POINT OF VIEW

FEBRUARY 2015

THE PART D DILEMMA

Medicare prescription drug plans are a tough, low-margin business that gets harder every year. But they are also a critical piece of a Medicare portfolio. You can succeed in Part D—but can you succeed alone?

AUTHORS
Jim Fields
Marcia Macphearson
Greg Berger

Medicare Part D presents a bit of a conundrum. It's in high demand and a gateway to larger opportunities, yet significant profitability challenges make it difficult to run solo. The Medicare Part D dilemma can be characterized as a:

A win for consumers: In many ways, Medicare Part D, the program that provides seniors with prescription drug coverage, has been a great success. For the nearly half of Medicare beneficiaries who have enrolled, it has provided medications at relatively low cost; the 2014 average monthly premium (weighted to reflect enrollment) is just $41.23. And costs to the taxpayer have been surprisingly low. In fact, net federal spending on Part D in 2013 was a stunning 50 percent less in Fiscal Year 2013 than the original Congressional Budget Office projections.

A gauntlet for plans: For insurers, however, and especially for smaller health plans, Part D is a difficult business, dominated by a handful of players and marked by extreme pressures on pricing, in which it is hard to achieve even the limited margins permitted by law. At the same time, given Part D's unique position as the Medicare insurance coverage that nearly every senior chooses—and the first one that most seniors encounter—it is an important gateway to other insurance products

Part D is an essential tool in establishing a relationship with seniors—a relationship that can in the long run be used to introduce them to a whole array of higher-margin products.

and thus a vital part of most health plans' overall go-to-market strategy. As a result, smaller health plans that aspire to success in the Medicare Advantage market find themselves in the unenviable situation of needing to succeed in a business that on its own terms doesn't really make sense for them. And Part D threatens to become even less desirable as CMS continues to ratchet up the regulations that govern it.

A game of economies: Achieving economies of scale is the critical success factor. As a result, small plans will be required to explore new partnerships that allow them access to the capabilities required to win in Part D without the traditional investment/operating costs associated with growing organically.

In this paper, we will describe why Part D is so difficult and how health plans can minimize the risk and maximize the benefit of remaining in this essential line of business.

WHY IT'S IMPORTANT TO PLAY

The challenges of Part D are substantial—so substantial that it probably makes sense to begin by discussing why a health plan should fight to maintain a position in the market.

It is not for the sake of profits. Margins are low in Part D and likely to remain that way. Rather, Part D is an essential tool in establishing a relationship with seniors—a relationship that can in the long run be used to introduce them to a whole array of higher-margin products such as Medicare Advantage and Medicare Supplement plans.

Why? Because Part D is the only commercially provided product in Medicare that requires seniors to make a decision or face a penalty. For many, it is their first substantive contact with Medicare and the first time that they need to ask what Medicare coverage is right for them and what other products they need. This is an important and confusing set of decisions. Research tells us several things about how seniors react to it:

Once they choose, they stick. Once seniors select a Part D plan, they are reluctant to revisit the issue. According to the Henry J. Kaiser Family Foundation, Medicare enrollees "seem willing to do just about anything to make their existing plans work." When seniors do change Part D plans, Kaiser maintains "increasing costs seem to be the main driver." Seniors want coverage from an insurance plan they recognize for the drugs they use at a cost they can afford and with access to pharmacies and pharmacists they trust. Then they want to be done with the decision.

PDP members buy other products. As consumers work on making their Part D decision, they also begin to consider Medicare Advantage, Medicare Supplement (Medigap), and other options. We interviewed several brokers and Medicare program executives, and the message was clear—the PDP decision often serves as a "foot in the door" to a broader conversation with enrollees about the portfolio of Medicare coverage options.

In an analysis of health plan members across seven states, Oliver Wyman found that 73 percent of seniors who purchased a PDP plan also purchased Medicare supplemental

Oliver Wyman found that 73 percent of seniors who purchased a PDP plan also purchased Medicare supplemental insurance or a Medicare (Cost) medical plan with the same payer entity.

insurance or a Medicare (Cost) medical plan with the same payer entity. The same was not true for the reverse, however: Only 38 percent of the people who enrolled in Medicare supplemental insurance or a Medicare (Cost) medical plan also enrolled in a PDP plan with the same carrier. These significantly different "attachment" rates suggest that those who enroll in a PDP plan are more likely to purchase other products with the same health insurer, therefore demonstrating how PDPs have the potential to drive business in other segments of a payer's Medicare portfolio.

A key advantage for some plans may be the value of a trusted name. The Kaiser research found, "Names [of insurance plans] matter to beneficiaries… At a most basic level, a plan from a company with a recognizable name seems most important."

