Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PART D SPONSORS: ESTIMATED RECONCILIATION AMOUNTS FOR 2006

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EXECUTIVE SUMMARY

OBJECTIVE

To assess the estimated reconciliation amounts that Part D sponsors will owe to or receive from Medicare for 2006.

BACKGROUND

The Medicare prescription drug program, known as Medicare Part D, provides an optional drug benefit to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, known as Part D sponsors, to provide prescription drug coverage for beneficiaries who choose to enroll in the program. During 2006, the first full year of the benefit, expenditures totaled more than $47 billion.

CMS makes monthly prospective payments to sponsors for providing prescription drug coverage to Medicare beneficiaries. These payments are based on estimates that sponsors provide in their approved bids prior to the beginning of the plan year. CMS makes prospective payments to sponsors for three subsidies based on sponsors' approved bids. These subsidies are: (1) the direct subsidy which, together with beneficiary premiums, is designed to cover the sponsor's cost of providing the benefit; (2) the reinsurance subsidy, which covers the Federal Government's share of drug costs for beneficiaries who have reached catastrophic coverage; and (3) the low-income cost-sharing subsidy, which covers the Federal Government's portion of the cost-sharing payments for certain low-income beneficiaries.

After the close of the plan year, CMS must reconcile these prospective payments with sponsors' actual costs to determine whether sponsors owe money to Medicare or Medicare owes money to sponsors. In addition, CMS must determine whether risk-sharing payments are required. Risk sharing requires the Federal Government to share in sponsors' unexpected profits and losses. The proportion of profits that sponsors must share with Medicare and the proportion of losses that sponsors are allowed to pass on to Medicare are based on risk corridors mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

This study assesses the estimated reconciliation amounts that Part D sponsors will owe to or receive from Medicare for 2006. It is based on preliminary estimates from CMS for all sponsors. We also collected and reviewed preliminary estimates from 16 sponsors with high

enrollments. We did not independently verify these estimates. The actual reconciliation amounts were not available at the time of our review.

FINDINGS

According to preliminary estimates, Part D sponsors owe Medicare a net total of $4.4 billion for 2006. According to CMS's estimates of reconciliation amounts, Part D sponsors owe a net total of $4.4 billion for 2006. Eighty percent of sponsors owe money to Medicare, whereas 20 percent of sponsors will receive money from Medicare for 2006.

The majority of the funds owed are profits that sponsors must repay to Medicare as a result of risk-sharing requirements. Almost two-thirds of the net total amount that sponsors owe results from risk-sharing requirements, about one-third is for the reinsurance subsidy, and a small amount is for the low-income cost-sharing subsidy. Sponsors that owe Medicare as a result of risk-sharing requirements overestimated the cost of providing the benefit in their bids. As a result, the prospective payments that these sponsors received from Medicare plus the beneficiary premiums were significantly greater than their costs.

CMS has no mechanisms to collect funds or to adjust prospective payments prior to reconciliation; therefore, sponsors have had the use of these funds for a significant length of time. CMS will not collect any funds from sponsors until it has completed reconciliation for 2006, which is scheduled to occur more than 9 months after the 2006 plan year has ended. According to CMS officials, there is no mechanism currently in place to collect the funds owed by sponsors prior to the completion of reconciliation. There is also no mechanism in place to identify situations in which prospective payments differ significantly from sponsors' actual costs or to adjust prospective payments accordingly to avoid large discrepancies at the end of the year. These circumstances have allowed sponsors to have the use of billions of dollars for a significant length of time.

RECOMMENDATIONS

These findings highlight the importance of ensuring the accuracy of Part D sponsors' bids and of aligning prospective payments with sponsors' actual costs. OIG is conducting work on sponsors' bids and on

CMS's oversight of the bid process. In addition, we recommend that CMS take the following actions:

Ensure that sponsors' bids accurately reflect the cost of providing the benefit to Medicare beneficiaries. CMS should ensure that sponsors' bids more accurately reflect their costs of providing the benefit. In light of the significant funds owed to Medicare for 2006, CMS should ensure that available data from the 2006, 2007, and any future plan years are incorporated in the subsequent bids. CMS should also take data from prior years into account when reviewing and approving bids.

Consider implementing an interim reconciliation process to reduce the amounts owed to Medicare. CMS could consider requesting that sponsors voluntarily submit preliminary data and use this information to identify significant amounts potentially owed to or from Medicare. For sponsors that owe Medicare, CMS could request that they voluntarily make interim settlements. CMS could also make interim payments to sponsors that are owed money from Medicare. Alternatively, CMS could consider undertaking statutory or regulatory changes necessary to implement a mandatory interim reconciliation process.

Better align monthly prospective payments with sponsors' actual costs. CMS should modify the Part D contracts to request, or seek authority to require, that sponsors prepare quarterly estimates of funds owed to or from Medicare. CMS could use these estimates as the basis for adjusting subsequent prospective payments. If appropriate, CMS could undertake statutory or regulatory changes necessary to make adjustments to the prospective payments. In addition, CMS should determine whether different methods of calculating monthly payment amounts would better align prospective payments with actual costs.

Consider seeking legislative changes to delay the adjustments to the risk corridors as specified by the MMA. The MMA requires that CMS widen the risk corridors and change the risk-sharing percentages beginning in 2008. If sponsors have large profits in 2008 and future years, these changes will decrease the Federal Government's share of the sponsors' profits and increase the amount that sponsors retain. These changes will also increase plan sponsors' exposure to unexpected losses, because they will reduce sponsors' ability to shift the burden of unexpected losses to the Government. We recommend that CMS review available data and, if appropriate, work with Congress to delay the statutory changes to the risk corridors until sponsors and CMS have

more experience with the Part D benefit and have implemented mechanisms that ensure that bids and prospective payments are more closely aligned with sponsors' Part D costs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with the recommendation that the data collected from the 2006 and subsequent plan years be used in the review of future bid submissions. CMS also stated that it has the authority to change payment methodologies for the low-income cost-sharing and reinsurance subsidies and that it is carefully examining possible options.

