

C H A P T E R

7

**Segmentation in
the stand-alone
Part D plan market**

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Chapter summary

The Part D program uses stand-alone prescription drug plans (PDPs) to provide drug coverage to beneficiaries in the fee-for-service (FFS) Medicare program. The insurers that participate in the PDP market, known as plan sponsors, can offer up to three plans, and they tailor those plans to appeal to different types of beneficiaries.

Most large sponsors follow the same general approach of dividing, or segmenting, the market based on beneficiaries' eligibility for Part D's low-income subsidy (LIS) and drug spending. Under this approach, sponsors use one plan to target LIS beneficiaries and two plans to target beneficiaries without the LIS—one for beneficiaries with low drug costs and one for beneficiaries with high drug costs. Sponsors differentiate their plans through a mix of program rules and changes in plan features such as premiums, beneficiary cost-sharing rules, formularies (the specific drugs covered by the plan), and pharmacy networks. Two distinctive features of this strategy are keeping the premium for the plan that targets LIS beneficiaries just below the LIS subsidy amount and offering plans with “enhanced” coverage (which combines standard Part D coverage with supplemental benefits) that turn out to have lower premiums than plans with “basic” coverage (which is limited to standard coverage only).

In this chapter

- The LIS has features that limit the incentives for plan sponsors to bid competitively with their basic PDPs
- Plan sponsors use a variety of strategies to differentiate their enhanced PDPs
- Plan sponsors periodically revamp their PDP lineups to introduce new low-premium plans
- Segmentation makes PDPs more profitable for plan sponsors but has implications for beneficiaries and program spending
- Policy changes that could improve competition and limit the negative impacts of segmentation

Segmenting the market makes PDPs more profitable for plan sponsors. For LIS beneficiaries, sponsors want to maximize the revenue they receive for each enrollee, which is easier to do when LIS enrollees are segmented into separate plans. For other beneficiaries, sponsors want to capitalize on the fact that beneficiaries are sensitive to premiums when they first select a PDP but rarely switch plans after that, which sponsors can do more easily by pairing a newer, low-premium plan that attracts new Part D enrollees with an older, more established plan with premiums they can increase more easily.

But for beneficiaries, the implications of a segmented market are more complicated. Segmentation benefits many enrollees who do not receive the LIS by giving them greater access to low-premium plans. At the same time, segmentation may make it harder for beneficiaries to understand their plan options, despite requirements that sponsors offer plans with meaningful differences. The common-sense distinction between “basic” and “enhanced” plans has been lost, and it can be difficult to determine what extra benefits are provided by enhanced PDPs with low premiums. In addition, beneficiaries in enhanced PDPs with high premiums likely pay more for their coverage than they otherwise would. For the Medicare program, segmentation likely increases Part D spending because it allows sponsors to charge higher premiums for plans that serve LIS beneficiaries and older plans that serve beneficiaries who do not receive the LIS.

Policymakers could consider several reforms that would either reduce the level of segmentation in the market or address some of the undesirable consequences of segmentation. These reforms include:

- Modifying the auto-enrollment process for LIS beneficiaries. Policymakers could give plan sponsors a stronger incentive to bid more competitively by auto-enrolling a larger share of new LIS beneficiaries in plans with lower premiums and reassigning LIS beneficiaries to new plans when premiums rise above the benchmark.
- Changing how the requirement for plans to have “meaningful differences” is administered. For example, policymakers could require enhanced PDPs to cover a minimum percentage of the out-of-pocket costs that their enrollees would otherwise pay for basic coverage. This approach would prevent sponsors from offering enhanced PDPs with very little additional coverage.
- Requiring PDP sponsors to treat their enrollees as a single risk pool for the purpose of providing basic coverage. Under this reform, every enrollee in a

sponsor's PDPs would pay the same premium for basic coverage and have the same formulary, cost-sharing rules, and pharmacy network. Sponsors would still be allowed to offer enhanced coverage, but they would do so by providing extra benefits on top of the uniform basic coverage, somewhat akin to an insurance rider. As under the current system, enrollees would pay for the full cost of any extra benefits through a supplemental premium.

Overall, segmenting the market based on beneficiaries' LIS eligibility is a greater concern than segmenting other beneficiaries based on their drug spending because it reduces the incentives for plans that serve the LIS population to bid competitively. The consequences of segmenting other beneficiaries based on their drug spending are more mixed, because segmentation reduces premiums for some beneficiaries while increasing premiums for other beneficiaries. Policymakers could therefore focus any reforms on measures that address the consequences of segmentation based on beneficiaries' LIS eligibility. ■

The Part D program relies on private plans to deliver prescription drug benefits to Medicare beneficiaries. These plans are either stand-alone prescription drug plans (PDPs) that provide coverage to beneficiaries in the fee-for-service (FFS) Medicare program or Medicare Advantage–Prescription Drug plans (MA–PDs) that provide both medical and drug coverage to beneficiaries in the MA program.

Every insurance company that participates in the PDP market (known as a plan sponsor) offers multiple plans. Plan sponsors tailor their plans to appeal to different parts of the Medicare population, and most large sponsors seek to divide, or segment, the market based on two factors: (1) whether a beneficiary receives Part D’s low-income subsidy (LIS) and (2) whether a beneficiary has low or high drug spending. Under this approach, sponsors offer three PDPs: one plan to target LIS beneficiaries and two plans to target beneficiaries without the LIS—one for beneficiaries with low drug costs and one for beneficiaries with high drug costs. Two distinctive features of this strategy are keeping the premium for the plan that targets LIS beneficiaries just below the LIS subsidy amount and offering plans with “enhanced” coverage that turn out to have lower premiums than plans with “basic” coverage.

This chapter reviews the policies governing the number of PDPs that sponsors can offer and examines the strategies that sponsors use to differentiate their plans. As part of this work, we analyzed relevant Part D administrative data and interviewed several actuaries with Part D expertise to get their perspectives. We assessed how segmentation in the PDP market affects beneficiaries and program spending, and we explored reforms that would either reduce the level of segmentation in the market or address some of the undesirable consequences of segmentation. Overall, segmenting the market based on beneficiaries’ LIS eligibility is a greater concern because it reduces the incentives for plans that serve the LIS population to bid competitively. The consequences of segmenting other beneficiaries based on their drug spending are more mixed, because segmentation reduces premiums for some beneficiaries while increasing premiums for other beneficiaries.

Background

Under the Part D program, all plans provide either *basic coverage*, which consists of a standard benefit defined in law or its actuarial equivalent, or *enhanced coverage*, which is basic coverage plus some type of additional benefits, such as a lower deductible or lower cost sharing. Medicare subsidizes the cost of basic coverage, while enrollees pay for the full cost of any additional benefits through a supplemental premium. All Part D sponsors are required by law to offer a basic plan; enhanced plans are optional.

Plan sponsors can offer up to three PDPs but must demonstrate that these plans have “meaningful differences”

At the start of the Part D benefit in 2006, CMS did not specify the number or type of PDPs that sponsors could offer, except for the statutory requirement that all participating sponsors had to offer a basic plan. In the years that followed, the agency expressed concern about the similarity among PDPs and the potential for similar plans to confuse beneficiaries and make it harder for them to select a plan. CMS encouraged sponsors to offer plans that provided beneficiaries with meaningful choices, but it could not require sponsors to make their PDPs more distinctive.

In 2010, CMS changed its approach by issuing a regulation that established the “meaningful difference” requirement for PDPs. Under this rule, CMS will not approve a PDP’s bid unless it is sufficiently different from the other bids submitted by the same sponsor. CMS prohibited sponsors from offering more than one basic plan (which had been a common practice at the time) because those plans have the same actuarial value and thus cannot be shown to be meaningfully different from each other. CMS also said sponsors could not offer more than two enhanced plans and that the second plan must cover some drugs in the “coverage gap” that then existed in the basic Part D benefit. When CMS began enforcing these limits in 2011, the number of PDPs dropped sharply.

When two sponsors are involved in a merger or acquisition, CMS gives the combined entity a two-year grace period before it must comply with the meaningful difference requirement. At that point,

the sponsor has to consolidate or close some of its PDPs. For example, in 2022, Cigna and Centene both consolidated plans following their respective acquisitions of Express Scripts and Aetna's PDP business. Before these mergers, all 4 companies offered 3 PDPs in each region, so these consolidations resulted in the elimination of 204 PDPs (2 former sponsors × 3 plans per region × 34 Part D regions).

CMS enforces the meaningful difference requirement by comparing the average out-of-pocket cost (OOPC) for a sponsor's PDPs. The agency estimates that cost by calculating what a nationally representative sample of Part D enrollees would spend on deductibles, copayments, and coinsurance under each plan. This approach accounts for plan-to-plan differences in both formularies (the specific drugs covered by each plan) and benefit structures (the specific cost-sharing rules for each plan). CMS has traditionally required the OOPC estimates for a sponsor's PDPs to differ by a specific dollar amount; bids for plans that have smaller differences were rejected. From 2011 to 2018, CMS used two separate OOPC thresholds: one for measuring differences between the basic plan and the first enhanced plan, and another for measuring differences between the first enhanced plan and the second enhanced plan. Those thresholds changed from year to year; the first ranged from \$18 to \$24 per month while the second ranged from \$12 to \$37 per month.

The gradual closure of the Part D coverage gap between 2011 and 2019 made it increasingly difficult for plan sponsors to have meaningful differences between their enhanced PDPs because the coverage of some drugs in the gap was the main feature that distinguished them. In 2014, CMS proposed limiting sponsors to offering just two PDPs—one basic plan and one enhanced plan—but did not finalize its proposal. In 2018, the agency instead eliminated the meaningful difference threshold between enhanced plans, effective in 2019. (Plan sponsors must still show that their enhanced PDPs are meaningfully different from their basic PDP, but they no longer have to show that their enhanced PDPs are meaningfully different from each other.) Sponsors are still limited to offering one basic plan and up to two enhanced plans.

CMS's approach for measuring meaningful differences lets it compare PDPs in a consistent manner but also has its limitations. The OOPC model has traditionally

used prescription drug claims that are four to five years old and do not reflect current utilization patterns, and it overstates the impact of adding or removing drugs from a plan's formulary by assuming that beneficiaries who take nonformulary drugs keep paying for them out of pocket instead of switching to another medication (Kranovich 2016). Drug manufacturers have argued that this assumption gives plan sponsors an incentive to cover fewer drugs in basic PDPs because they get credit toward the meaningful difference threshold by covering more drugs in enhanced PDPs (Pharmaceutical Research and Manufacturers of America 2017). One actuary we interviewed said the OOPC model also does not account for the effects of preferred pharmacy networks, which are a common PDP feature and increase out-of-pocket costs for enrollees who use nonpreferred pharmacies. Finally, the model's estimate of how much an enhanced PDP lowers out-of-pocket costs can differ substantially from the supplemental premium the plan actually charges for its extra coverage because the model uses a nationally representative sample of enrollees while the plan's premium is based on its specific mix of enrollees.

CMS has developed a revised OOPC model and will use it to review plan bids for 2023. Due to the switch to the new model, CMS will use another method to measure meaningful differences. CMS still expects a sponsor's enhanced plans to have lower OOPC estimates than its basic plan, but instead of using a specific dollar threshold, the agency will examine bids where the differences in the OOPC estimates are unusually small. It is unclear whether CMS will resume using a specific dollar threshold in the future. The revised model uses a different source for its claims data (a 0.1 percent sample of Part D claims instead of data collected in the Medicare Current Beneficiary Survey) and will have more recent data (two years old). The agency is also considering changes to the model that would make more realistic assumptions about how beneficiaries respond when they take a drug that is not covered on a plan's formulary. The actuaries we interviewed thought the revised model was an improvement and would make the meaningful difference requirement more rigorous.

Throughout this chapter, we divide PDPs into three groups: *basic*, *first enhanced*, and *second enhanced*.¹ The basic category is straightforward; these plans

**TABLE
7-1****More plan sponsors are offering enhanced PDPs,
and more beneficiaries are enrolling in them**

	2017	2018	2019	2020	2021	2022
Number of PDPs						
Basic PDP	359	361	348	382	378	302
First enhanced PDP	270	270	308	342	359	285
Second enhanced PDP	<u>117</u>	<u>151</u>	<u>245</u>	<u>224</u>	<u>259</u>	<u>179</u>
Total	746	782	901	948	996	766
Offer rates for enhanced PDPs						
First enhanced PDP	75%	75%	89%	90%	95%	94%
Second enhanced PDP	33	42	70	59	69	59
Enrollment (millions)						
Basic PDP	12.2	12.3	11.9	11.1	9.5	8.9
First enhanced PDP	4.5	4.6	5.0	4.4	5.5	6.4
Second enhanced PDP	<u>3.9</u>	<u>3.9</u>	<u>3.8</u>	<u>5.0</u>	<u>4.5</u>	<u>3.9</u>
Total	20.6	20.8	20.7	20.5	19.6	19.1
Enrollment (share)						
Basic PDP	59%	59%	58%	54%	48%	46%
First enhanced PDP	22	22	24	21	28	33
Second enhanced PDP	19	19	18	24	23	20

Note: PDP (prescription drug plan). We counted plans based on unique combinations of contract and plan numbers. When plan sponsors offered one enhanced PDP in a region, we included it in the "first enhanced" category; when sponsors offered two enhanced PDPs, we included the plan with the lower overall premium in the "first enhanced" category and the plan with the higher overall premium in the "second enhanced" category. Table does not include employer-sponsored plans or plans in the U.S. territories. Enrollment figures for 2017–2021 are for July of each year; enrollment figures for 2022 are for January. The number of PDPs dropped in 2022 largely because Centene and Cigna consolidated their PDPs to comply with the meaningful difference requirement. Components may not sum to totals due to rounding.

