

# Restructuring the Medicare Part D Benefit with Capped Beneficiary Spending

Estimating the impact of capping Medicare Part D beneficiary spending, reducing federal reinsurance, and moving the coverage gap discount program to the catastrophic phase.

Commissioned by Aetna

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## How would Medicare Part D spending be affected if the catastrophic phase included a drug discount program with no beneficiary cost sharing and reduced federal reinsurance?

As legislators and the Medicare Part D industry evaluate the impact of possible reforms to the Medicare Part D program, Aetna asked that we estimate the impact of capping beneficiary spending, reducing federal reinsurance, and replacing the coverage gap discount program<sup>i</sup> (CGDP) with a new discount program in the catastrophic phase.<sup>ii</sup> This policy design, which has not been proposed, could reduce federal spending in Medicare Part D.

### Executive Summary

We evaluated the 2020-2029 ten-year impact of illustrative changes to the Medicare Part D benefit. Each scenario eliminates beneficiary cost sharing above a newly defined out-of-pocket maximum (MOOP) and reduces federal reinsurance (reinsurance) from 80% to 20%. In addition, these scenarios replace the current non-low income specific CGDP with a newly defined catastrophic discount program.

The catastrophic discount program would provide payment of 8% to 10% for both low income and non-low income beneficiaries' brand claims after beneficiaries reach the MOOP. Aetna asked us to set the illustrative catastrophic discount program percent in each scenario such that we project no impact on total drug manufacturer discount program spending over the ten-year period if there are no behavioral changes. However, the impact of the restructured drug manufacturer discount program will vary by year and could have significant variations in discount payments by drug manufacturer with some drug manufacturers seeing a reduction in discount payments and others seeing an increase in discount payments.

Aetna asked that we examine four scenarios with MOOPs of \$2,500, \$3,000, \$3,500, and \$4,000. We estimate that non-low income beneficiary spending to reach the 2020 TrOOP falls between the \$2,500 and \$3,000 MOOPs but that the capped beneficiary cost sharing results in an overall reduction in beneficiary cost sharing at all four MOOPs.

We estimated the impact of the benefit design changes on the following stakeholders<sup>iii</sup> in the individual Medicare Part D market with the defined standard plan design:

- **Medicare Part D beneficiaries** through premium and cost sharing
- **Federal government** through reinsurance, direct subsidy payments, as well as low income premium and cost sharing subsidies.
- **Drug manufacturers** through the discount program.<sup>iv</sup>

The benefit design changes we modeled have varying impacts on beneficiaries and federal spending, but the scenarios generally reduce cost sharing for beneficiaries taking higher cost medications with offsetting increases in costs to other beneficiaries through premium increases.

We modeled each scenario with and without illustrative behavioral changes. In the former, we assumed the benefit structure changes have no impact including no changes to plan formularies, drug pricing, or beneficiary behavior. In the latter, Aetna asked that we demonstrate the impact of a 5% reduction in non-specialty brand drug spending as a result of drug pricing changes and plan management of high cost drugs.<sup>v</sup>

The following tables summarize our findings for the \$2,500 MOOP scenario with a 5% reduction in brand spending.

**FIGURE 1: 2020-2029 INDIVIDUAL MEDICARE PART D \$2,500 MOOP SCENARIO WITH 5% BRAND REDUCTION ESTIMATED FEDERAL GOVERNMENT IMPACT (\$ BILLIONS)**

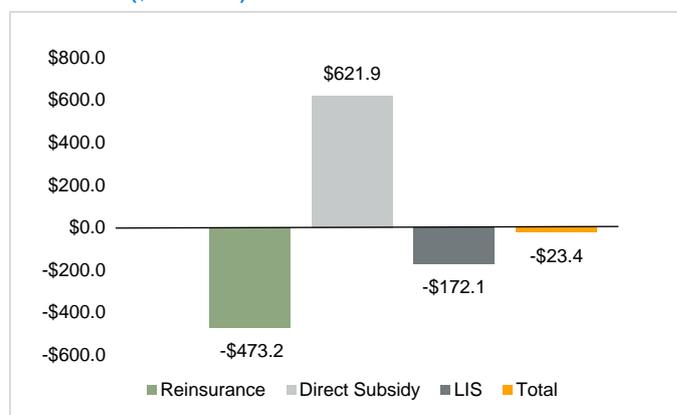


Figure 1 demonstrates our estimate that the \$2,500 MOOP scenario with a 5% reduction in brand spending will reduce reinsurance and low income subsidies (LIS)<sup>vi</sup> while increasing

direct subsidy payments such that overall federal spending is reduced by \$23.4 billion (or approximately 2%) over 2020-2029.

