Actuarial Equivalence of Medicare Prescription Drug Plans

A Luncheon Briefing Sponsored By

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Actuarial Equivalence of Medicare Prescription Drug Plans

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Presentation Goals

- Define and illustrate actuarial equivalence
- Summarize method used to determine actuarial equivalence under alternative Rx plan designs
- Provide examples of actuarially equivalent plans

Actuarial Equivalence – What is it?

- For a given population and prescription drug spending pattern:
  - Total costs under each plan design are the same
  - Net plan per member per month (PMPM) costs (total costs less member cost sharing) are the same
    - Cost sharing for individual members could vary between plan designs
  - Plan designs cover the same services
- Key assumptions:
  - Same population is enrolled under each plan design
  - No changes to behavior based on the benefits provided under each plan design

Example of Actuarial Equivalence

	Plan Design 1	Plan Design 2
Cost sharing type	Coinsurance	Copayments
Member cost sharing requirement	30% generic 50% brand	$7.50 generic $30.00 brand
Prescription average cost	$25 generic $60 brand	$25 generic $60 brand
Average member cost sharing	$7.50 generic $30.00 brand	$7.50 generic (1) $30.00 brand (1)
(1) Assumes all prescriptions cost more than the copayment or that the member pays the full copayment regardless of cost		

Actuarial Equivalence – What isn't it?

- Actuarially equivalent plan designs will not necessarily result in the same premiums because plans can develop their premiums to reflect:
  - Expected behavioral reactions to different plan designs (i.e. adverse selection)
  - Actual negotiated prices
  - Utilization management techniques (e.g. formularies, step therapies, etc.)

Method Used to Examine Costs and Determine Actuarial Equivalence

General Method

- Uses historical data adjusted to the time period being analyzed
- Calculates total allowed cost before applying plan design
- Applies the different plan designs to the total allowed cost to determine split between plan and members
- Adjusts alternative plan design until total member cost sharing under standard plan and alternative design are equal

Data

- Medicare+Choice data for members with unlimited benefits (over 50,000 members)
- Calendar year 2001 data adjusted to 2006
- No adjustments made to reflect different spending behavior of FFS population from M+C population
- Adjustments applied to reflect the age/gender distribution in Medicare FFS population
- **Data used for illustrative purposes only; actual costs of drug plans will differ**

Simplifying Assumptions

- Projected costs do not include:
  - PBM or pharmaceutical company rebates
  - PBM or other administrative fees
  - Any change in trend rates, generic/brand mix, or discounts/dispensing fees
  - Any plan design differences by income
- **Data used for illustrative purposes only; actual costs of drug plans will differ**

Distribution of Gross Allowed Claims by Member (2006)

Claims threshold	Percent of members with claims above threshold	Percent of spending above threshold
$0	89%	100%
$100	85%	96%
$250	79%	90%
$500	72%	82%
$1,000	59%	67%
$2,000	40%	44%
$4,500	13%	16%
$7,500	4%	5%

Impact of Deductible (2006)

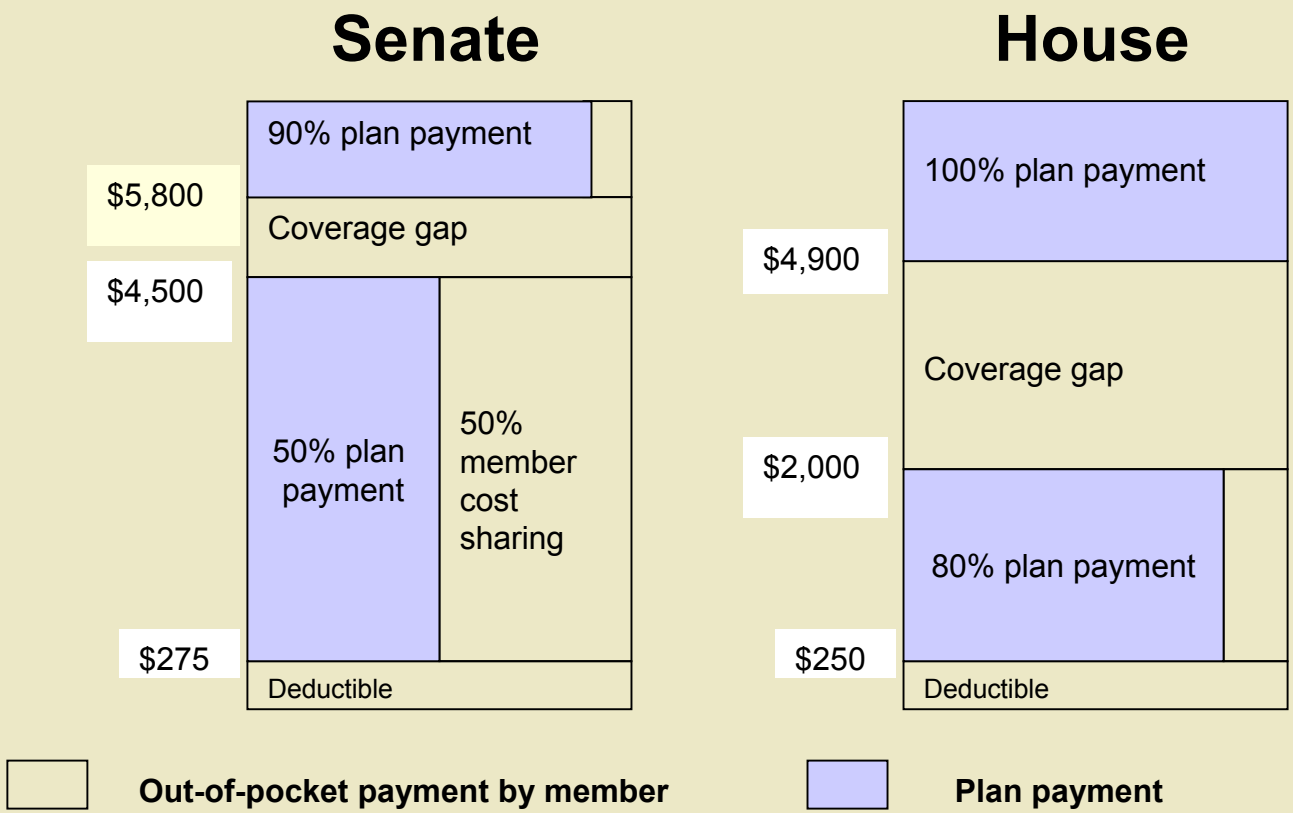
- $100 deductible eliminates 4% of total costs
- $250 deductible eliminates 10% of total costs
- $500 deductible eliminates 18% of total costs
- $1,000 deductible eliminates 33% of total costs