CMS did not concur with two of our recommendations. In response to the recommendation that CMS consider conducting an interim reconciliation process, CMS stated that it believes bidding accuracy will improve in coming years, thus eliminating this as an issue. Based on its interpretation of the statute, CMS also stated that there is no legal authority for an interim reconciliation of risk-sharing payments. Finally, in response to our recommendation that CMS consider seeking legislative changes to delay the adjustments to the risk corridors, CMS responded that it is only now able to analyze a full set of bidding and first-year utilization data. As a result, CMS stated that it would be premature to make recommendations to Congress for statutory changes before having a more complete analytic picture of whether the Government would benefit or be harmed by a change in the risk corridors.

We continue to recommend that CMS consider implementing an interim reconciliation process and consider seeking legislative changes to delay the adjustments to the risk corridors. CMS could request that sponsors make interim reconciliation settlements on a voluntary basis, when appropriate. Alternatively, CMS could consider pursuing statutory or regulatory changes necessary to implement a mandatory interim reconciliation process. Also, because only limited data are currently available, as CMS notes in its comments, there remains a significant risk that plans will owe large sums of money back to Medicare for 2008 and beyond. As such, it may be prudent to delay changes to the risk corridors until the sponsors and CMS have more experience with the Part D benefit and have implemented mechanisms, such as those we

have recommended, to ensure that bids and prospective payments are more closely aligned with sponsors' costs.

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INTRODUCTION

OBJECTIVE

To assess the estimated reconciliation amounts that Part D sponsors will owe to or receive from Medicare for 2006.

BACKGROUND

The Medicare prescription drug program, known as Medicare Part D, provides an optional drug benefit to Medicare beneficiaries.[1] The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, known as Part D sponsors, to provide prescription drug coverage for beneficiaries who choose to enroll in the program. During 2006, the first full year of the benefit, Medicare Part D expenditures totaled more than $47 billion.[2]

CMS makes monthly prospective payments to sponsors for providing prescription drug coverage to Medicare beneficiaries. These payments are based on estimates that sponsors provide in their approved bids prior to the beginning of the plan year.[3] After the close of the plan year, CMS must reconcile these payments with the sponsors' actual costs to determine whether sponsors owe money to Medicare or Medicare owes money to sponsors.

In a preliminary review of several sponsors' publicly available Form 10-K filings with the Securities and Exchange Commission, we found that several sponsors reported owing significant amounts of money to Medicare for the 2006 plan year. We alerted CMS to this issue in July 2007. This study assesses the total estimated amount that all Part D sponsors will owe to or receive from Medicare for 2006. The actual reconciliation amounts were not available at the time of our review. CMS issued the actual amounts on October 6, 2007. The estimates in this report are similar to the actual amounts.

[1] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

[2] "2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," p. 5. Available online at http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf. Accessed July 24, 2007.

[3] A plan year runs from January 1 to December 31 of the calendar year.

The Part D Benefit

CMS contracts with sponsors to provide the Medicare Part D benefit. These sponsors may offer a stand-alone prescription drug plan (PDP) or they can offer prescription drug coverage as a part of a managed care plan, known as a Medicare Advantage Prescription Drug Plan (MA-PD). In 2006, 224 sponsors offered a total of 3,426 plans.

Part D sponsors are required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to offer, at a minimum, a basic prescription drug benefit that is either the standard prescription drug benefit (described below) or is "actuarially equivalent" to the standard benefit.[4] Most beneficiaries are responsible for certain costs, which may include a monthly premium, an annual deductible, and coinsurance. However, certain low-income beneficiaries are eligible to receive assistance to pay some or all of these costs.

In 2006, the standard drug benefit had a deductible of $250.[5] In the initial phase of the Part D benefit, after the deductible is paid, beneficiaries contribute 25-percent coinsurance toward their drug costs and the plan pays the remaining 75 percent until combined beneficiary and plan payments reach a total of $2,250. After the $2,250 limit is reached, beneficiaries enter the coverage gap phase of the benefit, in which they are responsible for 100 percent of their drug costs. The catastrophic coverage phase begins when a beneficiary's out-of-pocket costs reach $3,600. This amount includes a beneficiary's deductible and coinsurance payments. Once beneficiaries reach $3,600 in out-of-pocket costs, they contribute approximately 5 percent coinsurance toward their drug costs. Of the remaining 95 percent of drug costs, the Part D sponsors are responsible for approximately 15 percent and Medicare pays 80 percent. The amount paid by Medicare is also referred to as the reinsurance subsidy. See Appendix A.

Plan Bids

Before the beginning of the plan year, sponsors are required to submit a bid for each plan they intend to offer.[6] Each sponsor submits a "standardized bid," which is an estimate of the average monthly revenue the sponsor needs to provide the basic benefit per beneficiary.

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[4] Actuarially equivalent means that the plan's benefits must be of a dollar value equivalent to that of the standard benefit.

[5] 42 CFR § 423.104.

[6] 42 CFR § 423.265.

This bid is based on the sponsor's anticipated drug costs, as well as the sponsor's administrative costs and expected profit. Sponsors must also submit an estimate for reinsurance and an estimate for low-income cost sharing. CMS reviews this information and determines whether to approve the final bid.[7] CMS then calculates the national average monthly bid from all plans' standardized bids.

CMS uses the national average monthly bid and the plan's standardized bid to calculate each plan's beneficiary premium. First, CMS sets the base beneficiary premium, which is a percentage of the national average monthly bid.[8] If a plan's bid is higher than the national average monthly bid, then the beneficiary's premium will be higher than the base premium by the amount of the difference. If a plan's bid is lower than the national average monthly bid, then the beneficiary's premium will be lower than the base premium by the amount of the difference. For example, if the national average monthly bid is equal to $100 and the base beneficiary premium is $26, then a plan with a bid of $90 ($10 less than the national average monthly bid) would have a beneficiary premium of $16.

The 2006 plan year was the first year of the benefit. Sponsors developed their 2006 bids with limited information about drug utilization and drug costs on which to base their bids. Sponsors also lacked much of the same information when they developed their 2007 bids.[9] Plan year 2008 is the first year in which the bids will be based on complete Part D utilization data from 2006.

