



Marketplace Assessment of Drug Plan Options

PDPs vs. MA-PDs

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Agenda

- Marketplace Status
- Data Integration and Measuring Performance
- Medicare Payment Policies
- The Future?



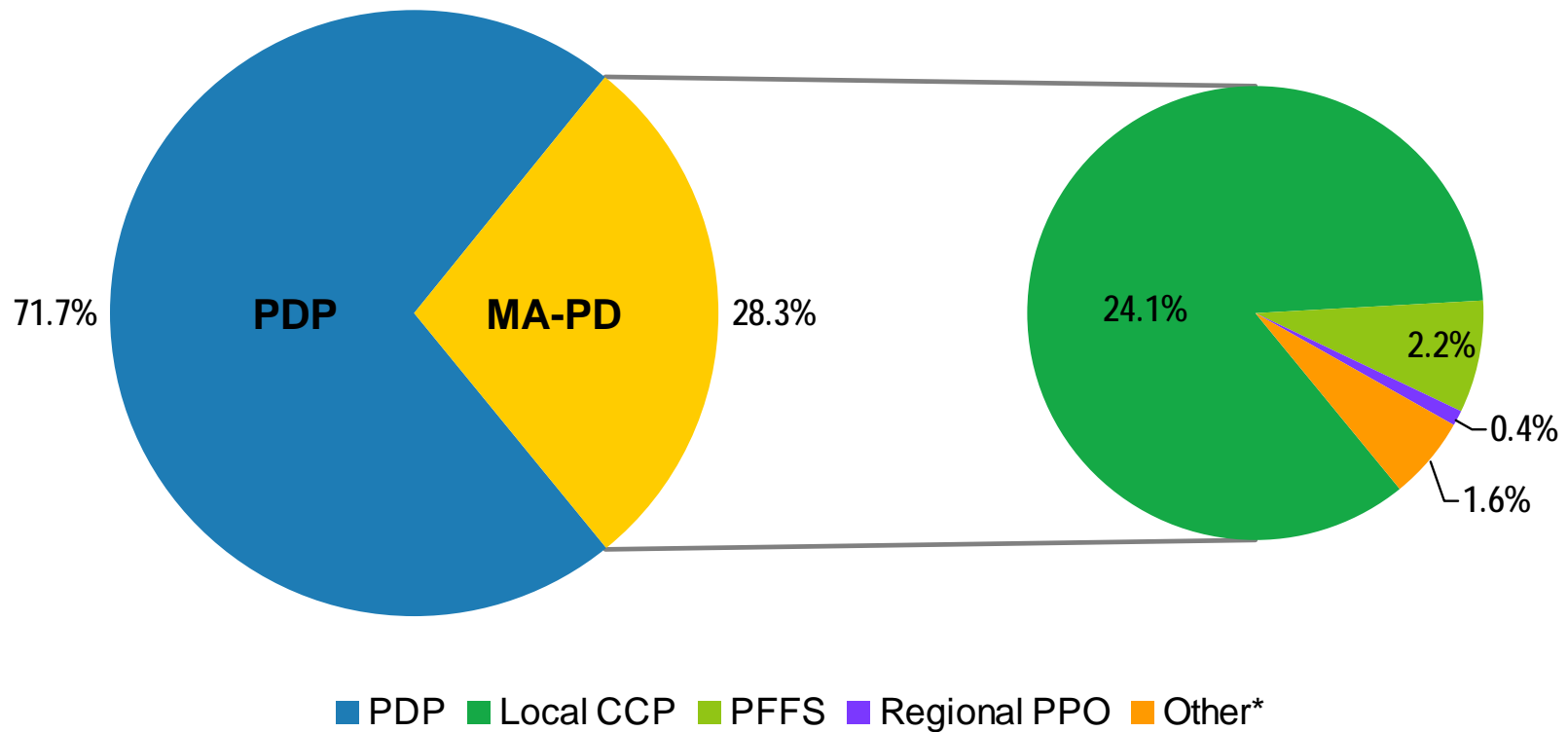
Status of Part D Marketplace PDPs vs. MA-PDs



