Rx Actuarial Equivalence Under MMA

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What is "actuarial equivalence?"

- In lay terms, benefits are "actuarially equivalent" if they would provide the same amount of sponsor payment for the same average person
- For actuaries, benefits are "actuarially equivalent" if:
  - Same services are covered (e.g., all therapeutic categories)
  - Total claims paid by the sponsor are the same under both designs for a membership class
  - Cost-sharing by individuals could differ for each option
- Assumes that the same population (i.e., same health risk) is measured under each option

Actuarial Equivalence-What it is not

- Actuarially equivalent plan designs will not necessarily result in the same premiums because insurers can develop their premiums to reflect:
  - Expected behavioral reactions to different plan designs (i.e., adverse selection)
  - Actual negotiated prices
  - Drug utilization management techniques (e.g. formularies, step therapies, etc.)

Standard Plan Designs (2006)

Deductible	$250
Beneficiary coinsurance	25%
Initial Coverage Limit	$2250 (includes $250 ded)
Out-of-pocket max	$3600
Attachment point (re-starts plan payment)	$5100 in total spending
Beneficiary coinsurance above OOP max	10%

Examples of MMA citations of Actuarial Equivalence

- Qualified Rx coverage: "alternative Rx coverage must be greater than or equal to actuarially equivalent benefits [Section 1860D-2(a)(1)(B)]
  - Reductions in cost-sharing in terms of deductible, coinsurance %, increase in the initial coverage limit, or any combination
- Actuarial equivalence to the 25% cost-sharing corridor [Section 1860D-2(b)(2)]
  - Explicit allowance for tiered copays

More Examples

- Determining the actuarial valuation of Rx coverage [Section 1860D-11(c)(1)]
  - The Secretary shall establish processes and methods for . . .
    - Actuarial valuation of standard Rx coverage
    - Actuarial valuations of alternative Rx coverage
    - Actuarial valuation of reinsurance subsidies
    - Use of generally accepted actuarial principles
    - Applying the same methods for both standard and alternative Rx coverage
- Allowable MedicareAdvantage-PD plan [Section 1860D-13(b)(5)]
  - MA-PD coverage meets requirements if actuarial value equals or exceeds the actuarial value of standard Rx coverage

One More Example

- Special Rules for Employer-Sponsored Programs [Section 1860D-22(a)(2)(A)]
  - The sponsor . . . provides the Secretary . . . with an attestation that the actuarial value of Rx coverage under the plan is at least equal to the actuarial value of standard Rx coverage
    - Much variation in employer-sponsored programs today
    - Questions about how the required retiree contributions will be evaluated, or do only benefits count?

Examples of Actuarially Equivalent Alternative Plan Designs

- Two Actuarially Equivalent Plan Design examples shown
  - tiered coinsurance design
    - different coinsurance levels for generic drugs, preferred brand drugs and non-preferred brand drugs
  - three tier copay plan design
    - different $ copays for generic drugs, preferred brand drugs and non-preferred brand drugs
- Standard population distribution from SOA research paper

Distribution of Gross Allowed Claims by Member (2006)

Claims threshold	Percent of members with claims above threshold	Percent of spending above threshold
$0	89%	100%
$100	85%	96%
$250	79%	90%
$500	72%	82%
$1,000	59%	67%
$2,000	40%	44%
$4,500	13%	16%
$7,500	4%	5%

General Method

- Uses historical data adjusted to the time period being analyzed
- Calculates total allowed cost before applying plan design
- Applies the different plan designs to the total allowed cost to determine split between plan and members
- Adjusts alternative plan design until total member cost sharing under standard plan and alternative design are equal

Data

- Medicare+Choice data for members with unlimited benefits (over 50,000 members)
- Calendar year 2001 data adjusted to 2006
- No adjustments made to reflect different spending behavior of FFS population from M+C population
- Adjustments applied to reflect the age/gender distribution in Medicare FFS population

Simplifying Assumptions

- Projected costs do not include:
  - PBM or pharmaceutical company rebates
  - PBM or other administrative fees
  - Any change in trend rates, generic/brand mix, or discounts/dispensing fees
  - Any plan design differences by income
- Same population under each illustrative plan design
- No change in behavior based on different plan design features

Distribution of Gross Allowed Costs (2006)

Cost sharing category	Percent of gross allowed costs
Deductible	10%
Between deductible and initial coverage limit	47%
Between initial coverage limit and out-of-pocket maximum	30%
Above out-of-pocket maximum	13%

Examples of Actuarially Equivalent Alternative Plan Designs

Cost Sharing Category	**MMA**	**Plan 1**
Deductible	$250	$250
Member coinsurance	25%	10% generic 25% pref brand 40% non-pref brand
Initial coverage limit	$2,250	$2,250
Out-of-pocket maximum	$3,600	$3,600
Approximate attachment point	$5,100	$5,100
Member coinsurance above OOP Max	10%	10%

Examples of Actuarially Equivalent Alternative Plan Designs

Cost Sharing Category	MMA	Plan 2
Deductible	$250	No deductible
Member coinsurance	25%	$10 copay for generic $35 for pref brand $50 for non pref brand
Initial coverage limit	$2,250	$4,000
Out-of-pocket maximum	$3,600	N/A
Approximate attachment point	$5,100	$5,100
Member coinsurance above OOP Max	10%	10%

Summary

- Can be very complicated
- A wide variety of plan features can be put together as an actuarially equivalent benefit
- Plans should be designed to appeal to a broad cross section of eligible members
- Clarification expected in the future
- Could result in lots of changes