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Medicare Part D Payment Demonstration Site Visit Report

Final Report

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EXECUTIVE SUMMARY

Under Medicare Part D, catastrophic coverage is provided by Medicare to limit plan liabilities and beneficiary out-of-pocket costs for prescription drugs. Catastrophic coverage begins after the beneficiary's true out-of-pocket (TrOOP) costs reach a statutory limit. In 2006, the TrOOP was set at \$3,600. Costs above the catastrophic limit are split three ways: 80 percent is paid by the government through reinsurance to the plan, 15 percent is paid by the Part D plan, and the beneficiary pays the greater of a 5 percent coinsurance or co-payments of \$2 for generic drugs and \$5 for non-generic drugs.

The Conference Report for the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 expressed concern that the structure of reinsurance might provide a disincentive for prescription drug plan sponsors to offer enhanced alternative drug coverage. Conferees suggested that the Centers for Medicare & Medicaid Services (CMS) use its demonstration authority to "allow private sector plans maximum flexibility to design alternative prescription drug coverage" (House Ways and Means, 2003). In response to these concerns, CMS launched a five-year Medicare Part D Payment Demonstration allowing plans to choose alternative payment methodologies for reinsurance. The purpose of this project is to evaluate the impact of this demonstration on beneficiaries, sponsors and Medicare program costs.

This report presents summaries of the findings from the site visit discussions with participating sponsors to better understand the reasons why the sponsors have decided to participate in the demonstration, whether they have designed the enhanced benefit for certain groups and their experiences in the demonstration.

Background

A participating prescription drug plan in the demonstration may choose one of the following three demonstration reinsurance payment options: (1) fixed capitation option; (2) flexible capitation option; and (3) MA rebate option. Demonstration plans under the fixed and flexible options "must provide a supplemental benefit that reduces or eliminates cost sharing including cost sharing in the deductible, between the deductible and initial coverage limit and/or in the coverage gap" (CMS, 2005b). The two capitation options replace the reinsurance subsidy of 80 percent of allowed costs after the beneficiary has \$3,600 in TrOOP with a capitation amount reflecting the actuarial value of that subsidy if offered under the standard benefit. The distinction between the "fixed" and the "flexible" capitation options is that catastrophic coverage is required to begin at \$5,100 of total drug expenditures for a beneficiary in the "fixed" option. The "flexible" option permits catastrophic coverage to begin at any point when the beneficiary has \$3,600 in TrOOP (CMS, 2005b,c).

The MA rebate option requires the MA plan to use rebate funds from the Part C bidding process to cover the additional cost of supplemental coverage. The supplemental benefit must fill in all or part of the standard benefit's coverage gap. This option permits the supplemental benefits that fill in the coverage gap to count toward the accumulation of the beneficiary's TrOOP. Under this option, reinsurance will be paid in a manner similar to non-demonstration Part D plans, 80 percent of allowed costs after the beneficiary has \$3,600 in TrOOP for 2006 (CMS, 2005b,c).

This demonstration will be limited to a 5-year period, 2006 through 2010. The demonstration plans participating in 2006 were generally widely available in both MA and MA-PDs regions (see Tables 1 and 2 in Section 1). The total number of PDPs offering an enhanced alternative design was 608 plans with 471 non-demonstration plans (77 percent) and 177 flexible capitation plans (23 percent), and the total MA-PDs offering an enhanced alternative design was 903 plans with 567 non-demonstration plans (63 percent), 303 flexible capitation plans (33 percent) and 33 fixed capitation plans (4 percent). There was no MA rebate plans offered in 2006.

As part of the overall demonstration evaluation, RTI conducted site visits to 10 organizations participating in the Part D reinsurance demonstration. The purpose of the site visits was to have detailed discussions with organizations about their decision to participate in the demonstration and offer enhanced Part D benefits. Additionally, site visit organizations were asked about a range of other implementation, service area selection, benefit design, marketing and enrollment issues. A range of organizations were considered for site visits, including both Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). Particularly targeted were large organizations participating in the demonstration that offered Part D benefits through both MA-PDs and PDPs.

Findings

Site visits were based on a detailed discussion protocol, which was forwarded to organizations in advance. The primary topics of the site visit discussions and the main findings were the following:

Reinsurance demonstration participation and development of demonstration products: A key element of the site visit discussions related to the impact of the reinsurance demonstration. Almost all of the organizations believed that the alternative reinsurance financing offered under the demonstration gave them the opportunity to offer a richer package of drug benefits or lower premiums than they would have been able to offer without the demonstration. Many organizations would have offered some Part D enhancements even without the demonstration financing, depending on the competitiveness of the market, although a few organizations specifically stated that without the demonstration they would not have been able to offer a Part D standalone plan with gap coverage. However, there was almost universal agreement that the demonstration allowed either “better” enhanced benefits, lower monthly premiums—or both—because of the demonstration. The majority of organizations participating in the demonstration chose the flexible capitation option, though some elected the fixed capitation option. No organizations (at least in 2006) chose the MA rebate options (a number of organizations admitted they were somewhat confused by this alternative). Organizations that chose the flexible capitation reinsurance option cited the relative ease of administration for this method. Another reason cited for the appeal of the flexible capitation option included a perception that there would be less adverse selection in using the flexible option over the fixed option because high-cost beneficiaries would choose plans with the fixed option

Design and characteristics of Part D products: A wide variation was found in the design of Part D products, with decisions based on individual organizational goals. A common thread in Part D product development was an upfront decision by organizations as to their level of interest

in the market penetration for Medicare PDPs and the MA program. The range and scope of Medicare Part D options tended to flow from this basic organization perspective. Some organizations reported that Medicare was a major organizational initiative and opportunity for them. These organizations tended to offer a wider range of product types (for example, within Medicare Advantage offering PPOs, PFFS, and HMOs, as well as expanding into standalone PDPs) and benefit packages to maximize enrollment and market penetration. Others reported a more conservative approach to Medicare. Some of these organizations reported constant pressure by parent companies to limit Medicare products. These organizations tended to offer Medicare Part D products similar to what they had offered in the past. However, a few of these more conservative organizations also decided to offer PDP products.

A key element of the design of benefit packages was the monthly premium. Organizations believed this is one of the primary focal points for potential enrollees. All organizations appeared to set the monthly premium with great care, looking particularly at how the monthly premium would position them in their respective markets. Some plans noted that specific premium levels (for example, in some markets, \$0 premiums for Medicare Advantage products) were absolutes for defining viable products. It was noteworthy that the two organizations with the richest gap coverage had markedly different premiums, one with \$0 (an MA-PD) and the other with over \$100 (a standalone PDP). Beyond premiums, strategies for defining formularies and drugs covered were also an important aspect of benefit design across all products. Most organizations with whom we spoke had closed formularies for their low option plans, meaning they have specific lists of covered and noncovered drugs. Higher-option plans often covered a broader range of drugs.

Marketing the Part D products to Medicare beneficiaries: The basic marketing approach for Part D related products varied considerably by organization. The adopted strategy tended to be decided at the organizational level, driven by marketing approaches used historically by these firms. The marketing did not vary by type of benefit or by demonstration or non-demonstration product groups. Consistent with marketing strategies used historically by Medicare Advantage firms, organizations tended to use company and descriptive trade names (such as “Senior Advantage” or “Senior Advantage Gold”) in marketing rather than terms that specifically describe the structure of the product (Medicare Advantage PPO, HMO, PFFS, etc.) or whether the product was basic or enhanced. Organizations did not report specifically marketing products as enhanced versus basic. Rather, they used trade names to convey the relative level of the benefits across the organization’s product profile.

Most organizations that offered both PDP and Medicare Advantage products described their marketing as “neutral”—that they did not push one product over another. One plan described this approach as “agnostic in product.” Large plans, who marketed large numbers of both Medicare Advantage and PDP products in many regions, also tended to develop relatively uniform product designs. This made development of marketing materials, sales approaches, and other marketing plans more streamlined. Most organizations indicated that their goal was to match the beneficiary with the best product for them. Otherwise, disenrollment rates would be too high. A few organizations, however, devoted most of their marketing resources to their Medicare Advantage products, and offered their standalone PDPs only as alternatives or for employer groups. Some organizations offering both standalone PDPs and MA-PDs had different strategies for marketing each product.