Source: MedPAC analysis of 2022 Part D landscape file and enrollment data.

provide the standard Part D benefit without any supplemental benefits. When sponsors offer just one enhanced PDP, we assigned it to the first enhanced category. When sponsors offer two enhanced PDPs, we assigned the plan with the lower overall premium (i.e., the premium for basic coverage plus the supplemental premium) to the first enhanced category and the plan with the higher overall premium to the second enhanced category.

Plan sponsors have become more likely to offer enhanced PDPs in recent years (Table 7-1). Five years ago, sponsors offered a first enhanced plan in 75 percent of the regions they served and a second enhanced plan in 33 percent of the regions they served. Those figures have since risen to 94 percent and 59 percent, respectively. The growth largely occurred in 2019, after CMS relaxed its meaningful difference requirement and made it easier for sponsors to offer two enhanced plans. In 2022, the PDP market has 28

**TABLE
7-2**

In 2020, spending and utilization patterns differed substantially across the three PDP types

	Basic PDPs	First enhanced PDPs	Second enhanced PDPs
Share of enrollees receiving the LIS	55%	3%	7%
Average annual spending			
Total drug costs	\$5,122	\$2,253	\$3,831
Basic benefit costs	\$3,436	\$1,426	\$2,478
Average number of 30-day prescriptions	55	44	56
Average cost for a 30-day prescription	\$93	\$51	\$69
Share of enrollees reaching the catastrophic phase	12%	3%	6%
Share of enrollees with no prescriptions	10%	8%	4%

Note: PDP (prescription drug plan), LIS (low-income subsidy). When plan sponsors offered one enhanced PDP in a region, we included it in the “first enhanced” category; when sponsors offered two enhanced PDPs, we included the plan with the lower overall premium in the “first enhanced” category and the plan with the higher overall premium in the “second enhanced” category. Spending figures do not include any postsale rebates or discounts. Prescription figures are based on standardized, 30-day counts. Figures do not include PDPs in the U.S. territories.

Source: MedPAC analysis of 2020 Part D landscape, enrollment, and prescription drug event data.

distinct plan sponsors. The 5 largest sponsors—CVS Health, Centene, Humana, UnitedHealth, and Cigna—offer the maximum 3 PDPs in all 34 Part D regions. They account for a majority of the first enhanced plans and almost all of the second enhanced plans. The other sponsors typically offer a basic plan and one enhanced plan.

Enhanced plans have also grown as a share of overall PDP enrollment, rising between 2017 and 2022 from 41 percent to 54 percent. Given how we define the “first enhanced” and “second enhanced” categories, the share of beneficiaries in those categories can fluctuate from year to year as plan sponsors modify their offerings. (For example, if a sponsor has one enhanced plan and introduces a second enhanced plan with a lower premium, the enrollment in the older plan shifts from the “first enhanced” category to the “second enhanced” category.) Currently, about a third of all PDP enrollees are in first enhanced plans and a fifth are in second enhanced plans.

Most major sponsors use the same general approach to segment the PDP market

When plan sponsors offer multiple PDPs, they try to tailor them to appeal to different parts of the Medicare population. Most major sponsors currently use the same basic approach to divide, or segment, the PDP market based on a beneficiary’s LIS eligibility and whether a beneficiary has low or high drug spending. Under this approach, sponsors offer three PDPs, and each plays a distinct role:

- The basic PDP targets LIS beneficiaries;
- The first enhanced PDP targets beneficiaries who do not receive the LIS and have low drug costs; and
- The second enhanced PDP targets beneficiaries who do not receive the LIS and have high drug costs.

There are clear differences in the mix of enrollees for each PDP type, which indicates that sponsors have

been able to segment the market to some degree (Table 7-2). LIS beneficiaries are heavily concentrated in basic PDPs. Compared with basic PDPs, enrollees in first enhanced PDPs have fewer prescriptions, use less expensive medications, and have much lower total drug costs. Total spending for enrollees in second enhanced PDPs is roughly halfway between the averages for the other two PDP types; they have about the same number of prescriptions as basic PDP enrollees but use less expensive drugs. The share of enrollees who reach the catastrophic phase of the Part D benefit follows a similar pattern. However, the share of enrollees with no prescriptions follows a different pattern—highest for basic PDPs (10 percent) and lowest for second enhanced PDPs (4 percent). The fact that basic PDPs have both the highest share of enrollees reaching the catastrophic phase and the highest share of enrollees with no prescriptions suggests that the spending distribution for LIS beneficiaries is somewhat bimodal.²

Although the mix of enrollees varies across the three PDP types, efforts by plan sponsors to segment the market do not work perfectly. For example, in 2021, 7 percent of LIS beneficiaries were enrolled in enhanced PDPs and 30 percent of beneficiaries without the LIS were in basic PDPs (data not shown). Similarly, some enrollees in first enhanced PDPs have high drug costs and some enrollees in second enhanced PDPs have low drug costs. Since Medicare beneficiaries can enroll in any PDP, can weigh different considerations when selecting a plan, and may not always select the plan that best meets their needs, there will always be limits on how effectively sponsors can segment the market.

Nonetheless, the relaxation of the meaningful difference requirement in 2019 has increased the level of segmentation in the PDP market in some respects. For example, before 2019, the share of beneficiaries without the LIS who were enrolled in basic PDPs had been slowly rising, from 37 percent in 2016 to 41 percent in 2018. Following the change, that figure has fallen to 30 percent. Similarly, the share of basic PDP enrollees who are LIS beneficiaries had been gradually declining in the years before 2019 but has since increased.

Segmentation is common in many health insurance markets—for example, Medicare Advantage has distinct plans (special needs plans) that serve beneficiaries who receive both Medicare and Medicaid, live in a nursing

home, or have certain chronic conditions. By itself, segmentation is not problematic; policymakers may decide to segment a market to achieve certain policy goals, such as the development of specialized plans that better serve populations with unusual care needs. However, segmentation in the PDP market may be more of a concern, because Part D has features (such as the auto-enrollment process for LIS beneficiaries) that encourage plan sponsors to charge higher premiums for certain types of plans.

The actuaries we interviewed emphasized that the major plan sponsors have many different lines of business and that PDPs are just one element of their overall business strategy. PDP enrollment is thus attractive partly because it supports those other lines of business. For sponsors that own a pharmacy benefit manager, specialty pharmacy, mail-order pharmacy, or retail pharmacy, PDPs can provide volume, administrative fees, and greater leverage with drug manufacturers. Sponsors that offer MA plans try to cultivate “brand loyalty” in their PDP enrollees and encourage them to switch to one of the company’s MA plans, which the actuaries said are much more profitable.

The LIS has features that limit the incentives for plan sponsors to bid competitively with their basic PDPs

Part D’s low-income subsidy covers most premiums and cost sharing for eligible beneficiaries and was designed by the Congress to use basic PDPs as the default form of drug coverage. The LIS’s premium subsidy has a dollar limit, known as the benchmark, that represents the maximum amount the LIS will pay for basic coverage. LIS beneficiaries who enroll in basic plans with premiums that are less than the benchmark do not pay a premium; those who enroll in basic plans with higher premiums pay the difference. In addition, LIS beneficiaries who enroll in enhanced PDPs must pay the plan’s supplemental premium, even if the plan’s overall premium is lower than the benchmark. The LIS thus gives beneficiaries a clear incentive to enroll in the subset of basic PDPs known as **benchmark plans** where they do not have to pay a premium.

The Part D program also ensures that LIS beneficiaries have coverage by automatically enrolling them in

benchmark PDPs if they do not select a drug plan. This approach gives plan sponsors an incentive to offer benchmark PDPs because auto-enrollment enables them to generate enrollment without incurring expenses such as marketing costs. In addition, if plans lose their benchmark status when CMS calculates Part D premiums and benchmarks for a new plan year, the agency will reassign LIS beneficiaries in the “losing” plans to other benchmark plans to ensure that they do not have to start paying a premium. (The auto-enrollment process does not apply to LIS beneficiaries who have selected a Part D plan on their own.) When there is more than one benchmark PDP in a region, CMS auto-enrolls LIS beneficiaries by randomly assigning them to one of the eligible plans. Each benchmark plan in a region typically receives an equal number of auto-enrollees.

Together, these two features—the lack of coverage for supplemental premiums and the use of auto-enrollment—have been very effective at channeling LIS beneficiaries into basic PDPs. In 2021, 92 percent of LIS beneficiaries with FFS coverage were enrolled in basic plans, and they represented a majority of the enrollees in basic PDPs. This approach provides LIS beneficiaries with a stable source of drug coverage, but it also reduces the incentives for benchmark plans to bid competitively. A plan that wants to serve LIS beneficiaries has an incentive to keep its premium below the benchmark to ensure that LIS beneficiaries can enroll without paying a premium and the plan can receive auto-enrollments. However, once a plan has qualified as a benchmark plan, it does not have an incentive to reduce its premium any further (Congressional Budget Office 2014). If the plan does lower its premium further below the benchmark, it cannot expect to receive any more LIS enrollees in return, for two reasons. First, every benchmark plan in a region typically receives the same number of auto-enrollments. Second, LIS beneficiaries do not have an incentive to switch to the plan because they will not benefit from the lower premium. (Medicare saves money if they enroll in the lower-premium plan instead of another benchmark plan that is more expensive, but the beneficiaries themselves pay no premium in either case.) At the margin, a benchmark plan that lowers its premium thus receives less Medicare revenue for the same number of LIS enrollees.

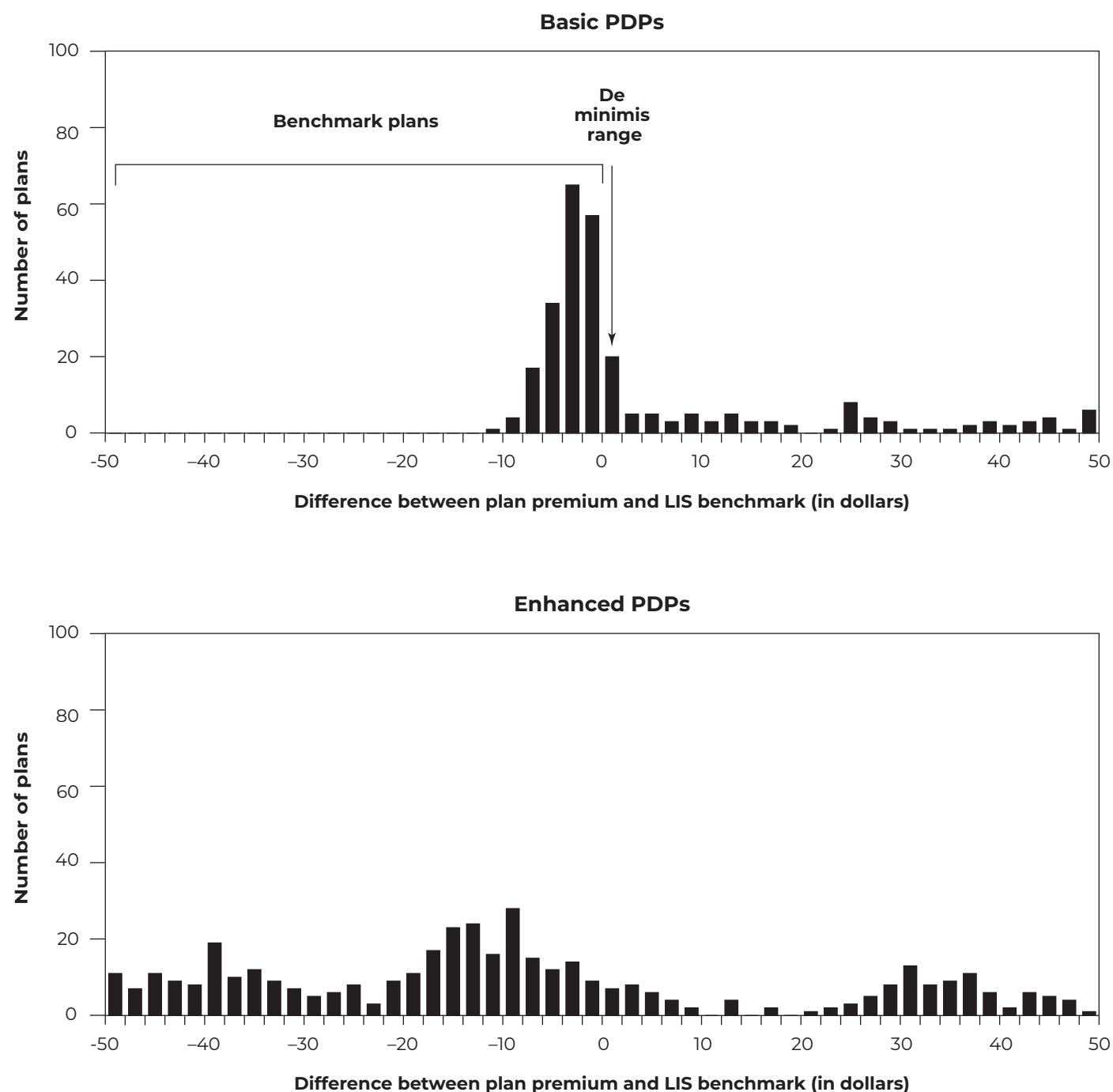
As a result, benchmark plans try to keep their premiums just below the LIS benchmark (Figure 7-1). The top half of Figure 7-1 shows the distribution of the 2022 premiums for basic PDPs, based on the difference between the plan's premium and the benchmark. Almost 90 percent of the benchmark plans have premiums that are within \$6 of the benchmark, and only one has a premium that is more than \$10 below the benchmark. Another cluster of PDPs have premiums that are slightly higher than the benchmark; CMS allows plans with premiums that exceed the benchmark by a “de minimis” amount, which has always been \$2, the option of waiving the remaining premium to avoid having their LIS enrollees reassigned to new plans. For comparison, the bottom half of the figure shows the distribution of the basic portion of the premiums for enhanced PDPs. These plans cannot qualify as benchmark plans, and their premiums do not show the same clustering pattern as basic plans.

