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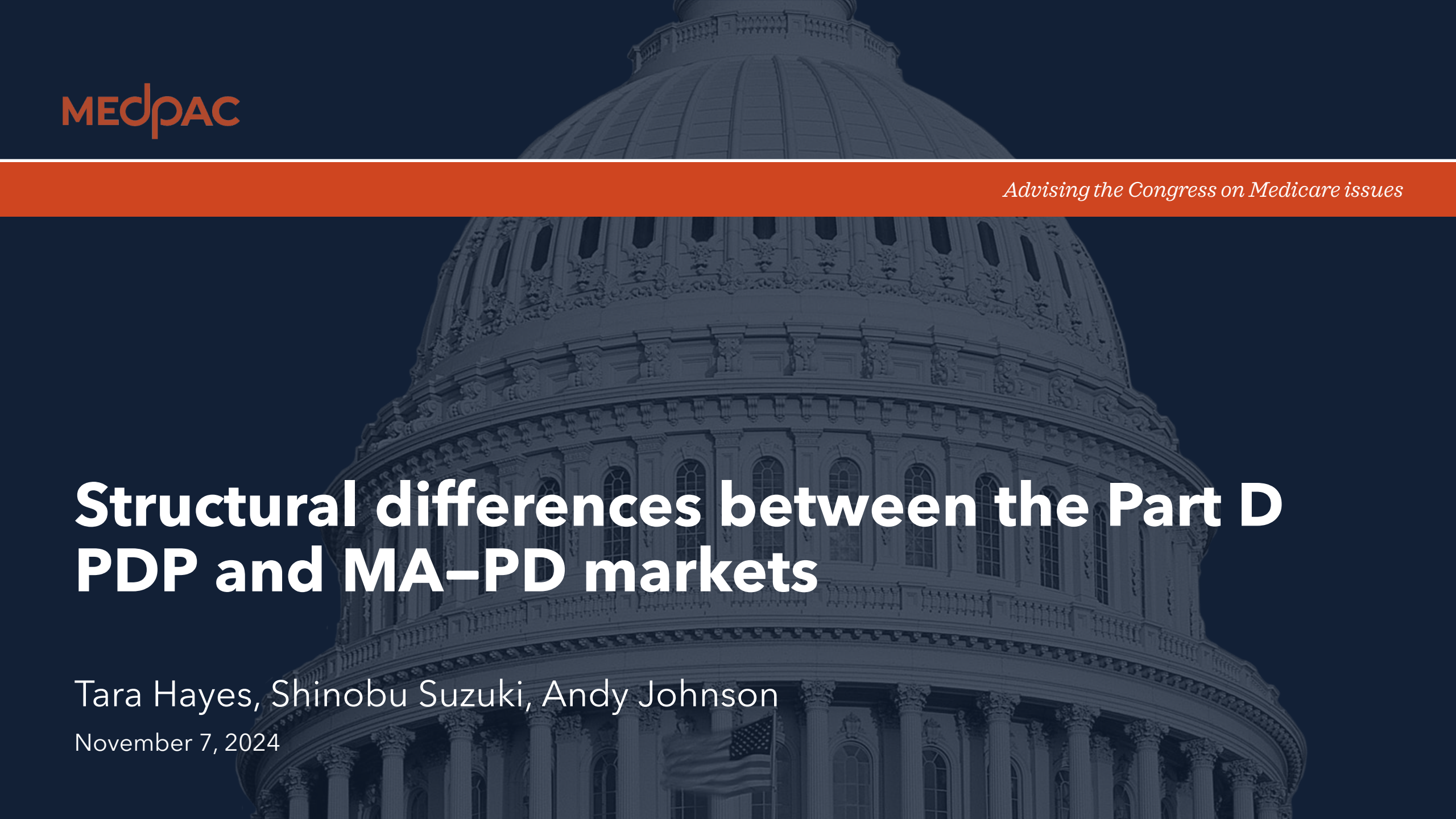


Structural differences between the Part D PDP and MA–PD markets

Tara Hayes, Shinobu Suzuki, Andy Johnson

November 7, 2024

The Part D program has evolved

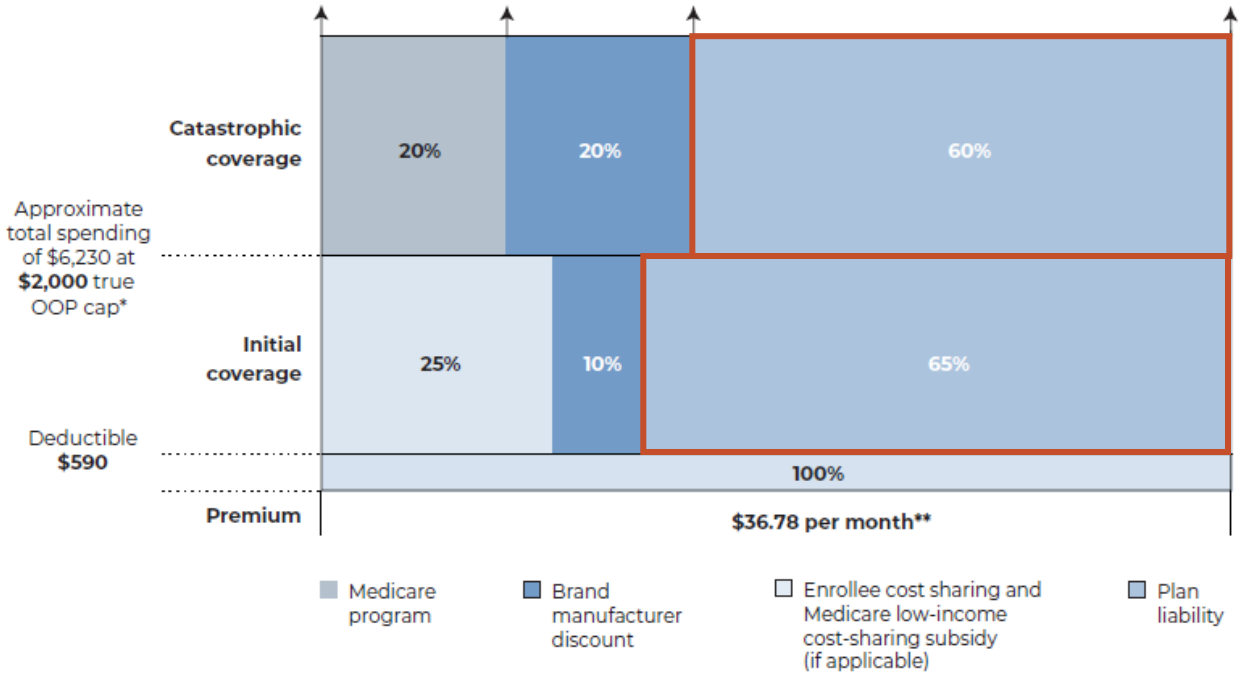
- The Part D program relies on competition among private plans
- Plans vary by premium, cost sharing, formulary, and pharmacy network
- Two distinct markets exist: stand-alone PDPs for FFS beneficiaries and combined medical and prescription drug coverage (MA–PDs) for MA enrollees
- Evolution of the two markets over time has implications for plan choice, beneficiary costs, and access to medications
- Structural differences between the MA program and FFS environment may be contributing to trends that raise concerns about the long-term stability of the PDP market

