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Similarities between Medicare Prescription Drug Plans and Commercial Exchanges

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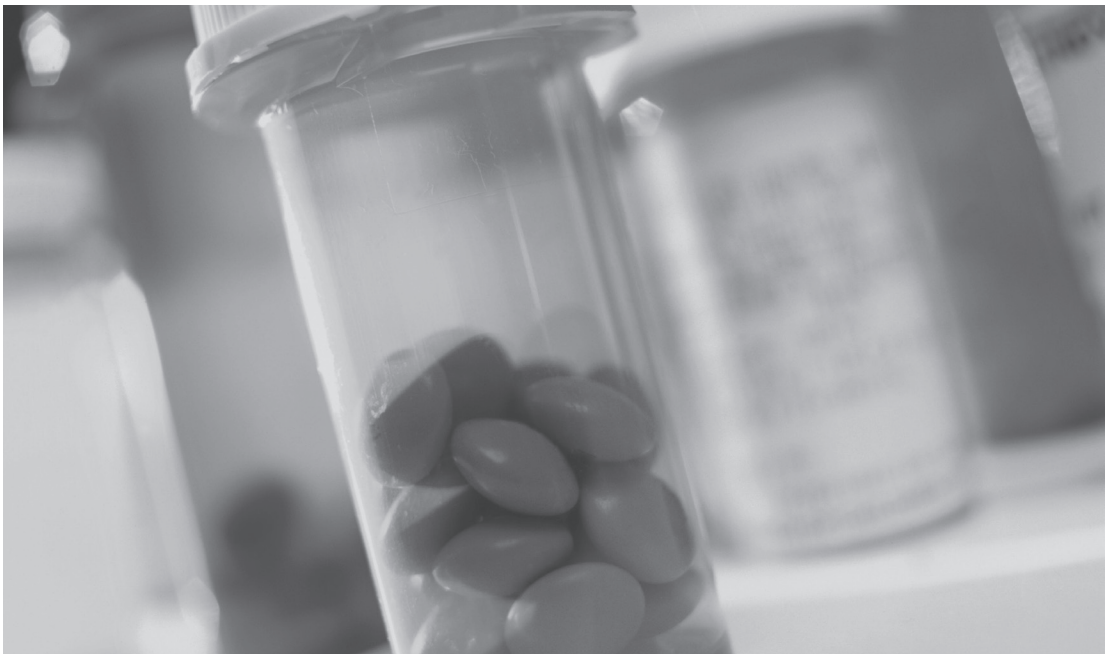

The Affordable Care Act (ACA) will change the competitive landscape of the commercial individual and small group markets. The individual market is expected to expand dramatically in 2014, when all individuals are required to obtain health coverage or pay a tax penalty. The American Health Benefit Exchanges (exchanges) included in the ACA for individuals are similar in many ways to Medicare's Prescription Drug Plan (PDP) market. The PDP market was created when the Medicare Part D benefit was launched in 2006. PDP carrier actions to date could help predict certain aspects of the exchange market.

The PDP market and commercial individual market exchanges have many similarities:

- *Online plan information and enrollment:* The Medicare Plan Finder website allows individuals to review coverage options and enroll online. Medicare prospective enrollees input their county of residence, low income status, current drugs, preferred pharmacy, and the Plan Finder ranks their choices for easy comparison. Similarly, the exchanges will provide benefit and premium options for individuals purchasing commercial coverage.
- *Mandated benefit differences:* The Centers for Medicare and Medicaid Services (CMS) requires PDP carriers to offer plans that are meaningfully different as measured by out-of-pocket costs (OOPC). Carriers offering multiple plans need to demonstrate that the OOPC differences between plans meet CMS thresholds. OOPC values for each plan are measured based on a standardized tool provided by CMS that incorporates drug formulary (the list of covered drugs and corresponding cost-sharing tiers) and plan benefits. Similarly, the exchanges will require plans to fall under different benefit tier levels (bronze, silver, gold, and platinum) based on actuarial differences between benefit plans. Again, actuarial values will be calculated based on standardized tools as opposed to actual plan experience.
- *Underwriting is prohibited:* Health status rating adjustments are not allowed in the PDP market. Health status adjustments are prominent in the individual (and small group) markets, where allowed by state regulators, but will not be permitted in the exchanges (or for any individual or small group plans as of January 2014).