The Congressional Budget Office (CBO) released a working paper in 2014 that examined how benchmark plans respond to these incentives (Congressional Budget Office 2014). CBO found that benchmark plans were less responsive than other basic plans to greater competition (in the form of another plan sponsor entering the market). Consistent with economic theory, CBO found that the entry of a new sponsor prompted both types of plans to reduce their bids, but the changes for benchmark plans were much smaller and not statistically significant. CBO also found that plans with premiums that were farther below the benchmark were more likely than plans with premiums that were closer to the benchmark to significantly increase their bids the following year. Both findings support the conclusion that the LIS limits the incentives for benchmark plans to bid competitively.

Further evidence that benchmark plans do not bid as competitively as they could comes from the behavior of plans that qualify for the de minimis option. Participation is voluntary, but the vast majority of eligible PDPs participate: Over the last five years (2018 to 2022), we found that 95 percent of the PDPs that qualified for the de minimis option (127 out of 134 plans) agreed to waive the additional premium. The high participation suggests that most of these PDPs were willing to serve LIS beneficiaries for less revenue than they stated in their bid. In addition, de minimis plans

**FIGURE
7-1**

The premiums for most benchmark PDPs are clustered around the LIS benchmark



Note: PDP (prescription drug plan), LIS (low-income subsidy). This figure is based on plan premiums and benchmarks for 2022 and does not include plans in the U.S. territories. Basic PDPs with premiums that exceeded the LIS benchmark by a “de minimis” amount (\$2 or less) could waive the difference and avoid having their LIS enrollees reassigned to other plans. For enhanced PDPs, we used the portion of the premium that reflects the cost of basic Part D coverage only; we did not include the supplemental premium that those plans charge to finance the cost of their enhanced benefits. This figure does not include plans with premiums that are more than \$50 below the benchmark (33 enhanced PDPs) or more than \$50 above the benchmark (30 basic PDPs and 11 enhanced PDPs).

Source: MedPAC analysis of CMS Part D premium and benchmark data.

know they are in danger of not qualifying as a zero-premium plan for LIS beneficiaries and tend to bid more conservatively the next year: 82 percent of the plans that took the de minimis option between 2017 and 2021 qualified as a benchmark plan the next year, and only 5 percent lost zero-premium eligibility altogether.

Plan sponsors use a variety of strategies to differentiate their enhanced PDPs

This section takes a closer look at how plan sponsors tailor their PDPs to appeal to different parts of the Medicare population. We examine four areas: premiums, cost sharing, formularies, and pharmacy networks.

Premiums for enhanced PDPs are often lower than premiums for basic PDPs and have declined in recent years

Under Part D, plan premiums are determined through competitive bidding. Plans submit bids reflecting the monthly cost of providing the standard Part D benefit or alternative coverage with the same actuarial value. CMS calculates the national average bid and a standard premium known as the base beneficiary premium.³ For 2022, the national average bid is \$38.18 and the base beneficiary premium is \$33.37. The premium for each plan equals the base beneficiary premium plus the difference between the plan's bid and the national average bid. As a result, plans with above-average bids have higher premiums and those with below-average bids have lower premiums. Plans that provide enhanced coverage also charge a supplemental premium that reflects the full cost of the additional coverage.⁴

The Part D actuaries we interviewed emphasized the key role that premiums play in the PDP market. They said premiums are the most important factor that many beneficiaries consider when choosing a plan and that premiums are particularly important to beneficiaries with low drug costs—the population many sponsors try to attract with their first enhanced PDP. Plan sponsors thus want to offer a PDP with a very low premium to attract these beneficiaries. This view is consistent with studies that have found many beneficiaries do not pick the Part D plan that best meets their needs because they put too much

emphasis on premiums over other factors like cost sharing (Abaluck and Gruber 2011).

In theory, plan sponsors should use their basic PDP as their low-premium option because it does not have any added costs for supplemental benefits. However, for sponsors that also want to attract LIS beneficiaries, this approach poses difficult trade-offs because lowering the basic PDP's premium to attract non-LIS beneficiaries worsens the financial picture for the plan's LIS beneficiaries. Plan sponsors also find it more difficult to manage LIS beneficiaries' drug spending because their cost sharing is limited to modest copayments, which makes it harder to keep premiums low.

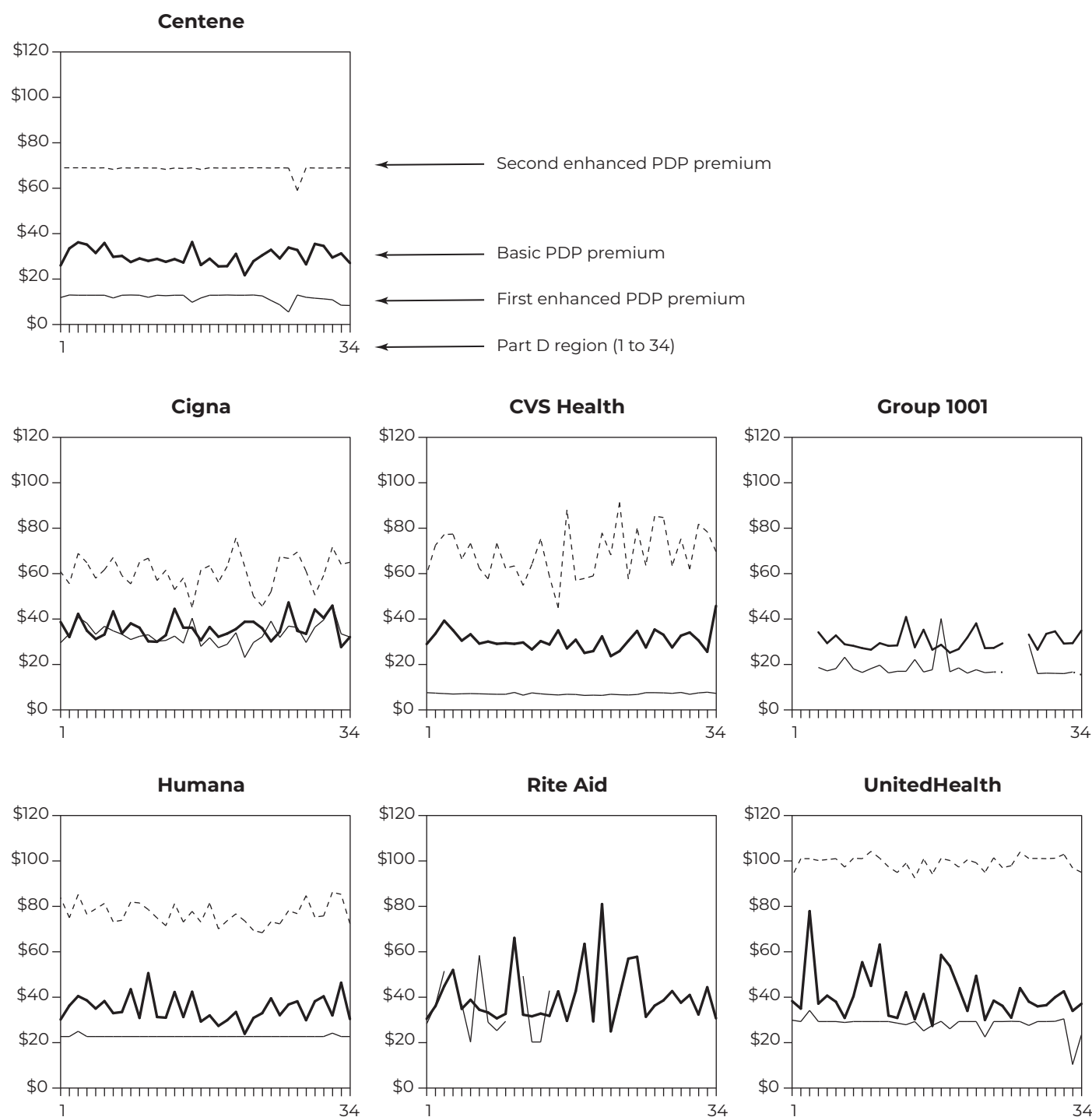
Given these challenges, many plan sponsors use an enhanced PDP as their low-premium option, despite its supposedly richer benefits. Segmenting the market in this manner lets sponsors offer a low-premium plan without reducing the revenue they receive for the LIS beneficiaries enrolled in their basic PDPs. Figure 7-2 shows the 2022 premiums for the PDPs offered by the seven largest plan sponsors. Five sponsors (Centene, CVS Health, Group 1001, Humana, and UnitedHealth) offer an enhanced PDP with a lower premium than their basic PDP in all or nearly all Part D regions. The only exceptions to this pattern are Cigna and Rite Aid, where the enhanced PDP premium is higher than the basic PDP premium in some regions and lower in others. When sponsors offer a second enhanced plan (Group 1001 and Rite Aid do not), their premiums are significantly higher than the premiums for the other two PDPs.

The practice of offering an enhanced PDP with a premium that is lower than the basic PDP's premium has been used since the early years of the program. In 2010, about half of the enrollees in first enhanced PDPs were in plans that had a lower overall premium than the sponsor's basic PDP. That figure fell to almost zero in 2011, likely due to the adoption of the meaningful difference requirement, but has risen steadily since then. This year, about 90 percent of the enrollees in first enhanced PDPs are in plans that have a lower premium than the sponsor's basic PDP.

Over the past five years, the relationship between the monthly premiums for basic PDPs and for enhanced PDPs has fundamentally changed (Table 7-3, p. 204).

**FIGURE
7-2**

In 2022, most major PDP sponsors offer an enhanced plan that has a lower premium than their basic plan



Note: PDP (prescription drug plan). Figures for enhanced plans include supplemental premiums.

Source: MedPAC analysis of 2022 Part D premium data.

**TABLE
7-3****Premiums for basic Part D coverage have increased for basic PDPs but decreased sharply for enhanced PDPs**

Average monthly premiums	2017	2018	2019	2020	2021	2022
All PDPs (basic coverage)	\$36	\$35	\$33	\$31	\$30	\$29
Basic PDPs	31	30	32	30	32	35
Enhanced PDPs						
Basic coverage	42	41	34	31	28	24
Supplemental coverage	<u>11</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>16</u>	<u>21</u>
Total premium	53	56	49	46	43	46

Note: PDP (prescription drug plan). Figures are enrollment-weighted averages for July of each year (2017–2021) or January (2022). Table does not include employer-sponsored plans or plans in the U.S. territories. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Part D premium and enrollment data.

In 2017, the premium that enhanced PDPs charged for basic coverage was \$11 higher, on average, than the premium for basic PDPs (\$42 vs. \$31). Since then, the average premium for enhanced PDPs has dropped sharply while the average premium for basic PDPs has risen somewhat. The premium that enhanced PDPs charge for basic coverage is now \$11 lower, on average, than the premium for basic PDPs (\$24 vs. \$35). At the same time, much of the decline in the basic portion of the premium has been offset by growth in supplemental premiums, which have almost doubled (from \$11 to \$21).

The actuaries we interviewed attributed the decline in the average premiums for enhanced PDPs to two factors. The first was higher enrollment growth in low-premium enhanced PDPs relative to other PDPs. The second was growth in direct and indirect remuneration (DIR), the postsale rebates and discounts that plans receive from drug manufacturers and pharmacies. Total DIR payments to Part D plans have grown rapidly over time, rising between 2007 and 2019 from less than 10 percent of total drug spending to 26.5 percent (Boards of Trustees 2021, Boards of Trustees 2015). One actuary said that plan sponsors have made particular efforts to generate more DIR, especially pharmacy DIR, in their low-premium enhanced plans—for example, by

giving enrollees stronger incentives to use preferred pharmacies (see the discussion of cost sharing later in the chapter). The overall growth in DIR has thus benefited those plans more than other PDPs, and their premiums have declined as a result. Plans use DIR to lower their bids, and when plans submit their bids, they include an estimate of the DIR payments they expect to receive. We analyzed plan bids for 2022 and found that, on a percentage basis, DIR has a larger impact on the bids for first enhanced PDPs than on the bids for basic PDPs and second enhanced PDPs.

The average premiums for enhanced PDPs obscure a great deal of underlying variation, as shown by the 2022 premiums for plans offered by the largest sponsors (Table 7-4). The premiums for first enhanced PDPs range from \$7 to \$35, but even when plans have relatively similar overall premiums, the basic and supplemental components may be very different. Three plans (offered by Centene, CVS Health, and Group 1001) have basic premiums that are actually negative, which occurs when the plan's bid is so far below the national average bid that the difference is larger than the base beneficiary premium. In these situations, plans must provide supplemental benefits that are at least equal in value to the difference between the plan's bid and the national average bid.