Note: PDP (prescription drug plan), FFS (fee-for-service), MA (Medicare Advantage).

Presentation roadmap

1. Part D payment system and enrollment shifts
2. Concerning trends in the prescription drug plan market
3. Structural features of the MA program that may affect PDP and MA–PD offerings
4. Changes in 2025
5. Discussion of findings and next steps

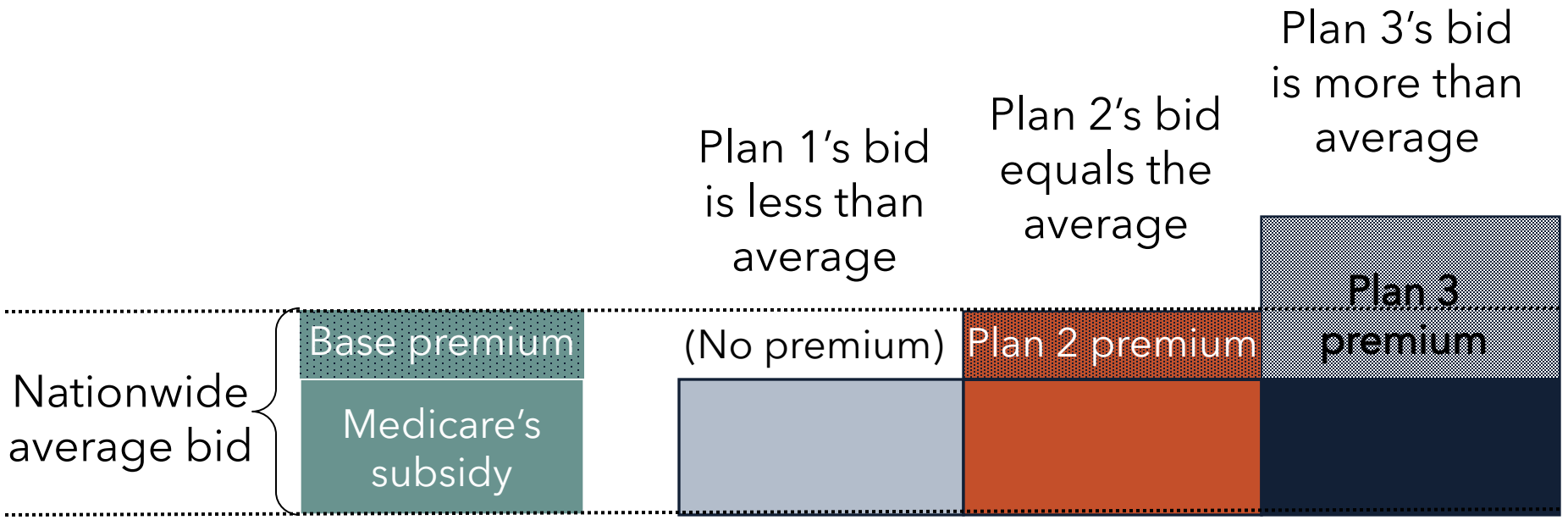
Part D defined standard benefit design, 2025



- Plan sponsors will be responsible for a majority of benefit spending above the deductible
- Medicare's subsidy of catastrophic coverage is shrinking while the program's direct subsidy grows

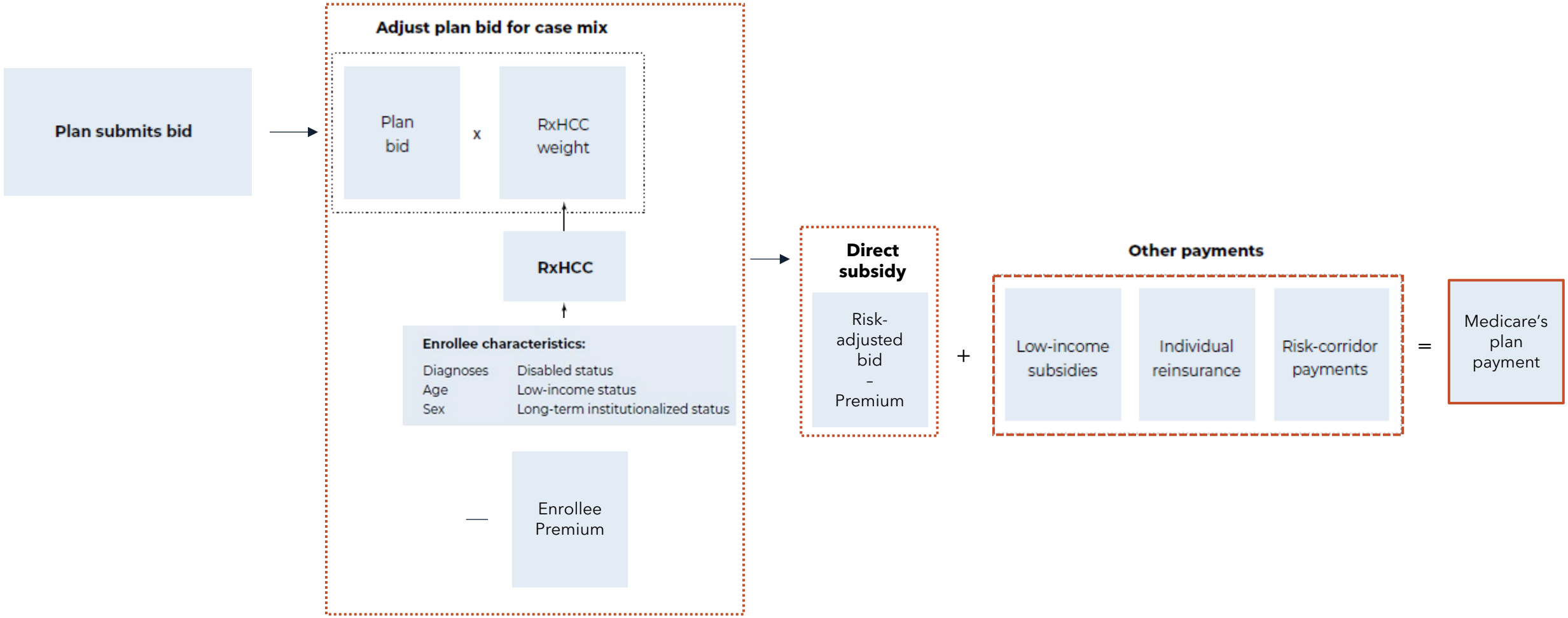
Note: OOP (out-of-pocket). This benefit structure is applicable to an enrollee who has no supplemental drug coverage and is taking a brand-name drug, biologic, or biosimilar for which a manufacturer will owe a discount under the Manufacturer Discount Program. For generic drugs, plan sponsors must cover 75% of enrollee spending between the deductible and OOP cap, and Medicare's reinsurance will pay for 40% of spending in the catastrophic phase. For enrollees with Medicare's low-income subsidy, the subsidy pays all cost sharing except nominal copayments.
* Equivalent to $2,000 in OOP spending for an individual without supplemental coverage.
** There is a base beneficiary premium of $36.78 (about $441 per year), which is less than 20% of expected Medicare Part D benefit costs per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.

