Segmentation in the stand-alone Part D prescription drug plan market

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April 7, 2022

MEDPAC

Prescription drug plans (PDPs) provide drug coverage to 19 million Medicare beneficiaries

- PDPs provide either basic or enhanced coverage
  - Basic = standard Part D benefit or its equivalent
  - Enhanced = basic coverage plus supplemental benefits
- Insurers that participate in the PDP market must offer a basic PDP and can offer up to two enhanced PDPs (for a total of three plans per region)
- An insurer's enhanced plans must have "meaningful differences" from its basic plan

Some key considerations for insurers when designing their PDPs

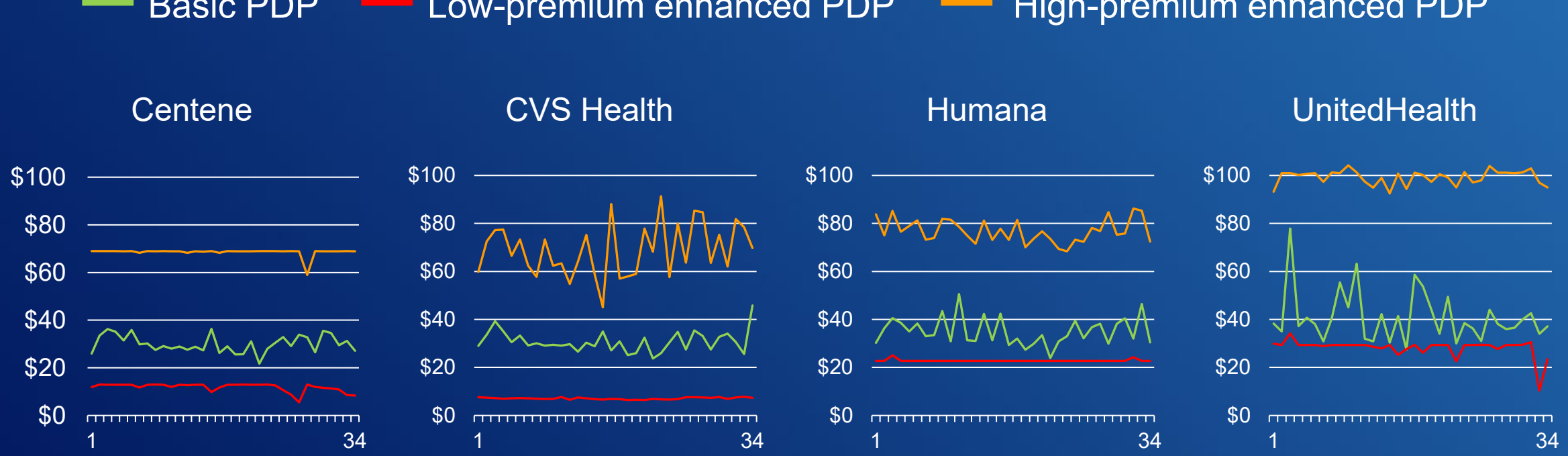
- Part D's low-income subsidy (LIS) pays for basic coverage up to a dollar limit known as the benchmark
  - → Maximize revenues for LIS enrollees by keeping premiums just below the benchmark
- Other enrollees are sensitive to premiums when they first pick a PDP but rarely switch plans after that
  - → Introduce plans with low premiums to attract enrollees
  - → Increase premiums in older plans with an established base of enrollees

Offering multiple PDPs makes it easier for insurers to meet these competing goals

- Insurers can tailor their PDPs to serve different types of beneficiaries and segment the market
- Most large insurers offer three plans and use the same general strategy:
  - Basic plan targets LIS beneficiaries
  - Enhanced plans target other beneficiaries – one plan for people with low drug costs, one plan for people with high drug costs

Segmentation has led insurers to price their PDPs in a distinctive pattern

Monthly premiums for 2022, by Part D region (1 to 34)



Note: Premiums for enhanced PDPs include supplemental premiums. Figures preliminary and subject to change.

Key features of low-premium enhanced PDPs

- Favorable coverage of certain generics
- Stronger incentives to use preferred drugs / pharmacies
- Targeted changes to plan formulary
  - Add older drugs to meet the meaningful difference threshold
  - Narrower coverage in some therapeutic classes
- Supplemental premiums are usually lower than the meaningful difference threshold
- Newer plans have more latitude to submit low bids

Key features of high-premium enhanced PDPs

- Most plans have no deductible
- Weaker incentives to use preferred drugs / pharmacies
- Broader formularies
- Supplemental premiums are usually higher than the meaningful difference threshold
- Enrollees pay higher premiums in return for richer coverage and broader access

Insurers periodically revamp their PDP lineups to introduce new low-premium plans

- Premiums for low-cost plans tend to rise over time
  - Plan bids eventually need to reflect actual experience and healthy enrollees can get sicker over time
  - Beneficiary inertia also gives insurers an incentive to increase premiums for older plans with an established enrollment base
- Insurers can consolidate their existing enhanced plans and launch a new, low-premium enhanced plan
- This dynamic does not affect basic plans

Some implications of segmentation

- PDP profits and program spending are higher than they would be without segmentation, but magnitude is unclear
- Easier for insurers to submit higher bids for basic plans and older enhanced plans
- Distinction between basic and enhanced plans is unclear
- Less cross-subsidization between low-cost and high-cost beneficiaries

Policy option #1: Modify how the meaningful difference requirement is administered