Subsidy Payments

Throughout the year, CMS makes prospective payments to sponsors for three subsidies based on sponsors' approved bids. These subsidies are: (1) the direct subsidy, (2) the reinsurance subsidy, and (3) the low-income cost-sharing subsidy.[10]

Direct subsidy. The direct subsidy, together with the beneficiary premiums, is designed to cover the sponsor's cost of providing the

[7] For the purposes of this report, we refer to the approved bids as bids.

[8] Section 1860D-13(3) of the Social Security Act mandates how the base beneficiary premium is calculated. In practice, it is equal to at least 25.5 percent of the national average monthly bid.

[9] Sponsors were required to submit bids for 2007 on June 5, 2006. Because enrollment did not close until May 15, 2006, sponsors had limited data about beneficiaries' drug utilization patterns.

[10] 42 CFR § 423.315.

benefit to each beneficiary. The direct subsidy is equal to the plan's standardized bid, adjusted for the health status of the beneficiary,[11] minus the beneficiary premiums. CMS makes monthly prospective direct subsidy payments to sponsors for each beneficiary enrolled in the plan.

Reinsurance subsidy. The reinsurance subsidy covers the Federal Government's share of drug costs for beneficiaries who have reached catastrophic coverage. CMS makes monthly prospective payments to sponsors based on the reinsurance estimate in the sponsor's bid, multiplied by the total number of beneficiaries enrolled in the plan.

Low-income cost-sharing subsidy. The low-income cost-sharing subsidy covers the Federal Government's portion of the cost-sharing payments for certain low-income beneficiaries. CMS makes monthly prospective payments to sponsors based on the low-income estimate in the sponsor's bid, multiplied by the total number of low-income beneficiaries enrolled in the plan.

Reconciliation

After the close of the plan year, CMS reconciles these prospective payments with the actual costs incurred by the sponsors.[12] CMS calculates a reconciliation amount for the reinsurance subsidy, for the low-income cost-sharing subsidy, and for risk sharing (discussed on the next page). This calculation determines the total reconciliation amount that each sponsor will owe to or receive from Medicare for the plan year.

CMS uses data submitted by the sponsors to complete reconciliation. Sponsors are required to submit prescription drug event (PDE) records for all covered drugs that are dispensed to enrollees throughout the year. These records include cost data for all Part D-covered drugs. CMS requires that sponsors submit final PDE data within 6 months of the end of the plan year.[13] Sponsors are also required to report direct and indirect remuneration. This includes any type of remuneration, such as drug discounts or drug rebates, that affects the actual costs of the drugs paid for by sponsors.

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[11] Adjustments are made according to the health status of the beneficiary. CMS assigns a risk score to each enrolled beneficiary based on the individual's health status and demographic characteristics.

[12] 42 CFR § 423.343.

[13] 42 CFR § 423.343(c)(1).

As part of reconciliation, CMS finalizes the direct subsidy payments based on updated information about the health status of enrolled beneficiaries. CMS also reconciles the reinsurance subsidy payments and the low-income cost-sharing subsidy payments with the sponsor's allowable costs.[14] As a last step, CMS uses the finalized direct subsidy payments to determine whether risk-sharing payments are required.

Risk Sharing

The purpose of risk sharing is to minimize unexpected profits or losses to sponsors. Risk-sharing payments are based on statutorily determined risk corridors.[15] The MMA established these risk corridors to allow the Federal Government and sponsors to share the profits and losses associated with providing the benefit.

To determine whether risk-sharing payments are required, CMS compares the plan's "target amount" to the plan's allowable costs. The target amount is the sum of the prospective direct subsidy payments and the beneficiary premiums, reduced by administrative costs. The plan's allowable costs are its Part D drug costs minus direct and indirect remuneration and the reinsurance subsidy. Depending on the difference between the target amount and the plan's allowable costs, Medicare may owe money to the sponsor or the sponsor may owe money to Medicare.

In 2006 and 2007, as shown in Chart 1 on the next page, if a plan's allowable costs are at least 2.5 percent above or below the target amount, then a portion of these profits or losses are subject to risk sharing. The risk sharing associated with each of the corridors, as mandated by the MMA, is described below:

- No risk-sharing payments are made if a plan's allowable costs are within 2.5 percent above or below its target amount.
- First risk corridor: If a plan's allowable costs are between 2.5 percent and 5 percent above its target amount, then sponsors receive payments from Medicare to cover 75 percent of these

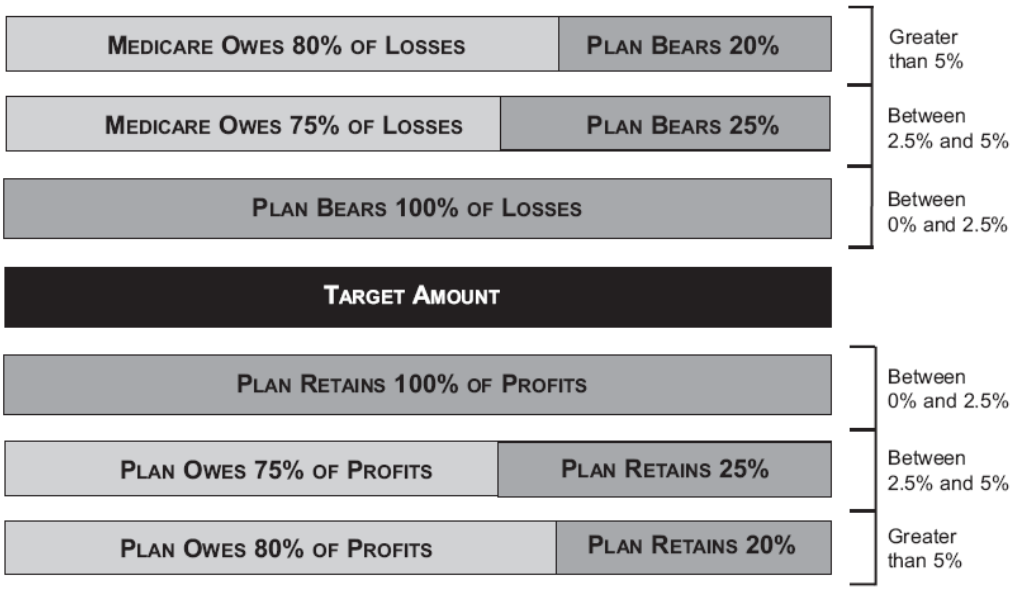
[14] To determine the allowable costs for reinsurance, CMS excludes administrative costs and subtracts a proportion of sponsors' direct and indirect remuneration.