Implementation of Part D products and enhanced plans: All the organizations cited implementation and operational issues related to the first year of the Part D program. These issues, however, rarely had any relationship to the demonstration per se. Organizations told us that while the demonstration options added some complexity to the overall Part D implementation, the pressures of the program as a whole were so great that the demonstration added only one additional issue to think about. The larger organizations explained that, through their government relations activities, they were expecting something along the lines of the reinsurance demonstration, and therefore began basic planning relatively early on in their Part D implementation process. Other smaller plans seemed to become aware of the demonstration options later on, and then relied on consultants to help them adjust their benefits and bids accordingly. In reviewing the distribution of enhanced benefit plans, a number of organizations chose to offer enhanced products outside the demonstration. Demonstration participants were asked for their theories on this unexpected outcome. The most prevalent response was that, in the rush to implement the Part D program as a whole, some organizations may not have had the time or resources to address the possibility of reinsurance demonstration participation. No demonstration participating organization offered a substantive reason why it might be in the interest of insurers to offer enhanced Part D benefits outside the demonstration, unless the enhancements were only below the initial coverage limit and did not involve filling in the coverage gap.

Perspectives on Part D and the demonstration: Despite having a number of concerns and suggestions for changes in the overall Part D program, all the organizations with whom we spoke thought that Part D was a good program and an important new part of Medicare. These organizations believed that CMS has done, in general, a good job of contending with a very difficult, very aggressive implementation. Most organizations compared implementation of the Part D program favorably when compared to implementation of the programmatic changes mandated by the Balanced Budget Act of 1997.

Organizations were universally supportive of the reinsurance demonstration and, as noted earlier, thought the financing available under the demonstration allowed them to offer better enhanced benefits for lower premiums. Most organizations said they would probably have offered some form of enhanced benefits even without the demonstration, but were clear the enhancements would have been less or the premiums and cost sharing would have been higher. In our site visits, we did not find that the demonstration had any real effects on the implementation issues that arose, or the marketing and education strategies organizations used.

Overall views of early success of the demonstration were positive among the organizations visited. Most organizations thought that so far, the demonstration overall has been a success. Most of the organizations have met or exceeded their enrollment goals set before the demonstration started. However, many organizations were only cautiously optimistic with respect to the financial success of the demonstration, mainly because of more adverse selection for their demonstration products than expected. These organizations had a “wait and see” attitude with respect to the ultimate success of the demonstration.

Perspectives of non-participating enhanced plans: As part of our evaluation, we also spoke with organizations who offered enhanced Part D plans, but chose not to participate in the demonstration. There are a large number of enhanced plans offered under Part D without the

benefits of demonstration participation; this questions the necessity of the demonstration to ensuring the availability of enhanced Part D products. The non-participating organizations we spoke with primarily cited operational limitations in explaining their decision. The decision to participate in the reinsurance demonstration initially had to be made at an extremely busy time when inaugural Part D bids and product implementation plans were due. Non-participating plans said they simply did not have the resources to evaluate this demonstration option; an option that was also viewed by these organizations as somewhat complex and confusing. In addition, these organizations also raised some concerns about forgoing the opportunity to reconcile actual expenditures in calculating reinsurance payments. These organizations were somewhat concerned about the added financial risk involved in demonstration participation.

SECTION 1 INTRODUCTION

1.1 Background

The purpose of this project is to evaluate the Centers for Medicare & Medicaid Services' (CMS') Medicare Part D Payment Demonstration.¹ In 2006, the Part D defined standard prescription drug benefit, with an average premium of about \$32 per month for basic benefits, includes an annual \$250 deductible that the beneficiary is responsible for paying. Between \$250 and the initial coverage limit of \$2,250 in total prescription drug costs, the Part D plan is responsible for 75 percent of costs and the beneficiary pays a 25 percent coinsurance. Beneficiaries are responsible for all costs between the initial coverage limit and until they have reached a \$3,600 threshold in true out-of-pocket costs (TrOOP).² Catastrophic coverage begins at the attachment point or threshold of \$3,600 in TrOOP. Costs in catastrophic coverage are split three ways, with the government providing reinsurance equal to 80 percent, the Part D plan covering 15 percent, and the beneficiary paying the greater of either a 5 percent co-insurance, or co-payments of \$2 for generic drugs and \$5 for non-generic drugs.

Coverage for the prescription drug benefit is provided either through standalone prescription drug plans (PDPs), which offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA-PDs), which offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Part C of Medicare. Standalone PDPs must offer a basic prescription drug benefit, and MA-PDs must offer either a basic benefit or broader coverage for no additional cost. If this required level of coverage is offered, PDPs or MA-PDs may also offer supplemental prescription drug benefits through enhanced alternative coverage for an additional premium, or MA-PDs may use Part A & B rebate credits.

Government payments to Part D plans are made through the following four mechanisms (CMS, 2005a): (1) the direct subsidy equals the standardized bid amount, adjusted for the risk characteristics of the enrollee, minus the monthly beneficiary premium for basic benefits; (2) reinsurance subsidies are equal to 80 percent of the allowable reinsurance costs attributable to prescription drug costs after the Part D enrollee has incurred TrOOP that exceed the annual out-of-pocket threshold; (3) low-income subsidies are government payments on behalf of certain beneficiaries based on their income and asset levels that cover part or all of the premium subsidy

¹ Because the demonstration allows for a change in the Part D reinsurance payment methodology, the demonstration was originally called the Medicare Part D Reinsurance Demonstration. Thus, in this report we sometimes refer to the Medicare Part D Payment Demonstration as the "Medicare Part D Reinsurance Demonstration."

² A payment for a prescription drug will constitute an "incurred cost" and could count toward a beneficiary's TrOOP threshold only if the payment is made by or on behalf of the beneficiary. Assistance with Part D cost – sharing from a state pharmaceutical assistance program or from a charity generally will count toward the TrOOP threshold. If the beneficiary is reimbursed for the costs by insurance, a group health plan, or other third-party arrangement, the costs will not count toward the TrOOP threshold. Payments for drugs that are not included on the plan formulary also will not be counted toward the TrOOP threshold (Covington & Burling, 2005).

amount and plan cost sharing; and (4) risk sharing arrangements involve symmetrical risk corridors in which the government either pays more of plan costs or recovers payments when a plan has allowable risk corridor costs above or below a target amount by certain percentages.

1.2 Understanding of the Medicare Part D Payment Demonstration

The project focuses on evaluating the impacts of the Medicare Part D Reinsurance Demonstration. Some stated goals of a government-provided reinsurance programs include reducing health care premiums, promoting premium stability, and reducing the number of uninsured (American Academy of Actuaries, 2005). The MMA Conference Committee Agreement (House Ways and Means, 2003) noted however that “the conditions under which the government provides reinsurance subsidies may create significant disincentives for private sector plans to provide supplemental prescription drug coverage.” To illustrate the Conference Committee’s concern, assume a PDP was to offer a supplemental policy that eliminated the coverage gap in the standard benefit. The beneficiary first pays a \$250 deductible, and then 25 percent coinsurance until the attachment point for catastrophic coverage of \$3,600 in TrOOP is reached, which corresponds to \$13,650 in total drug expenditures.³ The plan in effect does not receive \$6,840 in reinsurance subsidies [$(\$13,650 - \$5,100) \times 0.8 = \$6,840$]. This illustration shows the Conference Committee’s concerns that the Part D reinsurance program provides a significant financial disincentive for plans to provide supplemental coverage, which in theory could have jeopardized beneficiary choices of, and access to, supplemental prescription drug policies. To address this concern, the Conference Committee suggested use of the Secretary’s authority to “allow private sector plans maximum flexibility to design alternative prescription drug coverage.” The Conference Committee specifically stated that “CMS should demonstrate the effect of filling in the gap in coverage by reimbursing participating plans a capitated payment that is actuarially equivalent to the amount that plans would otherwise receive from the government in the form of specific reinsurance when an individual plan enrollee reaches the catastrophic attachment point.”

As discussed above, under the Part D program, participating organizations have the options of offering basic versus enhanced benefits. There are also variants of basic and enhanced benefits. These variants of plan offerings are important in understanding the full range of options available to beneficiaries, and are an element to be considered in evaluating the impact of the reinsurance demonstration on the range and type of plan options. Among basic plan variants, the Part D **standard defined benefit** in 2006 consists of (1) a \$250 deductible, (2) 75 percent coverage (25 percent coinsurance) up to an initial coverage limit of \$2,250 in total drug costs, (3) a gap in the coverage in which there is no coverage, and (4) a catastrophic benefit of 95 percent coverage once out-of-pocket spending of \$3,600 has been incurred. Sponsoring organizations also had the flexibility to offer an actuarial equivalent benefit to the standard defined benefit. The two types of actuarial equivalent plans are (1) standard coverage with **actuarially equivalent**

³ For the standard benefit in 2006, the beneficiary first pays a \$250 deductible, and then 25 percent coinsurance until the initial coverage limit of \$2,250 in total drug costs is reached, and the beneficiary has no coverage until the attachment point for catastrophic coverage of \$3,600 in TrOOP is reached. Under the standard benefit, \$3,600 in TrOOP corresponds to \$5,100 in total drug expenditures assuming the beneficiary had no source of other coverage.

cost sharing and (2) **basic alternative coverage**. “Actuarially-equivalent” plans have a similar overall structure to the defined standard benefit, but the cost sharing differs from the 25 percent coinsurance under the standard defined benefit. These actuarially-equivalent plans might have tiered co-payments of a low dollar amount for a generic drug and higher amounts for preferred brand-name drugs and for nonpreferred brand-name drugs. Under the basic alternative coverage model, plans have a different overall structure of the benefit, though they must be actuarially equivalent to the standard benefit. In this basic alternative coverage design, features such as a reduction in the deductible, changes in cost-sharing, and a modification of the initial coverage limit can be combined and still provide coverage with an actuarial value equal to standard coverage.