House and Senate Prescription Drug Plans

Standard Plan Designs (2006)

Cost sharing category	Senate Bill	House Bill
Deductible	$275	$250
Member coinsurance	50%	20%
Initial coverage limit	$4,500	$2,000
Out-of-pocket maximum	$3,700	$3,500 (means tested)
Approximate attachment point (total claims at which member hits out-of-pocket maximum)	$5,800	$4,900
Member coinsurance above out-of-pocket maximum	10%	0%

Standard Plan Designs (2006)



Estimates of Utilization and PMPM (2006)

- Senate Bill
  - 82% of prescriptions reimbursed at some level under standard plan
  - Approximately $102 net PMPM covered under standard plan (before member premium)
- House Bill
  - 59% of prescriptions reimbursed at some level under standard plan
  - Approximately $113 net PMPM covered under standard plan (before member premium)

Distribution of Gross Allowed Costs (2006)

	Percent of gross allowed costs	
Cost sharing category	**Senate Bill**	**House Bill**
Deductible	11%	10%
Between deductible and initial coverage limit	73%	45%
Between initial coverage limit and out-of-pocket maximum	6%	31%
Above out-of-pocket maximum	10%	14%

Current Bills and Actuarial Equivalence

- Requirements for offering alternative coverage
  - Actuarial value of total alternative coverage must meet or exceed that of of standard coverage
  - Unsubsidized value of alternative coverage must meet or exceed that of standard coverage
  - For members with costs equal to the initial coverage limit, value of alternative coverage must meet or exceed value of standard plan coverage

Current Bills and Actuarial Equivalence - continued

- Requirements for offering alternative coverage (continued)
  - Senate bill only
    - Deductible and out-of-pocket maximum cannot vary from the standard plan
  - House bill only
    - Out-of-pocket maximum cannot vary from the standard plan

Examples of Alternative Plan Designs Actuarially Equivalent to Senate Plan Design (2006)

Cost Sharing Category	Senate Bill	Plan 1	Plan 2	Plan 3
Deductible	$275	$275	$275	$275
Member coinsurance	50.0%	52.4%	40.0%	30.0%
Initial coverage limit	$4,500	$6,800	$2,830	$2,210
Out-of-pocket maximum (OOP max)	$3,700	$3,700	$3,700	$3,700
Approximate attachment point (total claims at which member hits OOP max)	$5,800	$6,800	$5,230	$5,055
Member coinsurance above OOP max	10%	10%	10%	10%
Approximate “doughnut hole” amount (attachment point less initial coverage limit)	$1,300	$0	$2,400	$2,845

Examples of Alternative Plan Designs Actuarially Equivalent to House Plan Design (2006)

Cost Sharing Category	House Bill	Plan 1	Plan 2	Plan 3
Deductible	$250	$250	$250	$250
Member coinsurance	20.0%	30.0%	40.0%	47.8%
Initial coverage limit	$2,000	$2,450	$3,300	$7,050
Out-of-pocket maximum (OOP max)	$3,500	$3,500	$3,500	$3,500
Approximate attachment point (total claims at which member hits OOP max)	$4,900	$5,040	$5,330	$7,050
Member coinsurance above OOP max	0%	0%	0%	0%
Approximate “doughnut hole” amount (attachment point less initial coverage limit)	$2,900	$2,590	$2,030	$0

Caveats

- These estimates are for illustrative purposes only.
- Due to data limitations and simplifying assumptions, actual costs of prescription drug plans will likely differ from those presented here.

Questions

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