**FIGURE 2: 2020-2029 INDIVIDUAL MEDICARE PART D \$2,500 MOOP SCENARIO WITH 5% BRAND REDUCTION ESTIMATED BENEFICIARY IMPACT (\$ BILLIONS)**

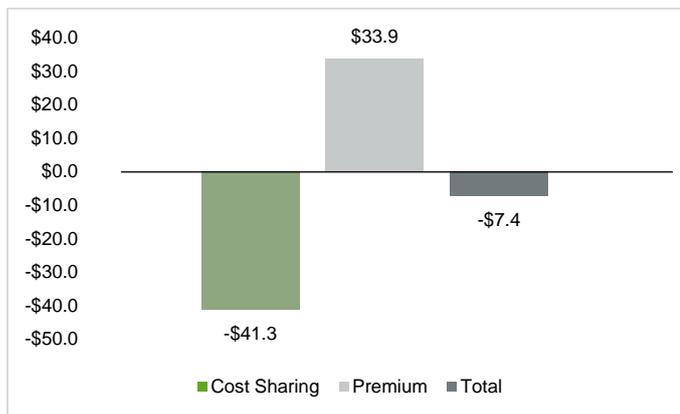


Figure 2 demonstrates our estimate that the \$2,500 MOOP scenario with a 5% reduction in brand spending will reduce beneficiary cost sharing which is largely offset by increases in beneficiary premium of \$33.9 billion (or approximately 20%) such that overall beneficiaries see a \$7.4 billion (or approximately 1.5%) reduction over 2020-2029. This would result in greater subsidization among beneficiaries as the cost sharing reduction will have a larger impact on beneficiaries who take more expensive medications while the premium increase will affect all beneficiaries paying premium. These estimates reflect the average beneficiary, and the savings/costs will vary based on each beneficiary’s plan selection, prescription drug use, and income.

In addition, with a 5% reduction in brand spending, we estimate that drug manufacturer discount payments will decrease by \$1.6 billion (which would be more than offset by drug manufacturers’ revenue losses from the behavioral changes).

## Findings

Figures 6 and 7 summarize the scenarios we modeled as well as the estimated impact of each scenario. The first scenario we examined applies a \$2,500 MOOP in 2020 (increased annually) rather than the \$6,350 TrOOP.<sup>vii</sup>

Because these scenarios eliminate the CGDP, which accumulates toward TrOOP, only the beneficiary cost sharing and low income cost sharing subsidies accumulate to MOOP. We estimate that non-low income beneficiaries will reach this out-of-pocket maximum with the defined standard benefit at \$2,500 in beneficiary cost sharing and \$8,700 in allowed claims in 2020.<sup>viii</sup> This compares to approximately \$2,750 in beneficiary cost sharing and \$9,700 in allowed claims to reach the 2020 TrOOP for an average non-low income beneficiary.<sup>ix</sup>

Reducing the reinsurance percentage with an offsetting increase in plan liability has no impact on federal spending in isolation (i.e., ignoring the impact of plan changes such as increased risk loads, non-benefit expenses, or changes in high cost claims management). That is, an even shift between reinsurance and plan liability will have an offsetting impact on the direct subsidy such that federal spending is neutral. If such a change in reinsurance and other regulatory changes enable plans to improve high cost claims management to more than offset increases in risk loads and non-benefit expenses, then there could be a reduction in total Medicare Part D spending and federal spending from reduced drug manufacturer revenue.

The benefit design changes we modeled may result in changes that affect the total cost of the Medicare Part D program including the following examples:

- Drug manufacturers would be subject to costs in the catastrophic phase with no cap on the total cost. This may result in changes to drug manufacturer pricing and rebate strategies.
- Plan bids<sup>x</sup> would reflect increased plan liability in the catastrophic phase. This may result in changes to plan formularies and management of higher cost drugs to the extent allowable under Part D requirements. This may also result in increased risk loads and non-benefit expenses.
- Beneficiaries with high cost medications would see a reduction in their out-of-pocket costs, which could increase utilization of higher priced products. This could be the result of improved adherence as well as reduced incentives to find cost effective alternatives. This could affect medical claims, which is not considered in this analysis of Medicare Part D spending.

