Article from

Health Watch

June 2019

Issue 89

Medicare Part D Settlements—A Primer

By Kate Herbig

For many Medicare actuaries, preparing bids for submission the first Monday in June is the culmination of their involvement in Medicare Part D. But it isn't the end of the story—during the plan coverage year, the Centers for Medicare & Medicaid Services (CMS) make monthly payments to plan sponsors based on these submitted bids. Then in the following year, these payments are adjusted based on actual claims costs, rather than bid projections, in a process known as Part D settlements. Part D plans are essentially financial intermediaries because they are federally funded and potential gains or losses are limited due to the risk-sharing arrangements with CMS; Part D settlements are a necessary part of this contractual arrangement.

Imagine this: You are an actuary responsible for monitoring experience for your company's Part D plans. When you make a simple comparison of total payments received from CMS and members versus payments out for claims, margins are looking great. However, when you estimate settlement amounts, you realize things don't look so rosy after all. Your prospective payments from CMS were higher than the associated claim costs, and your plan owes a significant settlement payment back to CMS. The large margins you were seeing in your initial calculation have disappeared. Some CMS payment components are considered "pass-through" payments, which will ultimately be trued up to actual costs through the settlement process, and should not be considered revenue.

It's important to estimate settlements well before the final true-up with CMS, which occurs roughly six to nine months after the end of the contract year. Anticipated future payments to or from CMS should be reflected in quarterly and year-end financial statements, impacting the total financial picture for the year—settlement payments equal to 5 to 10 percent of Part D revenue are not uncommon and could easily turn a projected profit into a loss if they are not accounted for properly. Part D settlement information will be reflected in the calculation of medical loss ratios, which are also settled with CMS after the end of the contract year, but calculated for Parts C and D in aggregate. In addition, due to the structure of the Part D benefit design, cash flows vary throughout the year; thus, plan sponsors must hold early payments received when the plan costs are low to pay for potential higher plan liabilities later in the year.

STRUCTURE OF SETTLEMENTS

There are four components of the Part D settlements arrangement: federal reinsurance, low-income cost-sharing subsidy (LICS), coverage gap discount program (CGDP) and risk-sharing corridor. All settlement calculations are done on a plan benefit package (PBP) basis (same as the filed bids), and not combined at the contract or plan sponsor level. This has an impact on risk-sharing corridor calculations in particular, where losses in one PBP are not offset by gains in another prior to calculating settlement amounts.

Federal Reinsurance

The Part D benefit design includes a catastrophic threshold, defined as a level of member out-of-pocket spending ($5,100 for 2019). Above this threshold, member cost sharing drops to 5 percent, plan liability is 15 percent, and CMS is liable for the other 80 percent of costs. The CMS liability is known as federal reinsurance. Plan sponsors estimate costs in the catastrophic phase and corresponding federal reinsurance during bid submission (due in June for the following bid year). CMS pays a prospective per member per month (PMPM) federal reinsurance payment to plan sponsors based on the filed bid amount. Once claims data is complete and final catastrophic claims costs are known, the reinsurance settlement is calculated as the difference between the actual CMS liability for catastrophic claims less prescription drug rebates allocated to reinsurance and total prospective reinsurance payments made to the plan sponsor. A positive value indicates that final costs were more than estimated, and a payment is made from CMS to the plan sponsor;

conversely, a negative value indicates a payment due from the plan sponsor to CMS.

LICS

Part D plan members with incomes below a certain percentage of the federal poverty level are identified as low-income (LI) members, and receive premium subsidies and reduced cost sharing. CMS pays the difference between filed plan cost-sharing and low-income cost-sharing levels as the LICS. As with reinsurance, plan sponsors estimate LICS costs during bid submission and receive a prospective PMPM LICS payment from CMS based on their bid. Once claims data is complete, calculation of the LICS settlement is analogous to the reinsurance settlement calculation.