In addition to the standard defined benefit and its two actuarial equivalent variants, PDPs and MA-PDs were also able to offer **enhanced alternative** prescription coverage that exceeds standard coverage by offering supplemental benefits such as an increase in the initial coverage beyond the standard \$2250 in total drug costs. On February 25, 2005, CMS announced in the Federal Register (Vol. 70, No. 37) the opportunity to participate in the Part D Payment Demonstration. The primary goal of the demonstration is to increase the number of offerings of supplemental benefits through these enhanced alternative coverage plans. The Instructions for the Part D Payment Demonstration (CMS, 2005b,c) provide an overview of the design of the demonstration, including a description of the following three demonstration options: (1) fixed capitation option; (2) flexible capitation option; and (3) MA rebate option. Demonstration plans under the fixed and flexible options “must provide a supplemental benefit that reduces or eliminates cost sharing including cost sharing in the deductible, between the deductible and initial coverage limit and/or in the coverage gap” (CMS, 2005b). All PDPs and MA-PDs are eligible to participate in certain options with the exception of the following: Program of All Inclusive Care for the Elderly (PACE), MA-PD employer only plans, and employer direct contract plans. This demonstration will be limited to a 5-year period, 2006 through 2010.

Generally, under the reinsurance demonstration, the capitation options replace the typical reinsurance subsidy of 80 percent of allowed costs after the beneficiary has \$3,600 in TrOOP with a capitation amount reflecting the actuarial value of that subsidy if offered under the standard benefit. The distinction between the “fixed” and the “flexible” capitation options is that catastrophic coverage is required to begin at \$5,100 of total drug expenditures for a beneficiary in the “fixed” option. The “flexible” option permits catastrophic coverage to begin at any point when the beneficiary has \$3,600 in TrOOP. Thus other things equal, plans would tend to have less risk under the flexible option than under the fixed option⁴, and beneficiaries with chronic, high-cost utilization of prescription drugs would tend to choose the fixed option over the flexible option. For MA plans that use rebate funds from the Part C bidding process to cover the additional cost of supplemental coverage, the MA rebate option permits supplemental benefits

⁴ With the fixed option, catastrophic coverage begins at \$5,100 total drug spending and plans are liable for 95 percent of drug costs from that point (the beneficiary pays 5 percent). With the flexible option, catastrophic coverage begins at a higher level of total beneficiary drug spending; below the catastrophic level, plan benefit designs are such that they are generally liable for less than 95 percent of drug costs.

that fill in the coverage gap to count toward TrOOP. In this option, reinsurance will be paid in a manner similar to non-demonstration Part D plans (CMS, 2005b,c).⁵

The overall evaluation will examine the impact of the demonstration on beneficiaries, drug plan sponsors (PDPs and MA-PDs) and Medicare program costs. From the beneficiary perspective, the evaluation will focus on the availability of, and enrollment in, enhanced alternative benefit packages offered by drug plan sponsors, as well as patterns of utilization of enrollees. The evaluation will also explore the advantages and disadvantages of participation from the perspective of drug plan sponsors (Federal Register, Vol. 70, No. 37).

Tables 1 and 2 show the overall distribution of Part D reinsurance demonstration participants in both MA and PDP regions in 2006. In general, these tables show that demonstration plans (and therefore enhanced Medicare Part D benefit packages) were generally widely available, though the number of options differed somewhat across different geographic areas in 2006. The exception was the availability of MA-PD demonstration plans in MA regions 1 (ME and NH), 2 (CT, MA, RI, VT), and 26 (AK). Only MA region 26, however, has no enhanced plans of any type (demonstration or non-demonstration). The fixed capitation plans were not offered by any of the PDPs.

Table 1
Regional distribution of Prescription Drug Plans (PDPs)

Counts of plans		Basic benefit plan			Enhanced alternative plans		
PDP region	States	Defined standard	Actuarial equivalent	Basic alternative	Non-demonstration	Demonstration Flexible capitation	Demonstration Fixed capitation
	Nationally	132	309	380	431	177	0
1	ME, NH	3	10	11	14	3	0
2	CT, MA, RI, VT	3	9	13	14	5	0
3	NY	8	7	14	12	5	0
4	NJ	6	9	12	12	5	0
5	DE, MD, D.C.	5	12	11	14	5	0
6	PA, WV	6	10	13	16	7	0
7	VA	4	10	10	12	5	0
8	NC	4	8	10	11	5	0
9	SC	7	10	11	12	5	0
10	GA	5	9	11	11	6	0
11	FL	4	8	11	14	6	0
12	AL, TN	7	8	9	12	5	0
13	MI	4	9	11	11	5	0
14	OH	5	9	10	13	6	0
15	IN, KY	4	9	10	13	6	0

(continued)

⁵ Demonstration plans must also offer a basic coverage plan, and MA-PDs choosing one of the capitated options are under the same requirement, but they may buy down all or part of the additional premium with Part A/B rebate dollars.

Table 1 (continued)
Regional distribution of Prescription Drug Plans (PDPs)

Counts of plans		Basic benefit plan			Enhanced alternative plans		
PDP region	States	Defined standard	Actuarial equivalent	Basic alternative	Non-Demonstration	Demonstration Flexible capitation	Demonstration Fixed capitation
16	WI	2	10	11	16	6	0
17	IL	4	8	12	13	5	0
18	MO	3	9	10	13	6	0
19	AK	3	9	10	13	5	0
20	MS	3	8	10	12	5	0
21	LA	3	8	11	12	5	0
22	TX	5	10	13	14	5	0
23	OK	2	10	11	14	5	0
24	KS	2	9	10	13	6	0
25	IA, MN, MT, NE, ND, SD, WY	4	9	11	11	6	0
26	NM	3	8	13	14	5	0
27	CO	3	9	11	14	6	0
28	AZ	3	10	13	12	5	0
29	NV	4	10	11	13	6	0
30	OR, WA	4	11	13	12	5	0
31	ID, UT	4	11	11	13	5	0
32	CA	4	10	14	13	6	0
33	HI	1	7	9	9	3	0
34	AK	0	6	9	9	3	0

NOTES: Counts of plans do not include employer only plans (800 series) and plans that were missing any geographic variable markers in the HPMS data set. Counts of plans also exclude plans offered only in U.S. territories. Columns of plan types may not add to the national total as some local plans may be offered in more than one region.

Source: RTI analysis of 2006 CMS Health Plan Management System (HPMS) Data

Table 2
Regional distribution of Medicare Advantage Prescription Drug Plans (MA-PDs)

Counts of plans		Basic plan benefits			Enhanced alternative plans		
MA region	States	Defined standard	Actuarial equivalent	Basic alternative	Non-Demonstration	Demonstration	Demonstration
						Flexible capitation	Fixed capitation
	Nationally	242	150	344	567	303	33
1	ME, NH	0	0	1	4	0	0
2	CT, MA, RI, VT	7	9	37	33	0	0
3	NY	39	22	33	68	6	2
4	NJ	1	10	2	7	16	0
5	DE, MD, D.C.	1	4	12	2	15	0
6	PA, WV	37	5	73	38	20	8
7	VA, NC	4	4	10	12	10	0
8	GA, SC	7	9	16	12	10	0
9	FL	19	19	19	170	38	0
10	AL, TN	12	1	20	18	6	0
11	MI	5	2	4	21	9	0
12	AL, TN	4	10	8	21	18	0
13	OH	2	4	0	13	8	0
14	IN, KY	13	7	19	20	16	4
15	AR, MO	4	5	7	13	13	0
16	LA, MA	10	4	3	5	16	0
17	TX	14	4	8	16	19	0
18	KS, OK	4	2	5	4	10	0
19	IA, MN, MT, NE, ND, SD, WY	14	7	18	13	6	1
20	CO, NM	4	2	19	15	11	0
21	LA	9	4	9	9	14	0
22	AZ	2	0	3	2	7	4
23	NV	16	20	9	16	13	2
24	CA	13	5	31	46	26	10
25	HI	2	2	2	7	0	2
26	AK	0	0	0	0	0	0

NOTES: Counts of plans do not include employer only plans (800 series) and plans that were missing any geographic variable markers in the HPMS data set. Counts of plans also exclude plans offered only in U.S. territories. Columns of plan types may not add to the national total as some local plans may be offered in more than one region.