Plan sponsors' bids determine enrollee premiums and Medicare subsidy



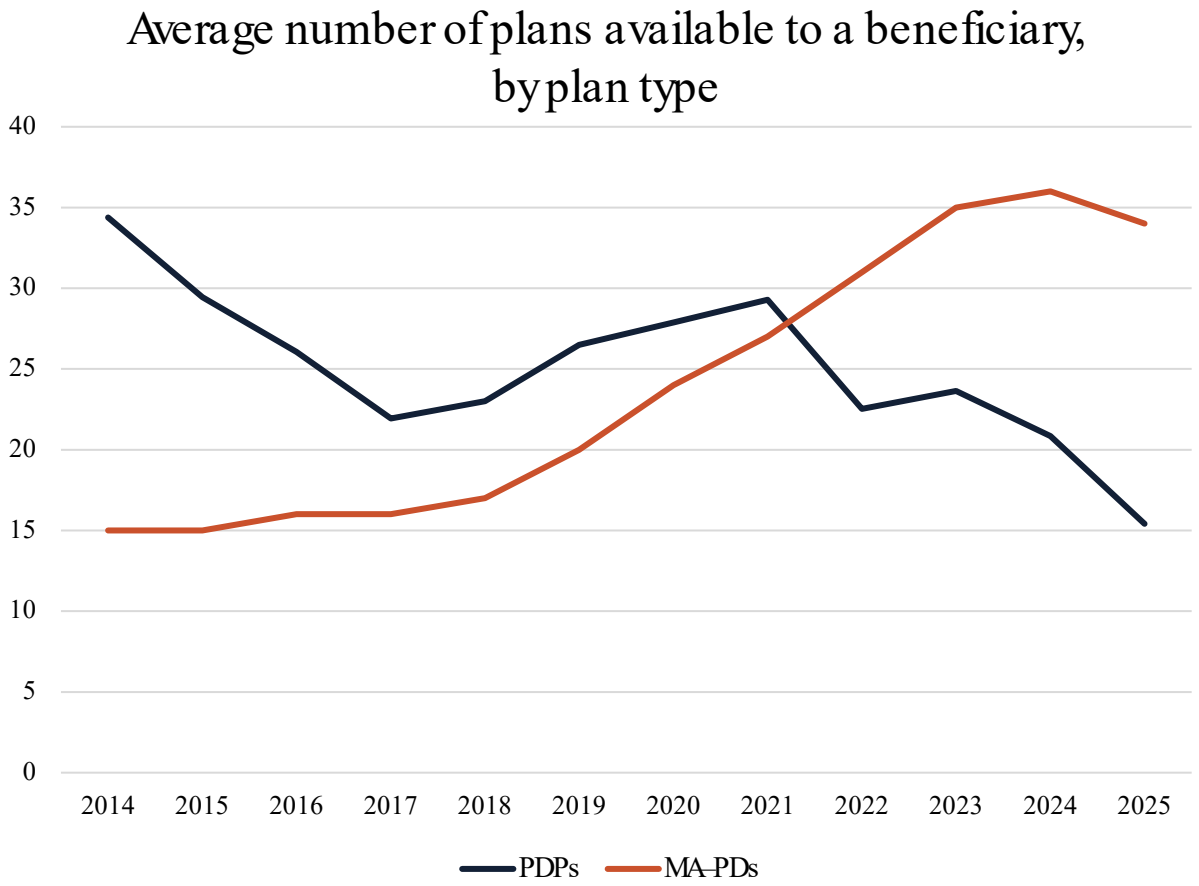
Note: MedPAC depiction of the Part D bidding process using hypothetical plans and plan bids.