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- *Risk adjustment:* PDPs submit competitive bids annually based on a standard 1.0 risk score. PDP revenue is adjusted to reflect the actual risk scores for members enrolled in the plan. Similarly, commercial premiums in the exchange will also be risk-adjusted.

- *Open enrollment:* The PDP market includes one annual open enrollment period where all individuals can change coverage or choose to stay with their existing plans by default (except for a few circumstances that permit decisions at other times). The limited open enrollment process makes it less likely that individuals will wait until they need services before purchasing coverage. While the details are yet to be clarified, the exchanges are also expected to include open enrollment periods.

The subsidization of premium is accomplished quite differently in the PDP market versus the exchange.

- *Subsidies for low-income members:* The PDP market includes varying premium and cost-sharing subsidies for low-income members based on need. Although the level of subsidy differs, there will also be low-income subsidies available in the exchanges.

- *Risk sharing:* The PDP market includes individual reinsurance and aggregate plan risk corridors to limit plan losses and gains. The exchanges will also include some form of reinsurance and risk-sharing provisions with plans to limit plan losses and gains. As the law is written, these are meant to be temporary in the exchanges. The PDP risk-sharing was also established with the potential to sunset, but CMS has chosen to carry it forward.

- *Penalties for not playing:* If individuals newly eligible for Medicare do not enroll in some form of sufficiently valuable prescription drug coverage, they must later pay penalties if and when they choose to enroll. These penalties increase their future premiums for the rest of their lives. Similarly, the exchanges will include "pay or play" penalties for individuals who choose not to purchase health insurance.

While the PDP program offers many obvious parallels, there are also some material differences:

The subsidization of premium is accomplished quite differently in the PDP market versus the exchange. In the PDP market, everyone's premium is subsidized by Medicare, but that subsidy is not necessarily understood or known because it is accomplished through risk-adjusted revenues to the carrier that allow that carrier to offer lower premiums. In the exchange market, only people with an income that is below 400 percent of the Federal Poverty Limit (adjusted for family size) are eligible for federal subsidy (and within that population, the subsidy grades down as incomes rise).

The exchanges will be competing with other commercial markets, because many individuals can obtain health insurance through their employers or purchase individual coverage outside the exchanges. By contrast, fewer employers provide Medicare Part D coverage to their active or retired employees. Also, Medicare beneficiaries can purchase drug coverage on a stand-alone basis with a PDP or included as part of a Medicare Advantage plan (MA-PD), while the exchanges will not offer stand-along drug options.

We expect the exchange plans to include more benefit variation within each category tier (bronze, silver, gold and platinum), at least where allowed by state regulation. Because PDPs cover prescription drugs only, there are fewer "levers" available for plans to differentiate products from their competitors. Also, the meaningful difference requirements for PDPs severely limit the ability of plans to introduce new products to the market without modifying existing strategies.

The PDP market includes a significant proportion of low-income members in need of assistance who are automatically assigned to PDPs if they do not voluntarily enroll in a plan that provides drug coverage. While the exchanges in some states may link Medicaid and commercial eligibility and health plan choices, Medicaid members will likely be largely outside of the exchanges in many states in 2014.

MA-PD and PDP plans offered by a given company have the same member premium for all enrollees. Although health status rating will no longer be

allowed, commercial plans in the exchange will be able to vary rates by age (limited to 3-to-1 variance for adults), tobacco use (limited to 1.5-to-1 variance), family structure (e.g., single vs. family contracts), and geographic area.

Exchange carriers can offer their products down to the county level whereas PDP service areas must cover an entire PDP region which can span multiple states and includes, at a minimum, an entire state. This coverage requirement for PDP has limited the number of PDPs. This could allow more local players to stay active in the exchanges.

Unsubsidized commercial medical plans will be much more expensive than PDP plans. As a result, commercial members may react differently to some of the market forces discussed in this article.