**TABLE
7-4**

In 2022, the premiums that enhanced PDPs charge for basic and supplemental coverage both vary widely

Plan sponsor	Plan name	Type	Average premium		
			Basic	Supplemental	Total
Centene	Wellcare Value Script	E1	-\$19	\$31	\$12
	Wellcare Medicare Rx Value Plus	E2	32	36	68
Cigna	Cigna Essential Rx	E1	21	14	35
	Cigna Extra Rx	E2	17	43	60
CVS Health	SilverScript SmartRx	E1	-5	13	7
	SilverScript Plus	E2	20	47	67
Group 1001	Clear Spring Health Premier Rx	E1	-12	30	18
Humana	Humana Walmart Value Rx Plan	E1	22	1	23
	Humana Premier Rx Plan	E2	66	11	77
Rite Aid	Elixir RxPlus	E1	10	18	28
UnitedHealth	AARP MedicareRx Walgreens	E1	23	6	29
	AARP MedicareRx Preferred	E2	72	28	100

Note: PDP (prescription drug plan), E1 (first enhanced PDP), E2 (second enhanced PDP). When plan sponsors offer one enhanced PDP in a region, we included it in the "first enhanced" category; when sponsors offer two enhanced PDPs, we included the plan with the lower overall premium in the "first enhanced" category and the plan with the higher overall premium in the "second enhanced" category. Figures are weighted using January enrollment and do not include plans in the U.S. territories. Components may not sum to totals due to rounding.

Source: MedPAC analysis of 2022 Part D premium and enrollment data.

Other first enhanced PDPs, such as those offered by Humana and UnitedHealth, have higher premiums for basic coverage but lower supplemental premiums. Humana is an extreme case; the average supplemental premium for its Humana Walmart Value Rx Plan is less than \$1. (The lowest amount, in Maine and New Hampshire, is just \$0.40.) Except for Wellcare Value Script, every first enhanced PDP has a supplemental premium that is lower than the \$22 meaningful difference threshold that all enhanced plans were required to meet in their 2022 bids, which indicates that the meaningful difference standard is not very effective at forcing sponsors to differentiate their plans.

For a given sponsor, the basic and supplemental premiums for its second enhanced PDP are almost

always higher than for its first enhanced PDP. But both components still vary widely across sponsors (from \$17 to \$72 for basic coverage and from \$11 to \$47 for supplemental coverage).

We asked actuaries why the composition of the premiums for enhanced PDPs, particularly those with low premiums, varies so much across sponsors. Some actuaries said the age of the plan was a factor: Newer plans have more latitude to make assumptions in their bids about the expected costliness of their enrollees, which can lead plans that hope to serve relatively healthy enrollees to have low bids and potentially negative premiums for basic coverage. Older plans must base their bids on historical experience; if their enrollees turn out to be more expensive than expected,

they will have higher bids and higher premiums for basic coverage. The actuaries we interviewed said it was very unlikely that an older plan would have a negative premium. One added that some plan sponsors may find the combination of a low or even negative premium for basic coverage and a relatively high supplemental premium attractive because Part D's risk corridors provide some protection against unexpected losses and the higher supplemental premium will do more to discourage LIS beneficiaries from enrolling.

Separately, the low supplemental premiums for many enhanced PDPs reflect limitations in how CMS enforces the meaningful difference requirement. The model that CMS uses to measure whether enhanced PDPs meet the requirement is based on a nationally representative sample of beneficiaries, while the actual premium that plans charge is based on the expected costs for their own mix of enrollees. Plans that have healthier enrollees will have lower supplemental premiums. The actuaries we interviewed also highlighted some strategies that plans can use to satisfy the requirement while keeping their actual premiums low, such as charging higher cost sharing when enrollees use nonpreferred pharmacies (this feature increases out-of-pocket costs for some enrollees, but CMS's model does not account for those costs) or adding certain drugs to their formulary (an issue we discuss in more detail in the formulary section). The actuaries said that it is very difficult to determine exactly what additional benefits a plan with low supplemental premiums provides relative to the standard Part D benefit.

Part D's risk-adjustment system has limitations that allow PDP sponsors to segment the market

Medicare pays Part D plans using a combination of capitated payments, which finance benefits covered by the competitive bidding process, and cost-based reinsurance, which finances 80 percent of spending in the benefit's catastrophic phase. CMS adjusts the capitated payments to account for differences in beneficiaries' health status: Plans with sicker enrollees receive higher payments and vice versa. The risk-adjustment system aims to limit the incentives for plans to avoid or underserve enrollees with above-average costs.

CMS makes these adjustments by using demographic information and diagnostic information from

claims to calculate a risk score that shows how the expected costs for a beneficiary compare with the overall average. For example, a risk score of 1.0 indicates that a beneficiary's expected costs equal the overall average, while a score of 1.3 indicates that a beneficiary's expected costs are 30 percent higher than the overall average.

CMS risk adjusts plan bids when it calculates the national average bid and each plan's premium for basic Part D coverage. In theory, risk adjustment should make it more difficult to segment the PDP market. Plans that want to attract healthier enrollees would like to submit low bids so they can have low premiums. Without risk adjustment, the low bids translate directly into low premiums. With risk adjustment, CMS divides each plan's bid by its average risk score, which increases the bids for plans with healthier enrollees because their average risk scores are less than 1.0, resulting in premiums that are higher and less attractive to healthy enrollees.

However, plan sponsors have still been able to segment the PDP market to some degree—as shown in Table 7-2 (p. 198) by the differences in the enrollees served by the three PDP types—which suggests that the risk-adjustment system is somewhat inaccurate. The actuaries we interviewed highlighted two particular limitations. First, the system predicts a beneficiary's gross drug costs (which are essentially payments at the pharmacy counter) and does not account for postsale rebates and discounts. Since the low-premium enhanced PDPs collect proportionally more rebates and discounts than other PDPs, their risk scores are too high relative to other plans, which puts downward pressure on their risk-adjusted bids and their premiums. Second, the system tends to overestimate spending for beneficiaries with very low drug costs and underestimate spending for beneficiaries with very high drug costs. These errors tend to offset each other when plans have a broad mix of enrollees, but the low-premium enhanced PDPs tend to have a disproportionate number of enrollees with low drug costs. One actuary said those plans are particularly interested in beneficiaries who do not use any medications; plans must compete to enroll those beneficiaries because they are so sensitive to plan premiums, but they are still profitable because the risk-adjustment system expects them to have some drug spending.

Beneficiary cost sharing

Under the standard Part D benefit for 2022, beneficiaries have a complicated cost-sharing structure with four distinct phases:

- a deductible of \$480;
- coinsurance of 25 percent on spending between \$480 and \$4,430, which is known as the initial coverage limit;
- coinsurance of 25 percent on spending between \$4,430 and the start of the catastrophic phase, which is typically around \$10,690; and
- coinsurance of 5 percent on any spending above \$10,690.

Beneficiaries once paid all costs in the third phase of the benefit, which is still referred to as the coverage gap and is treated as a distinct phase because the other 75 percent of spending is largely financed by manufacturer discounts on brand drugs.

However, Part D plans can offer alternative benefits that have the same actuarial value as the standard benefit, and all PDPs use this option. Plan sponsors prefer to offer alternative benefits because they can use formularies that favor certain drugs (and require enrollees to pay cost sharing that is effectively higher than 25 percent for some drugs and lower than 25 percent for other drugs). These changes in cost sharing are limited to the first two phases—the deductible and spending below the initial coverage limit—because plans have financial incentives that lead them to use uniform coinsurance in the coverage gap and catastrophic phases.

Nearly all enhanced PDPs partially or completely eliminate the Part D deductible

The Part D actuaries we interviewed said that, after the premium, the deductible is the most important feature for many beneficiaries when choosing a PDP. Plan sponsors respond to these preferences by trying to offer plans that reduce or eliminate the deductible, and there are clear differences among the three PDP types (Table 7-5, p. 208).

All basic PDPs have a deductible, with almost all (93 percent) using the standard deductible. The actuaries we interviewed said that it is difficult to design a basic

plan that eliminates the deductible and passes the tests for actuarial equivalence. Plan sponsors may also feel less need to eliminate or reduce the deductible because many basic PDP enrollees receive the LIS, which covers any deductible. About a quarter of basic PDPs exempt certain drugs from the deductible, usually generic medications on the two lowest formulary tiers.

In contrast, virtually all enhanced PDPs exempt some drugs from their deductible or eliminate the deductible entirely. Almost all first enhanced PDPs (91 percent) have a deductible but exempt certain drugs, while a majority of second enhanced plans (61 percent) eliminate the deductible entirely. Only one enhanced PDP, offered by a national plan sponsor in all 34 Part D regions, exempts some brand drugs (those on tier 3) from its deductible.

Copayment and coinsurance amounts differ in several ways

Under a PDP's alternative benefit package, the cost sharing for each medication depends on its formulary placement. All PDPs use tiered formularies that assign the drugs they cover to distinct groups, or tiers. Each tier has its own cost-sharing requirements, with enrollees paying more for drugs on higher tiers. The goal is to encourage enrollees to use lower-cost medications by placing them on “preferred” tiers with more favorable cost sharing. Plans can also charge lower cost sharing when enrollees fill prescriptions at a preferred pharmacy.

For several years now, all PDPs have used formularies that have five tiers:

- tier 1: preferred generic
- tier 2: generic
- tier 3: preferred drug
- tier 4: nonpreferred drug
- tier 5: specialty tier

As their names suggest, tiers 1 and 2 are limited to generic drugs. However, it is worth noting that those tiers do not include every generic on the formulary. Plans can include generics on any tier, and by some measures PDPs now cover more generic drugs on the higher tiers, which are usually associated with brand

**TABLE
7-5**

In 2022, enhanced PDPs are much more likely than basic PDPs to partially or completely eliminate the Part D deductible

	Basic PDPs		First enhanced PDPs		Second enhanced PDPs	
	Number	Share	Number	Share	Number	Share
Number of plans	302	100%	285	100%	179	100%
Standard deductible (\$480)	282	93	222	78	36	20
Reduced deductible (\$1 to \$479)	20	7	36	13	34	19
No deductible	0	0	27	9	109	61
Among plans with deductibles:						
Deductible applies to all formulary tiers	224	74	1	<1	0	0
Deductible does not apply to all formulary tiers	78	26	257	100	70	100
Among plans where deductible does not apply to all tiers:						
Tier 1 drugs exempt	3	4	68	26	0	0
Tier 1 and 2 drugs exempt	75	96	189	74	36	51
Tier 1, 2, and 3 drugs exempt	0	0	0	0	34	49

Note: PDP (prescription drug plan). When plan sponsors offer one enhanced PDP in a region, we included it in the "first enhanced" category; when sponsors offer two enhanced PDPs, we included the plan with the lower overall premium in the "first enhanced" category and the plan with the higher overall premium in the "second enhanced" category. Figures do not include plans in the U.S. territories.

Source: MedPAC analysis of 2022 Part D landscape and beneficiary cost files.

drugs (Avalere 2022). Brand-name drugs are covered on tiers 3, 4, and 5. The specialty tier is used for expensive drugs that cost more than a specific dollar threshold—in 2022, \$830 for a one-month supply.

The median cost-sharing amounts for the three PDP types are shown in Table 7-6. (These figures are for a 30-day supply from a retail pharmacy.) Nearly all plans use copayments for tiers 1 and 2 and coinsurance for tiers 4 and 5. Tier 3 is a mixed case, with some plans using copayments and others using coinsurance. There are some noteworthy differences among the PDP types:

- Each PDP type has very low copayments for drugs on tier 1 (\$0 or \$1) or tier 2 (\$4 or \$6) when enrollees use preferred pharmacies. However, the median copayments differ noticeably when enrollees use

nonpreferred pharmacies: for tier 1, \$6 in basic PDPs versus \$15 in first enhanced PDPs and \$10 in second enhanced PDPs. The larger differential may help the first enhanced plans, in particular, keep their premiums low and attract a more favorable mix of enrollees.

- For preferred drugs (tier 3), basic PDPs and first enhanced PDPs have similar cost-sharing amounts (preferred copayments of \$40 or \$42; preferred coinsurance of 17 percent or 18 percent). Second enhanced PDPs have much higher cost sharing, with preferred coinsurance of 45 percent.
- For brand drugs, a key consideration is the difference in cost sharing between tier 3 and tier 4—larger differences give enrollees stronger

**TABLE
7-6**

Median 2022 cost-sharing amounts, by PDP type and formulary tier

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
	Preferred generic	Other generic	Preferred drug	Nonpreferred drug	Specialty drug
Basic PDPs (n = 295)					
Preferred pharmacy	\$1	\$4	\$40 / 17%	39%	25%
Nonpreferred pharmacy	6	11	\$47 / 20%	40	25
First enhanced PDPs (n = 279)					
Preferred pharmacy	0	6	\$42 / 18%	45	25
Nonpreferred pharmacy	15	20	\$47 / 20%	50	25
Second enhanced PDPs (n = 176)					
Preferred pharmacy	1	4	45%	50	33
Nonpreferred pharmacy	10	20	47%	50	33

Note: PDP (prescription drug plan). All figures are for a 30-day supply dispensed by a retail pharmacy. When plan sponsors offer one enhanced PDP in a region, we included it in the "first enhanced" category; when sponsors offer two enhanced PDPs, we included the plan with the lower overall premium in the "first enhanced" category and the plan with the higher overall premium in the "second enhanced" category. For tier 3 drugs, 53 percent of basic PDPs use copayments and 47 percent use coinsurance, 63 percent of first enhanced PDPs use copayments and 37 percent use coinsurance, and 100 percent of second enhanced PDPs use coinsurance. The figures for tier 1 and tier 2 do not include three basic PDPs that use coinsurance; the figures for tier 4 do not include two enhanced PDPs that use copayments. This table does not include 16 PDPs that do not use preferred pharmacies (their enrollees pay the same cost sharing at all participating pharmacies) or PDPs in the U.S. territories.