[15] 42 U.S.C. § 1395w-115.

losses.[16] Conversely, if a plan's allowable costs are between 2.5 percent and 5 percent below its target amount, then the sponsor owes Medicare 75 percent of these profits.

- Second risk corridor: If a plan's allowable costs are more than 5 percent above its target amount, then the sponsor receives payments from Medicare to cover 80 percent of these losses. Conversely, if a plan's allowable costs are more than 5 percent below its target amount, then the sponsor owes Medicare 80 percent of these profits.

CHART 1: 2006–2007 Statutorily Determined Risk Corridors



Beginning in 2008, the risk corridor thresholds will widen and the risk-sharing percentages will change as mandated by the MMA.[17] For 2008 through 2011, the first risk corridor threshold will increase from 2.5 percent to 5 percent of the target amount and the second risk corridor threshold will increase from 5 percent to 10 percent of the target amount. In addition, the risk-sharing percentage for the first

[16] The MMA specifies that sponsors will receive payments from Medicare to cover 90 percent of these losses, rather than 75 percent, if at least 60 percent of PDPs and MA-PDs have allowable costs that are more than the first threshold and such plans represent at least 60 percent of beneficiaries enrolled in any plan. See 42 U.S.C. § 1395w-114.

[17] 42 U.S.C.§ 1395w-115.

corridor will change from 75 percent to 50 percent. These changes will decrease the percentage of unexpected profits that sponsors will owe to Medicare and increase the percentage of unexpected profits that sponsors will retain. These changes will also decrease the percentage of the sponsors' losses that they are permitted to shift to Medicare and increase the percentage of losses that sponsors will have to bear. See Appendix B.

METHODOLOGY

Scope

This study assesses the estimated reconciliation amounts that Part D sponsors will owe to or receive from Medicare for 2006. It is based on CMS's estimates for all sponsors. We also reviewed estimates from 16 sponsors with the PDPs or MA-PDs with the highest enrollments. The estimates from CMS and from the sponsors are preliminary. The actual reconciliation amounts were not available at the time of our review.

CMS Estimates of Reconciliation Amounts

We received and reviewed preliminary estimates from CMS of the amount each sponsor will owe to or receive from Medicare for the 2006 plan year. CMS calculated these estimates based on the best data available as of August 2007, which include PDE records updated as of July 31, 2007, and direct and indirect remuneration information updated as of August 14, 2007.

We reviewed CMS's estimates for all 224 sponsors that offered Part D plans in 2006. Specifically, we reviewed the total reconciliation amounts and the amounts for the reinsurance subsidy, the low-income cost-sharing subsidy, and risk sharing.

Sponsor Estimates of Reconciliation Amounts

We also requested and reviewed estimates from selected large sponsors. We identified the 10 sponsors with the highest PDP enrollments and the 10 sponsors with the highest MA-PD enrollments as of July 2006. Three sponsors were in both groups. In July 2007, we requested financial information from these 17 sponsors about their Medicare Part D business. We received complete information from 16 of these sponsors. In total, these 16 sponsors provided the Part D benefit to 77 percent of all Medicare beneficiaries enrolled in 2006.

For each sponsor, we requested and reviewed preliminary estimates of the amount it will owe to or receive from Medicare for the reinsurance subsidy, the low-income cost-sharing subsidy, and risk sharing. If information about each subsidy was not available, we requested and reviewed the total net amount that sponsors expect to owe to or receive from Medicare for 2006. We contacted the sponsors for additional information when we had any questions about the estimates they provided.

As a final step, we compared the 16 large sponsors' estimates to CMS's estimates to identify any large discrepancies. We did not expect the estimates to match exactly, primarily because the sponsors' estimates were based on data available at the time of their last update, whereas CMS's estimates were based on data available as of August 2007. Of the 16 sponsors, 12 provided estimates that were last updated between January and March 2007. Three other sponsors had updated their estimates as of May 2007, and the remaining sponsor had updated its estimates as of July 2007.

Limitations

The estimates from CMS and from the 16 large sponsors are self-reported. We did not independently verify any of these estimates. Additionally, the estimates from CMS and from the sponsors are preliminary. CMS will base its final reconciliation amounts on updated data; however, CMS staff have informed us that CMS anticipates relatively small changes to these amounts.

Standards

Our review was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

According to preliminary estimates, Part D sponsors owe Medicare a net total of $4.4 billion for 2006

CMS was scheduled to complete its reconciliation of payments made to Part D sponsors for the 2006 plan year in September 2007. In preparation, CMS developed preliminary estimates of the amounts that sponsors will owe to or receive from Medicare. According to these estimates, Part D sponsors owe a net total of $4.37 billion for 2006. This amount is equal to about $15 per month per enrolled beneficiary.[18]

As shown in Table 1, 80 percent of sponsors (180 of 224) owe money to Medicare for 2006. These sponsors owe an estimated total of $5.19 billion. The remaining 20 percent of sponsors (44 of 224) will receive an estimated total of $816 million from Medicare. The total amount that sponsors owe to Medicare is over six times the total amount that sponsors will receive from Medicare.

Table 1: Estimated Reconciliation Amounts by Sponsor, 2006

	Number of Sponsors	Total
Estimated Amount Sponsors Owe Medicare	**180**	**$5.19 billion**
Estimated Amount Sponsors Will Receive From Medicare	**44**	**($0.82 billion)**
Total Net Amount	**224**	**$4.37 billion**

Source: Office of Inspector General analysis of CMS estimates, August 2007.

The estimates from the 16 large sponsors from which we collected data are generally consistent with CMS's estimates for 2006. These 16 sponsors estimate owing a net total of $3.50 billion to Medicare. According to CMS's estimates, the same 16 sponsors owe a net total of $3.69 billion, a difference of about 5 percent.

[18] This estimate is based on the total number of enrollees as of July 2006. See CMS's "Annual Enrollment Report by Plan: Medicare Advantage/Part D Contract and Enrollment Data." Available online at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/EP/list.asp#TopOfPage. Accessed June 14, 2007.