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PDP Enrollment Exceeds MA-PD Enrollment by 2.5x in August 2006

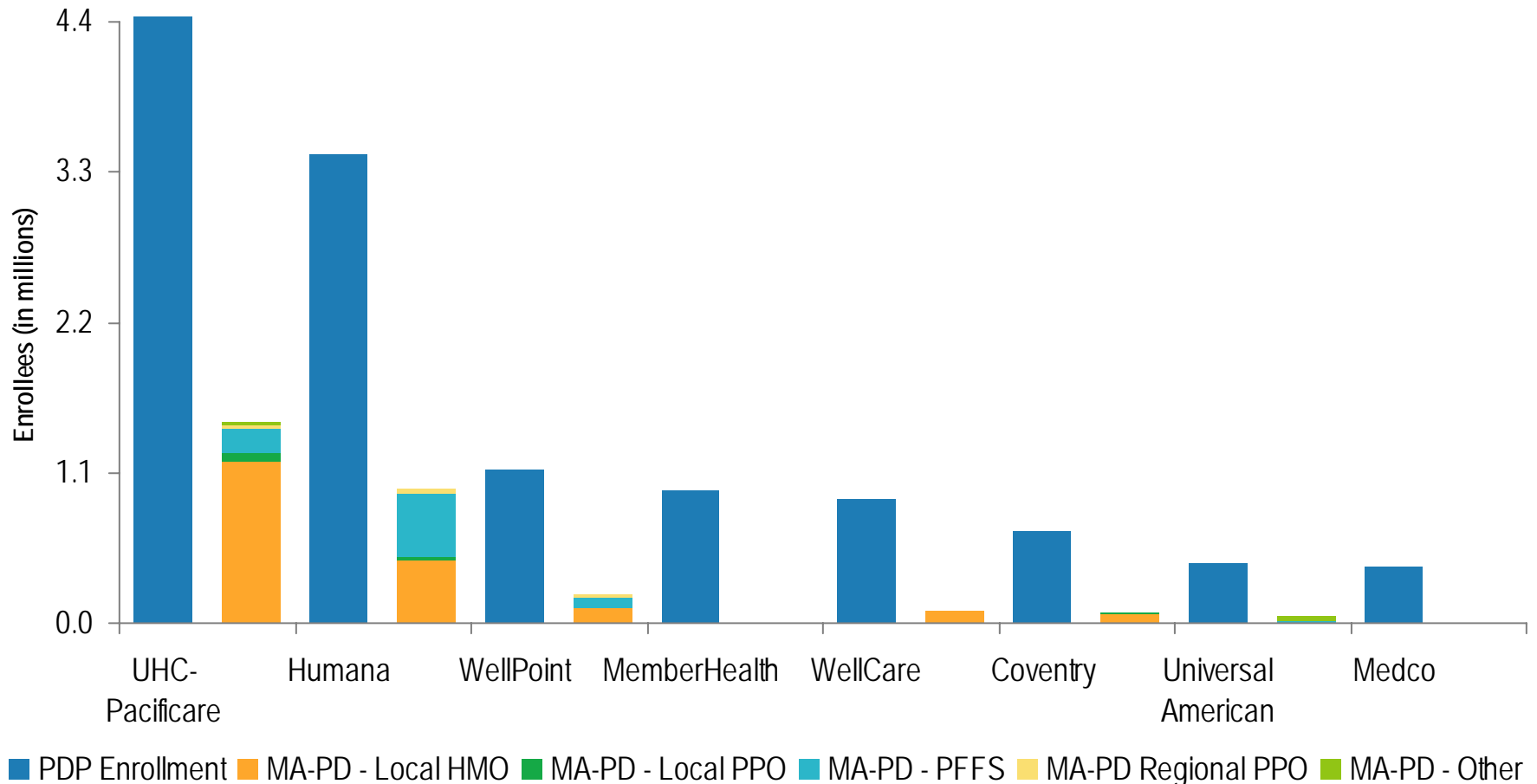
PDP vs. MA-PD Enrollment in 2006



SOURCE: Avalere Analysis of CMS Part D Enrollment Data Released August 2006



Top 8 Organizations By Enrollment Have Both PDP and MA-PD Offerings: Most Enrollees are in PDPs