Source: MedPAC analysis of 2022 Part D landscape and beneficiary cost files.

incentives to use the preferred drugs on tier 3. Compared with basic PDPs, first enhanced PDPs have higher coinsurance for their nonpreferred drugs (45 percent vs. 39 percent in preferred pharmacies) and thus do more to encourage enrollees to use preferred drugs. For second enhanced PDPs, the calculus appears to be different. The coinsurance amounts for tier 3 and tier 4 are fairly similar (45 percent vs. 50 percent) and there is little or no incentive to use a preferred pharmacy. These plans appear to focus on giving enrollees broader access (in terms of both drugs and pharmacies), somewhat akin to the difference between a preferred provider organization and an HMO.

- For the specialty tier, CMS sets limits on cost sharing that are linked to the plan's deductible.

Plans that use the standard deductible cannot require enrollees to pay more than 25 percent in coinsurance, while plans with no deductible can charge up to 33 percent in coinsurance. Most basic and first enhanced plans use the standard deductible, so the median coinsurance amount for them is 25 percent. More than half of the second enhanced plans eliminate the deductible, so the median coinsurance amount for them is 33 percent.

Relative to basic PDPs, then, first enhanced PDPs have stronger incentives for enrollees to use drugs on preferred tiers and to obtain their prescriptions from preferred pharmacies. Second enhanced plans provide broader access to brand drugs but also have features that encourage the use of preferred pharmacies, at least for generics on the lowest tiers.

Targeted differences in plan formularies

Under Part D, each plan develops its own formulary, which details the specific drugs that the plan covers, the tier placement for each drug, and the drugs that are subject to some type of utilization management. CMS requires all formularies to meet certain minimum standards to ensure that they provide adequate coverage. For example, plans must cover at least two drugs in each therapeutic class and all drugs in six classes where access is considered especially important (immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics).

Plan sponsors typically have a separate formulary for each PDP type.⁵ We used 2022 data to see how much these formularies differ. We counted the number of drugs on each formulary based on their active ingredients. Most drugs have multiple dosage strengths, and many have multiple dosage forms, such as tablet versus injection; we gave plans credit for covering a drug if their formulary had at least one dosage strength/form with the drug's active ingredient. When plans cover multiple dosage strengths/forms of a drug, these are usually on the same tier, but there are instances when they appear on multiple tiers (for example, the tablet version could be on the preferred tier while the injectable version is on the nonpreferred tier). We assigned drugs to the lowest tier where they appear on a formulary. Finally, we classified drugs as either brand or generic using CMS's formulary reference file, which lists every drug that Part D plans can potentially cover and indicates which drugs have generic versions available.

Figure 7-3 compares the formularies for the PDPs offered by the five largest plan sponsors. There are six columns for each sponsor: The three columns on the left show the share of brand drugs covered by each PDP, and the three columns on the right show the share of generic drugs covered by each PDP. The denominator for each column is the total number of either brand drugs ($n = 572$) or generic drugs ($n = 784$) in the formulary reference file.

We found that these sponsors' basic plans cover roughly the same number of drugs—between 58 percent and 62 percent of brands, and between 76 percent and 78 percent of generics. Relative to the basic plan, a sponsor's enhanced PDPs usually cover more brand drugs, but the differences are often

relatively small. For example, the CVS Health plans cover 58 percent, 60 percent, and 61 percent of brand drugs. All five sponsors cover more generic drugs in their enhanced plans than they do in their basic plan.

These figures measure the total number of drugs covered by each PDP, and it is worth keeping in mind that their coverage for specific drugs can vary. For example, while an enhanced plan may cover more drugs than a basic plan, there may still be drugs that are covered by the basic plan but not by the enhanced plan. The number of covered drugs may also change more for some tiers than others. Even when sponsors cover more drugs in an enhanced plan, the change in the number of drugs on a favorable tier may be more limited. For example, CVS Health's second enhanced plan, SilverScript Plus, covers more brand drugs than its basic plan (348 vs. 334), but the change in the number of drugs on the preferred tier is smaller (73 vs. 69) (data not shown). The clearest example of a sponsor offering an enhanced PDP with a more generous formulary is UnitedHealth, which covers 69 percent of brand drugs and 86 percent of generics in its second enhanced plan, compared with 62 percent and 76 percent, respectively, in its basic plan. (As shown in Figure 7-2 (p. 203), this plan's premiums are also much higher than the premiums for the other plans offered by the major sponsors.)

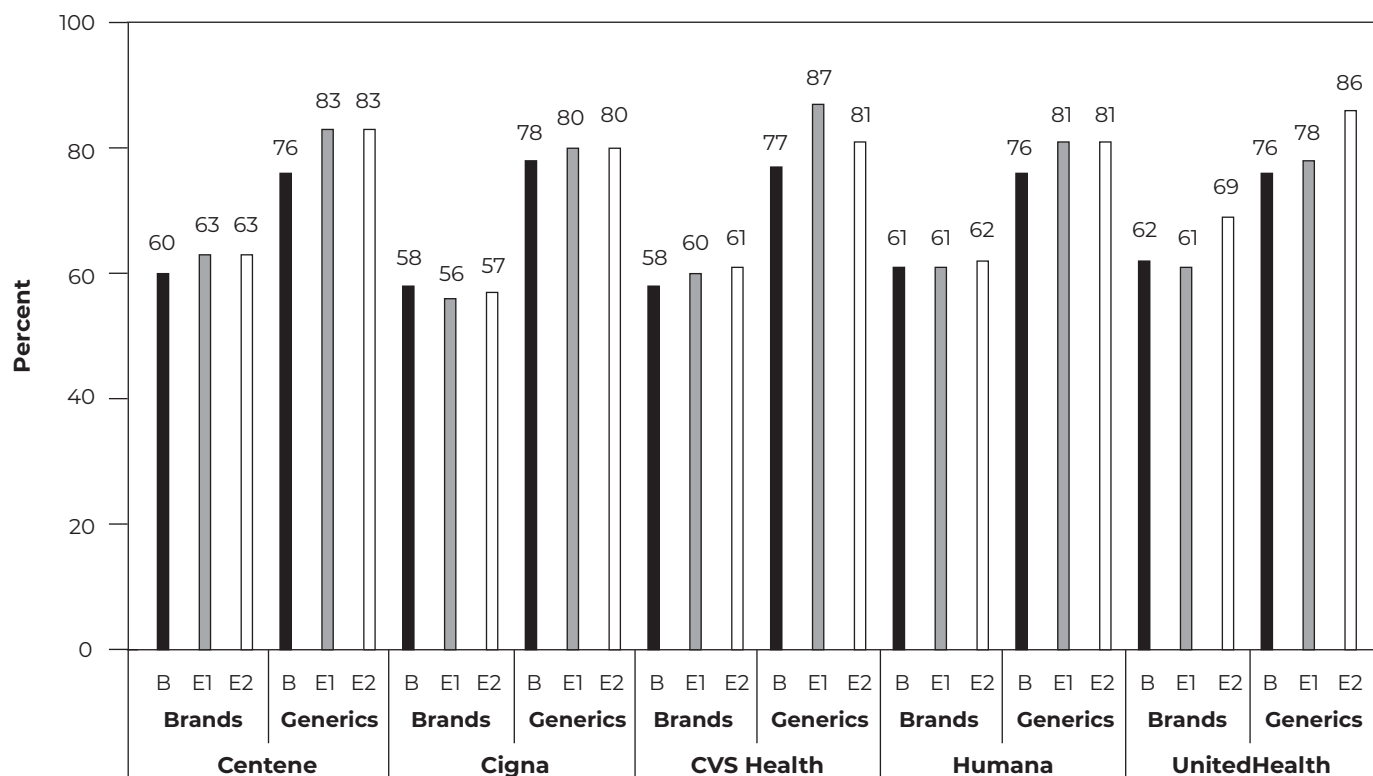
We also looked for differences across a sponsor's PDPs in the share of drugs that are subject to utilization management—quantity limits, prior authorization, or step therapy—but did not find any significant variation. When sponsors employ utilization management, they appear to do so in a reasonably consistent manner across their PDPs.

During our interviews with Part D actuaries, we asked about formulary differences across a sponsor's PDPs, particularly for the basic plan versus first enhanced plan. The actuaries said that there could be systematic differences, but these would involve a limited number of drugs and thus would be difficult to identify using broader metrics like the number of covered drugs. The actuaries pointed out two areas where formularies could differ:

- ***Adding older drugs to an enhanced PDP's formulary to satisfy the meaningful difference requirement.*** The OOPC estimates that CMS uses to measure whether plans have meaningful differences are

**FIGURE
7-3**

Share of brand and generic drugs covered in 2022 by the PDPs offered by the five largest plan sponsors



Note: PDP (prescription drug plan), B (basic PDP), E1 (first enhanced PDP), E2 (second enhanced PDP). Each plan sponsor shown in this figure offers two enhanced PDPs; we included the plan with the lower overall premium in the "first enhanced" category and the plan with the higher overall premium in the "second enhanced" category. Figures do not include plans in the U.S. territories. The denominator for these figures is the number of either brand drugs ($n = 572$) or generic drugs ($n = 784$) listed in the 2022 formulary reference file.

Source: MedPAC analysis of 2022 Part D formulary files.

based on older claims data; for example, the model used to review 2022 plan bids was based on claims data from 2016 to 2017. This lag lets sponsors get credit toward the meaningful difference requirement by adding older drugs that are no longer widely used to an enhanced plan's formulary. These changes reduce the enhanced plan's OOPC in the CMS model but may have little practical effect. So while enhanced plans tend to cover more drugs than basic plans, those differences may not always be very meaningful.

The hepatitis C treatment Sovaldi provides a good example. The drug was approved by the

Food and Drug Administration in 2013 and had a significant impact on Part D spending before being rapidly eclipsed by newer drugs. In 2016 and 2017, the years used to provide claims data for the OOPC model that CMS used to review 2022 plan bids, total spending on Sovaldi—measured at the pharmacy counter, before manufacturer rebates—was \$930 million and \$210 million, respectively. By 2020, spending on Sovaldi had fallen to \$4 million. (Only 50 beneficiaries had claims.) Nevertheless, for 2022, the five largest plan sponsors all cover Sovaldi in their first enhanced PDP but not their basic PDP.

- **Excluding a few drugs in high-spending therapeutic areas from an enhanced PDP's formulary.** Another problem with using the number of covered drugs to measure a formulary's generosity is that Part D spending is highly concentrated in a few therapeutic classes. The actuaries we interviewed said that plan sponsors can have a significant impact on a plan's projected costs by narrowing their coverage in a handful of therapeutic classes such as rheumatoid arthritis drugs, diabetes medications, and anticoagulants (blood thinners).

Anticoagulants are a case in point. Part D spending on these drugs has been very high in recent years, driven largely by two medications—Eliquis (total spending of \$9.9 billion in 2020) and Xarelto (\$4.7 billion). For 2022, the five largest plan sponsors cover both drugs on the preferred tier in their basic PDPs, but two sponsors do not cover Eliquis in their first enhanced PDP, and a third sponsor places the drug on the plan's nonpreferred tier.

The actuaries we interviewed thought the new OOPC model that will be used to review plan bids for 2023 would make the tactic of covering older drugs less effective because the new model has more current data on drug spending patterns. CMS has also discussed refining the model to account for beneficiaries switching to other drugs if their current medication is not covered; the model now assumes that beneficiaries continue to pay for their current medication on an out-of-pocket basis. This change could make it easier for plan sponsors to cover fewer drugs in their first enhanced PDPs, but it is unclear if it will be implemented. (Right now, sponsors that cover a drug in their basic PDP but not their enhanced PDP effectively pay a penalty because the model assumes that all of the spending on that drug becomes out-of-pocket spending, which makes it harder for the enhanced plan to meet the meaningful difference requirement. Under a model that accounts for drug switching, that penalty would be smaller.)

Some low-premium enhanced PDPs have smaller pharmacy networks

Some commercial health plans try to manage their drug spending by contracting with a limited network of

pharmacies that dispense medications at a lower cost. Part D does not allow PDPs to use a similar approach because all plans are required to have pharmacy networks that provide adequate access and plans must contract with any pharmacy that agrees to accept the plan's terms and conditions.

However, plan sponsors can achieve some of the same aims as a limited pharmacy network by designating some network pharmacies as "preferred pharmacies." Enrollees in these plans pay lower cost sharing when they use a preferred pharmacy (Table 7-6, p. 209). When pharmacies participate in a preferred network, they agree to make a variety of postsale payments to plans—known as pharmacy DIR payments—in return for higher prescription volume. This year, nearly all PDPs (98 percent) have a preferred pharmacy network.

We examined whether the major plan sponsors use the same pharmacy network for all of their PDPs (Table 7-7). Broadly speaking, the major sponsors' pharmacy networks are roughly similar in size, with between 60,000 and 65,000 participating pharmacies nationwide. However, the number of preferred pharmacies is more varied. Several sponsors (Centene, Cigna, Group 1001, and Rite Aid) have between 28,000 and 35,000 preferred pharmacies. CVS Health (about 23,000), UnitedHealth (about 19,000), and Humana (about 10,000) have progressively smaller preferred networks.