Aetna requested that we model the impact of the benefit design changes with an associated 5% reduction in non-specialty brand drug spending. This reduction does not reflect a shift in utilization to generic drugs but reflects a reduction in brand pricing and utilization resulting from reductions in drug pricing and increased plan management of high cost drugs.

**FIGURE 3: 2020-2029 INDIVIDUAL MEDICARE PART D IMPACT OF \$2,500 MOOP SCENARIO (\$ BILLIONS)**

	Without Behavioral Changes	With 5% Brand Reduction
Beneficiary	\$1.6	-\$7.4
Federal Government	-\$1.6	-\$23.4
Drug Manufacturers	\$0.0	-\$1.6

Without behavioral changes, we estimate that the \$2,500 MOOP scenario increases average beneficiary costs by \$1.6 billion and reduces federal government costs by the same \$1.6 billion.

With behavioral changes that reduce non-specialty brand costs by 5%, we estimate that this benefit design reduces beneficiaries' spending by \$7.4 billion, reduces federal spending by \$23.4 billion and reduces drug manufacturers' discount program payments by \$1.6 billion (which would be more than offset by drug manufacturers' revenue losses from the behavioral changes).

We also looked at other scenarios summarized in Figures 6 and 7. For example with a higher MOOP we estimate that there would be additional federal savings as well as additional costs for beneficiaries.

Figure 4 illustrates the shifting between cost sharing and premium for the \$2,500 MOOP scenario for the average beneficiary.

**FIGURE 4: 2020-2029 INDIVIDUAL MEDICARE PART D \$2,500 MOOP SCENARIO ESTIMATED BENEFICIARY IMPACT (\$ BILLIONS)**

	Without Behavioral Changes	With 5% Brand Reduction
Cost Sharing	-\$36.2	-\$41.3
Premium	\$37.8	\$33.9
<b>Total</b>	<b>\$1.6</b>	<b>-\$7.4</b>

The reduction in cost sharing summarized in Figure 4 will have a larger impact on beneficiaries who take more expensive medications, while the premium increase will affect all beneficiaries paying premium. This represents a shifting of costs away from the higher cost beneficiaries (i.e., greater subsidization between beneficiaries). These estimates reflect the average beneficiary, and the savings/costs will vary based on each beneficiary's plan selection, prescription drug use, and income.

For example, without behavioral changes we estimate that an illustrative non-low income beneficiary with \$15,000 in annual claims (all brand products) would have approximately a \$450 reduction in annual cost sharing in 2020 with a \$100 increase in annual premium. In contrast, a non-low income beneficiary with \$5,000 in annual claims would have no change in cost sharing while paying the same \$100 increase in annual premium.

Figure 5 summarizes the impact of the \$2,500 MOOP scenario on the various federal subsidies to the Medicare Part D program.

**FIGURE 5: 2020-2029 INDIVIDUAL MEDICARE PART D \$2,500 MOOP SCENARIO ESTIMATED FEDERAL GOVERNMENT IMPACT (\$ BILLIONS)**

	Without Behavioral Changes	With 5% Brand Reduction
Federal Reinsurance	-\$470.3	-\$473.2
Direct Subsidy	\$635.9	\$621.9
Low Income Premium Subsidy	\$17.2	\$15.5
Low Income Cost Sharing Subsidy	-\$184.4	-\$187.6
<b>Total</b>	<b>-\$1.6</b>	<b>-\$23.4</b>

Figure 5 illustrates our projection that LICS and reinsurance will decrease with offsetting increases in the direct subsidy and LIPS.

## Additional Disclosures

We calculated the projections presented in this report using Milliman's 2019 Medicare Part D Analysis and Rating Tool. We calibrated the model with Milliman's 2017 manual claims data. Our manuals provide separate low income and non-low income claim probability distributions with allowed spend levels based on the average price for drugs by product type and distribution channel.

We projected the 2017 claims data to 2019 using trends and contracting terms consistent with our expectation for the 2019 individual Medicare Part D market. Our expectations were informed by Milliman's annual survey of Medicare Part D sponsors and are representative of our expectations for a typical individual Medicare Part D plan.

We projected 2020 through 2027 using trends, individual Medicare Part D enrollment, and Medicare Part D benefit parameters from the 2018 Medicare Trustees report<sup>xi</sup> with the following additional considerations:

- We projected the 2028 and 2029 enrollment, trends, and benefit parameters based on the rate of change between 2026 and 2027 in the 2018 Medicare Trustees Report.
- We scaled the 2018 Medicare Trustees Report trends when we applied the trends to generic, brand and specialty drugs to reflect that we expect cost increases to be driven by brand and specialty AWP increases and specialty utilization increases.
- We increased the 2020 MOOP annually for each of the model years at the same rate as the projected TrOOP increases.