Additionally, CMS regulations permit PDP sponsors to market other health-related products to their current PDP enrollee population, thus giving plans an ongoing captive marketing pool as enrollees' benefit needs change over time.

WHY IS PART D SO HARD?

Because seniors must enroll in Part D or face a penalty, and because it truly does provide great value to participants, enrollment has grown rapidly since the program launched in 2006. Between 2009 and 2014, national PDP enrollment grew from approximately 17.4 million to 23.4 million. That represents an annual growth rate of 6.1 percent, roughly double the growth of the Medicare-eligible population. This reflects an increase in PDP market penetration from 38 percent of the Medicare eligible population to 44 percent today.

And yet many stand-alone PDP plans are losing enrollees each year. For example, of the 79 unique PDP contract entities with enrollees in June 2013 and June 2014, approximately 49 percent saw declining enrollment from the previous year . Overall enrollment is rising however, but is concentrated in a few plans that are garnering the bulk of the increase. (Exhibit 1). Additionally we know from our work with clients that many others are struggling to stay in the black on their PDP business. According to a Kaiser study, approximately three out of four PDPs that existed at Part D's inception in 2006 are no longer in the market in 2014.

Exhibit 1: PDP marketing consolidation: Fewer plans but rising enrollment

	JUNE 2009	JUNE 2010	JUNE 2011	JUNE 2012	JUNE 2013	JUNE 2014
Number of unique PDP plans	94	91	84	83	79	80
Total PDP enrollees (millions)	17.6	17.8	18.8	20.0	22.7	23.6
Average PDP enrollment per contract (thousands)	187	196	224	241	288	295

Source: Kaiser Family Foundation

Meanwhile, the market is rapidly consolidating. As of June 2014 three companies command more than 55 percent collectively—UnitedHealth Group (22%), SilverScript (18%), and Humana (16%). Each of these plans offers a PDP product in all of the 34 PDP regions, making each a truly national player. These plans have the scale to achieve administrative efficiencies, manage the costly compliance demands, and strike broader co-branding arrangements that bolster their member capture. For example, UnitedHealth Group partnered with AARP on its PDP, CVS Caremark owns SilverScript, and Humana and Walmart have a joint co-branded product.

Indeed, CMS seems eager to intensify marketplace consolidation. The agency has stated: "We believe it is in the Part D program's best interest to be more discriminating about the entities with which we partner to deliver the Part D benefit."

Smaller plans are finding the deck is stacked against them for several reasons:

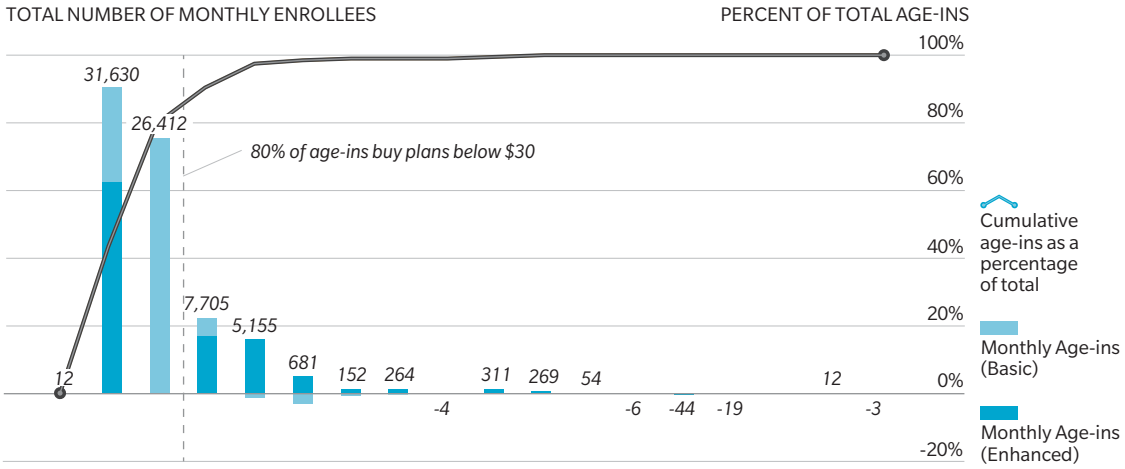
High fixed costs, low margins. Comparing Parts A and B (medical benefits) with Part D is like comparing dollars and dimes. Across all US counties, the average 2014 fee-for-service Medicare medical reimbursement was $756.15 per member per month (PMPM). The national average Part D bid for the same year was only $75.88 PMPM—10 percent of medical reimbursement.