Although there is substantial variation in the size of pharmacy networks *across* sponsors, there appears to be less variation *within* sponsors. Many large sponsors use the same pharmacy network for all of their PDPs. However, in two notable instances, a sponsor has a smaller pharmacy network for its first enhanced PDP: CVS Health (where the number of preferred pharmacies is the same as for the basic PDP but the total number of network pharmacies is 33 percent lower) and UnitedHealth (where the number of preferred pharmacies is 54 percent lower than for the basic PDP and the total number of network pharmacies is 12 percent lower).

These findings suggest that, when it comes to pharmacy networks, the main differences in a sponsor's PDPs are the cost-sharing amounts that enrollees pay at preferred and nonpreferred pharmacies, rather than the size of the pharmacy network itself.

TABLE
7-7

In 2022, most large plan sponsors use the same retail pharmacy network for all PDPs

Plan sponsor	Plan name	Type	Network retail pharmacies		Percent difference from basic plan	
			Preferred	Total	Preferred	Total
Centene	All plans		27,940	59,880		
Cigna	Cigna Secure Rx	B	30,153	64,053		
	Cigna Essential Rx	E1	30,153	64,053	0	0
	Cigna Extra Rx	E2	31,723	65,898	5	3
CVS Health	SilverScript Choice	B	23,351	65,528		
	SilverScript SmartRx	E1	23,351	43,761	0	-33
	SilverScript Plus	E2	23,351	65,528	0	0
Group 1001	All plans		29,301	64,080		
Humana	All plans		9,508	60,847		
Rite Aid	All plans		35,406	52,696		
UnitedHealth	AARP MedicareRx Saver Plus	B	19,398	60,936		
	AARP MedicareRx Walgreens	E1	9,019	53,426	-54	-12
	AARP MedicareRx Preferred	E2	19,398	60,936	0	0

Note: PDP (prescription drug plan), B (basic PDP), E1 (first enhanced PDP), E2 (second enhanced PDP). When plan sponsors offer one enhanced PDP in a region, we included it in the "first enhanced" category; when sponsors offer two enhanced PDPs, we included the plan with the lower overall premium in the "first enhanced" category and the plan with the higher overall premium in the "second enhanced" category. Figures do not include mail-order pharmacies or plans in the U.S. territories.

Source: MedPAC analysis of 2022 Part D landscape and pharmacy files.

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

Up to this point, our analysis of plan sponsors' efforts to segment the PDP market has been mostly cross-sectional, focusing on differences among the three PDP types in a given year, usually 2022. However, the prevailing three-plan strategy also tends to follow a distinctive pattern over time.

As we have seen, the low-premium enhanced PDP plays a key role in the three-plan strategy by targeting beneficiaries who do not receive the LIS and have

low drug costs. The low premiums for these plans are their biggest selling points, but their premiums tend to increase over time. The actuaries we interviewed said that it was very difficult for sponsors to keep the premiums in these plans low over time. They noted that when sponsors first introduce low-premium plans, they can make assumptions about the expected costliness of their enrollees that turn out to be optimistic and force the plans to increase their bids and premiums in later years. They also said that even when plans do attract desirable enrollees, such as beneficiaries who do not use any drugs, those enrollees' costs often rise in later years as their health worsens and they use more medications.

These explanations attribute the growth in premiums to external forces that are beyond a plan's control, but the dynamic is also entirely consistent with studies that have found this pricing strategy is profitable for plans (Ho et al. 2017, Marzilli Ericson 2014). Those studies have observed that beneficiaries are very price-sensitive when they first select a Part D plan but rarely switch plans after that. This behavior gives sponsors an incentive to offer plans that initially have low prices and then raise those prices later, once the plan has attracted a sufficient number of enrollees. Sponsors also have an incentive to periodically introduce new low-priced plans so they can continue attracting enrollees (Marzilli Ericson 2014).

Figure 7-4 shows how this dynamic has played out in recent years for CVS Health and Humana, two of the largest PDP sponsors. The top half of the figure shows the average premium for each plan, and the bottom half shows the corresponding enrollment.

CVS Health had stopped offering two enhanced PDPs in 2014 (except following an acquisition), but it resumed offering a second plan in 2019, possibly as a result of the easing of the meaningful difference requirement. The company made two attempts to launch a second plan, and the contrast between them is instructive. In 2019, CVS Health deviated from the strategy that plan sponsors typically use by launching a plan with a substantially higher (instead of lower) premium than its existing enhanced PDP. The plan was not well received—only about 30,000 people enrolled—and it was closed at the end of the year.⁶ In 2021, the company switched gears and launched an enhanced PDP with a much lower premium (about \$7, on average). This plan has been very popular and now has about 1.2 million enrollees.

Unlike CVS Health, Humana has offered three PDPs for many years. Between 2015 and 2019, the average premium for its second enhanced PDP rose appreciably, from \$53 to \$76, and the plan's enrollment gradually declined. This behavior is consistent with the theory that sponsors will raise premiums more for established plans because their enrollees are unlikely to switch plans. The company also had a lower-premium enhanced PDP, but its enrollment growth slowed noticeably in 2018, which may have raised concerns about the potential for declining enrollment in both enhanced plans. Sponsors must notify CMS of their

intent to offer a new plan about 14 months before the start of a plan year, so the soonest the company would have been able to modify its PDP offerings to address any potential concerns was 2020. In 2020, Humana combined the two plans into a single PDP, with an average premium of \$58, and introduced a new enhanced PDP with an average premium of \$13.⁷

Note that these competitive dynamics did not apply to the companies' basic PDPs because many of their enrollees are LIS beneficiaries and sponsors cannot offer more than one basic plan.

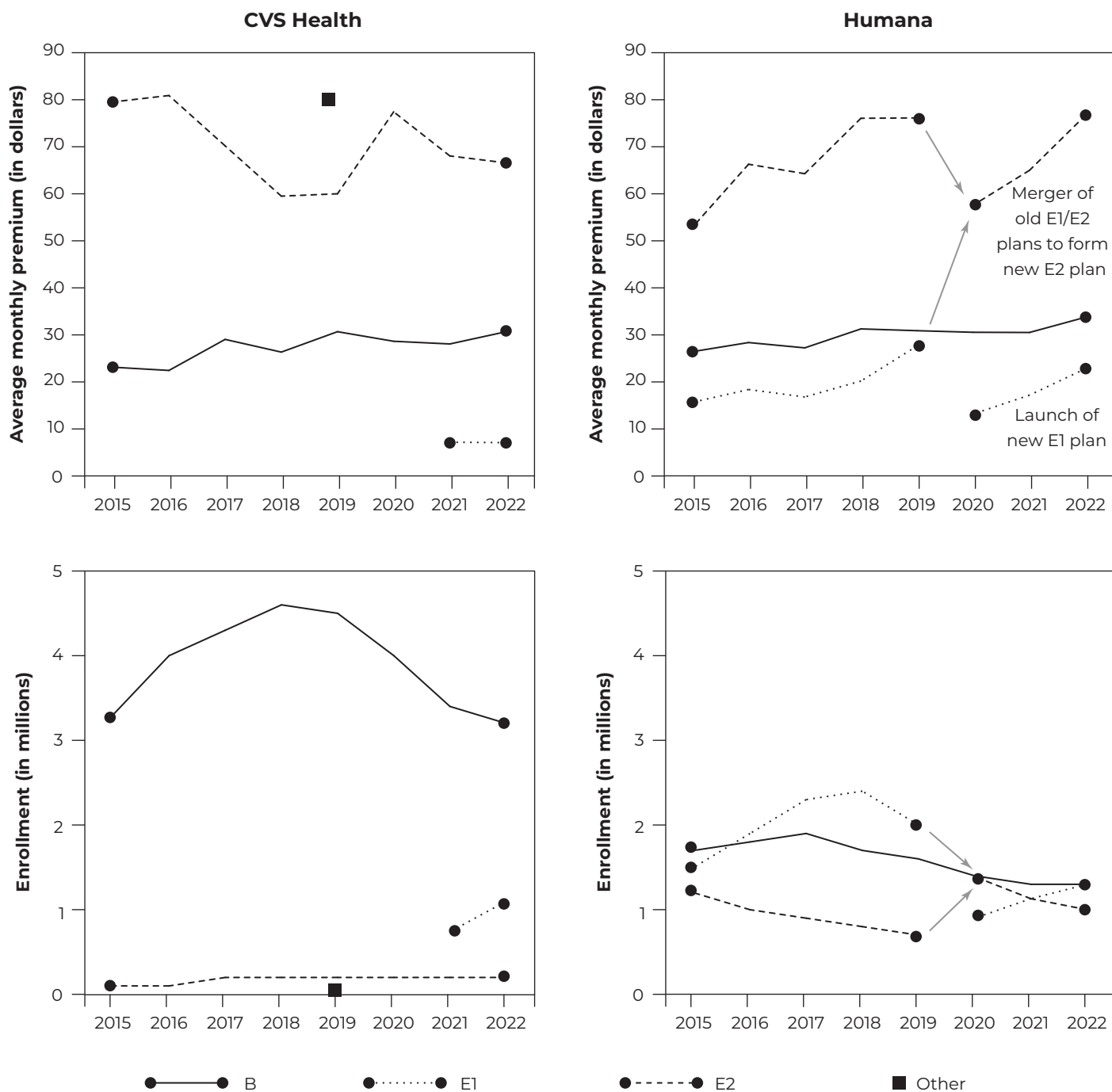
Segmentation makes PDPs more profitable for plan sponsors but has implications for beneficiaries and program spending

Our examination of the PDP market demonstrates how segmentation has been driven by a combination of policy choices and efforts by plan sponsors to differentiate their plans. These factors have led to the development of three distinct types of PDPs that each target a different part of the Medicare population:

- Sponsors use their basic PDP to target LIS beneficiaries because Part D has two features that strongly encourage these beneficiaries to enroll in basic PDPs—the LIS premium subsidy does not cover supplemental premiums and only basic plans can qualify as benchmark plans and receive auto-enrollments. LIS beneficiaries can join an enhanced PDP if they pay the supplemental premium, but only 7 percent do so. The concentration of LIS beneficiaries in basic PDPs lets sponsors use their enhanced PDPs to target beneficiaries who do not receive the LIS.
- Sponsors target beneficiaries who do not receive the LIS and have low drug costs by offering enhanced PDPs that have very low premiums and little or no cost sharing for some generic drugs (for example, by waiving the deductible and having \$0 copays for generics on the lowest formulary tiers). These plans are more tightly managed because enrollees have to pay higher cost sharing if they use a nonpreferred drug or a nonpreferred pharmacy; some plans may also cover fewer drugs in certain

**FIGURE
7-4**

Plan sponsors periodically revamp their PDP lineups so they can keep offering a low-premium enhanced plan



Note: PDP (prescription drug plan), B (basic PDP), E1 (first enhanced PDP), E2 (second enhanced PDP). When plan sponsors offer two enhanced PDPs, we refer to the plan with the lower overall premium as the "first enhanced" PDP and the plan with the higher overall premium as the "second enhanced" PDP. Premium and enrollment figures are for July of each year (2015–2021) or January (2022). Premiums for enhanced PDPs include supplemental premiums. Table does not include plans in the U.S. territories.

Source: MedPAC analysis of Part D premium and enrollment data.

key therapeutic classes or have smaller pharmacy networks. This tighter management makes it easier for these plans to collect DIR payments that lower their premiums. These plans also benefit from limitations in the enforcement of the meaningful difference requirement, the risk-adjustment system, and the bidding process.

- Sponsors target beneficiaries who do not receive the LIS and have high drug costs by offering enhanced PDPs that have high premiums but also reduce or eliminate the Part D deductible and have a somewhat broader formulary. These plans are also less tightly managed because the financial penalties (i.e., the higher cost sharing) for enrollees who use nonpreferred drugs or nonpreferred pharmacies are smaller.

For plan sponsors, this strategy for segmenting the market makes PDPs a more profitable line of business than if they did not segment. Plan sponsors want to maximize the revenue they receive for LIS beneficiaries while also offering a low-premium plan to attract other beneficiaries. There is no clear way to do this with a single PDP; efforts to achieve one goal make it harder to achieve the other goal. Covering beneficiaries with and without the LIS in separate plans lets sponsors avoid this trade-off by charging higher premiums in their basic PDPs and lower premiums in one of their enhanced PDPs. For beneficiaries without the LIS, sponsors also want to capitalize on the fact that many beneficiaries are sensitive to premiums when they first select a Part D plan but are unlikely to switch plans after that. The ability to offer two enhanced PDPs lets sponsors have a newer low-premium plan that is attractive to new Medicare beneficiaries and an older established plan where they can more easily raise premiums.

For beneficiaries, the implications are more complicated. In some ways, segmentation makes it harder for beneficiaries to understand their plan options, even with the meaningful difference requirement. The common-sense distinction between “basic” and “enhanced” plans has been lost, and it can be difficult to determine what extra benefits the low-premium enhanced PDPs provide. Nevertheless, those plans have been popular and allow many beneficiaries to pay lower premiums for their drug coverage than they might under other financing arrangements (for

example, if Part D had a standard national premium like Part B). However, beneficiaries in high-premium enhanced PDPs likely pay higher premiums than they otherwise would, and to the extent that segmentation makes PDPs more profitable for plan sponsors, aggregate beneficiary spending on premiums is higher.

For the Medicare program, segmentation (by allowing PDPs to charge higher premiums for some beneficiaries and making PDPs more profitable) increases spending for the basic Part D benefit, although the impact would be very difficult to quantify. Spending on the LIS premium subsidy is likely higher as well. When Part D was created, the expectation was that basic PDPs would have lower premiums than enhanced PDPs. Lawmakers thus tied the premium subsidy to the cost of basic coverage because the LIS covers most out-of-pocket costs and they wanted to limit program spending by enrolling LIS beneficiaries in lower-cost plans for basic coverage. The proliferation of low-premium enhanced PDPs means that the LIS premium subsidy is now essentially tied to a higher-cost plan instead of a low-cost plan.