The majority of the funds owed are profits that sponsors must repay to Medicare as a result of risk-sharing requirements

Almost two-thirds of the net total amount that sponsors owe to Medicare results from risk-sharing requirements. About one-third is for the reinsurance subsidy, and a small amount is for the low-income cost-sharing subsidy. The total amount that sponsors owe Medicare based on risk sharing is over 200 times the total amount that sponsors will receive from Medicare based on risk sharing. See Table 2.

Table 2: Estimated Reconciliation Amounts by Type of Payment, 2006

	Risk Sharing	Reinsurance Subsidy	Low-Income Cost-Sharing Subsidy
Estimated Amount Sponsors Owe to Medicare	**$2.75 billion**	**$2.14 billion**	**$1.09 billion**
Estimated Amount Sponsors Will Receive From Medicare	**($0.01 billion)**	**($0.55 billion)**	**($1.07 billion)**
Total Net Amount	**$2.74 billion**	**$1.59 billion**	**$0.02 billion**

Source: Office of Inspector General analysis of CMS estimates, August 2007.

Sponsors owe an estimated net total of $2.74 billion as a result of risk-sharing requirements

Risk sharing allows the Federal Government and sponsors to share in unexpected profits and losses associated with providing the Part D benefit. According to preliminary estimates, sponsors owe Medicare a total of $2.75 billion, while Medicare owes sponsors a total of $13 million. This results in a net total of $2.74 billion owed to Medicare.

Eighty-five percent of sponsors (191 of 224) have profits that trigger risk sharing, requiring them to pay a portion of their profits to Medicare. These sponsors overestimated the cost of providing the benefit in their bids. As a result, the prospective payments that these sponsors received from Medicare plus the beneficiary premiums were significantly greater than their costs. Sponsors' overestimates of their costs also resulted in higher beneficiary premiums. Beneficiaries do not directly recoup any of the money that they paid in higher premiums.

In contrast, 10 percent of sponsors (22 of 224) have losses that trigger risk sharing, requiring Medicare to pay additional money to them. These sponsors underestimated the cost of providing the benefit in their bids. As a result, the prospective payments that these sponsors received from Medicare plus the beneficiary premiums were significantly less than their costs. The remaining 5 percent of sponsors (11 of 224) have minimal gains or losses, so no risk-sharing payments are required.

Based on this information, we estimate that the total amount of sponsors' profits subject to risk sharing is at least $3.4 billion for 2006.[19] Sponsors will repay $2.75 billion of this amount to Medicare, and sponsors will retain—at a minimum—the remaining $688 million in unexpected profits. Because this is a conservative estimate, sponsors' unexpected profits for 2006 are most likely higher.[20]

In addition, the MMA mandates changes to the risk corridors beginning in 2008. These changes will decrease the proportion of profits and losses that sponsors must share with Medicare. Therefore, if sponsors continue to have unexpectedly high profits, the percentage of these profits that they are required to share with Medicare will decrease.

Sponsors owe an estimated net total of $1.59 billion to Medicare for the reinsurance subsidy

The reinsurance subsidy covers the Federal Government's portion of drug costs for beneficiaries who reach catastrophic coverage. According to preliminary estimates, sponsors owe a net total of $1.59 billion to Medicare for the reinsurance subsidy in 2006.

Seventy-five percent of sponsors (169 of 224) owe money to Medicare for the reinsurance subsidy. These sponsors overestimated the cost of providing catastrophic coverage in their bids. Consequently, the amount that Medicare paid prospectively was greater than the Federal share of actual reinsurance costs. As a result, these sponsors must refund the difference to Medicare. Conversely, 21 percent of sponsors

[19] These profits are in addition to the profits that are built into the sponsor's bid. The profits in the bid are a part of the sponsor's administrative costs, which are subtracted before risk sharing is calculated.

[20] This is a conservative estimate because we did not have information about sponsors' target amounts and actual costs. Instead, we assumed that the total amount is subject to the risk corridor that allows sponsors to keep the smallest proportion of profits. This risk corridor requires sponsors to pay CMS 80 percent of the profits and allows sponsors to keep 20 percent of the profits. However, in reality, sponsors keep a higher portion of the profits that are within 5 percent of the target amount.

(48 of 224) underestimated the cost of providing catastrophic coverage in their bids. As a result, these sponsors will receive additional payments from Medicare. For the remaining 3 percent of sponsors (7 of 224), no funds are owed for the reinsurance subsidy.[21]

Sponsors owe an estimated net total of $24 million to Medicare for the low-income cost-sharing subsidy

The low-income cost-sharing subsidy payments are made on behalf of certain beneficiaries based on their income and assets. According to preliminary estimates, sponsors owe a net total of $24 million to Medicare for the low-income cost-sharing subsidy for 2006.

Sixty-five percent of sponsors (146 of 224) owe money to Medicare for the low-income cost-sharing subsidy. These sponsors overestimated the cost of providing the benefit to low-income beneficiaries in their bids and received prospective payments that were greater than their actual costs. Conversely, 35 percent of sponsors (78 of 224) underestimated the cost of providing the benefit to low-income beneficiaries. These sponsors will receive additional payments from Medicare.

CMS has no mechanisms to collect funds or to adjust prospective payments prior to reconciliation; therefore, sponsors have had the use of these funds for a significant length of time

CMS will not collect any funds from sponsors until it has completed reconciliation for 2006, which is scheduled to occur more than 9 months after the 2006 plan year has ended. According to CMS officials, there is no mechanism currently in place to collect the funds owed by sponsors prior to the completion of reconciliation. There is also no mechanism in place to identify situations in which prospective payments differ significantly from sponsors' actual costs or a mechanism to adjust prospective payments accordingly to avoid large discrepancies at the end of the year. These circumstances have allowed sponsors to have the use of billions of dollars for a significant length of time.

There is also no formal mechanism in place to make additional interim payments to sponsors or to adjust prospective payments if large amounts are owed to sponsors. Nevertheless, according to a CMS official, CMS made additional interim payments in 2006 to a few sponsors that reported

[21] Note that some plans do not receive prospective reinsurance subsidies from CMS.

they did not receive sufficient funds because their expenses for low-income enrollees exceeded the low-income cost-sharing estimates in their bids.