SOURCE: RTI analysis of 2006 CMS Health Plan Management System (HPMS) Data

1.3 Purpose of this Case Study Report

As part of the overall demonstration evaluation, RTI conducted site visits to 10 organizations participating in the Part D reinsurance demonstration. The purpose of the site visits was to have detailed discussions with organizations about their decision to participate in the demonstration and offer enhanced Part D benefits. We also asked site visit organizations about a range of other implementation, service area selection, benefit design, marketing and enrollment issues. A range of organizations were considered for site visits, including both PDPs and MA-PDs. We particularly targeted large organizations participating in the demonstration that offered Part D benefits through both MA-PD and PDPs. Site visits were based on a detailed discussion protocol, which was forwarded to organizations in advance. A copy of this protocol is attached as Appendix A to this report. The main topics of the site visit discussions were the following:

- Reinsurance demonstration participation
- Design and characteristics of Part D products
- Marketing the Part D products to Medicare beneficiaries
- Implementation of Part D products and enhanced plans
- Perspectives on Part D and the demonstration

This report presents summaries of our findings from the site visit discussions organized by each of these discussion areas. To protect the confidentiality of the participating plans, we present comments only in summary form and do not attribute specific comments to individual plans.

1.4 Site Visit Organizations

Table 3 summarizes the 10 demonstration participants with whom we conducted discussions. We visited and prepared a case study on each with the exception of WellPoint; this organization provided detailed written responses to our protocol. Most of the national or large regional organizations—Aetna, Humana, United HealthCare/PacifiCare and WellPoint—offer both MA-PD and PDP products that participate in the demonstration. The exception is Kaiser, consistent with their traditional focus on the HMO product, offers only this model under Medicare and the demonstration. Local and smaller regional organizations we visited generally offered only MA-PDs, though some also offered PDPs.

Table 3
Description of demonstration site visit organizations and products

Demonstration site visit organization	Plan type	Core service areas	Profit/nonprofit	Scope of Medicare products
Arcadian	HMO	Arkansas, Arizona, Texas, Washington	For Profit	Local
Aetna	HMO Local PPO Regional PPO PDP	New York, Maryland, New Jersey, Pennsylvania, California, Delaware, Virginia, Florida, Georgia, Illinois, Texas, Arizona, and Ohio	For Profit	National
Group Health, Inc.	PPO PDP	New York	Nonprofit	Local
Humana	HMO Local PPO Regional PPO PFFS PDP	National	For Profit	National
Independence Blue Cross	HMO Local PPO Regional PPO PDP	Pennsylvania	For Profit	Regional
Kaiser	HMO	National	Nonprofit	National
Northern Plains Alliance	Regional PPO PDP	Iowa, South Dakota, North Dakota, Minnesota, Montana, Nebraska, Wyoming	For Profit	Regional
People's Health Network/Tenet	HMO POS Local PPO	Louisiana	For Profit	Local
United HealthCare/ PacifiCare	HMO Local PPO Regional PPO PFFS PDP	MA products: Alabama, Florida, Illinois, Missouri, North Carolina, New York, Ohio, Rhode Island PDP products: National	For Profit	National
WellPoint	HMO Local PPO Regional PPO PFFS PDP	National	For Profit	National

We present summary findings from our site visit discussions in the remainder of this report. It is important to note that the views expressed here are those of the organizations we visited, and therefore may include subjective statements rather than objective evidence.

SECTION 2 REINSURANCE DEMONSTRATION PARTICIPATION AND DEVELOPMENT OF DEMONSTRATION PRODUCTS

2.1 Reasons for Joining the Demonstration

A key element of our site visit discussions related to the impact of the reinsurance demonstration. *Almost all of the organizations we visited believed the alternative reinsurance financing offered under the demonstration gave them the opportunity to offer a richer package of drug benefits or lower premiums than they would have been able to offer without the demonstration.* Many organizations believed they would have offered some Part D enhancements even without the demonstration financing, depending on the competitiveness of the market, although a few organizations specifically stated that without the demonstration they would not have been able to offer a Part D standalone plan with gap coverage. However, there was almost universal agreement that the demonstration allowed either “better” enhanced benefits, lower monthly premiums—or both—because of the demonstration. We were told by many plans that by joining the Part D demonstration, organizations were able to use the upfront reinsurance payment to lower premiums, which made the enhanced plans more attractive to beneficiaries and thereby decreased the risk of adverse selection because of the higher enrollment. Without the lower premiums, many organizations believed it was likely that only beneficiaries with very high utilization rates would purchase enhanced plans. This was a particularly important point for organizations in the benefits and pricing of the standalone PDPs. Unlike the MA-PD plans, standalone PDPs do not benefit from the potential application of Medicare Parts A and B bidding “rebate” funding.

A common response from organizations with whom we spoke was that beneficiaries had a strong demand for enhanced benefits, especially for gap coverage. Without gap coverage, beneficiaries felt that they were paying something for nothing in the gap because they still had to pay a premium, but did not receive any coverage. Some organizations who traditionally had offered MA products with prescription drugs benefits commented that they had to offer an enhanced product to make their benefits as generous as their previous prescription drug plans. These organizations tended to be located in historically high Medicare reimbursement areas that offered \$0 or very low premiums and no deductible plans with generous benefits including unlimited coverage for generics. Organizations in these markets commented that they could only continue to offer these types of products using an enhanced alternative plan. As well as lower premiums, gap coverage was a common enhancement made possible by the demonstration.

We learned that many organizations had specific monthly premium goals for their MA and PDP products. In some cases, MA-PD organizations believed strongly that only \$0 premium plans would be marketable in their service areas. Other organizations had specific monthly premiums they could not exceed in order to meet enrollment targets. Therefore, for this large number of organizations, the demonstration reinsurance financing was critical in “making the numbers work” for offering an enhanced Part D product at the “target” monthly premium.

Some plans did see a downside to participation in the demonstration. Without the demonstration, they would be paid 80 percent of reinsurance-eligible costs (under the standard Part D reinsurance provision). With the demonstration, they are paid a set capitated amount,

independent of actual drug costs. Thus, the demonstration required plans to take the risk for enrollees' catastrophic drug costs. When considering whether to participate in the demonstration, some plans balanced the catastrophic drug cost risk against the expected reinsurance payments under the demonstration. These plans concluded that the net gain from participating in the demonstration varied by the degree of enhancement in their Part D products. Less enhancement implied less gain to participating in the demonstration. Only in Part D enhanced products where gap coverage was added were the expected reinsurance payments high enough to offset the reinsurance capitation risk created by the demonstration. A number of the plans we interviewed did not participate in the demonstration for benefit packages where the only enhancements were to eliminate the initial deductible or reduce co-payments. For these types of enhancements, expected reinsurance payments were not significantly higher under the demonstration, and were outweighed by the reinsurance capitation risk, or the demonstration was simply not considered very relevant.

2.2 Rationale for Choosing the Specific Reinsurance Options

The majority of organizations participating in the demonstration chose the flexible capitation option, though some MA-PDs elected the fixed capitation option. No organizations (at least in 2006) chose the MA rebate options (a number of organizations admitted they were somewhat confused by this alternative). Organizations that chose the flexible capitation reinsurance option cited the relative ease of administration for this method. Other reasons cited for the appeal of the flexible capitation option included a perception that there would be less adverse selection in using the flexible option over the fixed option because high-cost beneficiaries would choose plans with the fixed option.⁶ Also, the flexible option postpones the beneficiary drug spending level at which plans become liable for 95 percent of drug costs (the catastrophic benefit) to above the fixed option threshold of \$5,100 in total drug spending.

One plan argued that, under the fixed option, \$5,100 of allowed claims costs triggers the catastrophic threshold. This is different from the \$3,600 in TrOOP under the flexible option. This plan had set up its benefit design, operational claims processing systems, and marketing around TrOOP. Therefore, electing the fixed option would have required major changes to focus on allowed claims cost that it did not want to make. Organizations also said that the flexible option is easier to explain because it is based on \$3,600 true out-of-pocket dollars.