We did not reflect any other projection assumptions such as rebate and discount improvements or beneficiary plan migration.

We limited our analysis to the defined standard plan design in the individual Medicare Part D market. Our modeling includes

standalone Prescription Drug Plans (PDPs) and Medicare Advantage plans that provide drug coverage (MA-PDs). Our modeling ignores group coverage through Employer Group Waiver Plans (EGWPs) which would also be impacted by these policy changes. Our modeling also ignores alternative and enhanced benefit designs which would change the realized impact of these policy changes.

In performing this analysis, we relied on data and other information provided by CMS. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

This report summarizes our estimates of the impact of various Medicare Part D benefit changes. This information may not be appropriate, and should not be used for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, third parties who receive this work product. Any third party recipient of this work product who desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs. Any releases of this report to a third party should be in its entirety. Milliman does not endorse any

public policy or advocacy position on matters discussed in this report.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We do not provide legal advice, and recommend that readers consult with legal advisors regarding legal matters. This report provides objective quantification of a legislative change and is not advocating for such change. This report represents the opinion of the author and is not representative of the views of Milliman.

I, Andrea Sheldon, am a Principal & Consulting Actuary for Milliman. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

**FIGURE 6: 2020-2029 INDIVIDUAL MEDICARE PART D  
IMPACT OF \$2,500 MOOP SCENARIO WITHOUT BEHAVIORAL CHANGES  
(\$ BILLIONS)**

	<b>Base Scenario</b>	<b>\$2,500 Scenario</b>	<b>\$3,000 Scenario</b>	<b>\$3,500 Scenario</b>	<b>\$4,000 Scenario</b>
<b>Scenario Description</b>					
Beneficiary Cat Coinsurance	5%	0%	0%	0%	0%
Catastrophic Reinsurance	80%	20%	20%	20%	20%
Discount Program Phase	Gap	Cat	Cat	Cat	Cat
Discount Program Percent	70%	8.3%	8.6%	8.9%	9.3%
% Beneficiaries Reaching Cat (NLI/LI)	3% / 18%	3% / 23%	3% / 22%	3% / 21%	3% / 20%
<b>2020 Description</b>					
TrOOP/MOOP	\$6,350	\$2,500	\$3,000	\$3,500	\$4,000
Allowed Spend to Reach Cat (NLI/LI)	\$9,700 / \$9,050	\$8,700 / \$5,200	\$10,700 / \$5,700	\$12,700 / \$6,200	\$14,700 / \$6,700
Beneficiary+LICS Spend to Reach Cat (NLI/LI)	\$2,750 / \$6,350	\$2,500	\$3,000	\$3,500	\$4,000
<b>2029 Description</b>					
TrOOP/MOOP	\$10,600	\$4,300	\$5,000	\$5,600	\$6,900
Allowed Spend to Reach Cat (NLI/LI)	\$16,200 / \$15,050	\$15,050 / \$8,750	\$17,850 / \$9,450	\$20,250 / \$10,050	\$25,450 / \$11,350
Beneficiary+LICS Spend to Reach Cat (NLI/LI)	\$4,600 / \$10,600	\$4,300	\$5,000	\$5,600	\$6,900
<b>Impact by Stakeholder (\$b)</b>					
Beneficiary		\$1.6	\$3.4	\$5.3	\$8.5
Federal Government		-\$1.6	-\$3.4	-\$5.3	-\$8.5
Drug Manufacturers		\$0.0	\$0.0	\$0.0	\$0.0
<b>Beneficiary Impact (\$b)</b>					
Cost Sharing		-\$36.2	-\$30.0	-\$24.1	-\$14.1
Premium		\$37.8	\$33.4	\$29.4	\$22.6
<b>Total</b>		<b>\$1.6</b>	<b>\$3.4</b>	<b>\$5.3</b>	<b>\$8.5</b>
<b>Federal Government Impact (\$b)</b>					
Federal Reinsurance		-\$470.3	-\$476.1	-\$481.6	-\$490.9
Direct Subsidy		\$635.9	\$622.7	\$610.3	\$590.2
Low Income Premium Subsidy		\$17.2	\$15.3	\$13.4	\$10.3
Low Income Cost Sharing Subsidy		-\$184.4	-\$165.3	-\$147.4	-\$118.1
<b>Total</b>		<b>-\$1.6</b>	<b>-\$3.4</b>	<b>-\$5.3</b>	<b>-\$8.5</b>