Consumerism observations from the PDP market

Market forces have contributed significantly to the current shape of the PDP competitive landscape. Over time, many PDP carriers have evolved into certain niches that differentiate their products. PDPs have shown significant creativity in developing benefits that are attractive, while also designed to hold down costs. It is very possible that a similar evolution will occur in the exchange markets. Members shop around for various reasons. Healthier individuals may gravitate to the lowest possible premium, while those with existing healthcare needs will likely look for plans that include their doctors and will be more interested in the details and coverage levels offered by each carrier.

Many lessons can be learned from the PDP evolution to date:

The PDP market is very consumer-sensitive. Assisted by the virtues of the Plan Finder tool, members can shop annually more easily. This environment makes the lowest premium plans, or plans with the lowest OOPC for members using drugs, stand out because the website automatically displays plans ranked by lowest to highest cost. CMS also publishes a quality score (the star rating), which is meant to reflect a carrier's overall performance on many measures and which can influence a member's choice of plan.

Implication: Even with risk adjustment, exchange carriers need to consider the influence on prospective members of information available on the exchange website. PDPs (and MA plans) take great care to match their expected risks with the potential for adverse selection. If a plan's actual risk scores do not match the anticipated risk profile, anti-selection can cause problems. With risk adjustment entering the commercial space, that means more focus on claims coding, risk selection without underwriting, and product matching to the assumed risk.

Many PDPs are affiliated with certain organizations or preferred pharmacy networks. UnitedHealthcare, for example, has its PDP products affiliated with the American Association of Retired Persons (AARP), which has proved to be a powerful marketing tool. Other popular plans showing growth in 2012, such as Humana's co-branded Walmart PDP and Coventry's Value Plus plan, include preferred pharmacy networks where members pay less out of pocket if they fill their prescriptions at preferred pharmacies. In 2013, a majority of national PDP carriers will include a preferred pharmacy network on at least one of their plans.

- *Implication:* Narrow network plans may also become more common over time in the exchange markets, particularly in metropolitan areas with competing hospital systems.

  Some PDPs have targeted the low-income subsidy (LIS) market. LIS members who do not voluntarily enroll in Part D are automatically assigned to PDPs with premiums below state-specific thresholds. Some PDP carriers have consistently submitted premiums below these thresholds and have grown largely through LIS automatic assignment. Other carriers have focused more on the non-LIS market. As a result, the LIS percentage is typically either over 80 percent or under 20

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The PDP market has been a very useful precedent for what exchange plans could evolve into.

percent for top PDP carriers, depending on their LIS and premium strategies.

- *Implication*: Some commercial plans may develop products targeting low-income members who commonly gain and lose Medicaid eligibility throughout the year as their income levels fluctuate. The exchanges could introduce new opportunities for carriers to offer improved continuity of coverage and smoother transitions for this population.

  Some PDPs offer mail order prescriptions at no cost to the member in order to steer them to mail order pharmacies that can fill prescriptions for three months at a time. Brand-name-only deductibles and low generic copays encourage the use of lower-cost generic alternatives compared to brand-name drugs. PDPs lead commercial plans in generic use rates by a significant margin. These strong incentives in the PDP market are a likely driver for this difference.

- *Implication:* Exchange plans may develop innovative ways to design benefits that reduce their costs by encouraging members to utilize cost-effective alternatives. As an example, plans may take a very close look at their drug plans and maintain limited formularies and/or maximize rebates generated by each formulary. Also, as with PDP, these new formularies may favor generic and mail order uses to further lower costs.

  Scale is an advantage in the PDP space. Mergers have been frequent and in some cases involve several hundred thousand members. The large national PDPs dominate the market.

- *Implication:* It is difficult to predict whether that theme will translate to the exchanges. It's likely that smaller players will be able to find a competitive niche in an exchange if they can optimize the advantages of being nimble.

The PDP market has been a very useful precedent for what exchange plans could evolve into. Commercial health plans would likely find it useful to talk to their Medicare leaders, or others familiar with how Medicare products have successfully grown and thrived over the last several years, in order to gain insights into their future.

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