We found that the larger organizations with in-house actuarial and analytic capabilities generally chose a demonstration financing option based on detailed modeling and simulation of the alternatives. Most, but not all, of these organizations chose the flexible capitation option. Smaller organizations tended to contract with actuarial firms for consulting services and relied on these consultants to recommend a demonstration financing option. In these cases, organizations tended to follow the advice of their consultants without necessarily having a detailed understanding of the tradeoffs between the different models. These organizations were

⁶ Under the fixed option with gap coverage, high drug utilizing beneficiaries would enter catastrophic coverage with its lower 5 percent coinsurance when their TrOOP—or true out of pocket costs—would be less than \$3,600. Under the flexible option, they would have to pay \$3,600 in out of pocket costs before receiving catastrophic coverage.

quite straightforward in telling us that, under the pressure of the Part D implementation, they did not have the time to become more involved in the decision.

2.3 Factors in Determining the Part D Bid

Organizations with whom we spoke used a range of factors in determining their Part D bid. One common approach among many organizations was bidding based on an understanding of the markets in which they were operating, sometimes gained from prior experience offering MA, or even nonstandard Medigap, prescription drug products. Somewhat contrary to the current Medicare bidding process, most organizations tended to start their bid development process with a “target” premium for various markets. From that point, organizations tended to work backwards by considering what kinds of benefits and cost sharing could be accommodated for that price. Then organizations continued to work backwards, considering the benchmark premium for their areas, to determine their final bid price. Organizations acknowledged that this process might be somewhat different than what CMS had in mind, but argued that it was necessary to “do business in the real world.” A number of organizations were quite clear that if they could not develop products with the right premiums (sometimes \$0 per month) for specific markets, their products would not be viable.

Because many organizations with whom we spoke did not have extensive experience in pricing prescription drug benefits for the Medicare population, hiring of consultants and purchasing data was a common strategy, even among the larger organizations. Even with this assistance, many organizations described product and bid development in 2006 as “something of an educated guess.”

SECTION 3 DESIGN AND CHARACTERISTICS OF PART D PRODUCTS

3.1 Overview of Part D Standard and Enhanced Products

We found a wide variation in the design of Part D products, with decisions based on individual organizational goals. A common thread in Part D product development was an upfront decision by organizations as to their level of market penetration for Medicare PDPs and Medicare Advantage. The range and scope of Medicare Part D options tended to flow from this basic organization perspective. Some organizations report Medicare—including Medicare PDPs and Medicare Advantage—as major organizational initiatives and opportunities. These organizations tended to offer a wider range of product types (for example, within Medicare Advantage offering PPOs, PFFS, and HMOs, as well as expanding into standalone PDPs) and benefit packages to maximize enrollment and market penetration. Others reported a more conservative approach to Medicare. Some of these organizations reported constant pressure by parent companies to limit Medicare products. These organizations tended to offer Medicare Part D products similar to what they had offered in the past. However, a few of these more conservative organizations also decided to offer PDP products.

As noted, some organizations offered a range of plans to appeal to all market segments and maximize enrollment. Some organizations would have offered even more plans, but were discouraged from doing so by CMS regulations (CMS was concerned about beneficiary confusion caused by availability of too many plans). Other organizations, particularly some of the MA plans interviewed, offered fewer options, even only one Part D plan. These organizations stressed simplicity, avoiding risk segmentation, marketing advantages, continuity with previous drug benefits, and a desire for all enrollees to have generous drug benefits because that was clinically appropriate and a cost-effective way to practice medicine. MA-PDs felt they could effectively integrate Part C and Part D benefits, and that drug benefits could substitute for some Part C costs (e.g., avoid hospitalizations).

Of course, because we visited only demonstration participants, all these organizations had made a business decision to offer enhanced Medicare Part D products. The predominant reason given for this decision was they felt enhanced products were likely to be in demand by potential enrollees. Most of the MA participating organizations we visited specifically used Medicare Parts A and B rebates to fund enhanced benefits. Organizations offering PDPs offered enhanced options because they felt these would be popular with beneficiaries. In general, across most of the plans, organizations did not believe that basic plans, with no additional coverage expansions either in the coverage gap, reducing initial deductibles, and/or through expanded initial coverage limitations, would be the choice of many Medicare beneficiaries. In a few cases, organizations told us that they believed nonenhanced prescription drug coverage was simply a poor design that would not meet their goal of offering the best medical care to their enrollees.

Few plans reported any intention of making major benefit design changes in 2007, either to their enhanced or basic plans. However, it should be noted that this is generally not feasible under Part D. Approved benefit packaged cannot change during a coverage year, and significant changes to formularies are also not allowed by CMS. Most organizations felt they needed to give

their current designs more time before making major changes, although cost pressures were causing some plans to raise premiums or reduce benefits for 2007. No organizations with whom we spoke had any plans to change benefits, such as formularies, mid-year unless there was a need to add new drugs to their formularies. One exception we noted was from two organizations that planned to discontinue or restructure their highest benefit options. Organizations that offered a relatively high level of benefits (such as more extensive coverage in the gap) experienced adverse selection that may make these products unsustainable at affordable premiums. One of the organizations who had this experience attributed this outcome to the surprisingly effective use of various prescription drug pricing tools by high prescription drug utilizers. Premiums on high-option plans were being significantly raised for 2007 in some cases to reflect the adverse selection that was experienced. Also, several insurers found that their “mid-option” plan was not as successful as their high or low option plans. Price sensitive beneficiaries chose the low option plan, which also receives auto-enrollees, while beneficiaries with high drug utilization or who wanted the best coverage chose the high option plan. The mid-option plan was not seen as attractive by either group. In response, several insurers are making their mid-option plans more attractive by reducing the premium gap between their low and mid-options, or improving the benefits of their mid-option.

3.2 Premiums, Cost Sharing, and Formulary

A key element of the design of benefit packages was the monthly premium. Organizations believe this is one of the primary focal points for potential enrollees. All organizations appeared to set the monthly premium with great care, looking particularly at how the monthly premium would position them in their respective markets. Some plans noted that specific premium levels (for example, in some markets, \$0 premiums for Medicare Advantage products) were absolutes for defining viable products. It was noteworthy that the two organizations with the richest gap coverage had markedly different premiums, one with \$0 (an MA-PD) and the other with over \$100 (a standalone PDP).

Beyond premiums, strategies for defining formularies and drugs covered were also an important aspect of benefit design across all products. Most organizations with whom we spoke had closed formularies for their low option plans, meaning they have specific lists of covered and noncovered drugs. Higher-option plans often covered a broader range of drugs. However, several organizations noted that the covered drugs listed on formularies did not fully measure access to specific drugs, because that was also affected by other drug utilization and management policies and exceptions/appeals/denial processes.

Most organizations also used drug tiers with different cost sharing by beneficiaries within the tiers. The common approach was to place generic drugs in the lowest tiers with the lowest cost sharing. Brand name drugs with higher cost sharing were placed in upper tiers. Specialty drugs were placed in the highest tiers. Variation among organizations was found primarily in the number of tiers. Many plans had three or four tiers, though one large organization only used two drug tiers. Organizations tended to agree that having too many tiers, although a potential way to control drug utilization, is too confusing for beneficiaries, and this confusion outweighed potential benefits. We did find that smaller organizations, which relied on large national

pharmacy benefit management (PBM) companies, reported following the benefit structure of these PBMs rather than designing their own pharmacy products.

There was a wide range of variation in the type and level of cost sharing that plans applied within the tiers. Set co-payments (for example, \$5 per prescription) were most common among lower drug tiers that often included generic drugs. Use of coinsurance (for example, 10 percent of the cost of the drug) was more common in the higher tiers. However, plans sometimes used only co-payments in all tiers. The actual amounts of the cost sharing varied widely.

In general, organizations universally described the cost sharing as a source of confusion for Medicare beneficiaries. Organizations reported spending a great deal of time explaining these elements of the benefit design to their enrollees. Of particular concern was confusion over what cost sharing applied to the coverage gap. Organizations reported that many enrollees believed only their cost sharing, and not the total cost of the drug, determined whether they entered the coverage gap. Some of the larger organizations devoted significant resources to sending monthly beneficiary notices on enrollee coverage status to try and address this confusion.

3.3 Cost Containment and Utilization Management Strategies

Organizations with whom we spoke use many strategies to help manage the drug utilization of its enrollees. Encouraging enrollees and physicians to use generic drugs was the most prevalent cost containment strategy across all plans. As noted above, smaller organizations followed the protocols of their pharmacy benefit management subcontractors. Use of these strategies tend to be at the organizational level, and are not applied only to enhanced products under the demonstration, though at least one large organization did apply different utilization strategies for their high-end demonstration plan because there are more drugs on the open formulary. Common strategies include step therapy, quantity limits (e.g., Viagra, 6 tablets only), pre-authorization, and mandatory or first use of generics. Plans did differ in their application of utilization management strategies depending on the particular drug and prescription drug tiers.