The actuaries we interviewed did not see segmentation as a significant problem, particularly for enhanced PDPs, and were uncertain about its effect on program spending. One actuary thought that other Part D features were much more problematic—particularly Medicare’s use of cost-based payments (reinsurance) to cover 80 percent of spending in the catastrophic phase, which he thought reduced the incentives for plans to manage costs, and plan sponsors’ use of DIR payments to lower premiums instead of providing discounts at the point of sale, which he thought provided too little insurance protection to individuals with high drug costs. Another actuary thought the three-plan limit was reasonable and gave beneficiaries a good mix of choices.

Policy changes that could improve competition and limit the negative impacts of segmentation

The segmentation of the PDP market results in higher program spending and makes it difficult for beneficiaries to understand how the coverage offered by some enhanced PDPs differs from basic coverage.

**TABLE
7-8**

Illustrative examples of how more auto-enrollees could be assigned to benchmark plans with lower premiums

	Plan A	Plan B	Plan C	Plan D	Plan E
Plan premium	\$22	\$24	\$26	\$28	\$30
Share of auto-enrollees assigned to each plan:					
Current auto-enrollment process	20%	20%	20%	20%	20%
<i>Example 1:</i> Plan with lowest premium gets an extra 20% of auto-enrollments; remaining 80% divided equally	36	16	16	16	16
<i>Example 2:</i> Plans with lower premiums get progressively larger shares of auto-enrollments	30	25	20	15	10
<i>Example 3:</i> Reduce number of benchmark plans from five to four; divide auto-enrollments equally	25	25	25	25	0

Although the market is segmented in two ways (by beneficiaries' LIS eligibility and, for beneficiaries who do not receive the LIS, by drug spending), the segmentation of LIS beneficiaries into distinct plans may be more problematic because the plans that serve those beneficiaries have limited incentives to bid competitively and because the effects of segmenting beneficiaries who do not receive the LIS are mixed (benefiting some enrollees but not others). In this section, we examine some potential reforms that would address these shortcomings and could thus improve competition, but would also require policymakers to consider a variety of trade-offs.

Modify the auto-enrollment process for LIS beneficiaries

Potential reforms to the auto-enrollment process could focus on changing two key features: (1) the practice of assigning the same number of beneficiaries to every benchmark plan in a region and (2) the practice of assigning beneficiaries to basic plans only. These changes would apply to both the initial auto-enrollment of new LIS beneficiaries who have not selected a plan and the reassignment of beneficiaries when plan premiums rise above the benchmark.

Assign more LIS beneficiaries to plans with lower premiums

The practice of assigning the same number of auto-enrollees to each benchmark PDP plays a key role in discouraging those plans from bidding more competitively. At the margin, benchmark plans have no incentive to further lower their premiums because they do not receive any additional LIS enrollment in return.

Policymakers could give benchmark PDPs a stronger incentive to bid more competitively by assigning a larger share of auto-enrollees to plans with lower premiums. This change could be made in one of several ways. Table 7-8 provides three illustrative examples, using a hypothetical region with five benchmark plans. Under the existing process, each plan receives 20 percent of the auto-enrollments. This allocation is close to the current reality: In 2022, there are an average of 5.3 benchmark plans in each region, those plans receive an average of 19 percent of the auto-enrollees in their region, and more than 90 percent of plans receive between 14 percent and 25 percent.

In the first example, CMS would reserve 20 percent of the auto-enrollments for the plan with the lowest

premium and divide the other 80 percent equally among all plans. This approach would increase the share for Plan A, which has the lowest premium, from 20 percent to 36 percent and reduce the shares for the other four plans from 20 percent to 16 percent. In the second example, CMS would rank plans based on their premiums and assign progressively larger shares of the auto-enrollees to plans with lower premiums. This approach would increase the shares for Plans A and B while reducing the shares for Plans D and E. In the third example, the plan with the highest premium (Plan E) would lose its eligibility as a benchmark plan. CMS would reduce the number of benchmark plans from five to four but still divide auto-enrollments equally, which would increase the share assigned to Plans A through D from 20 percent to 25 percent.

One challenge with all three examples is that CMS might need to limit the number of PDPs that qualify as benchmark plans. (Under the current system, the number of plans is determined by the bidding process and the subsequent calculation of the benchmark.) This issue is easiest to see with example 3, which explicitly aims to reduce the number of plans relative to the current system. But it might also apply with examples 1 and 2, given the need to assign more auto-enrollees to low-premium plans to spur greater competition. For example, under example 2, selecting a smaller number of benchmark plans would allow the incremental difference in the share of the auto-enrollees going to each plan to be larger, which would give plans a stronger incentive to bid competitively. If there were four or five benchmark plans, the incremental difference could be 5 percentage points to 10 percentage points. By comparison, if there were seven plans, the incremental difference would have to be much smaller, perhaps 2 percentage points to 3 percentage points, and the shares for the last few benchmark plans (those with the sixth- and seventh-lowest premiums) would be much smaller than they typically are now, which could discourage some plan sponsors from competing to serve LIS enrollees.

If CMS limited the number of benchmark plans, the agency would need to decide whether the number of plans in each Part D region would be the same. Under the current system, the number of plans has varied both across regions and within a given region from year to year. Between 2017 and 2021, the average number of benchmark plans in each region ranged

from 2.6 in Florida to 9.4 in Arizona. Within a given region, the average difference between the largest and smallest number of benchmark plans that were offered during that same period was 3.3 plans. Selecting the same number of benchmark plans in each region could thus increase the number of benchmark plans in some regions, decrease the number in some regions, and have little impact in some regions.

Another factor to consider is the number of plan sponsors that might be interested in offering benchmark plans. As a practical matter, only seven companies currently offer these plans. (Those companies are shown in Figure 7-2 on p. 203; together, they account for 98 percent of the benchmark PDPs offered in 2022.) Selecting a small number of benchmark plans in each region, such as two or three plans, would create a stronger incentive for plans to bid competitively because each benchmark plan could receive a large number of auto-enrollees. However, policymakers would also need to consider other factors, such as ensuring that LIS beneficiaries had a reasonable number of benchmark plans available.

Changing the auto-enrollment process to reward lower-bidding plans would likely also require policymakers to develop a new method for calculating the LIS benchmarks. Under the current system, the benchmark equals the average premium for basic coverage in a region, with the premium for each plan weighted by its LIS enrollment. However, changes in the distribution of LIS enrollees across benchmark plans now have relatively little effect on the benchmark because their premiums do not vary significantly. If the reforms to the auto-enrollment process prompted plans to bid more competitively, they would put downward pressure on the benchmarks because the premiums for at least some plans would be lower and the LIS enrollment in those plans would be higher. However, this downward pressure could create an undesirable dynamic that reduces the number of benchmark plans over time.

As an illustration, consider a hypothetical region where the benchmark is \$30 and there are five benchmark plans. Given the incentives of the current system, the premiums for the benchmark plans are clustered just below the benchmark and range from \$28 to \$30. The auto-enrollment process is then modified to assign more beneficiaries to lower-premium plans, but the process for setting the benchmark stays the same. The

new auto-enrollment process spurs plans to lower their premiums to the amounts shown in Table 7-8 (p. 217), which in turn reduces the benchmark to \$28 (data not shown). Now that the benchmark is lower, Plan E no longer qualifies as a benchmark plan and its beneficiaries are reassigned to Plans A through D. The following year, this cycle might repeat itself, with the benchmark dropping again because more beneficiaries are enrolled in lower-premium plans and Plan D losing its eligibility. At the extreme, this process might continue until Plan A is the only benchmark plan left in the region, assuming no new plans enter the market.⁸

The possibility that a new auto-enrollment process might lead to this downward spiral raises the same issue we explored earlier: whether policymakers should be more explicit about the number of benchmark plans that would be chosen in each region. Under the current system, the number of plans is determined by the bidding process, although the Part D statute specifies that each region must have at least one benchmark PDP. Policymakers could increase the minimum number of plans (for example, to two or three plans) to ensure that LIS beneficiaries have multiple plans available and to help avoid, or at least limit, any downward spiral in the number of benchmark plans. Policymakers could also give CMS the authority to specify the exact number of benchmark plans that would be chosen in each region.

If the minimum number of plans were higher, CMS could continue setting the LIS benchmark equal to the average premium and then, if needed, raise that amount to ensure that a sufficient number of benchmark plans was available. For example, returning to Table 7-8 (p. 217), if there had to be at least three benchmark plans in each region and the average premium was \$25, CMS would set the benchmark at \$26, the premium for the third-lowest plan (Plan C). If CMS specified the exact number of plans that would be chosen, it could dispense with the calculation of the average premium and simply set the benchmark at the premium for the last plan that qualified.

Although assigning more auto-enrollees to plans with lower premiums would encourage plans to lower their bids, we do not know how much bids would change in response. This uncertainty makes it difficult to estimate the potential savings from changing the auto-enrollment process—and any related changes to

the benchmark-setting process—and to know which approach to rewarding lower-premium plans would generate the largest savings. Of the three illustrative approaches shown in Table 7-8 (p. 217), the concept in example 2—in which plans with lower premiums receive a progressively larger share of the auto-enrollments—is arguably the most promising because every plan would have an incentive to reduce its premium below that of its nearest competitor. Given the uncertainty about how plans would respond, policymakers could consider giving CMS flexibility to develop the specific method for assigning more auto-enrollees to lower-premium plans and to modify it as needed as the agency gains experience with the new auto-enrollment process. Changes to the auto-enrollment process could also increase the number of LIS beneficiaries who are reassigned to the new plans, at least initially, and the agency could use its existing authority to mitigate any disruption (for example, by temporarily increasing the de minimis exception for plans that narrowly miss the benchmark).

Assign LIS beneficiaries to enhanced PDPs when these plans are less expensive than basic PDPs

One way to reduce segmentation would be to change the auto-enrollment process so LIS beneficiaries are no longer assigned exclusively to basic PDPs. For example, the process could auto-enroll beneficiaries in a sponsor's lowest-cost plan, regardless of whether it is a basic PDP or enhanced PDP. This determination could be based only on the plan's premium for basic coverage because LIS beneficiaries do not need any supplemental benefits. Similarly, if LIS beneficiaries were assigned to enhanced PDPs, the plan could provide basic coverage only.

In theory, this reform would reduce segmentation by spreading the LIS population across basic and enhanced PDPs and would reduce program spending by auto-enrolling LIS beneficiaries in PDPs that often have lower premiums than basic PDPs. However, it may not work well in practice. The low-premium enhanced PDPs that are now available have low premiums partly because they manage drug spending more tightly. Features such as higher cost sharing for nonpreferred drugs and nonpreferred pharmacies would not be as effective with LIS beneficiaries because their cost sharing is limited to relatively modest copayments (in 2022, \$3.95 for a generic and \$9.85 for a brand).

In addition, to the extent that these lower-premium plans charge higher cost sharing for drugs that LIS beneficiaries use, savings from lower LIS spending on premium subsidies could be at least partly offset by higher LIS spending on cost-sharing subsidies.

As a result, the actuaries we interviewed thought the premiums for these enhanced PDPs would increase if they received LIS auto-enrollments. The actuaries thought sponsors might stop offering these plans entirely if they were unable to keep their premiums lower than those of their basic PDPs. CMS now reassigns LIS beneficiaries to new plans when their current plans lose benchmark status. If sponsors did continue offering these enhanced PDPs, their premiums might rise and fall after they gained or lost benchmark status, which could lead to a substantial increase in LIS reassignments. The savings from this reform might therefore end up being smaller than anticipated while generating instability.

Change how the requirement for plans to have “meaningful differences” is administered

The contrast between the meaningful difference threshold that enhanced PDPs must meet during the bid review process and their supplemental premiums—which can be much lower, particularly for low-premium enhanced PDPs—indicates that the current approach for measuring meaningful differences is somewhat ineffective. As discussed, CMS has made some changes to its OOPC model that make the model more accurate and will strengthen the meaningful difference requirement, and it may make further changes of this kind in the future.

Policymakers could consider other reforms as well. For example, the OOPC model estimates the difference in out-of-pocket costs for a sponsor’s basic and enhanced PDPs using a nationally representative sample of enrollees. However, the meaningful difference requirement has limited relevance for LIS beneficiaries, because the vast majority of them (more than 90 percent) are in basic PDPs and sponsors cannot offer more than one basic PDP. The requirement is much more relevant for other beneficiaries who are deciding whether to enroll in a basic PDP versus an enhanced PDP. Policymakers could thus consider excluding LIS beneficiaries from the OOPC model to make

its estimates more reflective of the population that actually enrolls in enhanced PDPs.

Another option would be to require enhanced PDPs to cover a minimum percentage of the out-of-pocket costs that their enrollees would otherwise pay for basic coverage. This approach would prevent sponsors from offering enhanced PDPs with very little additional coverage. For example, all enhanced PDPs could be required to cover at least 10 percent of beneficiary cost sharing in the deductible and initial coverage phases of the standard benefit (the parts of the benefit where enhanced PDPs now provide most of their supplemental benefits). Policymakers could also consider requiring a sponsor’s second enhanced PDP to cover a higher percentage than its first enhanced PDP, such as 20 percent instead of 10 percent. This approach could be more challenging to administer because plan bids would need to be reviewed on more of a case-by-case basis than they are now with the OOPC model, but it should still be feasible since the information that plans submit as part of their bids is highly standardized.