Although CMS does not have mechanisms in place to collect funds or adjust the prospective payments prior to reconciliation, many of the sponsors have estimates of the amounts they will owe to or receive from Medicare available earlier in the calendar year. Four of the sixteen large sponsors that we contacted reported that they calculated estimates for reinsurance, low-income cost sharing, and risk sharing in January 2007. Six other sponsors calculated the estimates by the end of the first quarter of 2007. One sponsor calculated its estimate in April 2007. The remaining five sponsors could not provide us with a specific timeframe regarding the availability of estimates.

These issues continue to be a concern because sponsors may also owe significant amounts to CMS for the 2007 plan year. For the 2006 plan year, sponsors had limited information about drug utilization and drug costs to develop their bids. Sponsors also lacked much of the same information when they developed their 2007 bids and therefore they may have also overestimated their costs for 2007.[22]

[22] Sponsors were required to submit bids for 2007 on June 5, 2006. Because enrollment did not close until May 15, 2007, sponsors had limited data about beneficiaries' drug utilization patterns.

RECOMMENDATIONS

Preliminary estimates indicate that Part D sponsors owe a net total of $4.4 billion to Medicare for the 2006 plan year, the first year of the Part D benefit. About two-thirds of this amount is profit that sponsors must repay to Medicare as a result of risk-sharing requirements and nearly one-third is based on reconciliation of the reinsurance subsidy. In general, sponsors overestimated the cost of providing the Part D benefit in their bids, causing both unexpected profits that are subject to risk-sharing requirements and higher beneficiary premiums. Additionally, we found that CMS has no mechanisms in place to collect funds owed by sponsors or to adjust prospective payments prior to reconciliation. The lack of such mechanisms has allowed sponsors to have the use of billions of dollars for a significant length of time.

These findings highlight the importance of ensuring the accuracy of Part D sponsors' bids and of aligning prospective payments with sponsors' actual costs. OIG is conducting work on sponsors' bids and on CMS's oversight of the bid process. In addition, we recommend that CMS take the following actions:

Ensure That Sponsors' Bids Accurately Reflect the Cost of Providing the Benefit to Medicare Beneficiaries

CMS should ensure that sponsors' bids more accurately reflect their costs of providing the benefit. In light of the significant funds owed to Medicare for 2006, CMS should ensure that available data from the 2006, 2007, and any future plan years are incorporated in the subsequent bids. CMS should also continue to impress upon sponsors that their bids should more accurately reflect the costs of providing the benefit. Finally, CMS should also take data from prior years into account when reviewing and approving bids.

Consider Implementing an Interim Reconciliation Process To Reduce the Amounts Owed to Medicare

Because of the timing for sponsors to submit bids for 2007 (which occurred in mid-2006), plans may also owe significant amounts to CMS for the 2007 plan year. Therefore, CMS could consider requesting that sponsors voluntarily submit preliminary data and use this information to identify significant amounts potentially owed to or from Medicare. For sponsors that owe Medicare, CMS could request that they voluntarily make interim settlements. CMS could also make interim payments to sponsors that are owed money from Medicare. Alternatively, CMS could consider undertaking statutory or regulatory

changes necessary to implement a mandatory interim reconciliation process.

Better Align Monthly Prospective Payments With Sponsors' Actual Costs

CMS should modify the Part D contracts to request, or seek authority to require, that sponsors prepare quarterly estimates of funds owed to or from Medicare. CMS could use these estimates as the basis for adjusting subsequent prospective payments and thus avoid large differences at the end of the year. If appropriate, CMS could undertake statutory or regulatory changes necessary to make adjustments to the prospective payments. In addition, CMS should also determine whether different methods of calculating monthly payment amounts would better align prospective payments with actual costs.

Consider Seeking Legislative Changes To Delay the Adjustments to the Risk Corridors as Specified by the MMA

The MMA requires that CMS widen the risk corridors and change the risk-sharing percentages beginning in 2008. If sponsors have large profits in 2008 and future years, these changes will decrease the Federal Government's share of the sponsors' profits and increase the amount that sponsors retain. These changes will also increase plan sponsors' exposure to unexpected losses, because they will reduce sponsors' ability to shift the burden of unexpected losses to the Government. We recommend that CMS review available data and, if appropriate, work with Congress to delay the statutory changes to the risk corridors until sponsors and CMS have more experience with the Part D benefit and have implemented mechanisms that ensure that bids and prospective payments are more closely aligned with sponsors' Part D costs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with one of our recommendations and stated that it is carefully examining possible options for another recommendation. CMS also stated that it believes that the variance between prospective and reconciled payments will markedly decrease over time as both Part D sponsors and CMS have actual program data available to support program administration. Based on CMS's comments, we modified the language in the final report to further clarify our recommendations.