For high-cost beneficiaries, particularly beneficiaries identified with specific diseases, organizations provided a Medication Therapy Management (MTM) program that was required by CMS. In this program, RNs and pharmacists review the targeted prescription drugs for these beneficiaries. Another approach employed by some plans (particularly Medicare Advantage plans) focuses on physician education as a drug utilization strategy. Physicians are educated to know which drugs are best for the enrollee and what alternative drugs are available. Organizations that use this approach employ drug education coordinators. They evaluate physician prescribing patterns, profiling physicians and providing feedback to them. While it might theoretically be more feasible to apply utilization management in an MA-PD than in a standalone PDP, organizations with both types of drug plans were generally consistent across plans in their utilization management strategies.

3.4 Pharmacy Network

We found little variation among organizations with respect to pharmacy networks. This is not surprising given the requirement that all plans meet TRICARE pharmacy access network

standards, which are quite broad. Organizations almost universally will allow enrollees to fill prescriptions at any pharmacy willing to accept their pricing and policies. In general, pharmacy networks are very large and include nearly all of the pharmacies in the relevant market area or even nationally. The one exception was an MA organization that owned its own pharmacies, which are the primary source for its enrollees' prescriptions. Organizations with whom we spoke have arrangements with large pharmacy chains, and will include local pharmacies whenever possible. Organizations report that they willingly include additional pharmacies at enrollee request.

SECTION 4 MARKETING OF PART D PRODUCTS

4.1 Basic Approach

The basic market approach for Part D related products varied considerably by organization. The adopted strategy tended to be decided at the organizational level, driven by marketing approaches used historically by these firms. We did not find that marketing varied by type of benefit or by demonstration or non-demonstration product groups. Consistent with marketing strategies used historically by Medicare Advantage firms, organizations tended to use company and descriptive trade names (such as “Senior Advantage” or “Senior Advantage Gold”) in marketing rather than terms that specifically describe the structure of the product (Medicare Advantage PPO, HMO, PFFS, etc.) or whether the product is basic or enhanced. Organizations did not report to us specifically marketing products as enhanced versus basic. Rather, they used trade names to convey the relative level of the benefits across the organization’s product profile.

One large organization that offers a wide range of PDP and Medicare Advantage products took an aggressive marketing approach and made contact with beneficiaries through a range of sources including large discount retailers, private insurance agents, direct mail, television advertisements, internet links and tools, informational call centers, dedicated sales staff and local seminars. They told us that they prefer to use one-on-one contact with beneficiaries considering enrollment in Medicare Advantage. Other organizations we spoke to use some of these marketing techniques, but it was less common for other organizations to use such a wide range of approaches. A number of organizations, particularly smaller ones, did rely on private insurance agents to market to Medicare beneficiaries. Only a few plans used enrollment based incentives for their marketing staff.

Most organizations that offer both PDP and Medicare Advantage products described their marketing as “neutral”—that they did not push one product over another. One plan described this approach as “agnostic in product.” Large plans marketing large numbers of both Medicare Advantage and PDP products in many regions also tended to develop relatively uniform product designs. This made development of marketing materials, sales approaches, and other marketing plans more streamlined. Most organizations told us that their goal was to match the beneficiary with the best product for them. Otherwise, disenrollment rates would be too high. A few organizations, however, devoted most of their marketing resources to their Medicare Advantage products, and offered their standalone PDPs only as alternatives or for employer groups. Some organizations offering both standalone PDPs and MA-PDs had different strategies for marketing each product. For example, one organization took an integrated marketing approach for maximum exposure of their standalone PDP product, partly because of a lack of time. However, for their MA-PD product, they identified categories of consumer types, and put together benefit packages to reach each of these types.

Auto assigned enrollees were attractive to plans because there is no marketing cost in enrolling them.

4.2 Knowledge Level of Beneficiaries

In general, most organizations told us that beneficiaries did not understand Part D and they really needed better knowledge of what was being offered. They did not feel there was any real difference in the level of understanding among enrollees in demonstration versus non-demonstration products.

It was common for organizations to report that their marketing representatives do a large amount of education, explaining what Medicare Part D would cover as well as the Parts A/B benefits under Part C. Organizations generally felt that implementation of Part D was a great boost to get beneficiaries to re-think their options, including Medicare Advantage products. Organizations did admit that there is something of a mix of beneficiary knowledge. One plan described beneficiaries this way: “Some are in the know from being online, and some are completely oblivious.” Another organization, while agreeing that the overall level of beneficiary knowledge was low, was very surprised at the number of beneficiaries (or their advocates) who clearly made some attempt to use the Medicare or comparative Web sites. One large organization told us that 40–60 percent of seniors calling their organizations say they have access to the Internet, which “amazed” them.

When we visited most organizations, in the summer and early fall, they were beginning to have more beneficiaries entering the coverage gap. Organizations anticipated that many beneficiaries did not completely understand this aspect of Part D. A common misunderstanding reported by organizations through their interaction with beneficiaries was what costs applied towards entering the coverage gap. Most enrollees believe the coverage gap is triggered by their cost sharing, not the total cost of drugs. They do not understand it and are surprised when one month a prescription is covered and the next month it is not.

4.3 Strategies to Attract and Retain Enrollees

Most organizations reported that they rely on loyalty and customer service to retain their enrollees. A number of organizations, particularly the larger organizations, stress that they are in Medicare for the long run.

A few plans stressed their brand names to attract and retain beneficiaries. These organizations believe it is their name that many beneficiaries know and trust and that they have a following of loyal customers that they hope will purchase Part D coverage from their organization.

Another small group of organizations had specific retention programs, including dedicated staff who reach out to newly enrolled members to make sure they know what is coming, what to do about problems, explain the rules, give them basic information, and keep in touch.

4.4 Part D and Medicare Advantage Marketing

Organizations felt that, overall, Part D was helpful for Medicare Advantage marketing/enrollment because Part D is offered through private plans and educates beneficiaries

about private plans in Medicare. Part D allows plans to cross-market their Part C MA plans to beneficiaries, and beneficiaries gain more familiarity with Medicare Advantage organizations, increasing their likelihood of enrolling in an MA plan. Also the Part C rebate dollars allow organizations to offer Part D cheaper through an MA plan than a standalone plan, which further increases beneficiary interest/enrollment in MA.

However, other organizations thought Part D created challenges for organizations with substantial existing Medicare Advantage enrollment. For these organizations, the goal was to convince beneficiaries to make no changes and remain with their existing plans. One such organization, like others with large existing Medicare Advantage enrollment, did outreach to its existing members about Part D; it said “don’t worry, you will get Part D through your plan, you don’t need to do anything.” Another organization reported many of their existing beneficiaries mistakenly enrolled in standalone PDPs even though this MA-PD offered generous Part D coverage at a zero premium. Because of the large amount of information the beneficiaries were receiving regarding the need to sign up for Part D, some beneficiaries were confused and enrolled in standalone PDPs. Finally, a few MA-PDs told us that because now Medicare beneficiaries can receive prescription drug coverage without enrolling in MA (through a standalone PDP), they thought they had lost some of their MA enrollment to fee-for-service.

SECTION 5

IMPLEMENTATION OF PART D PRODUCTS AND ENHANCED PLANS

5.1 Implementation and Operational Issues/Problems in Launching the Part D Products

All the organizations with whom we spoke cited a range of implementation and operational issues related to the first year of the Part D program. *These issues, however, rarely had any relationship to the demonstration per se. Organizations told us that while the demonstration options added some complexity to the overall Part D implementation, the pressures of the program as a whole were so great that the demonstration added only one additional issue to think about.* The larger organizations told us that, through their government relations activities, they were expecting something along the lines of the reinsurance demonstration and therefore began basic planning relatively early on in their Part D implementation process. Other smaller plans seemed to become aware of the demonstration options later on, and then relied on consultants to help them adjust their benefits and bids accordingly. In reviewing the distribution of enhanced benefit plans, we did notice that a number of organizations chose to offer enhanced products outside the demonstration. We asked the demonstration participants for their theories on this unexpected outcome. The most prevalent response was that, in the rush to implement the Part D program as a whole, some organizations may not have had the time or resources to address the possibility of reinsurance demonstration participation. No participating organization offered a substantive reason why it might be in the interest of insurers to offer enhanced Part D benefits outside the demonstration, unless the enhancements were only below the initial coverage limit and did not involve filling in the coverage gap.