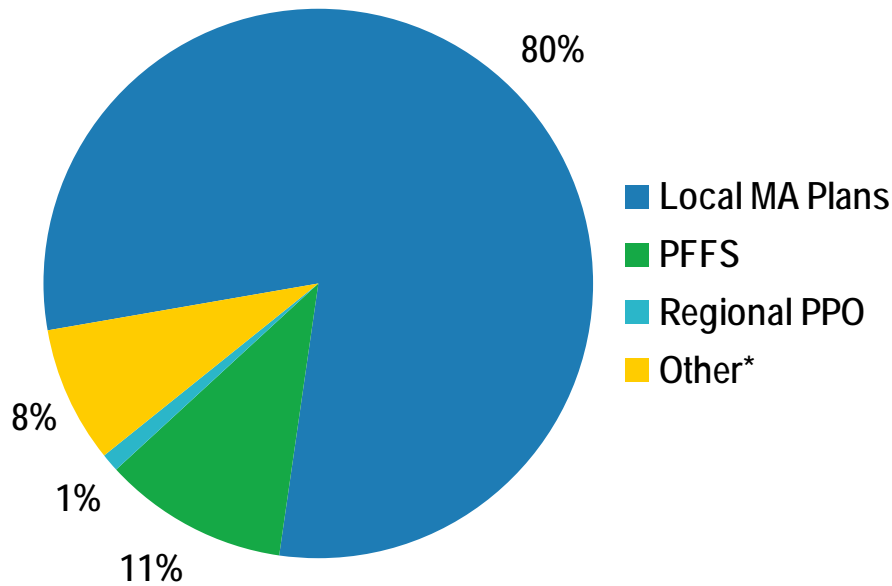
SOURCE: Avalere Analysis of CMS Part D Enrollment Data Released August 2006