- Insurers can meet requirement by making changes to their formulary that have little practical effect
- Low-premium enhanced PDPs may provide little added value over basic coverage
- Two potential reforms to consider:
  - Remove LIS beneficiaries from the model used to evaluate meaningful differences
  - Require enhanced plans to cover a minimum percentage of beneficiary cost sharing for basic coverage

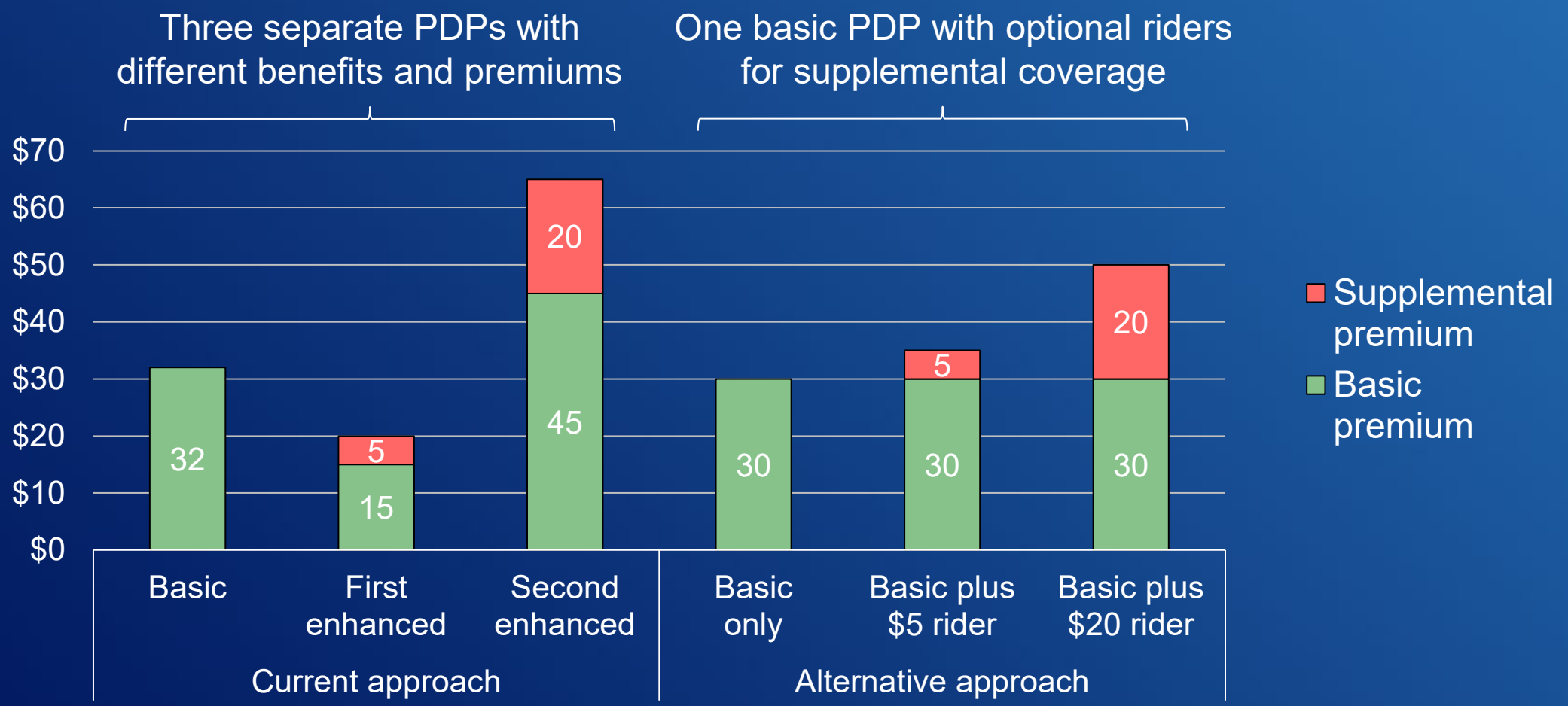
Policy option #2: Modify the auto-enrollment process to include enhanced PDPs

- LIS beneficiaries now auto-enrolled in basic PDPs only
- Beneficiaries could be enrolled in enhanced PDPs if they have lower premiums for basic coverage
- This approach might not work well in practice
  - Drug spending for LIS beneficiaries is harder to manage because their cost sharing is limited
  - Premiums for enhanced PDPs would probably increase if they receive LIS auto-enrollments, reducing any savings
  - Potential for more LIS reassignments at the end of each year

Policy option #3: Require insurers to treat their PDP enrollees as a single risk pool

- Each PDP is now treated as a separate risk pool with its own premium, cost-sharing rules, and formulary
- With a single risk pool, insurers would treat all PDP enrollees in each region as a single bloc
  - All enrollees would be in the basic PDP with the same premium, cost-sharing rules, and formulary
  - Enhanced coverage would be sold as optional riders

Illustrative example of how an insurer's PDPs would be structured using a single risk pool



With a single risk pool, insurers would no longer be able to segment the PDP market

- Clear hierarchy between basic and enhanced coverage
- Higher premiums for enrollees in low-premium enhanced plans; lower premiums for enrollees in high-premium enhanced plans
- Changes to LIS cost-sharing rules would make it easier for insurers to manage drug spending
- Level of beneficiary interest in riders is unclear

Discussion

- On balance, is segmentation a problem in the stand-alone PDP market?
- Feedback on potential reforms
  - Changes to meaningful difference requirement
  - Auto-enroll LIS beneficiaries in low-cost enhanced PDPs
  - Require sponsors to treat PDP enrollees as a single risk pool