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The unintended effects of the Medicare Part D low income subsidy

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ABSTRACT

Objectives: Medicare Part D is the voluntary program that provides insurance for prescription drugs to 37 million US elderly. This form of public insurance is delivered exclusively through a choice-based private insurance market, where Medicare pays various types of subsidies. The objective of this paper is to analyze how the subsidy paid to low income enrollees induces insurers to distort their plan premiums.
Methods: Combining both an analysis of the incentives created by the different regulations and empirical evidence obtained from plan level data for the years between 2006 and 2013, the paper evaluates the presence of premium distortions associated with insurers response to the low income subsidy.
Results: The findings indicate that insurers cluster premiums at the value that maximizes the rents they earn on enrollees receiving the low income subsidies. Moreover, insurers use the possibility of offering multiple insurance plans to manipulate the amount of the subsidy and increase further their rents.
Conclusions: This study indicates the need to reform the subsidy system in Medicare Part D and offers guidance on the essential elements of the low income subsidy reform.

1. Introduction

Medicare is a public health insurance program for the elderly and disabled in the United States that covers over 50 million beneficiaries. Medicare consists of several parts. Parts A and B cover hospital and outpatient services, respectively, under a fee-for-service model. Part C allows consumers to switch from fee-for-service to government-subsidized managed care administered by private insurers. Part D, introduced in 2006, is a voluntary program that provides insurance for prescription drugs.

In 2014, Part D had an enrollment of 37 million individuals and its cost for the government was estimated to be $75 billion. The distinguishing feature of this program is the delivery of insurance exclusively through a choice-based private insurance market. The public intervention is limited to paying subsidies and setting the rules under which the insurers operate. Hence, Part D is an important testing ground for how the government can regulate a publicly financed privately delivered health insurance program.

This paper focuses on the intended and, especially, the unintended effects of the Part D subsidies on insurer pricing strategies. In Part D, subsidies are in various forms and account, overall, for 90% of insurer revenues, while premiums paid by enrollees only constitute the remaining 10% of revenues [20]. This paper shows how the regulations

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involving the low income subsidy (LIS), which Medicare pays to plans enrolling beneficiaries of limited financial resources, might induce distortions in plan pricing choices. By linking together two parts of the regulation, that is the algorithm through which the LIS amount is calculated and the rule according to which low income enrollees are assigned to plans, I argue that insurers are capable of and do distort premiums. In particular, since Medicare pays the premium of low income enrollees in full as long as their premium is not higher than a threshold amount called the Low Income Premium Subsidy Amount (LIPSA), premiums can be increased up to the LIPSA without losing low income enrollees. Hence, for plans with a high share of LIS enrollees, insurers will try to forecast the LIPSA and set premiums equal to it. Furthermore, since the LIPSA is endogenously determined as a weighted average of plan premiums, a second type of distortion can result when insurers offering more than one plan use some of their plans to bolster the LIPSA. Using plan level data for the years between 2006 and 2013, I show evidence consistent with the presence of both types of distortions. I then conclude discussing the negative effects of premium distortions and some remedies.

This study contributes to a small but growing literature on the determinants of premiums in Part D. In particular, the idea presented in this paper is further developed in [4,5] to quantify the effect of the LIS-induced distortion on premium growth and consumer's welfare. Meanwhile, the current paper is concerned exclusively with establishing the presence of premium distortions and their evolution as regulations change between 2006 and 2013. The focus on supply side issues distinguishes this work from the majority of studies which focus on demand-side questions [1,11,14,10,15,19]. Finally, since Part D low income enrollees are mainly Medicare–Medicaid *dual eligibles*, this study contributes to the analysis of the mechanism used to provide drugs to this important population group [17,7,9,18].

2. Relevant regulations

In Part D, enrollees are divided into two groups, LIS receivers (35% of all enrollees) and "regular enrollees." LIS beneficiaries are the dual Medicare–Medicaid eligibles as well as certain institutionalized enrollees and enrollees with combination of assets and income below certain thresholds. Every year, regular enrollees choose a plan and pay its premium. In contrast, the Center for Medicare and Medicaid Services (CMS) randomly assigns LIS enrollees to plans where they are charged a zero premium. Premiums have a "basic component," meant to cover those drugs belonging tot he Part D formulary, and an "enhanced component," when additional drugs outside this formulary are offered. The LIS equals either the basic component of the plan premium or the LIPSA, whichever is less. The combined effect of the two rules described below is essential for the analysis of the effects of the LIS on premiums.

(1) *LIPSA calculation:* The LIPSA, the dollar amount of the LIS, is computed every year separately for each one of the 34 regions in which the US is divided. Its calculation involves several steps: The first step entails calculating premiums: Every year, insurers submit to CMS a *bid* for each of their Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MA-PD). MA-PD provide Medicare Part A/B services in addition to the drugs of Part D, while PDP cover only drugs. The bid is the price requested by the insurer to enroll a beneficiary in its plan in the following year. This is *not* the premium. The premium is obtained by subtracting from the bid a "direct subsidy" which CMS calculates as (approximately) 65% of the average of all the bids submitted for that year (weighted by plans enrollment in the previous year). The second step entails calculating region-specific LIPSA as the average of the premiums in the region. The averaging method used from 2009 onward is a weighted average of the premiums' basic component with weights equal to plan shares of LIS enrollees. Before 2009, a hybrid system was used where, roughly, PDP were equally weighted, while MA-PD were enrollment-weighted [4].

(2) *LIS Enrollees Plan Assignment:* By default, LIS enrollees are randomly assigned by CMS to a PDP. The eligible plans for assignment are those without an enhanced component of the premium (called "basic plans") and with a premium no higher than the LIPSA. Although LIS beneficiaries can opt out of this auto-enrollment and choose any Part D plan, in 2010 only 30% of enrollees had opted out. These LIS enrollees, known as "choosers," might end up paying a positive premium, unless every year they self-enroll in an eligible plan.

An important feature of LIS enrollees assignments is that, if a plan eligible in a year t remains eligible into the following year $t+1$, it retains all the LIS enrollees it got assigned in period t. If it loses eligibility, however, CMS removes all previously assigned LIS enrollees. These enrollees are then reassigned at random among the eligible plans of that year, with one crucial exception. If the plan losing eligibility belongs to a multi-plan insurer with another eligible plan in the same region, then the random reassignment takes place within the eligible plans of the same insurer. From 2001, a newer regulation known as "meaningful difference" limited, but not eliminated, the presence of multi-plan firms by requiring that no more than two "enhanced" plans and at most one "basic" plan could be offered per brand.

Finally, it is important to stress that although LIS enrollees consume more drugs than regular enrollees, various provisions (the "three R's:" risk adjustment, reinsurance and risk corridors) limit insurer costs for high-consumption enrollees. First, CMS risk adjusts the direct subsidy so that plans with higher risk enrollees are paid more. An additional risk adjustment factor increases the payments for plans enrolling LIS enrollees. Second, CMS pays insurers the "catastrophic subsidy" which covers 80% of enrollees expenditures above (approximately) $6500. Third, at the end of every year, plans either pay or receive a transfer from CMS depending on how much their profits/losses exceed a risk corridor.