Most MA-PD Plans Are Local Serving Either One County or Multiple Counties

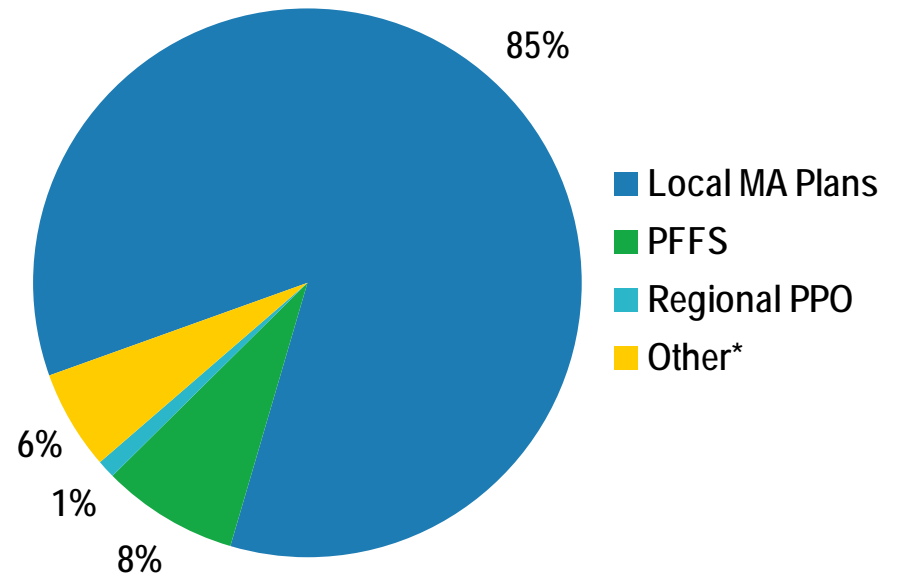
Total MA Plans

N = 23,668,713



MA Plans Offering Prescription Drug Coverage

N = 22,683,272



SOURCE: Avalere Analysis of CMS Data Released August 2006

*Other includes Demos, Cost Plans, and PACE

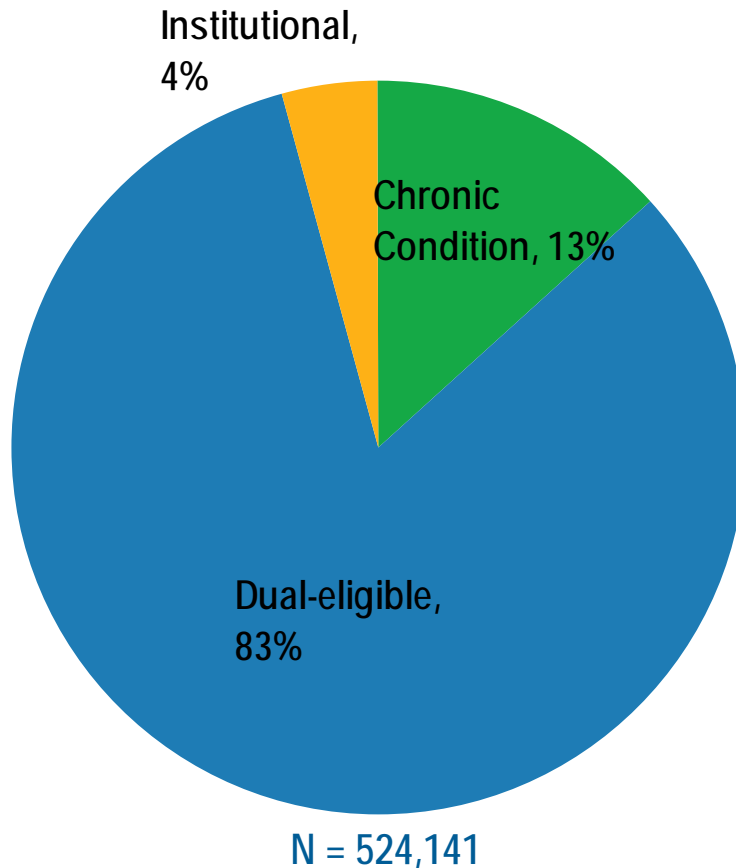


Special Need Plans (SNPs): A Growing Opportunity for Medicare Advantage

- SNPs function very similar to MA plans but must also provide the Part D drug benefit as well as additional services targeted to specific populations
- SNPs were initially estimated to enroll approximately 75,000, but enrollment has increased to over 500,000 in 2006
- Since SNPs target certain high-risk populations like the chronically-ill, their risk-adjusted payments tend to be high, which can be a profitable opportunity if costs are managed well
- PDPs cannot provide the type of tailored/integrated benefit that SNPs can

SNP Enrollment Is Primarily in SNPs: Designated for Dual-Eligible Beneficiaries

SNP Enrollment by SNP Type



430,000 Medicare beneficiaries are enrolled in dual eligible SNPs which make up 82% of the plans in the 2006 SNP market