5.2 Views of Early Success

For most organizations, success was defined in terms of enrollment in their products. The majority of organizations with whom we spoke, particularly the large organizations who marketed aggressively, defined their Part D products as highly successful. However, a few organizations we visited were slightly disappointed in their enrollment figures. No organizations had specific plans to abandon the Medicare Part D program. Organizations were also cautious about declaring either success or failure after only one year of Part D experience.

A few plans that offer a range of enhanced benefits reported experiencing adverse selection in their “high end” plans. Because of this worse than expected selection, organizations may either raise premiums for these high benefit plans and/or discontinue them. Also, some “mid-option” plans had not drawn as much enrollment as anticipated, and were being repositioned.

SECTION 6 PERSPECTIVES ON PART D AND THE DEMONSTRATION

Despite having a number of concerns and suggestions for changes in the overall Part D program (described in Section 5), all the organizations with whom we spoke thought that Part D was a good program and an important new part of Medicare. These organizations believed that CMS has done, in general, a good job of contending with a very difficult, very aggressive implementation. Most organizations compared implementation of the Part D program favorably when compared to implementation of the programmatic changes mandated by the Balanced Budget Act of 1997.

Organizations were universally supportive of the reinsurance demonstration and, as noted earlier, thought the financing available under the demonstration allowed them to offer better enhanced benefits for lower premiums. Most organizations said they would probably have offered some form of enhanced benefits even without the demonstration, but were clear the enhancements would have been less or the premiums and cost sharing would have been higher. In our site visits, we did not find that the demonstration had any real effects on the implementation issues that arose, or the marketing and education strategies organizations used.

Overall views of early success of the demonstration were positive among the organizations we visited. Most organizations thought that so far, the demonstration overall has been a success. Most of the organizations have met or exceeded their enrollment goals set before the demonstration started. However, many organizations were only cautiously optimistic with respect to the financial success of the demonstration, mainly because of more adverse selection for their demonstration products than expected. These organizations had a “wait and see” attitude with respect to the ultimate success of the demonstration.

One overriding theme we heard was related to the costs of the implementation process for Part D, which was reported as very, very expensive. Organizations described the bidding process as particularly expensive and resource-intensive. We heard this from organizations of all sizes, though smaller organizations found this to be a particularly acute problem. Organizations hoped that these costs would eventually decrease as the program matures and as CMS guidance and policies stabilize. If the administrative costs of participation do not decrease, organizations report that these costs could be reflected increasingly as decreased benefits or increased premiums for beneficiaries.

Organizations we interviewed made a few specific suggestions for improvements in the demonstration and in Part D.

- *Lift the prohibition on demonstration enrollment of beneficiaries with employer only coverage:* Several organizations would like to see an elimination of the prohibition of beneficiaries with employer group drug stipends enrolling in demonstration plans. (These are beneficiaries who do not have “creditable coverage” through their employer, and the employer does not get the 28 percent subsidy. Rather, the employer gives the beneficiary a stipend to use in individually purchasing a Part D policy.) These organizations found this prohibition to be one of the worst characteristics of the demonstration. They felt that this is a large market that could benefit from enhanced

coverage. (These beneficiaries are at minimum 2–5 percent of the employer market in 2006, and are expected to grow as a proportion. Especially smaller employers want to do this, i.e., give retirees a stipend to buy a drug plan.) These organizations stated that CMS reasons for the prohibition are (1) to not give employers an incentive to drop coverage (if beneficiaries could get enhanced coverage through the demonstration, employers might drop coverage) and (2) to not jeopardize budget neutrality. But the insurers did not find these reasons convincing enough to retain the prohibition.

- Provide more beneficiary education on Medicare Part D: Organizations we spoke with believe beneficiaries need more and ongoing education from CMS on Part D benefits since many of them appear confused by it. Beneficiaries could also use a common framework incorporating all the different plan features to compare different plans and organizations when making decisions on which Part D plan they want (e.g., open versus closed formulary, step therapy, exceptions policy).
- Better measurement of access to drugs: CMS needs to develop better metrics to measure enrollee access to drugs than simply the number of drugs listed on the formulary. CMS should measure the rate at which enrollees actually get drugs, which depends on plans' exceptions processes, prior authorization, etc. Two specific metrics suggested include the percentage of prescriptions that require prior authorization and the percentage of prescriptions filled on each of a plan's drug tiers.
- Allow innovation and flexibility in plan types: Some organizations insurers made a plea for CMS/Congress not to standardize and "commoditize" Part D like Medigap policies A-J, but rather, to allow innovation and competition.
- Offer more of a level playing field between MA-PD and standalone PDPs. Several MA plans felt that CMS' marketing and presentation of Part D was too focused on standalone PDPs, and was not sensitive to the situation of MA enrollees. CMS needs to make it clear that MA enrollees do not have to enroll in a standalone plan.

SECTION 7 PERSPECTIVES OF NON-PARTICIPATING ENHANCED PLANS

An unexpectedly large number of organizations chose to offer enhanced Part D plans without participating in the demonstration. This raises questions about the necessity of offering the alternative reinsurance mechanisms available under the demonstration for ensuring the availability of enhanced Part D products. During the summer of 2007, RTI conducted telephone discussions with non-demonstration Part D plans who offer enhanced products. Our goal was to understand the reasons why organizations chose to offer enhanced plans without participation in the demonstration. We identified several organizations that fit into this category, and solicited either written or oral feedback. Two organizations chose to respond to our questions through brief telephone discussions.

While there were some subtle differences between the two organizations in their reasons for not participating in the demonstration, a common underlying reason for non-participation was timing of the demonstration application. Organizations reported that they were already at maximum operational capacity in 2005, given the due dates for Part D implementation and submitting inaugural Part D bids. Staff working in their Medicare products were already overwhelmed by all the information related to Part D they were required or asked to review, which left little time and resources available to consider this optional payment demonstration. One organization recalled that the different options available under the demonstration were complex, and there was very limited time to interpret the different financing options and come to a rational decision. This organization also noted that it would have been helpful had CMS offered a set of financial impact scenarios or “what ifs” to help in their decision making process. One of the two plans we spoke with is a large national organization, so relative organizational size seems not to have been a determining factor in demonstration participation.

Another issue raised was the concern that the reinsurance demonstration essentially placed more risk on participating organizations. Non-participating organizations seemed hesitant to forgo the opportunity to reconcile actual experience and expenditures in calculating reinsurance payments. Also, non-participating organizations seemed unclear about the financial implications of each reinsurance demonstration options. Plans noted that without any financial scenarios to draw from, the decision to choose an option was too difficult and cumbersome at the time. The rebate option created even more confusion and didn’t seem feasible, particularly since the Part D deductible could not be waived under this option. One organization we spoke with recalled an added cost of \$3.13 per member per year (PMPY) in order to ensure budget neutrality under the demonstration reinsurance capitated payment arrangement. This “fee” was viewed as a negative to participation.

When asked whether these organizations considered entering the demonstration during more recent bid years, one organization admitted that they forgot to re-evaluate this option for their most recent bid season (2008 plan year). The other organization stated that they will continue to monitor the demonstration going forward, but that their experience in offering Part D

plans did not yet seem suitable for participating in the demonstration. Both organizations will take the demonstration under greater consideration in future bid years should it still be offered.

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APPENDIX
PART D PAYMENT DEMONSTRATION PARTICIPANT SITE VISIT
DISCUSSION GUIDE

Part D Payment Demonstration Participant Site Visit Discussion Guide

FINAL

1. GENERAL OVERVIEW—BASIC ORGANIZATIONAL INFORMATION

The focus of this part of the interview is to obtain basic background, and ease into the more detailed part of the interviews. This general overview should not take more than 20 minutes – don't spend valuable time on this level of information. Also, many MCOs will have their own introductory presentation. If so, this section is not necessary.

- 1.a Description of your organization and the Part D prescription drug product(s) your organization offers. Describe any significant partners, including Pharmacy Benefit Management (PBM) firms associated with your Part D product.
- 1.b Description of the key characteristics of your market area in terms of Part D Prescription Drug products and competitors, Medigap/employer retiree prescription drug insurance benefits, provider networks, and beneficiary characteristics.
- 1.c (if an MA-PD plan) Description of the MA plans you offer, including HMOs, local PPOs, regional PPOs, PFFS plans and their drug benefits.
- 1.d Describe how the prescription drug market place has changed as a result of the Part D implementation, from your organization's perspective.