While the revenues are significantly smaller in Part D than in Medicare Advantage, the regulatory requirements for Part D plans are not meaningfully less. Each year, stand-alone PDPs are subject to similarly complex, expensive compliance processes as Medicare Advantage plans. Furthermore, PDPs are subject to CMS's MLR regulation that a minimum of 85 percent of premium revenue be used to cover claim costs. Given the low top-line revenue for PDP plans, the remaining 15 percent—minus the cost of compliance and administration—leaves very little room for profit. Plans that offer an MAPD plan, Retiree Group drug coverage options, and a standalone Part D plan may have some ability to share the administrative cost burdens across both membership populations to help their cost efficiency. However, plans that offer standalone Part D and a Medicare supplemental plan only will not have the same types of synergy. Additionally, CMS has increased its compliance demands in recent years—as evidenced by a growing number of sanctions on PDP and Medicare Advantage plans (from six in all of 2008 to 36 by the end of November 2014). The penalty for a CMS sanction can include fines, temporary halts on new enrollment, and in extreme cases a forced plan exit—devastating consequences for a small plan that struggles to meet baseline compliance criteria.

Extreme price sensitivity. The PDP landscape is highly competitive. Enrollees in each region could choose from an average of 34 stand-alone PDP options in 2014—not including the dozens of prescription drug coverage options available through Medicare Advantage (MAPD) offerings.

Faced with a multitude of choices, PDP enrollees are very sensitive to price. Our analysis shows that in June 2014, half of individual PDP enrollees belonged to plans with a monthly premium below $40. And 80 percent of the Medicare age-ins who selected individual PDP plans in the first six months of 2014 chose plans with monthly premiums below $30 (see Exhibit 2).

Exhibit 2: Monthly age-ins selecting PDPs in 2014, by premium (nationally)



PREMIUM ($)	0-10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100	100-110	110-120	120-130	130-140	140-150	150-160	160-170	170-180
# Basic Products	1	23	213	198	87	48	15	5	2	1	0	1	0	0	0	0	0	0
# Enhanced Products	0	34	0	47	85	102	67	46	9	37	48	40	39	21	6	0	1	2

Source: Oliver Wyman analysis

Notes Plans have negative numbers of age-ins if the actual age-ins were fewer than the assumed age-out rate of 3.5%

This trend is exacerbated among Basic plan enrollees: more than 95 percent of them selected plans below $30. Additionally, PDPs with premiums below a "benchmark" price set by CMS each year can receive automatic enrollment of the low income subsidy eligible population—which represents close to 11 million enrollees—creating strong incentive to maintain low premiums.

CMS rules make it hard to keep up. It should be no surprise that the PDP marketplace is competitive. Congress designed it that way. As the Congressional Budget Office stated in its July analysis, "Many elements of the Medicare Part D program were designed to foster competition between plan sponsors… Because of the competitive design of Part D, plan sponsors have ongoing incentives to provide a combination of characteristics that attract potential enrollees while keeping premiums low."

That may be true overall, but in fact new CMS regulations make it more difficult for undersized plans to offer lower prices. PDPs are required to price their offerings each year based on the previous year's member experience—a provision intended to prevent plans from unfairly underpricing each other. Many health plans that found themselves locked into unfavorable prices would reset their baseline by launching a new PDP offering. The new regulations block that strategy by limiting carriers to only one PDP sponsor contract (and thus no more than one basic and two enhanced plans) in any region. In effect, PDP plans will be locked-in to the pricing position they have achieved with few opportunities to reposition themselves to attract new enrollment.

Although PDP itself is a low margin business, PDP enrollees still reflect 44 percent of the Medicare eligible population and play a role in a comprehensive Medicare product portfolio.

MEETING THE PDP CHALLENGE

Although PDP itself is a low margin business, PDP enrollees still reflect 44 percent of the Medicare eligible population and play a role in a comprehensive Medicare product portfolio. As a result, plans both large and small have focused on optimizing the traditional plan activities, including: finding administrative efficiencies, maintaining tight management of compliance demands to avoid costly sanctions, rolling out therapeutic management programs, developing smart benefit/formulary designs for PDP products, and ramping up sales and marketing efforts to draw continued attention to PDP.

These traditional plan optimization activities have become table stakes and lend the most advantage to the plans that have the scale to achieve cost economies. But they will not be enough to position small sized PDP plans for success in tomorrow's Part D market. We believe plans will need to take more drastic steps to win:

Understand your goal. An under-sized, free-standing PDP by itself is a very difficult business to be in. It is crucial to understand how you plan to use your PDP to help feed other revenue streams. Do you have an adequate array of products targeted at your potential PDP members? How are you using the customer's never-to-be-repeated first encounter with the Medicare system to demonstrate how you offer value in other areas? What are your plans for the whole customer life cycle?