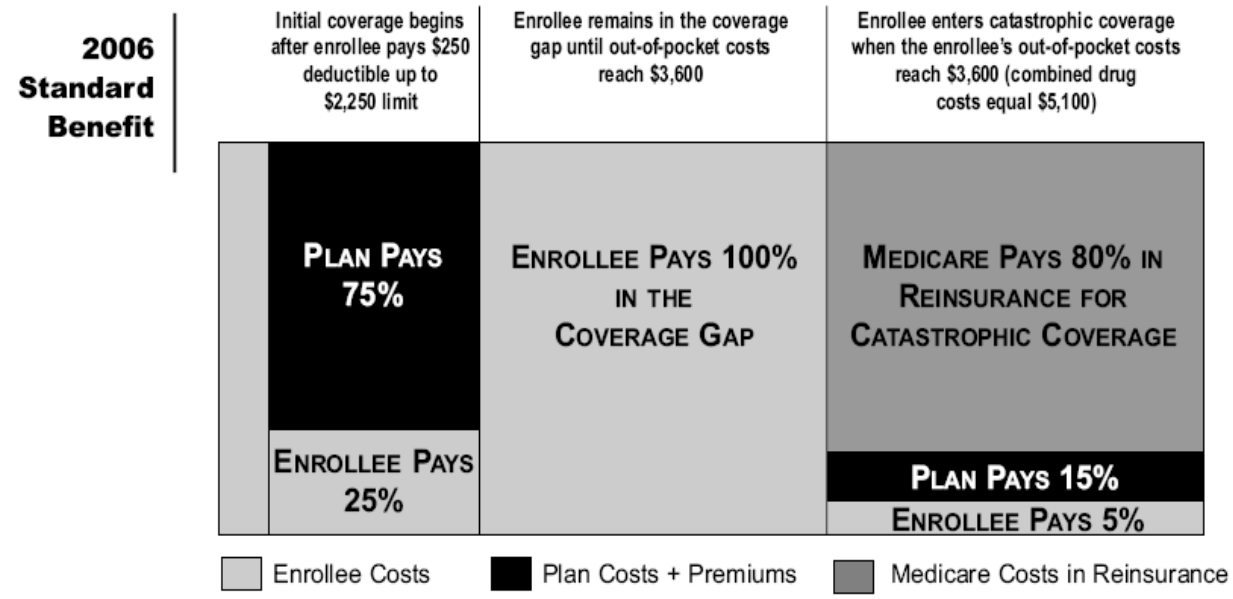
CMS concurred with the recommendation that the data collected from the 2006 and subsequent plan years be used in the review of future bid submissions. CMS also stated that it has the authority to change payment methodologies for the low-income cost-sharing and reinsurance subsidies and that it is carefully examining possible options. CMS further stated its interpretation that the statute does not allow for payment adjustments for risk sharing before the coverage year has ended.

CMS did not concur with two of our recommendations. In response to the recommendation that CMS consider conducting an interim reconciliation process, CMS stated that it believes bidding accuracy will improve in coming years, thus eliminating this as an issue. Based on its interpretation of the statute, CMS also stated that there is no legal authority for an interim reconciliation of risk-sharing payments. Finally, in response to our recommendation that CMS consider seeking legislative changes to delay the adjustments to the risk corridors, CMS responded that it is only now able to analyze a full set of bidding and first-year utilization data. As a result, CMS stated that it would be premature to make recommendations to Congress for statutory changes before having a more complete analytic picture of whether the Government would benefit or be harmed by a change in the risk corridors. The full text of CMS's comments is included in Appendix C.

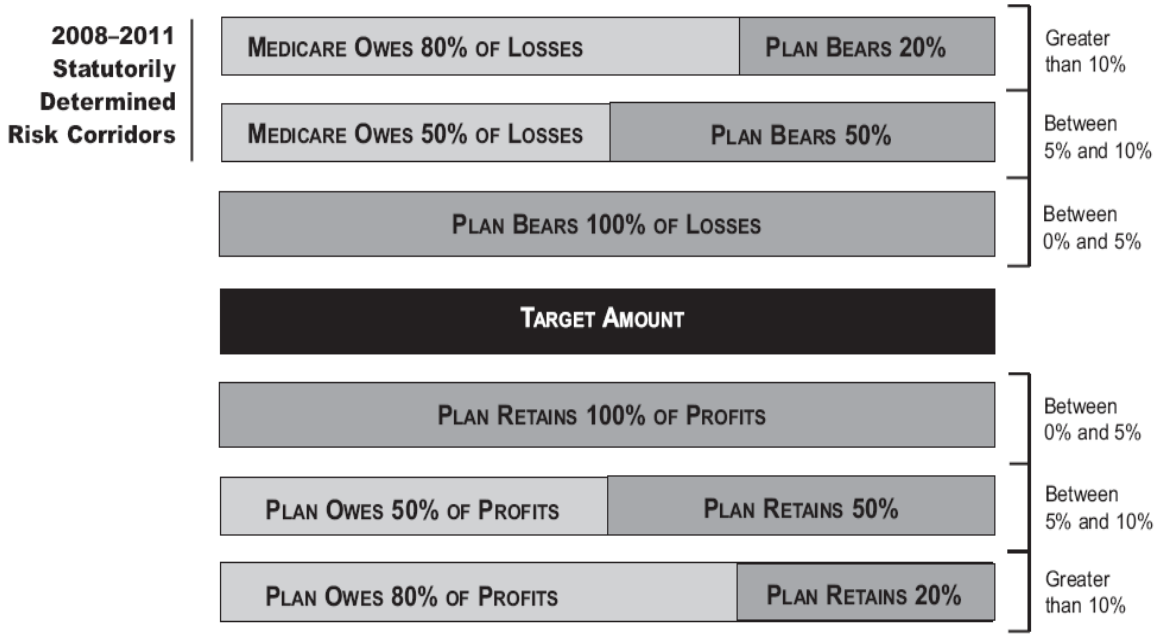
We continue to recommend that CMS consider implementing an interim reconciliation process and consider seeking legislative changes to delay the adjustments to the risk corridors. CMS could request that sponsors make interim reconciliation settlements on a voluntary basis, when appropriate. Alternatively, CMS could consider pursuing statutory or regulatory changes necessary to implement a mandatory interim reconciliation process. Also, because only limited data are currently available, as CMS notes in its comments, there remains a significant risk that plans will owe large sums of money back to Medicare for 2008 and beyond. As such, it may be prudent to delay changes to the risk corridors until the sponsors and CMS have more experience with the Part D benefit and have implemented mechanisms, such as those we have recommended, to ensure that bids and prospective payments are more closely aligned with sponsors' costs.

As discussed in our findings, the total amount of unexpected profits sponsors received in 2006 is considerably greater than the amount sponsors will repay to Medicare as a result of risk sharing

requirements. Under the current risk-sharing requirements, sponsors are permitted to retain at least 20 percent of these unexpected profits, with the remainder owed to Medicare. These profits subject to risk-sharing are in addition to the profits that sponsors anticipate and include in their bids.