CGDP

Once total claims costs exceed a level called the initial coverage limit (ICL), the member enters the coverage gap. Historically, members were responsible for all drug costs within the coverage gap until reaching the catastrophic threshold; however, non-low-income (NLI) member cost sharing in the gap has been gradually decreasing since the passage of the Affordable Care Act (ACA) of 2010 and will be 25 percent starting in 2020, equal to pre-ICL defined standard cost sharing.[1]

For brand drugs filled by an NLI member, pharmaceutical manufacturers are responsible for 70 percent of drug costs in the gap. This is known as the coverage gap discount program. Plan sponsors invoice actual CGDP amounts to pharmaceutical manufacturers on a quarterly basis. As with other subsidies, plan sponsors estimate CGDP costs as part of bid submission and receive a prospective PMPM CGDP payment from CMS, which is reduced for amounts invoiced to manufacturers. Reconciliation occurs six months after the end of the year, after six quarterly invoices. CMS pays the plan sponsor (or receives from, for a negative value) the difference between total CGDP costs reported in experience less payments received via manufacturer payments and prospective payments.

Risk-Sharing Corridor

CMS shares financial risk with plan sponsors in the Part D program. A target amount is set using Part D basic premium and direct subsidy payments and excluding an estimated load for administrative costs and margin. Not all claim costs are subject to risk sharing; in particular, benefits in excess of the defined standard benefit plan design in Enhanced Alternative plans (e.g., lowered or eliminated deductibles, lower cost sharing and costs for supplemental drugs) are not subject to risk corridor settlements. Plan liabilities under defined standard coverage, less rebates and reinsurance settlements, are then compared with the target amount. Plan sponsors retain all risk within 5 percent of bid target, with CMS sharing in an increasing portion of both upside and downside risk as variation of actual costs from targets increases. Table 1 shows the relative shares of risk for CMS and plan sponsors at different ratios of actual experience to the target cost.

Table 1
Relative Shares of Risk for CMS and Plan Sponsors

Actual Compared With Target	Plan Share	CMS Share
<90%	20%	80%
90 to 95%	50%	50%
95 to 105%	100%	0%
105 to 110%	50%	50%
>110%	20%	80%

As with reinsurance, LICS and CGDP settlements, risk corridor settlements are determined once final annual claims costs are known. Unlike with other settlement amounts, the assumption at bid submission is that risk corridor settlements will be $0—that is, that claim costs will match bid projections—therefore, no prospective risk corridor payments are made prior to settlement.

TIMING OF CASH FLOWS

While reinsurance and LICS subsidy payments are steady throughout the year, associated claims costs are not. Reinsurance costs, which are $0 until members reach the catastrophic threshold, are generally low at the beginning of the year and increase throughout the year, as members' year-to-date costs grow. LICS costs also generally vary over time, with high subsidies during the deductible phase, lower subsidies needed in the pre-ICL coverage phase where standard plan cost sharing is lower, and higher subsidies as members reach the coverage gap and catastrophic phase. Figure 1 shows what the reinsurance subsidy cash flows may look like for a plan.

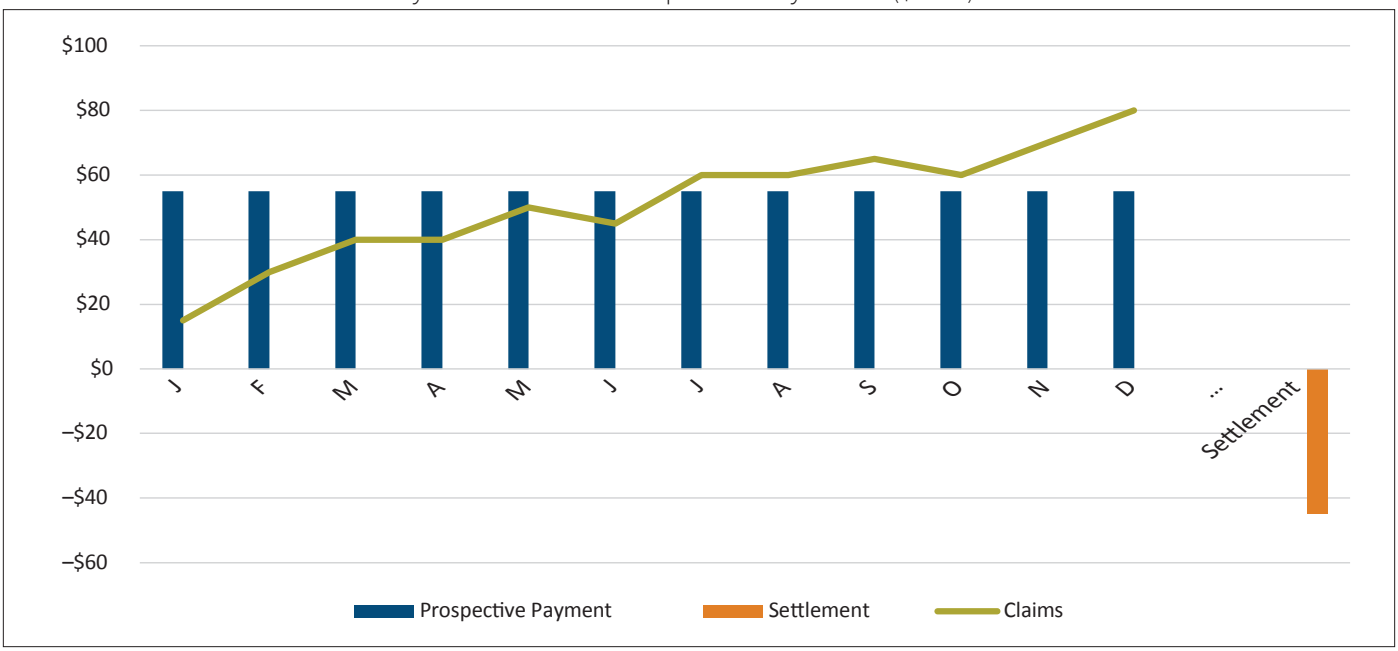
In this example, a plan sponsor receives $55,000 per month from CMS. Reinsurance costs are $15,000 in January, well below the monthly prospective payment, and grow to $80,000 over the course of the year. When settlement true-up happens, the plan sponsor has received $45,000 more in reinsurance subsidy payments than has actually been paid out in claims and must repay this money to CMS.