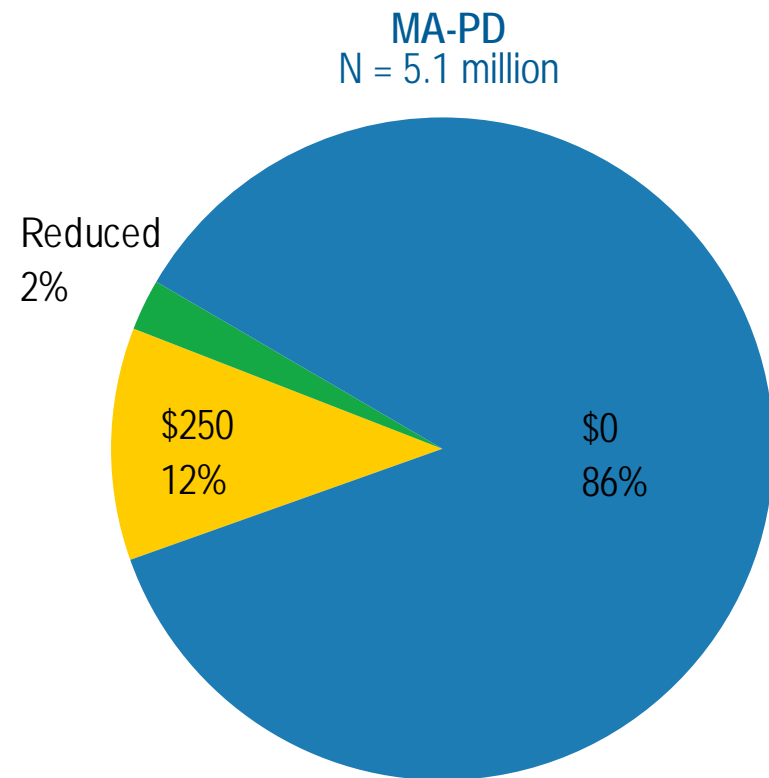
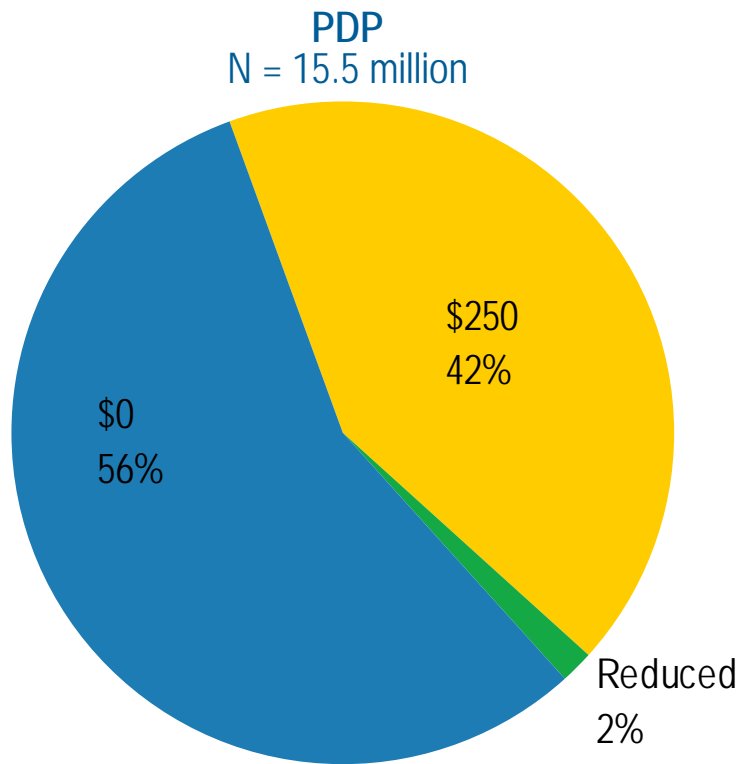
- 70,000 are enrolled in SNPs for beneficiaries with chronic conditions
- 22,000 are enrolled in SNPs for the institutional (e.g., nursing home) population

Source: Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Plan benefit and formulary design data from April 2006. Enrollment data from July 2006. Analysis excludes lives in Part D plans with fewer than 10 enrollees. Includes lives enrolled in employer/union only Part D plans and the U.S. territories.



Majority of MA-PD Lives Are in Plans w/ No Deductible

Percent of Enrollment in PDPs/MA-PDs Offering \$0, Reduced, and Standard (\$250) Deductibles