**FIGURE 7: 2020-2029 INDIVIDUAL MEDICARE PART D  
\$2,500 MOOP SCENARIO WITH 5% BRAND REDUCTION  
ESTIMATED FEDERAL GOVERNMENT IMPACT  
(\$ BILLIONS)**

	<b>Base Scenario</b>	<b>\$2,500 Scenario</b>	<b>\$3,000 Scenario</b>	<b>\$3,500 Scenario</b>	<b>\$4,000 Scenario</b>
<b>Scenario Description</b>					
Beneficiary Cat Coinsurance	5%	0%	0%	0%	0%
Catastrophic Reinsurance	80%	20%	20%	20%	20%
Discount Program Phase	Gap	Cat	Cat	Cat	Cat
Discount Program Percent	70%	8.3%	8.6%	8.9%	9.3%
% Beneficiaries Reaching Cat (NLI/LI)	3% / 18%	3% / 23%	3% / 22%	3% / 20%	3% / 19%
<b>2020 Description</b>					
TrOOP/MOOP	\$6,350	\$2,500	\$3,000	\$3,500	\$4,000
Allowed Spend to Reach Cat (NLI/LI)	\$9,700 / \$9,050	\$8,700 / \$5,200	\$10,700 / \$5,700	\$12,700 / \$6,200	\$14,700 / \$6,700
Beneficiary+LICS Spend to Reach Cat (NLI/LI)	\$2,750 / \$6,350	\$2,500	\$3,000	\$3,500	\$4,000
<b>2029 Description</b>					
TrOOP/MOOP	\$10,600	\$4,300	\$5,000	\$5,600	\$6,900
Allowed Spend to Reach Cat (NLI/LI)	\$16,200 / \$15,050	\$15,050 / \$8,750	\$17,850 / \$9,450	\$20,250 / \$10,050	\$25,450 / \$11,350
Beneficiary+LICS Spend to Reach Cat (NLI/LI)	\$4,600 / \$10,600	\$4,300	\$5,000	\$5,600	\$6,900
<b>Impact by Stakeholder (\$b)</b>					
Beneficiary		-\$7.4	-\$5.6	-\$3.8	-\$0.4
Federal Government		-\$23.4	-\$25.3	-\$27.2	-\$30.7
Drug Manufacturers		-\$1.6	-\$1.6	-\$1.6	-\$1.6
<b>Beneficiary Impact (\$b)</b>					
Cost Sharing		-\$41.3	-\$35.3	-\$29.5	-\$19.5
Premium		\$33.9	\$29.7	\$25.7	\$19.1
<b>Total</b>		<b>-\$7.4</b>	<b>-\$5.6</b>	<b>-\$3.8</b>	<b>-\$0.4</b>
<b>Federal Government Impact (\$b)</b>					
Federal Reinsurance		-\$473.2	-\$478.9	-\$484.3	-\$493.5
Direct Subsidy		\$621.9	\$609.1	\$597.1	\$577.3
Low Income Premium Subsidy		\$15.5	\$13.6	\$11.7	\$8.7
Low Income Cost Sharing Subsidy		-\$187.6	-\$169.1	-\$151.7	-\$123.2
<b>Total</b>		<b>-\$23.4</b>	<b>-\$25.3</b>	<b>-\$27.2</b>	<b>-\$30.7</b>