CONCLUSION AND OTHER CONSIDERATIONS

This article discussed the basics of Part D settlements. When estimating settlements, there are a number of other important considerations, including:

- **The impact of Part D risk scores changes.** Risk scores change midyear, leading to changes in prospective payments received from CMS. They also change after the end

Figure 1
Illustrative Federal Reinsurance Payments and Actual Experience by Month ($000s)



Note: For simplification, the example in this chart does not incorporate any membership changes or other adjustments that may impact the prospective payment amounts.

of the year, due to lagged diagnosis data runout. Risk scores impact the direct subsidy payments received from CMS, and in turn will affect profit margins and thus risk corridor settlements.

- **Impact of rebate projections.** Differences in actual rebates received versus those projected affect both reinsurance and risk corridor settlements. Plan liability is calculated net of rebates, so higher than projected rebates will lower plan liability and increase any potential settlement payments to CMS, or decrease the receivable from CMS.

- **Seasonality and midyear projections.** Projecting settlements with a partial year of data requires additional consideration. Part D cost components and plan membership are not level throughout the year, and the seasonality patterns may differ from plan to plan. Care is needed to project cost components on a month-by-month basis for those months that do not yet have data. Midyear changes in the mix of NLI versus LI mix will also impact final settlement projections, since CGDP payments apply only to NLI members, while LICS applies only to LI members.

- **Treatment of employer group waiver plans (EGWPs).** EGWPs are not subject to all settlements received by individual plans. EGWPs do not receive risk-sharing corridor payments. In addition, EGWPs with a noncalendar contract year do not receive reinsurance payments either and are, therefore, not subject to reinsurance settlements.

For a full picture of a Medicare Part D plan's financial performance, it is necessary to understand how settlements will impact ultimate financial results. Some costs are the sole responsibility of the plan sponsor, while others will be shared with CMS. Some payment components are final, while others are pass-through payments that will be trued up to actual costs. Recognizing which expenses and payments are which is important when monitoring a plan's health. It is also crucial to monitor expected settlement payments over time to avoid surprises at the time of settlement. ■

Kate Herbig, FSA, MAAA, is a consulting actuary at Milliman. She can be reached at *Kate.herbig@milliman.com*.

ENDNOTE

1 The defined standard benefit design is divided into phases, with a deductible, 25 percent coinsurance for allowed costs up to an ICL, gap cost sharing until member out-of-pocket spending hits an out-of-pocket limit known as the true out-of-pocket (TrOOP) limit, and catastrophic cost sharing of roughly 5 percent thereafter. For 2019, the deductible is $415, the ICL is $3,820, and the TrOOP limit is $5,100. Gap coinsurance is 37 percent for generics and 25 percent for brand drugs in 2019 for non-low-income members.