2006 Standard Benefit
Initial coverage begins after enrollee pays $250 deductible up to $2,250 limit
Enrollee remains in the coverage gap until out-of-pocket costs reach $3,600
Enrollee enters catastrophic coverage when the enrollee's out-of-pocket costs reach $3,600 (combined drug costs equal $5,100)
PLAN PAYS 75%
ENROLLEE PAYS 25%
ENROLLEE PAYS 100% IN THE COVERAGE GAP
MEDICARE PAYS 80% IN REINSURANCE FOR CATASTROPHIC COVERAGE
PLAN PAYS 15%
ENROLLEE PAYS 5%
Enrollee Costs
Plan Costs + Premiums
Medicare Costs in Reinsurance

APPENDIX ~ B


2008–2011 Statutorily Determined Risk Corridors
Medicare Owes 80% of Losses
Plan Bears 20%
Greater than 10%
Medicare Owes 50% of Losses
Plan Bears 50%
Between 5% and 10%
Plan Bears 100% of Losses
Between 0% and 5%
Target Amount
Plan Retains 100% of Profits
Between 0% and 5%
Plan Owes 50% of Profits
Plan Retains 50%
Between 5% and 10%
Plan Owes 80% of Profits
Plan Retains 20%
Greater than 10%

APPENDIX ~ C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 11 2007

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report, "Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006" OEI-02-07-00460

The Centers for Medicare & Medicaid Services (CMS) appreciates the OIG's analysis and recommendations provided in the OIG draft report entitled "Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006." CMS strives for bidding integrity, and, therefore, maximum alignment between prospective payments based on estimates provided in the bids and reconciled payments based on actual allowable costs. CMS believes that all the payments for the Part D program have been made in accordance with the intent of the law, and that the variance between prospective and reconciled payments will markedly decrease over time as both Part D sponsors and CMS have actual program data available to support program administration.

While we share your concerns about the significant refunds that Part D sponsors owe CMS, and have previously reached out to your staff to highlight this as an area that requires attention, we believe that some of the recommendations in this report are premature and require more longitudinal analysis. We appreciate the opportunity to provide comments on this report.

Below are CMS' comments regarding the OIG's recommendations:

OIG Recommendation:

The CMS should ensure that sponsors' bids accurately reflect the cost of providing the benefit to Medicare beneficiaries.

CMS Response:

As we have previously indicated, the costs of Medicare Part D continue to be much lower than had been expected.[1] Neither CMS nor the Part D plans could have predicted these lower costs. Indeed, as the independent American Academy of Actuaries recently noted,

[1] See press release online at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895

there "were many unknown factors in a new program of this magnitude, and risk corridors appear to have succeeded in providing incentives to participate. They also prevented windfall profits or excessive losses, which may have occurred with a new, innovative program and a paucity of reliable actuarial data on which to base cost estimates".[2]

The CMS concurs with the recommendation that the experience gained and data collected from the 2006 and subsequent coverage years be used to assist in the review of future plan bid submissions. Indeed, the CMS Office of the Actuary (OACT) specifically directed in April 2007 guidance that "plans with experience providing Part D benefits in contract year 2006 are expected to use Prescription Drug Event (PDE) transactions, including State-to-plan and plan-to-plan PDEs as base period experience for contract year 2008".[3] Note this was the earliest that such data were available.

OIG Recommendation:

For 2007, CMS should consider implementing an interim reconciliation process to reduce the amounts owed to Medicare.

CMS Response:

The CMS believes that bidding accuracy will markedly improve in coming years, thus eliminating this as an issue. If issues persist, CMS has the authority to require any data necessary to accurately make payments, but it is unclear how valid interim estimates would be. In other words, we are concerned that interim estimates based on partial data will only add unnecessary complexity and administrative burden while failing to provide an accurate picture of allowable costs. Furthermore, there is no legal authority for an interim reconciliation of risk sharing payments. Section 1860D-15(e) of the Social Security Act clearly instructs the Agency to make risk-sharing adjustments-the final phase of the reconciliation process-based on allowable costs for the entire coverage year.

OIG Recommendation:

For 2008 and subsequent years, CMS should better align monthly prospective payments with sponsors' actual costs.

CMS Response:

Concerns over low-income cost sharing and reinsurance prospective payments are not new. Indeed, CMS outlined the potential issues with prospective payments dating back to the August 3, 2004, Notice of Proposed Rulemaking (NPRM) for Part D. That is why CMS proposed several different methods for both low-income cost sharing and reinsurance subsidy payments (see 69 Fed. Reg. 46,632, 46,689-91 (Aug. 3, 2004)). While none of

[2] http://www.actuary.org/pdf/medicare/partd_0307.pdf

[3] "Instructions for completing the Medicare Prescription Drug Plan bid pricing tool for contract year 2008" OMB Approved # 0938-0944

the proposed methods could have eliminated all concerns due to the complexity of the Part D program and the lag times required to collect, calculate, and report all the relevant payment information (e.g., claims, True Out-Of-Pocket costs, and rebates), the prospective payment method articulated in the Part D final rule and subsequent guidance balances the many considerations related to Part D payments, including the need to protect sponsor cash flow (see 70 Fed. Reg. 4,194, 4,313-14 (Jan. 28, 2005)). CMS has the authority to change payment methodologies for the low-income cost sharing and reinsurance subsidies, and we are carefully examining possible options.

However, as you have expressed in your findings, the majority of the funds owed are for risk-corridor adjustments, not these subsidy payments. As noted above, the statute does not allow for payment adjustments for risk sharing before the coverage year has ended.

OIG Recommendation:

The CMS should seek legislative changes to delay the adjustments to the risk corridors as specified by the MMA.

CMS Response:

Congress created Part D as a risk-based capitated program driven by market forces. Risk is mitigated on both sides by the symmetrical risk sharing arrangement established at 1860D-15(e) of the Social Security Act. Part D is not a cost based or fee-for-service program. Again, CMS believes that bidding accuracy will markedly improve in coming years, thus eliminating this as an issue. We are only now able to analyze a full set of bidding and first year contract year utilization data. As a result, it would be premature to make recommendations to Congress for statutory changes before having a more complete analytic picture of whether the government would benefit or be harmed by a change in the risk corridors.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

Miriam Anderson served as the team leader for this study. Staff from the Office of Audit Services who contributed to this report include Jeffrey Cohen and Amanda Fleck. Other principal Office of Evaluation and Inspections staff who contributed to this report include Taryn Eckstein, Michelle McInnis, David Rudich, and Cynthia Thomas.