Solve the fixed cost puzzle. Regulatory and compliance issues are a disproportionate burden on smaller PDP plans—as illustrated in Exhibit 3, small plans generate so little revenue that they are hard pressed to cover vendor costs (and certainly aren't getting the most favored drug discounts and PBM rates). It is crucial to find a way to drive greater scale. There are a number of alternatives... but they disproportionately require partnership: PDP plans can merge or collaborate to spread their PDP costs over a larger base. They can buy services from another PDP plan (or sell their own services to another PDP). They can form consortiums. The appropriate choice will depend very much on the circumstances the health plan finds itself in. But if this challenge is not met, the PDP business will become increasingly risky and untenable for small and mid-sized players over the next few years.

Exhibit 3: Why scale matters

Under CMS's medical loss ratio limits, a PDP covering 10,000 lives can generate only $1.2 million for administrative costs or profit, which is not sufficient to cover even table stakes vendor or internal administrative costs.

PDP LIVES		10,000	100,000	1,000,000
	PMPM			
Revenue ($M)	$68.00	$8	$82	$816
Admin & Profit ($ millions)	15%	$1.2	$12.2	$122.4
Table Stakes Administrative Services:				
	Claims		Formulary Management	
	Enrollment		Medication Therapy Management	
	Customer Service		Product Design	
	Marketing		Compliance	
	Broker Commissions		Actuarial/Pricing	
	Legal		Bid Development	

Source: Oliver Wyman analysis

Partner to win. The high fixed cost, low margin aspect of the Part D business clearly lends itself to economies of scale as a key success strategy. For new, small or geographically constrained plans the capabilities and timeframes needed to achieve the necessary scale on their own can be an insurmountable hurdle. Finding a partner creates a viable path to jump the scale curve. While outsourcing arrangements are a possibility and have been shown to work in some settings, they struggle from the fact that the contract holder still must maintain many of the regulatory compliance duties and several of the go-to-market activities. Ultimately we expect a growth of white label offerings where a handful of national contract holders develop Part D offerings that could be branded to serve the needs of plans spread across different Part D regions (e.g. coalitions of Blue Cross and Blue Shield Plans, coalitions of local or provider owned health plans, etc.). Finding "out-of-the-box" brand partners is a strategy that has been very successful in the Part D market in recent years as well. Both United and Humana have proven that partner entities can vastly improve market presence for a PDP plan. Through its partnership with AARP, United has stronger brand positioning with its target market. For Humana, its partnership with Walmart provides access to the retailer's drug sourcing, distribution methods, and preferred networks that enable consistently lower prices and bring a household brand name. These partnerships are important though difficult for small plans to replicate. As a coalition, a group of PDP plans would have the scale and national coverage to entice a prominent retailer.

CONCLUSION

While there are some examples of undersized PDPs achieving success in Part D, they are the minority, and we believe they are short lived if they continue with business as usual. Part D is an important product in a company's Medicare portfolio and it is predominantly a low cost / price game. As such, plans will need to band together as a consortium or look for a partner that can give them the scale needed to succeed.

Oliver Wyman is a global leader in management consulting. With offices in 50+ cities across 25 countries, Oliver Wyman combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. The firm's 3,000 professionals help clients optimize their business, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is a wholly owned subsidiary of Marsh & McLennan Companies [NYSE: MMC], a global team of professional services companies offering clients advice and solutions in the areas of risk, strategy, and human capital. With 52,000 employees worldwide and annual revenue exceeding $10 billion, Marsh & McLennan Companies is also the parent company of Marsh, a global leader in insurance broking and risk management; Guy Carpenter, a global leader in risk and reinsurance intermediary services; and Mercer, a global leader in human resource consulting and related services.

Oliver Wyman's Health & Life Sciences practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Deep healthcare knowledge and capabilities allow the practice to deliver fact-based solutions. In 2011 Oliver Wyman launched a Health Innovation Center (OWHIC) dedicated to promoting positive change in healthcare. OWHIC champions innovation by disseminating proven innovations; envisioning market-based solutions to today's and tomorrow's challenges; and establishing a cross-industry community of thought-leaders to share and shape ideas.

To learn more about the Oliver Wyman Health & Life Science's government programs perspective, please contact Jim Fields at jim.fields@oliverwyman.com

For more information, visit www.oliverwyman.com

Follow Oliver Wyman on Twitter @OliverWyman

www.oliverwyman.com

OLIVER WYMAN