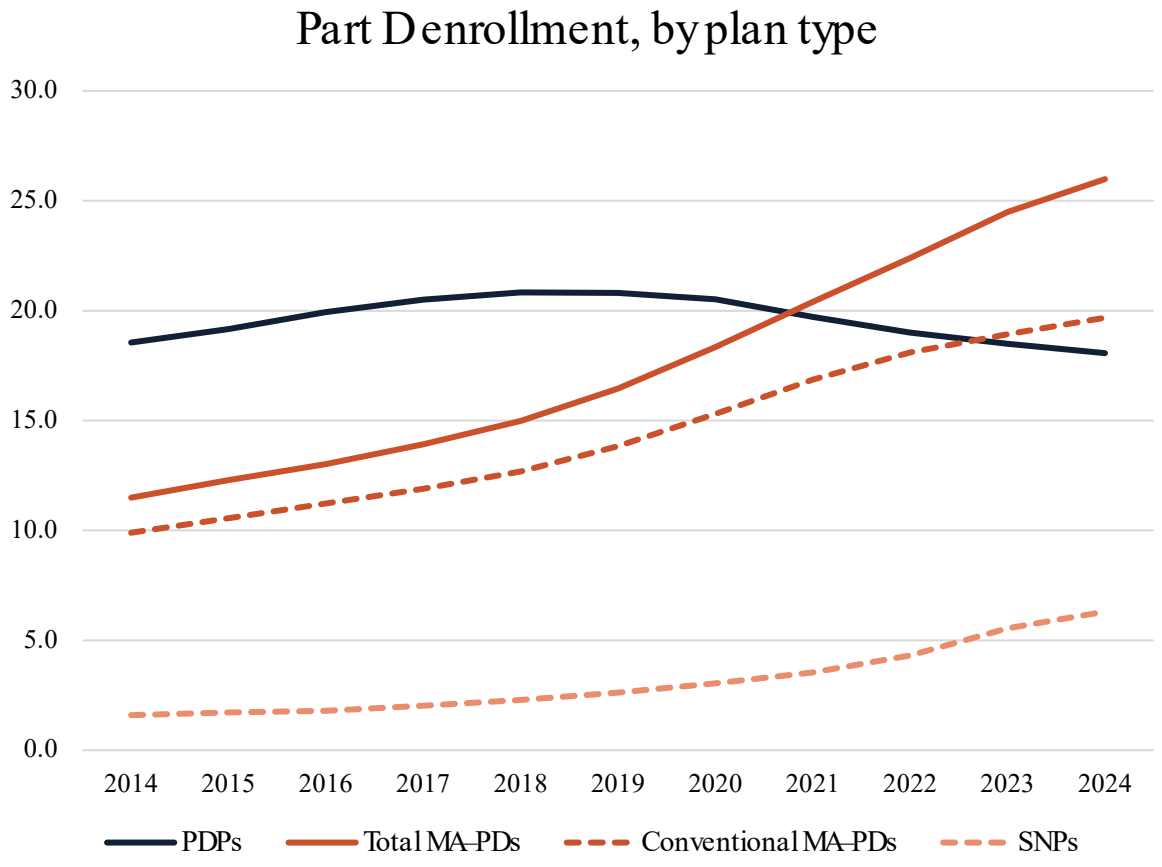
Medicare's payments to Part D plans



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster. CMS uses five separate sets of model coefficients: for enrollees in long-term institutions, aged enrollees with low incomes, aged enrollees without low incomes, disabled enrollees with low incomes, and disabled enrollees without low incomes.
* Assuming no adjustments needed to adhere to new 6% cap on annual increase in base beneficiary premium.

Plan offerings and enrollment continue to shift away from PDPs

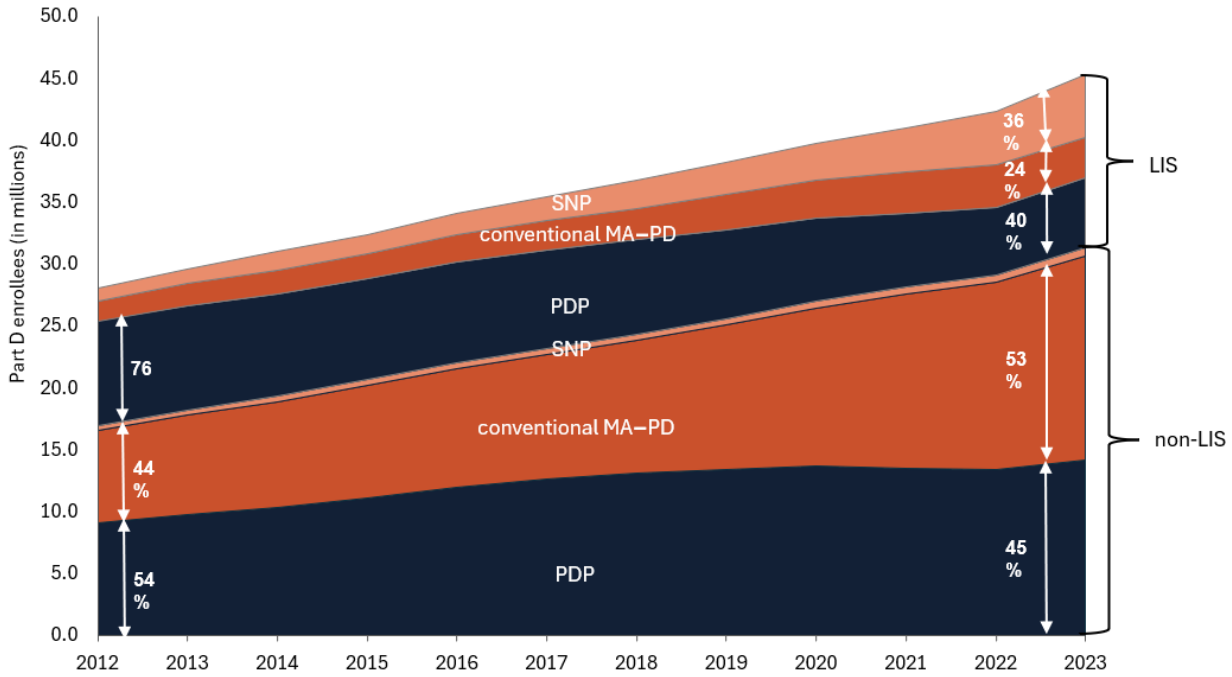




Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), SNP (special needs plan). "MA-PDs" refers to plans that are open to all MA-PD enrollees (i.e., excludes SNPs). These figures do not include individuals enrolled in employer group waiver plans.

Source: MedPAC analysis of the monthly enrollment files from CMS.

PDP market share has decreased among enrollees with and without the LIS, 2012–2023



- Non-LIS enrollment in PDPs
  - 2012: 54%
  - 2023: 45%
  - Most have moved to conventional MA–PDs
- LIS enrollment in PDPs
  - 2012: 76%
  - 2023: 40%
  - Most have moved to SNPs (particularly D–SNPs)

Note: PDP (prescription drug plan), LIS (low-income subsidy), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (special needs plan), D–SNP (dual-eligible special needs plan). Percentages shown reflect enrollees in a given plan type as a share of enrollees with and without the LIS, respectively, in 2012 and 2023 (i.e., the components add to 100% for the respective (with and without the LIS) market). SNPs accounted for 2% of enrollees without the LIS between 2012 and 2023. Analysis is based on enrollment in July of each year.