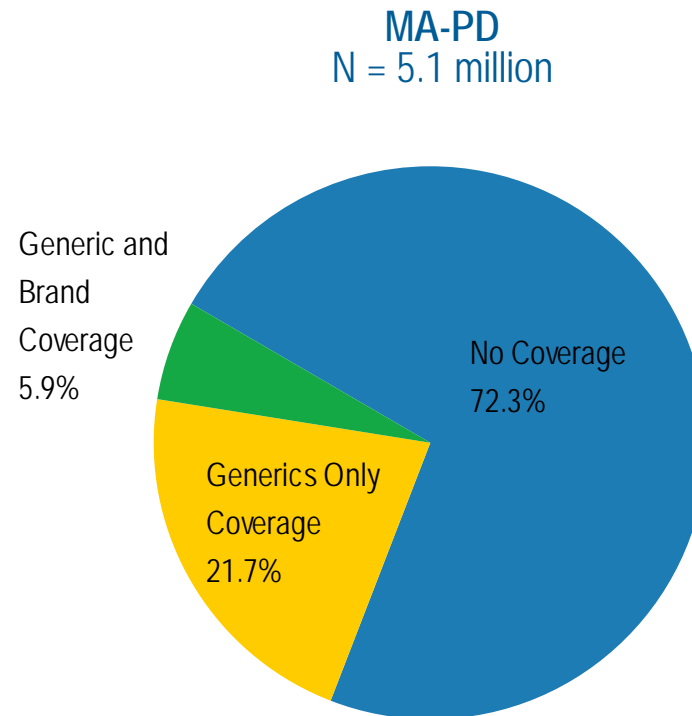
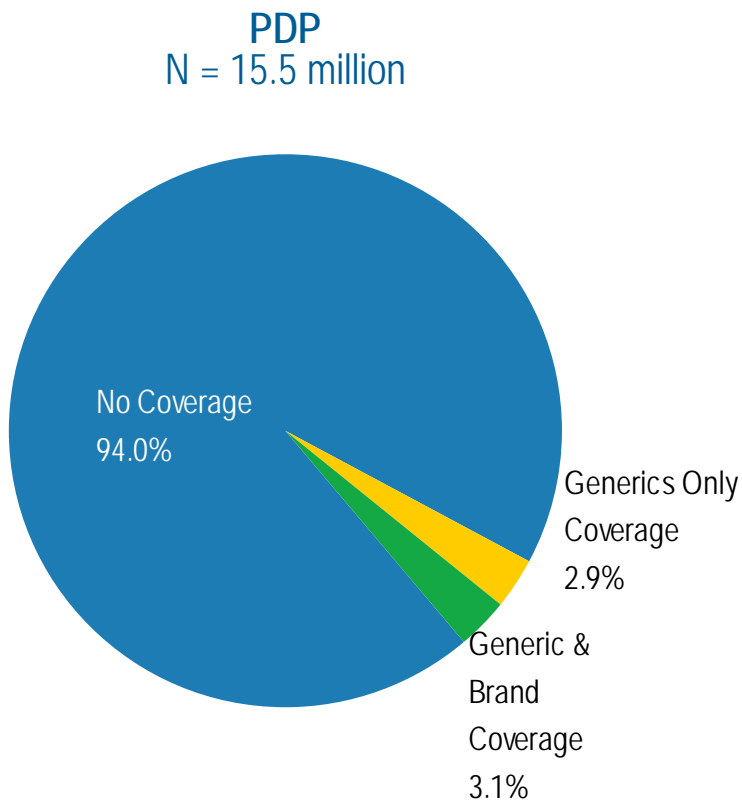


Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Plan benefit and formulary design data from April 2006. Enrollment data from July 2006. Analysis excludes lives in PDPs/MA-PD plans with fewer than 10 enrollees, lives in employer/union only Part D plans, and lives in the U.S. territories.



Most PDP Enrollees Have No Gap Coverage while 1/3 of MA-PD Enrollees Do Have Gap Coverage