These changes to the meaningful difference requirement would not reduce segmentation directly; sponsors would still be able to offer three PDPs and would seek to tailor them to attract different types of beneficiaries. But these changes would help ensure that all enhanced PDPs provide some minimum additional value to the basic Part D benefit and would likely make it more difficult for sponsors to offer low-premium enhanced PDPs.

Require PDP sponsors to treat their enrollees as a single risk pool

One approach that would use changes to the Part D bidding process to effectively eliminate segmentation is an alternative that CMS discussed in a 2014 proposed rule but did not pursue further (Centers for Medicare & Medicaid Services 2014).⁹ Under this alternative, plan sponsors would be required to treat their PDP enrollees as a single bloc (or risk pool) for the purpose of providing the basic Part D benefit. (Right now, each PDP is a separate risk pool, which is why the premiums for many first enhanced PDPs, which have healthier enrollees, are often much lower.) Plan sponsors would submit one bid for their entire PDP population in a given region, which means that every enrollee would pay the same premium for basic coverage and

have the same formulary, cost-sharing rules, and pharmacy network. Sponsors would still be allowed to offer enhanced coverage, but only by providing extra benefits on top of the uniform basic coverage, somewhat akin to an insurance rider. As under the current system, enrollees would pay for the full cost of any extra benefits through a supplemental premium.

Figure 7-5 (p. 222) illustrates how this alternative would work. In this example, a hypothetical sponsor now offers three PDPs: a basic plan, a low-premium enhanced plan, and a high-premium enhanced plan. Each plan is a separate risk pool, with its own bid, formulary, cost-sharing rules, and pharmacy network. As we have seen, the formularies and cost-sharing rules for each PDP typically differ, but the pharmacy network may be the same. The mix of enrollees in each plan differs, and their premiums for basic coverage range from \$15 to \$45. The first enhanced plan has an overall premium of \$20 (\$15 for basic coverage and \$5 for supplemental benefits) and the second enhanced plan has an overall premium of \$65 (\$45 for basic coverage and \$20 for supplemental benefits).

Under the alternative, the sponsor would still offer three PDPs but treat its entire PDP population as a single risk pool for the purpose of providing basic coverage, and all enrollees would pay the same \$30 premium for basic coverage. The enhanced plans would continue to charge supplemental premiums of \$5 and \$20, respectively, but those costs would be added to the uniform \$30 premium for basic coverage, and their overall premiums for those plans would now be \$35 and \$50.

With a single risk pool, plan sponsors would no longer be able to segment the market to increase profits (or program spending). For example, putting all enrollees in the same risk pool would put downward pressure on LIS benchmarks due to the broader need for sponsors to keep their premiums competitive, and sponsors would no longer be able to raise premiums more rapidly for older enhanced plans. Although plan sponsors would have stronger incentives to manage drug spending for LIS enrollees, their ability to do so would be limited because the LIS covers most cost sharing. The Commission has on several occasions recommended making limited changes to the LIS to encourage beneficiaries to use less expensive drugs.

Most recently, our package of recommendations to redesign the Part D benefit included establishing a higher LIS copayment amount for nonpreferred and nonformulary drugs (Medicare Payment Advisory Commission 2020).

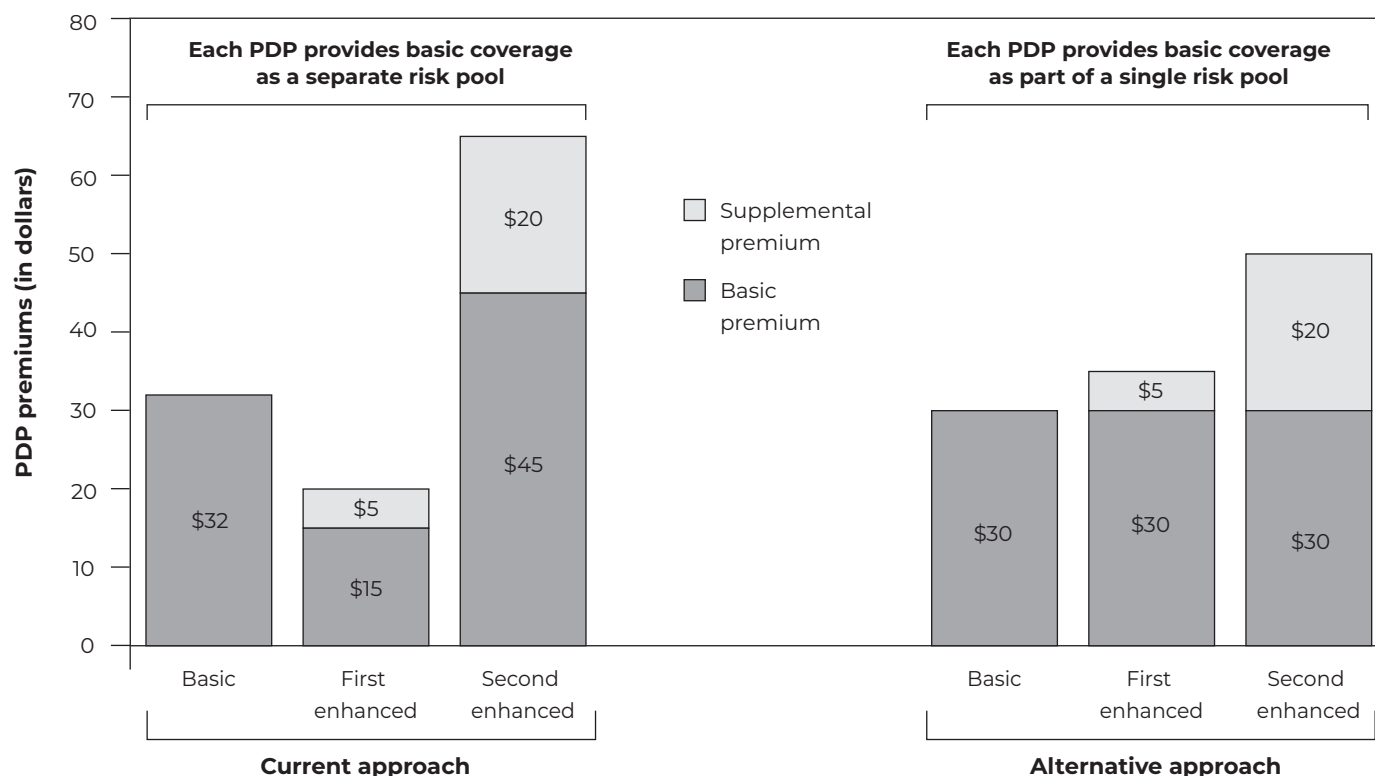
The alternative would also create a clear hierarchy where the basic PDP is always the lowest-cost option and enhanced coverage is always more expensive. This arrangement would likely make it easier for beneficiaries to understand the differences between basic and enhanced coverage and determine which plan meets their needs. Sponsors could also be required to clearly explain how the coverage they offer in their enhanced plans differs from the basic coverage they offer to all PDP enrollees.

The sponsor's premium for basic coverage under the alternative would depend on several factors. First, the share of enrollees who are in basic PDPs versus low-premium enhanced PDPs versus high-premium enhanced PDPs varies, both across sponsors (for example, in Figure 7-4 on p. 215, the share of enrollees in basic PDPs is higher for CVS Health than for Humana) and within an individual sponsor (for example, the share of enrollees in basic PDPs is higher in regions where the basic PDP qualifies as a benchmark plan and receives auto-enrollments). Sponsors would also need to determine what formularies to use for plans that serve the broader Medicare population rather than a particular segment. For some beneficiaries, such as those in high-premium enhanced PDPs, the single formulary might cover fewer drugs than their current plan; for other beneficiaries, such as those in basic PDPs, the single formulary might cover more drugs. Sponsors would need to go through a similar process to develop a single set of cost-sharing rules.

Despite these uncertainties, it seems likely that many enrollees who are now in low-premium enhanced PDPs would pay higher premiums, while many enrollees who are now in high-premium enhanced PDPs would pay lower premiums. The impact on basic PDP enrollees would probably be more variable—lower in many instances but sometimes higher. With all of a sponsor's PDP enrollees in a single risk pool, healthier enrollees would cross-subsidize sicker enrollees more extensively than they do now. However, the increase in premiums might prompt some beneficiaries with very low drug costs to consider dropping their Part D

**FIGURE
7-5**

Illustrative example of how PDP premiums would change if plan sponsors treated their enrollees as a single risk pool



Note: PDP (prescription drug plan). When plan sponsors offer two enhanced PDPs, we refer to the plan with the lower overall premium as the “first enhanced” PDP and the plan with the higher overall premium as the “second enhanced” PDP.

coverage entirely, although the program’s late-enrollment penalty would discourage this behavior.

Another source of uncertainty would be the potential impact on the LIS benchmarks that determine which basic PDPs qualify as benchmark plans. When plans lose their benchmark status, CMS reassigns the LIS enrollees in those plans to other benchmark plans to ensure that they do not have to pay a premium.¹⁰ In recent years, the number of reassignments has been low (usually affecting between 1 percent and 3 percent of the LIS beneficiaries in PDPs), but this number could increase under the alternative, at least during the first few years following the transition to a single risk pool. CMS could reduce the amount of disruption by temporarily increasing the benchmarks or the so-called

“de minimis” exception that allows plans that narrowly miss the benchmark to waive the difference and keep their LIS enrollees.

Under the alternative, policymakers could reconsider some issues raised by the existing enhanced PDPs. For example, would sponsors be allowed to offer more than two enhanced plans? Since all of a sponsor’s PDP enrollees would have the same basic coverage, policymakers could consider giving sponsors more flexibility. That said, it is unclear whether sponsors would be interested in offering more enhanced plans under the alternative, because they would no longer be able to use those plans to segment the PDP market in their favor. Would enhanced plans still be required to meet a meaningful difference requirement, and if so,

how would it be administered? Under the alternative, there may be less need for the requirement because the differences between the premiums for a sponsor's basic and enhanced PDPs would provide clearer signals about the differences in their coverage and sponsors could be required to explain those differences in their marketing materials.

The actuaries we interviewed thought relatively few beneficiaries would pay for supplemental coverage under the alternative and expressed concern about the potential for adverse selection. One actuary said that MA plans can offer optional supplemental benefits, but few beneficiaries buy them. However, adverse selection is a concern for any type of optional insurance, and

it is unclear whether it would be worse under the alternative than in the current market. For example, concerns about adverse selection likely explain why no enhanced PDPs reduce beneficiary cost sharing in the catastrophic phase of the Part D benefit. If sponsors were required to treat their PDP enrollees as a single risk pool, their basic coverage would probably have a deductible (since the actuaries we interviewed said it is difficult for basic PDPs to eliminate the deductible and still meet actuarial equivalence tests). If that happened, the experience with enhanced PDPs suggests that a significant number of beneficiaries could be interested in supplemental coverage that partially or completely eliminates the deductible. ■

Endnotes

- 1 This chapter focuses only on PDPs that are available to all Medicare beneficiaries and thus excludes employer-sponsored PDPs, which have significant enrollment (about 4.4 million in 2022) but are available only to beneficiaries who worked for the company that sponsors the plan.
- 2 The relatively high share of LIS beneficiaries without a prescription could be partly due to factors beyond those beneficiaries being in good health, such as obtaining drugs from other programs such as the Veterans Administration or a state pharmacy assistance program, or lack of access to physicians and pharmacies.
- 3 The base beneficiary premium equals 25.5 percent of the sum of the national average bid and the amount that plans project Medicare will spend on cost-based payments (known as reinsurance) for enrollees with catastrophic drug costs.
- 4 MA-PDs participate in a separate bidding process to determine their payment rates for providing the Part A and Part B benefit package. As part of this process, most plans receive MA rebates that they use to provide extra benefits for their enrollees. Sponsors can use their MA rebates to finance the cost of any enhanced Part D benefits or to cover some or all of the premium that enrollees would otherwise pay for basic Part D coverage.
- 5 For 2022, there are 28 PDP sponsors, and only 5 sponsors use the same formulary for more than one PDP type. All five sponsors are regional Blue Cross Blue Shield insurers.
- 6 The plan, called SilverScript Allure, was also unusual because it used the rebates and discounts it received from drug manufacturers to reduce beneficiary cost sharing at the point of sale. (Part D plans typically use these rebates and discounts to reduce premiums instead of cost sharing.) This difference was one reason why the plan's premiums were high, but the larger point about the challenges of introducing a high-premium plan remains.
- 7 CMS does not allow sponsors to consolidate a first enhanced PDP into a second enhanced PDP unless the enrollees in the first plan experience no reduction in benefits. This policy gives sponsors another reason to offer richer benefits in their second enhanced PDP.
- 8 It is worth noting that the benchmark is based on the premiums for both PDPs and MA-PDs, and the presence of MA-PDs in the calculation would probably dampen this dynamic to some extent. The auto-enrollment changes outlined in this chapter would apply to PDPs only and would probably not have much effect on MA-PD premiums. As a result, the MA-PD component of the benchmark might not change much, which would reduce the impact of any changes in the PDP component on the overall benchmark.
- 9 The 2014 proposed rule contained numerous proposals affecting the MA and Part D programs. The preamble to the rule outlined several options for reducing segmentation as potential topics for future rulemaking.
- 10 Reassignment applies only to LIS beneficiaries who have been auto-enrolled in a plan. LIS beneficiaries who have selected a plan on their own are not affected.

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