- <sup>i</sup> **Coverage Gap Discount Program:** Starting in 2011, drug manufacturers were required to cover 50% of ingredient drug cost for brand-name drugs taken by non-low income beneficiaries in the Medicare Part D coverage gap. The Balanced Budget Act of 2018 revised the coverage gap discount to be 70% of ingredient cost for brand and biosimilar products for non-low income beneficiaries. This program does not apply to drug spend for low income beneficiaries and only applies to the drug spend in the coverage gap phase.
- <sup>ii</sup> **Catastrophic Phase:** The spending phase of the Medicare Part D benefit above the True out-of-Pocket cost threshold. Under the current Medicare Part D plan design, the federal government covers 80% of gross drug cost through reinsurance and beneficiaries pay 5% of gross drug cost, subject to minimum copays. Plan sponsors cover the remaining liability, or approximately 15% of gross drug cost in this phase. In our modeling, we ignored the minimum copays in the catastrophic phase.
- <sup>iii</sup> **Additional Stakeholders:** Our modeling assumes that the only stakeholders are the Medicare Part D beneficiaries, the federal government, and drug manufacturers. For example, we did not model the potential impact on pharmacies, Medicare Part D plans, or medical plans. We have assumed that all impacts on Medicare Part D plans are passed through to the other stakeholders through adjusted beneficiary premiums, low income premium subsidy payments, and direct subsidy payments (e.g., we have assumed that plans will retain the same margin and have the same non-benefit expenses in all scenarios such that plans are “neutral” in all scenarios). The impact of the benefit design changes discussed in this report will vary by plan (e.g., beneficiary migration between plans, varying impact of changes to the risk score model, etc.).
- <sup>iv</sup> **Drug Manufacturers’ Revenue and Costs:** We did not model revenue and costs for drug manufacturers other than drug discount program payments. We are not reflecting the impact of changes in drug pricing, changes in drug rebates, or changes in drug utilization on drug manufacturer revenue.
- <sup>v</sup> **Behavioral Changes:** At Aetna’s request, we modeled the illustrative impact of a 5% reduction in non-specialty brand spending from changes driven by the restructured benefit design. This reduction does not reflect a shift in utilization to generic drugs and instead reflects a reduction in brand pricing and utilization resulting from drug pricing changes as drug manufacturers are subject to cost sharing in the catastrophic phase with no cap on the total cost and plan management of high cost drugs as plan liability increases in the catastrophic phase. We applied this reduction uniformly to all ten years being modeled for this illustration and did not reflect the likely phasing in of such impacts. Other behavioral changes are also possible as all stakeholders respond to the restructured benefit. We summarized two illustrative scenarios in this report, but others are also possible.
- <sup>vi</sup> **Low Income Subsidies:** Our modeling reflects the federal government’s costs associated with low income premium subsidies (LIPS) and low income cost sharing subsidies (LICS). For this analysis, we assumed that (1) 95% of total premiums associated with low income beneficiaries are paid by LIPS, and (2) 95% of beneficiary cost sharing associated with low income beneficiaries is paid by LICS.
- <sup>vii</sup> **True Out-of-Pocket (TrOOP) Cost:** Out-of-pocket cost threshold at which Medicare Part D beneficiaries reach the catastrophic phase. Currently both beneficiary cost-sharing and coverage gap discount program payments accumulate toward TrOOP. The inflation rate for TrOOP has been suppressed for several years due to a provision in the Affordable Care Act (ACA), and is estimated to be \$6,350 in 2020 in the Medicare 2018 Trustees Report.
- <sup>viii</sup> **MOOP Allowed Claim Threshold:** The following summarizes the allowed claim threshold where beneficiaries reach the \$2,500 MOOP in 2020:
- $MOOP = \text{Deductible} + (\text{ICL} - \text{Deductible}) * (\text{ICL Cost Sharing}) + (\text{Allowed Threshold} - \text{ICL}) * (\text{Gap Cost Sharing})$
  - $\$2,500 = \$435 + (\$4,020 - \$435) * 25\% + (\$8,695 - \$4,020) * 25\%$
- <sup>ix</sup> **TrOOP Allowed Claim Threshold:** The following summarizes the allowed claim threshold where the average non-low income beneficiary reaches the \$6,350 TrOOP in 2020 (assuming 90% of gap claims costs are from brand drugs for the average non-low income beneficiary):
- $TrOOP = \text{Deductible} + (\text{ICL} - \text{Deductible}) * (\text{ICL Cost Sharing}) + (\text{Allowed Threshold} - \text{ICL}) * (\text{Gap Cost Sharing}) + (\text{Allowed Threshold} - \text{ICL}) * (\text{Percent Brand}) * (\text{CGDP})$
  - $\$6,350 = \$435 + (\$4,020 - \$435) * 25\% + (\$9,723 - \$4,020) * 25\% + (\$9,723 - \$4,020) * 90\% * 70\%$
- <sup>x</sup> **Plan Bids:** Medicare Part D plan sponsors are required to submit bid pricing tools (BPTs) to CMS for approval as part of rate development. Direct subsidy payments and beneficiary premiums are based on the bids plans submit annually.
- <sup>xi</sup> **Medicare 2018 Trustees Report:** “2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.” The Boards of Trustees, Federal Hospital Insurance, and Federal Supplementary Medical Insurance Trust Funds. June 2018. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf>

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