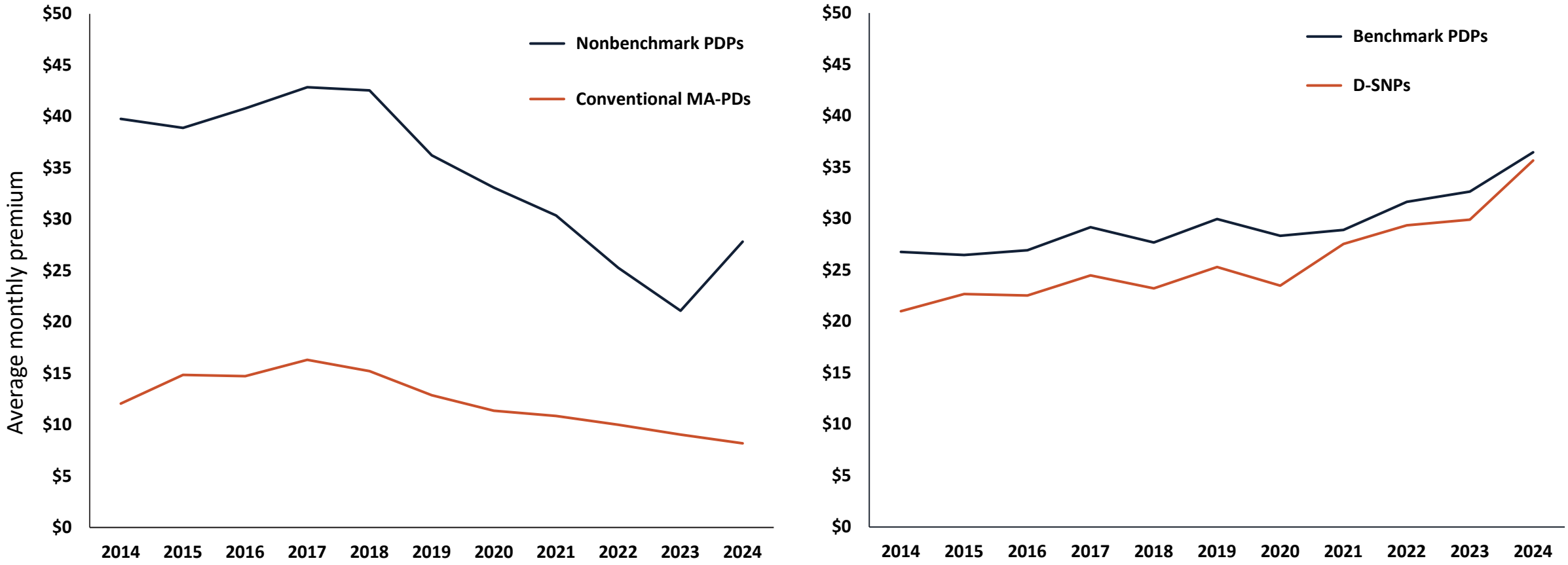
Source: CMS Common Medicare Environment files.

Stability of the PDP market is important for Medicare beneficiaries

- PDPs have a unique role in Part D:
  - Allow FFS beneficiaries to receive Part D drug coverage
  - Ensure that LIS beneficiaries have premium-free options ("benchmark plans")
- Trends that raise concerns about the stability of the PDP market:
  - Higher enrollee premiums than MA–PDs
  - Fewer PDPs qualify as premium free to LIS beneficiaries
  - Higher gross costs but lower risk scores than MA–PDs
  - More likely to incur losses than MA–PDs

Note: PDP (prescription drug plan), FFS (fee-for-service), LIS (low-income subsidy), MA–PD (Medicare Advantage–Prescription Drug [plan]).

Trend 1: Average premium charged by PDPs exceeds that of MA–PDs



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), D–SNP (dual-eligible special needs plan). Weighted by enrollment in the month of July of each year. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be over- or underestimation of benefit costs if there is an event that was not expected when the bids were prepared before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

Trend 2: Fewer PDPs qualify as premium free to beneficiaries with LIS

- Benchmark plans are PDPs with premiums at or below LIS benchmarks*
  - Premium free to LIS beneficiaries (other plans are typically not premium free because the LIS only pays for basic premium up to the benchmark amount)
  - Only plans into which LIS beneficiaries may be automatically enrolled
- Number of benchmark plans has declined over the past decade:
  - In 2025, on average, there will be 4 benchmark plans per region, down from 10 in 2014
  - In 2025, 5 regions (out of 34 regions) will have just 2 benchmark plans

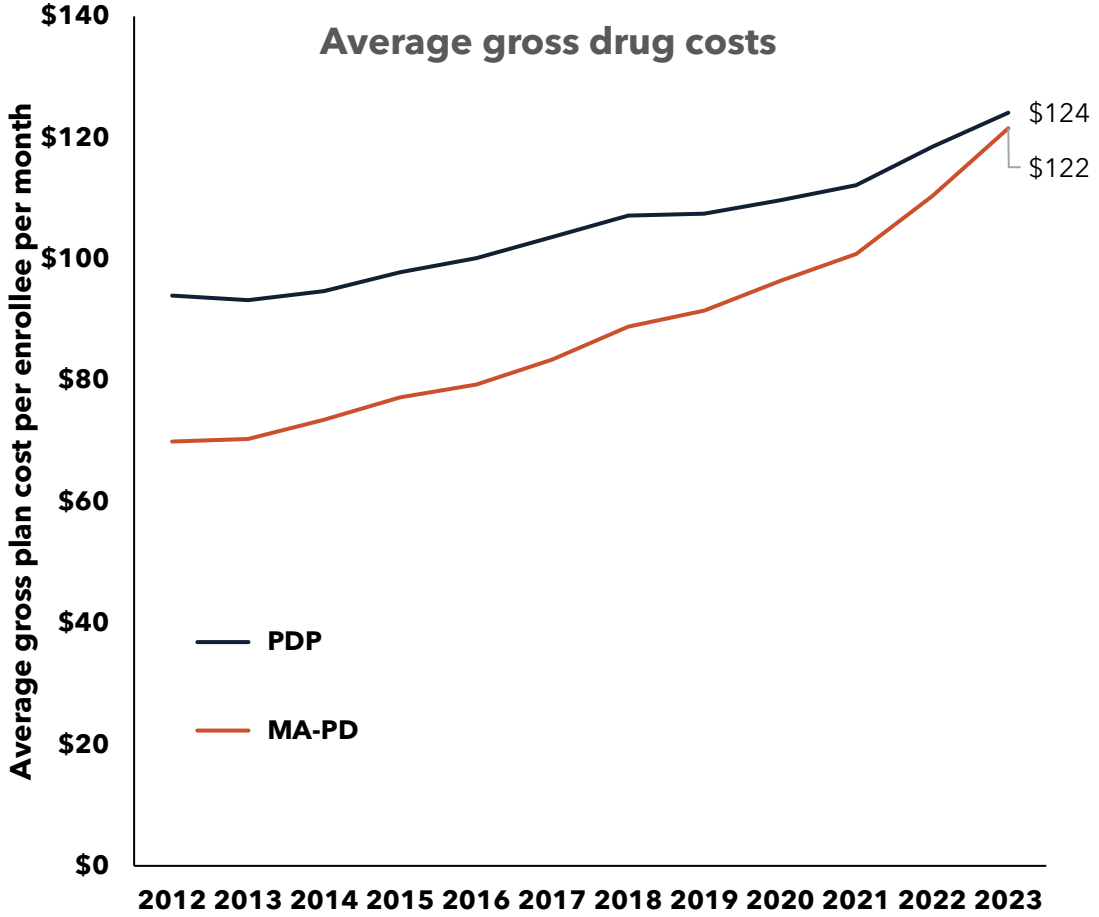
Note: PDP (prescription drug plan), LIS (low-income subsidy).
* LIS benchmarks are calculated separately for each of the 34 PDP regions using plan bids and weighted by LIS enrollment in both PDP and Medicare Advantage–Prescription drug plans.

