then CMS only reimburses for the claims that it has recognized. Sometimes CMS rejects some of the claims paid by a plan, thereby reducing the claim amounts that CMS recognizes in the settlement. It also is possible that

| | January | February | March | April | May | June | July |
|---|---|---|---|---|---|---|---|
| BOM balance | 0 | 1,202,444 | 2,359,686 | 3,371,337 | 4,136,600 | 4,454,064 | 4,221,701 |
| **PREMIUMS/SETTLEMENTS** | | | | | | | |
| LICS | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 |
| Reinsurance | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 |
| Net inflow | 10,000,000 | 10,000,000 | 10,000,000 | 10,000,000 | 10,000,000 | 10,000,000 | 10,000,000 |
| **CLAIMS** | | | | | | | |
| LICS | 8,000,000 | 7,750,000 | 7,500,000 | 7,250,000 | 7,000,000 | 6,750,000 | 6,500,000 |
| Reinsurance | 800,000 | 1,100,000 | 1,500,000 | 2,000,000 | 2,700,000 | 3,500,000 | 4,300,000 |
| Net outflow | 8,800,000 | 8,850,000 | 9,000,000 | 9,250,000 | 9,700,000 | 10,250,000 | 10,800,000 |
| Interest | 2,444 | 7,242 | 11,651 | 15,263 | 17,464 | 17,637 | 15,570 |
| Net cash flow | 1,202,444 | 1,157,242 | 1,011,651 | 765,263 | 317,464 | -232,363 | -784,430 |
| EOM balance | 1,202,444 | 2,359,686 | 3,371,337 | 4,136,600 | 4,454,064 | 4,221,701 | 3,437,271 |

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| | August | September | October | November | December | January+1 | February+1 |
|---|---|---|---|---|---|---|---|
| BOM balance | 3,437,271 | 1,697,710 | -1,301,484 | -6,066,463 | -14,107,475 | -29,446,016 | -29,565,982 |
| **PREMIUMS/SETTLEMENTS** | | | | | | | |
| LICS | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 0 | 0 |
| Reinsurance | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 5,000,000 | 0 | 0 |
| Net inflow | 10,000,000 | 10,000,000 | 10,000,000 | 10,000,000 | 10,000,000 | 0 | 0 |
| **CLAIMS** | | | | | | | |
| LICS | 6,250,000 | 6,000,000 | 5,750,000 | 5,500,000 | 5,250,000 | 0 | 0 |
| Reinsurance | 5,500,000 | 7,000,000 | 9,000,000 | 12,500,000 | 20,000,000 | 0 | 0 |
| Net outflow | 11,750,000 | 13,000,000 | 14,750,000 | 18,000,000 | 25,250,000 | 0 | 0 |
| Interest | 10,439 | 805 | -14,978 | -41,012 | -88,541 | -119,967 | -120,455 |
| Net cash flow | -1,739,561 | -2,999,195 | -4,764,978 | -8,041,012 | -15,338,541 | -119,967 | -120,455 |
| EOM balance | 1,697,710 | -1,301,484 | -6,066,463 | -14,107,475 | -29,446,016 | -29,565,982 | -29,686,438 |

some claims paid by the plan just do not show up in CMS records. Regardless of cause, the entire cost of these unrecognized claims ultimately falls back onto the plan.

Historically, pharmacy claims have experienced rapid runoff. It is not atypical for 99 percent of pharmacy claims to be paid during the fill month. Most of the lag is caused by prescriptions filled late in one month, with the corresponding claim being paid in early in the following month. Such has not been the case with Med D claims. Retroactivity is a major source of Med D claim lag. This occurs when a participant is assigned to a plan not just beginning at the first month on the plan's records, but also retroactive to earlier months. For example, CMS might assign a beneficiary to a plan in October, but make the coverage retroactive back to March. The plan would then become responsible for all of this beneficiary's claims for the entire past seven months.

Another source of claim lag results is caused by State Pharmacy Assistance Plans (SPAPs) and Medicare Secondary Payer Plans (MSPs). If either of these types of plans provides a benefit that is later discovered to have been covered by Med D, this benefit is then assigned to the plan in which the beneficiary is a member. Such claims might come many months after the original fill date.

Long-lag LICS and reinsurance claims are not a big difficulty if posted before the cutoff date for inclusion in the CMS settlement. This cutoff is typically six months after the close of the benefit year. If long-lag claims are posted in time and match CMS records, then the plan's only loss is the interest the claim amount would have earned between the payment date and the settlement date. But claims that are posted after the cutoff date are not likely to be included in the settlement. Unless CMS later reopens the settlement and allows claims that are posted after the cutoff date, the plan loses the entire cost of the claim.

Rebates introduce another potential risk. Pharmacy rebates, which are called "Direct and Indirect Remuneration" (DIR) in Med D terminology, do not affect LICS. But DIR is a significant component of reinsurance results. A portion of DIR is credited against reinsurance claims based upon the ratio of drug costs in excess of the catastrophic threshold to the total of all drug costs in the plan. This is called the DIR ratio. The amount of DIR applied against reinsurance claims is equal to 80 percent of the DIR ratio times the plan's DIR. The risk here involves the amount of DIR reported and the amount actually received. Med D regulations stipulate that all of the DIR reported be applied toward the risk corridor and reinsurance settlements. To the extent that a plan does not receive the entire amount of DIR reported, it absorbs the entire loss.

| | March+1 | April+1 | May+1 | June+1 | July+1 | August+1 | September+1 |
|---|---|---|---|---|---|---|---|
| BOM balance | -29,686,438 | -29,807,384 | -29,928,823 | -30,050,757 | -30,173,187 | -30,296,117 | -30,419,547 |
| **PREMIUMS/SETTLEMENTS** | | | | | | | |
| LICS | 0 | 0 | 0 | 0 | 0 | 0 | 19,500,000 |
| Reinsurance | 0 | 0 | 0 | 0 | 0 | 0 | 9,900,000 |
| Net inflow | 0 | 0 | 0 | 0 | 0 | 0 | 29,400,000 |
| **CLAIMS** | | | | | | | |
| LICS | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reinsurance | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Net outflow | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Interest | -120,946 | -121,439 | -121,934 | -122,431 | -122,929 | -123,430 | -64,043 |
| Net cash flow | -120,946 | -121,439 | -121,934 | -122,431 | -122,929 | -123,430 | 29,335,957 |
| EOM balance | -29,807,384 | -29,928,823 | -30,050,757 | -30,173,187 | -30,296,117 | -30,419,547 | -1,083,590 |

There are pragmatic ways of dealing with these risks. Cash flow risk can be mitigated with reliable claim projections that are accordingly reflected in the bids. Other risks can be reduced with judicious claims processing, careful monitoring and restraint of expenses, and diligent coordination of information with CMS and the pharmacies. While there is certainly money to be made writing Med D insurance, never should anyone write it in the belief that the LICS and reinsurance pieces are entirely risk-free. ■

The Sunday before the 2011 Society of Actuaries (SOA) Health Meeting, the Untapped Opportunities group sponsored a "Health Careers Networking Reception." This reception was very well-attended, and the SOA gave away five wonderful raffle prizes to the attendees. Congratulations to these winners:

- ***Fang Tian***—Gift certificate for either a career coaching session or digital library session.
- ***Sudha Shenoy***—$50 Amazon gift card.
- ***Ronald Poon Affat***—$50 Amazon gift card.
- ***Matt Elston***—Book: The Influential Actuary, by David C. Miller.
- ***Lee Parrott***—Book: The Influential Actuary, by David C. Miller.