Percent of Enrollment in PDPs/MA-PDs Offering Coverage in the Gap

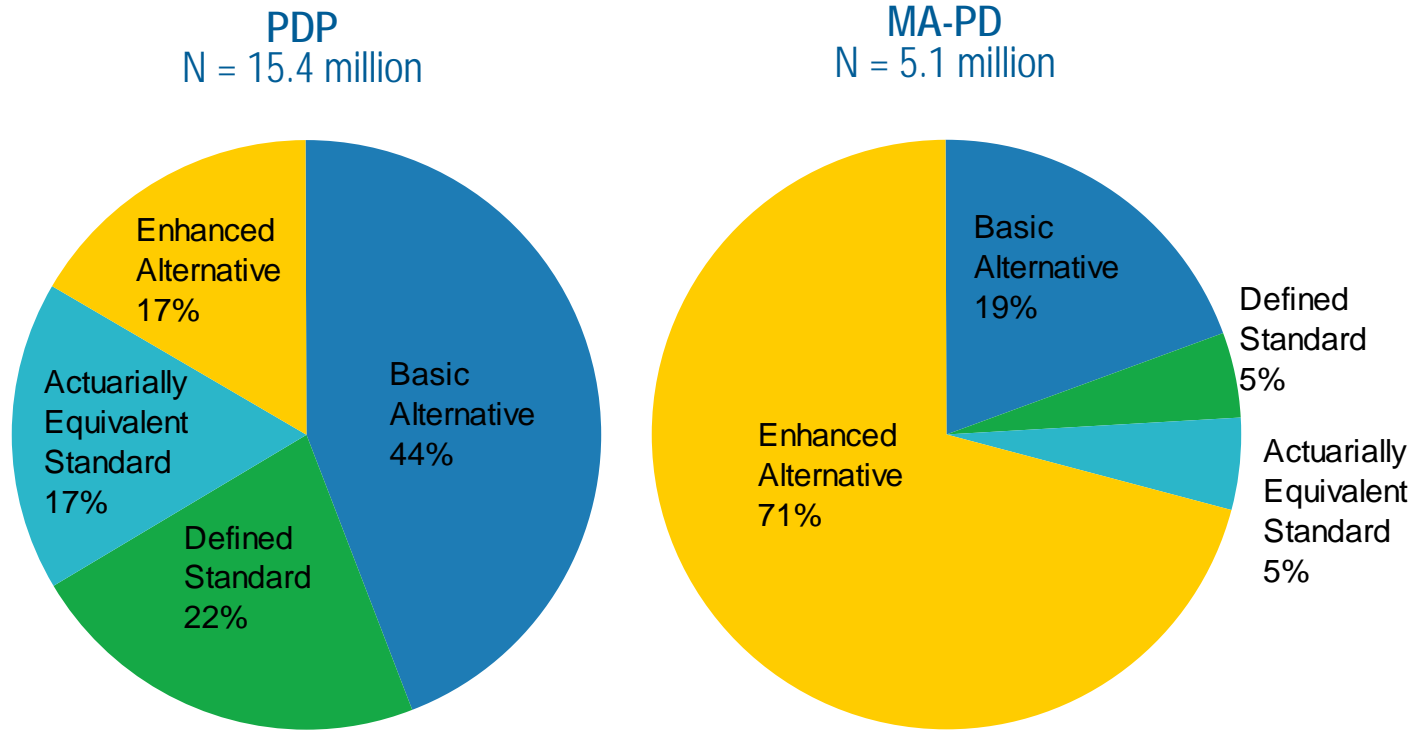


Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Plan benefit and formulary design data from April 2006. Enrollment data from July 2006. Analysis excludes lives in PDPs/MA-PD plans with fewer than 10 enrollees, lives in employer/union only Part D plans, and lives in the U.S. territories.



Most MA-PD Enrollees Chose Plans w/ Enhanced Benefits

Percent of Enrollment in PDPs/MA-PDs By Benefit Design



The four benefit types are:

Defined Standard:
the standard benefit as defined in law

Actuarially Equivalent Standard:
same benefit structure as the defined standard, but varies cost-sharing across tiers

Basic Alternative:
actuarially equivalent to the defined standard, but may alter the benefit structure (e.g., deductible) and vary cost-sharing across tiers

Enhanced Alternative:
actuarially more generous than the defined standard; may include non-Part D covered drugs and coverage in the gap

Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Plan benefit and formulary design data from April 2006. Enrollment data from July 2006. Analysis excludes lives in PDP/MA-PD plans with fewer than 10 enrollees, lives in employer/union only Part D plans, and lives in the U.S. territories. Note: Benefit design data is unknown for two plans accounting for 106 lives.