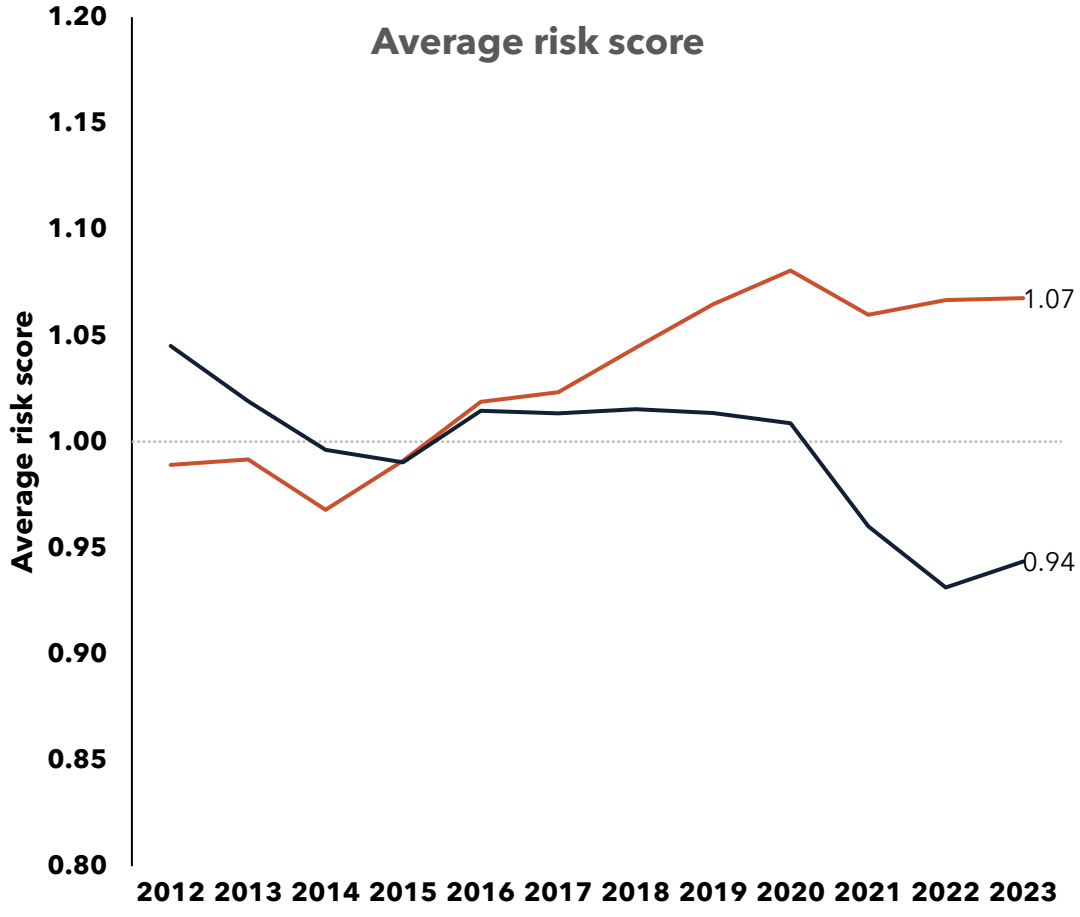
Part D's RxHCC risk-adjustment model

- Like the CMS–HCC model used in MA, the RxHCC model uses:
  - Demographic and diagnostic information to predict an enrollee's costs
  - Diagnoses grouped into condition categories (ranked into hierarchies)
  - Diagnoses from physician and inpatient & outpatient hospital records, including chart reviews and health risk assessments, in MA encounter or FFS claims data
- Substantial (82%) overlap in the diagnoses used in the two models
- Unlike the CMS–HCC model, the RxHCC model:
  - Uses *gross* drug costs, which differ from benefit costs net of rebates
  - Is normalized across *all* Part D enrollees,* so coding differences affect payment distribution across plans but do not, by themselves, have budgetary impact

Note: RxHCC (prescription drug hierarchical condition category), CMS–HCC (CMS hierarchical condition category), MA (Medicare Advantage), FFS (fee-for-service).
* The CMS–HCC model is normalized across FFS beneficiaries.

Trend 3: PDPs have higher average gross costs but lower risk scores than MA–PDs





Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). "MA–PD" includes both conventional MA–PDs and special needs plans.
Source: Part D risk-score file, prescription drug event data, and enrollment files from CMS.