2.0 DEVELOPMENT AND CHARACTERISTICS OF THE PART D PAYMENT DEMONSTRATION PLAN PRODUCT(S)

The purpose of this part of the interview is to receive a detailed understanding of why the PDPs decided to participate in the demonstration, how they would describe (and market) the Part D enhanced demonstration product, and why they chose the specific geographic service area and benefit package structure.

- 2.a What were the reasons why your organization decided to offer an enhanced Part D benefit?

- *Necessary for competitive reasons*

- *Necessary to attract sufficient enrollees*
- *Reasonable given the availability of the reinsurance demonstration*
- *Wanted to offer a full range of drug benefit options, from basic through enhanced*
- *Believed could offer enhanced Part D benefit efficiently and earn profit*
- *(if an MA-PD) Attracts enrollment for our MA plan(s)*
- *(if an MA-PD) Improve care coordination for our MA plan enrollees*

2.b Why did your organization decide to participate specifically in the reinsurance demonstration in order to offer an enhanced Part D benefit?

- *Wanted to obtain extra reinsurance payments available under the demonstration*
- *Only way to afford to offer an enhanced benefit*
- *Alternative reinsurance payment is critical given uncertainty*
- *Demonstration offered a way to guard against adverse selection financial impacts when offering a voluntary enrollment enhanced benefit*

2.c What factors went into determining your Part D bid?

- *Induced demand factor*
- *Beneficiary premium*
 - *Premiums for basic vs. enhanced plans*
- *Projected utilization*
- *Take us through the process of putting together your Part D bid and what factors you considered.*

2.d What was your rationale for choosing the specific reinsurance options?

- *Flexible capitation, fixed capitation, MA rebate*

- *How did you think the alternatives would affect the beneficiaries attracted to enroll?*
 - *Beneficiaries with chronic, high-cost utilization of prescription drugs tend to choose fixed option*
- *How did you model the revenue and risk to the plan under each of these options?*
 - *Plans tend to have less risk under the flexible option*
- *Probe particularly for anyone with fixed capitation, as this is far less common*

2.e What enhanced benefit, if any, would you have offered in the absence of the demonstration’s alternative reinsurance payments?

2.f Why did your organization choose to offer enhanced benefits in specific regions (or nationally)? (if a local MA-PD, phrase question in terms of service areas)

- *What characteristics of regions were important in making these participation decisions?*
- *Probe for importance of factors including number of Medicare eligibles, projected health status, projected utilization, urbanicity, concentration of providers.*
- *Are there regions, or characteristics of regions, that would make offering an enhanced benefit undesirable?*
- *Competitive considerations?*

2.g How do you view the roles of individual-level reinsurance versus the plan-level risk corridors in protecting your plan against risk?

- *Did the risk corridors affect your decisions to offer enhanced benefits, participate in the demonstration, choice of specific reinsurance option, and offer a Part D benefit?*
- *What will be the effect of the gradual widening of the risk corridors?*
- *What about induced demand?*
- *What about adverse selection?*
- *(for MA-PD plans) What was the anticipated effect of the Part D enrollees and benefit on non-drug utilization?*

3.0 INITIAL IMPLEMENTATION OF THE PART D ENHANCED BENEFIT and PART D PAYMENT DEMONSTRATION

The focus of this part of the interview is to determine how the implementation and early operations of the Part D benefit and reinsurance demonstration have progressed for PDPs.

Target Interviewee: Medicare corporate product manager

3a. What implementation and operational issues/problems did you encounter in launching the Part D products? Was your organization “ready” for Part D implementation? Was the timeline for Part D too aggressive?

- *Were there any special issues associated with enhanced versus basic benefit packages?*

3b. For the Part D enhanced benefit, what is your organization’s view of early “success” in terms of enrollment, attracting beneficiaries, and financial results?

- *Enrollment expectations for enhanced versus basic benefit package*
- *Any worrisome utilization trends noted for the enhanced package (perhaps signaling adverse selection)*

4.0 DETAILS ON THE PART D ENHANCED PRODUCT – BENEFIT PACKAGE, COST CONTAINMENT STRATEGIES, PRICING STRATEGIES, PROVIDER NETWORK

The purpose of this section of the interview is to get more detail on the enhanced Part D benefit offered by this PDP, compared to standard benefits. Attempt to get details rather than a generic listing of the benefits.

Target Interviewee: Medicare corporate product manager

4a. Please discuss the details of your enhanced Part D benefit package, focusing on any benefit details that differ from the standard package.

- *Differences in premiums*
- *Differences in co-pays/coinsurance and deductibles*
- *Differences in formularies*
- *Differences in provider networks*
- *Concern about adverse selection as a result of benefit package design?*
- *If offers multiple benefit packages (within region/service area), what are they and what is the strategy for offering?*

4b. How often do you think your organization might change the Part D benefit package(s)? Annually? More often?

- *What would prompt these changes, for example in formulary?*

4c. What utilization strategies does your organization have in place?

- *Direct limits (e.g., exclusion of specific drugs)*
- *Utilization management approaches (e.g., prior authorization, step therapy, therapeutic substitution, closed formulary, preferred drug list, mandatory generic substitution)*
- *Cost sharing approaches (e.g., copayments, tiered copayments, coinsurance, reference pricing)*
- *General utilization review strategies (e.g., retrospective drug utilization review)*
- *Education strategies (e.g., education of physicians and beneficiaries on the benefits of generic drugs)*
- *Lower transaction costs (e.g., incentives for increased use of mail-order for mail-order pharmacies and/or mandatory mail order for maintenance medications)*
- *Differences between enhanced and standard benefit*

4d. (If an MA-PD) What is your strategy, if any, in coordinating your prescription drug benefit with your non-drug benefits?

- *Is this affected at all by offering an enhanced drug benefit?*

4e. What drug pricing/cost strategies does your organization have in place?

- *Use of purchasing pools*
- *Higher rebates through market leverage*
- *Requirements to make prices and rebates transparent*
- *Lower dispensing fees to the pharmacy*
- *Use of restricted pharmacy networks*
- *Differences between enhanced and standard benefit*

4f. Could you tell us about the provider network that exists for your organization's PDP plan(s)?

- *Selection and recruitment of the retail and/or mail order pharmacies?*
- *What provisions are there, if any, for out-of-area services, e.g., "snowbird" beneficiaries?*

5. MARKETING THE PDP PRODUCTS TO MEDICARE BENEFICIARIES

This section may be of some interest given concerns about beneficiary's ability to understand the Part D benefit.

Target Interviewee: Medicare Marketing Manager

5a. May we have copies of all marketing and enrollment materials used in relation to your PDP product(s)?

5b. What is your basic approach to marketing PDP plans to Medicare beneficiaries?

- *Advertising*
- *Beneficiary education*
- *Specific sales force*
- *Relying on Medicare Compare, other sources*
- *Other activities*

5c. Are enhanced PDP products marketed any differently than basic packages? Why or why not?

5d. What are your expectations about the knowledge level of Medicare beneficiaries in your regions regarding the Medicare PDP plans? Does your organization engage in any educational outreach, either as part or separate from marketing efforts?

- *Do beneficiaries understand the enhanced benefit as well as the standard benefit?*

5e. What are your organizations' strategies to attract and retain Medicare enrollees for the enhanced PDP product(s)?

5f. What does your organization anticipate will be the types of Medicare beneficiaries attracted to the enhanced PDP product?

5g. (for MA-PDs) How does the new drug benefit fit into your overall marketing for your Medicare Advantage plan?

- *Does the new Rx benefit help MA recruiting? If so, why?*
 - *e.g., does it make beneficiaries more likely to enroll in MA because they can get Rx and medical benefits from the same organization?*
 - *or does Part D hurt MA recruiting because now beneficiaries can get a drug benefit without signing up for an MA plan?*

5h. (for MA-PDs offering multiple types of plans) Does your drug benefit differ at all among types of plans you may offer, e.g., HMOs, PPOs, regional PPOs, PFFS? If so, why? Do you offer enhanced benefits in all plans or only some? Are you participating in the demonstration for all types of plans?

6.0 CLOSING DISCUSSION – PDP ORGANIZATIONS’ PERSPECTIVES ON FUTURE CHANGES/IMPROVEMENTS IN THE MEDICARE PART D PROGRAM

This is a way to close out the interview by getting a bigger picture view from the plans.

Target Interviewee: Medicare corporate product manager or Corporate Vice President

6a. From the viewpoint of your organization, how can the Medicare Part D program be made more attractive to Medicare beneficiaries?

6b. From your organization’s perspective, how could the Medicare Part D program be made attractive to current and potential PDP plans?

- *Essentially, how could Medicare ensure that there will be PDP plans in all regions in the future, beyond this first “trial period” year?*