Data Integration and Performance Measurement



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■■■ Data Integration a Focus of CMS: MA Plans Will Be Better Positioned for Market Opportunities

- CMS has expressed strong interest in eventually integrating medical and pharmacy claims to drive a better understanding of quality and costs in the Medicare program
- Currently, CMS is collecting certain data elements through the prescription drug event (PDE) file in Part D
- MA-PDs may be better positioned than PDPs to facilitate and use the data collected through these efforts
- MA-PDs have more incentive to promote the integration of these data sets and potentially market the results of this data to clients (e.g., employers)

Legislative Push for Data Integration

- Data from the Medicare drug benefit can be linked with hospital, ambulatory care, and other data to create **a new comprehensive data resource**
- The data can be used to:
 - » Study drug safety
 - » Effectiveness of medical care in older adults, low-income, disabled, and vulnerable populations
- Data integration will provide new tools for agencies such as the FDA, CDC, AHRQ, NIH, CMS, and research organizations
- MA-PDs will have an easier time integrating Medicare Parts A, B, and D data when/if this data integration effort takes effect

Managed Care May Be The Next Frontier in Pay for Performance

- To date, CMS has not initiated a public/private partnership to identify and validate managed care-specific quality measures for use in the Medicare program
- Most Medicare providers are engaged in these efforts already:
 - » Physician Voluntary Reporting Program
 - » Ambulatory Quality Alliance
 - » Pharmacy Quality Alliance
 - » Hospital Quality Improvement Program
- Managed care could be next with regard to a focus on reporting and pay-for-performance initiatives
- More than likely quality measures will be tied closely to those being identified through the efforts mentioned above



Medicare Payment Policies: Driving Differences Between PDPs and MA-PDs



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MA Plans Are Typically Being Paid Above Fee-For-Service Costs for the Medical Benefit¹

- MA plans, particularly local plans in rural areas, are benefiting from capitated payments for medical costs that are much higher than fee-for-service (FFS) costs in the counties they serve
 - » Previously, rural and urban payment floors were established to encourage managed care participation
 - » While these floors no longer exist, local MA plans are now paid by the greater of 102% of FFS costs or the national average Medicare growth rate (regional plans are paid based on a blend between local and national rates)
- *These increased payments afford MA plans more flexibility in offering supplemental benefits like a reduced Part D premium*

1 - According to the latest MedPAC report of MA spending relative to FFS, MA plans will be paid on average 11% more than FFS in 2006.
http://www.medpac.gov/publications/other_reports/MEDPAC_briefs_MA_relative_payment.pdf

■■■ Reinsurance Demonstration An Opportunity for MA-PD Plans to Manage Costs Across Both Medical and Pharmacy Benefits

- Reinsurance Demonstration May Benefit MA-PDs over PDPs
 - » Reinsurance is incorporated into a single capitated payment to plans
 - » MA-PDs can benefit the most because they will have access to Parts A, B, D, and reinsurance payments (Part D catastrophic) in one lump payment
 - » PDPs will have higher risk in adopting the reinsurance demo because they have less funds to spread the risk

Predictive Power of Part D Risk Adjustment May Be Debated

- Part D Risk Adjuster Model assigns predictive costs and relative factors to condition categories (RXHCCs)
 - » Disease groups are derived from the CMS–HCC risk model, but have been modified to reflect drug spending rather than medical spending
- Data used for the first years of the Part D benefit model based on drug expenditure data from federal retirees in Blue Cross Blue Shield (BC/BS) Federal Employee Health Benefit plan
- $R^2 = 0.23$ for spending, $R^2 = 0.23$ for plan liability
 - » Similar to predictive power of MA risk adjuster
- Payment implications
 - » CMS estimates that risk adjuster will overpay for people in the lowest and highest deciles of predicted costs
 - » Unclear whether plans will view adjuster as adequate

■ ■ ■ The Future?

- Will Part D organizations angle to move lives from the stand alone benefit to an integrated benefit?
 - » Slow uptick in MA enrollment but still relatively stable
 - » Very modest growth in the regional PPO space
 - » Most Part D organizations with a significant number of lives offer an MA-PD product
 - » Within MA-PD offerings, seeing large growth in the private fee-for-service market
- Will Congress and/or CMS eventually reduce MA medical payments to align with fee-for-service costs?
 - » Impact on interest in Part D market growth
 - » Role of risk adjustor in debate about payment adequacy?
- What opportunities exist for MA-PDs that give them significant advantages and will the market respond?
 - » Medication therapy management programs (MTMP)
 - » Data integration products
 - » Supplemental benefits (low premiums, more generics)