Trend 4: PDPs are more likely to incur losses compared with MA-PDs

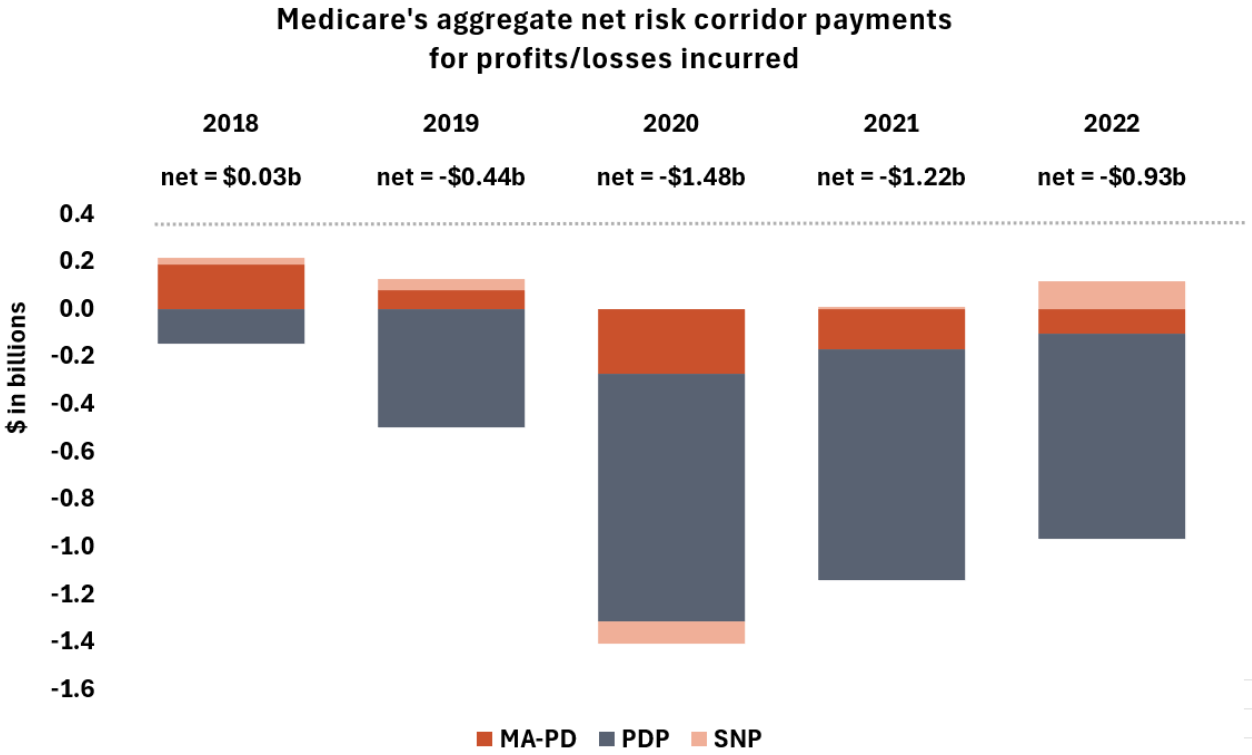
TA = plan bid – administrative costs – profit

- Symmetric risk corridors limit each plan's overall losses or profits
  - Plan incurs loss: Medicare makes a payment to plan when actual spending is greater than 105% of the plan's TA
  - Plan makes profit: Plan makes a payment to Medicare when actual spending is less than 95% of the plan's TA

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), TA (target amount). Positive amounts reflect payments from plans to Medicare (for a portion of the profits beyond the amounts assumed in bids); negative amounts reflect Medicare payments to plans to cover a portion of their losses in risk corridors.

Source: MedPAC depiction of Part D's risk corridors.

Trend 4: PDPs are more likely to incur losses compared with MA–PDs (cont.)



- Risk-corridor payments show that plans, on net, incurred losses after 2018
- Risk-corridor profits/losses do not account for profit margins included in bids
- Positive amount (net profit): Medicare's payments to plans < payments from plans to Medicare
- Negative amount (net loss): Medicare's payments to plans > payments from plans to Medicare
- Between 2018 and 2022, most of the risk-corridor payments were for losses incurred by PDPs

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (special needs plan). Positive amounts reflect payments from plans to Medicare (for a portion of the profits beyond the amounts assumed in bids); negative amounts reflect Medicare payments to plans to cover a portion of their losses in risk corridors. Excludes employer group waiver plans, Program of All-Inclusive Care for the Elderly, and demonstration plans. CMS determines whether any risk-corridor payments are due by comparing plan bids for basic benefits with actual spending.

Source: Plan reconciliation data from CMS.

Structural features of the MA program that may affect PDP and MA–PD offerings

- MA–PDs have an additional funding source (MA rebates) to enhance their Part D offerings or to buy down premiums
- MA–PDs may adjust premiums after CMS publishes national average bid and subsidy amounts to achieve their intended premiums
- MA–PDs can segment the market by enrollees' LIS status using D–SNPs that are available only to dually eligible enrollees in MA
- MA plans can document additional diagnosis codes, which may contribute to higher Part D risk scores

Note: MA (Medicare Advantage), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), D–SNP (dual-eligible special needs plan).

Structural feature #1: MA–PDs have an additional funding source (MA rebates) to enhance Part D offerings

- MA rebates have helped to keep average MA–PD premiums below those of PDPs
- MA–PDs use MA rebates to subsidize the costs of supplemental Part D benefits
- PDPs do not have any additional funding source; their bids and the full expected costs of any supplemental benefits determine enrollee premiums

Note: MA–PD (Medicare Advantage–Prescription drug [plan]), MA (Medicare Advantage), PDP (prescription drug plan).

Structural feature #2: MA–PDs may adjust premiums after CMS publishes national average amounts

- May help stabilize MA–PD premiums across years, ensure premium-free status for LIS, and maximize LIS premium revenue
- PDPs do not have this additional opportunity
- PDPs that "miss" the LIS benchmark may:
  - Lose LIS enrollees (bid too high),
  - Waive up to $2 in "excess" premiums to maintain premium-free status for LIS (bid too high), or
  - Receive lower payments (bid too low)

Note: MA–PD (Medicare Advantage–Prescription drug [plan]), LIS (low-income subsidy), PDP (prescription drug plan).

Structural feature #3: MA–PDs can segment the market by enrollees' LIS status using D–SNPs

- Enrollees with and without the LIS face different financial incentives:
  - Medicare's cost-sharing subsidy pays all or nearly all of LIS enrollees' cost-sharing liability
  - Differences in incentives may affect how plans design their formularies and benefits (e.g., D–SNPs use defined standard benefit)
- PDPs cannot perfectly segment the market (all PDPs serve both LIS and non-LIS beneficiaries)
  - Face greater challenges in balancing the need to offer an attractive benefit (e.g., with copayments) while managing spending to keep premiums low

Note: MA–PD (Medicare Advantage–Prescription drug [plan]), LIS (low-income subsidy), D–SNP (dual-eligible special needs plan), PDP (prescription drug plan).

Structural feature #4: MA plans' ability to document additional diagnoses may contribute to higher Part D risk scores

- Since 2012, the average risk score for MA–PD enrollees has risen more rapidly than for PDP enrollees
- Trends in risk scores are not consistent with the trends in gross costs
- Because the RxHCC model is normalized across all Part D enrollees, coding differences could:
  - Result in higher risk scores and payments for MA–PDs, offset by lower risk scores and payments for PDPs
  - Affect distribution of payments across plans but do not, by themselves, have budgetary effects
- In 2025, CMS is applying separate normalization factors for MA–PDs and PDPs to "more accurately reflect Part D costs in each of these two sectors"

Note: MA (Medicare Advantage), MA–PD (Medicare Advantage–Prescription drug [plan]), PDP (prescription drug plan), RxHCC (prescription drug hierarchical condition category).

Source: https://www.cms.gov/files/document/2025-advance-notice.pdf, https://www.cms.gov/files/document/2025-announcement.pdf.

Illustrative example: How coding differences may affect Part D plan bids and premiums

	Plan A	Plan B	Nationwide average
Average expected basic benefit cost (plan's share)	$50	$50	$50
Part D market share	50%	50%	100%
Average risk score	1.10	0.90	1.00
Risk standardized plan bid	$45	$56	$51
Enrollee premium	25	35	BBP = 30
Medicare's direct subsidy	25	15	21

Numbers in **black** are assumptions.
Numbers in **orange** are calculated amounts.

- Risk scores affect plan bids and enrollee premiums
  - RSPB = Expected cost / average risk score
  - Premium = BBP + (RSPB – national average bid)
- Plan A with a higher average risk score has:
  - Lower bid (RSPB)
  - Lower enrollee premium
  - Higher direct subsidy

Note: RSPB (risk-standardized plan bid), BBP (base beneficiary premium). Dollar amounts shown are per enrollee per month. RSPB is the plan's bid standardized to a 1.0 risk score. BBP is the enrollees' share of expected total benefit costs (including the individual reinsurance paid by Medicare). The remainder is paid by Medicare (direct subsidy and individual reinsurance). Figures shown in orange are rounded to the nearest whole number.

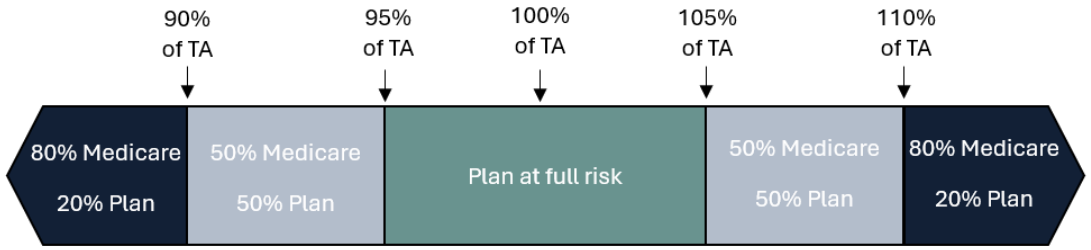
Part D redesign should improve plan incentives but may amplify the effects of structural differences

- Beginning in 2025, more insurance risk will shift to plans
  - Expected to improve plan incentives
  - Higher share of basic benefit costs will be paid on a capitated basis (direct subsidy)
  - Accurate risk adjustment will be even more important
- National average monthly bid amount for 2025:
  - Increased 179% to $179.45, up from $64.28 in 2024
  - Average direct subsidy would rise nearly 5x to ~$143, from just under $30 in 2024
  - BBP would increase by 6%, the maximum amount allowed under law, to $36.78 (without the 6% cap, BBP would be $55.98)
- CMS created the Part D Premium Stabilization Demonstration for PDPs

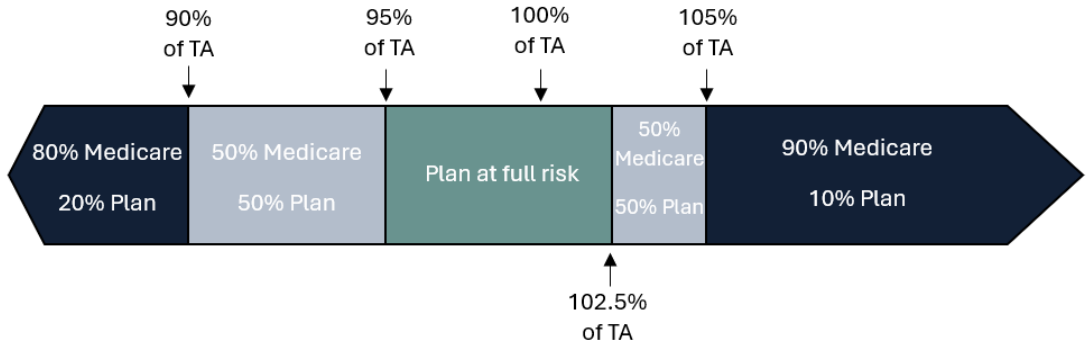
Note: BBP (base beneficiary premium), PDP (prescription drug plan).
Source: https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf.

The Part D Premium Stabilization Demonstration for PDPs

Standard risk corridors



Demonstration risk corridors



Target amount = plan bid – administrative costs – profit

- CMS implementing demo for PDPs to moderate effects of large and varied premium increases
  - $15 reduction in beneficiary premium
  - $35 cap on annual premium increase
  - More generous, asymmetric risk corridors
- Even with the additional premium subsidy, the average total Part D premium for PDPs will be higher than that of MA–PDs
- CBO estimates the demonstration will cost about $5 billion in 2025

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription drug [plan]), TA (target amount), CBO (Congressional Budget Office). "Standard risk corridor" refers to the risk-corridor structure set by statute and used for all Part D plans not participating in the Part D Premium Stabilization Demonstration.

Source: https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf, https://www.cbo.gov/system/files/2024-10/Arrington_et_al_Letter_PartD_0.pdf.

Next steps and discussion

- We plan to conduct further analyses of Part D data focused on two main areas:
  - How differential coding patterns may affect Part D risk scores
  - How different incentives and funding sources may affect the generosity of drug coverage and formulary design in the two markets
- Findings from those additional analyses will be presented in the spring
- Questions and discussion

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