POLICY BRIEF

ADVERSE SELECTION IN PRIVATE, STAND-ALONE DRUG PLANS AND TECHNIQUES TO REDUCE IT

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ADVERSE SELECTION IN PRIVATE, STAND-ALONE DRUG PLANS AND TECHNIQUES TO REDUCE IT

Private insurance companies currently offer a variety of health insurance products for individuals. In most cases, these products are underwritten, whereby insurers may charge higher premiums to people with expensive health needs or, alternatively, deny coverage altogether. Despite this underwriting ability, no insurance companies now offer stand-alone prescription drug coverage. Why is this? One major factor may be that the cost of offering and administering a drug-only product is quite expensive. Consequently, the high premiums that insurers would need to charge would discourage enrollment of people with relatively low drug expenses. Thus, insurers would find it difficult to offer an attractive product.

The problem stems from adverse selection, whereby those who anticipate moderately high drug costs are more interested in purchasing drug coverage, particularly generous drug coverage, than those who anticipate low costs. Because future annual prescription drug costs generally are easier for an individual to calculate and predict than total health care spending, adverse selection is of greater concern for drug-only plans than for plans covering a broader range of health care services. Further, the risks associated with a stand-alone benefit cannot be spread across a range of categories (as is usually the case for health insurance); nor can health and drug costs be counterbalanced.

This brief explores how adverse selection may impair the implementation of a drug benefit that relies on private, drug-only plans, and examines ways the federal government would need to intervene to mitigate the consequential problems. To make the drug benefit work for beneficiaries, plans need to compete on quality rather than on attracting the least expensive enrollees. This brief uses as examples the stand-alone drug benefits proposed in the 2003 bills that passed the House and the Senate.

Predictability of Drug Spending

For many Medicare beneficiaries, individual prescription drug use and spending generally are predictable from year to year and much more predictable than, say, emergency hospitalizations. For example, many beneficiaries with chronic conditions, such as heart disease and arthritis, may remain on the same or similar drugs for long periods of time, if not for the remainder of their lives. As a consequence, many individuals display a relatively stable drug-spending pattern.

Medicare beneficiaries, who are able to collect their pharmacy receipts and calculate their total prescription drug spending for one year, often can make a fairly accurate estimate of their next year's drug spending. With this information, they can compare this amount to the costs and likely benefits of a prescription drug plan. Consequently, without substantial premium subsidies, people who calculate low annual drug expenses are less likely to purchase drug coverage. This population is considerable in size—24 percent of all Medicare beneficiaries in 2006 are projected to have drug costs of $500 or less (Figure 1). However, beneficiaries still may be willing to purchase drug coverage to protect themselves against high *unexpected* drug costs. Beneficiaries with drug spending in the range of $1,500 or $2,000 to $5,000 (accounting for more than one-third of all Medicare beneficiaries not living in long-term care facilities) are likely taking daily medications for one or more chronic conditions, and thus may anticipate that they will have about the same level of spending from year to year.[1]

Therefore, without other incentives to join, insurers may anticipate that their applicant pool will consist disproportionately of beneficiaries who expect to have significant drug costs. Although only 29 percent of all beneficiaries will have annual expenses of $4,000 or more, the share of beneficiaries with high drug costs actually purchasing drug coverage may be disproportionately greater than the share of those spending less—a daunting prospect for potential insurers. This scenario helps explain why no insurer currently offers a stand-alone drug policy. Three of the 10 currently available Medigap policies (private, supplemental insurance plans for Medicare beneficiaries) cover prescription drugs, among other benefits. However, these three policies are expensive and account for only 6 to 8 percent of all Medigap policies in use.[2]

Standard (Non-Subsidy) Mechanisms for Reducing Adverse Selection

Several regulatory techniques may help reduce risk selection by plans and by beneficiaries. These mechanisms include guaranteed-issue requirements, delayed enrollment penalties, standardized benefit packages, plan service area requirements, and

[1] In both the House and Senate bills, covered beneficiaries with this level of spending are likely to experience gaps in coverage (often referred to as "donut holes"), effectively increasing their share of total drug expenditures. Drug benefit design issues concerning people with chronic conditions is discussed further in Cristina Boccuti, Marilyn Moon and Krista Dowling, *Chronic Conditions and Disabilities: Trends and Issues for Private Drug Plans* (New York: The Commonwealth Fund, October 2003).

[2] Deborah J. Chollet and Adele M. Kirk, "Medicare Supplemental Insurance Markets: Structure, Change and Implications for Medicare," Report to the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington, D.C.: Mathematica Policy Research, Inc., December 2001). A more in-depth discussion of drug coverage through Medigap can be found in Cristina Boccuti and Marilyn Moon, *Private, Individual Drug Coverage in the Current Medicare Market* (New York: The Commonwealth Fund, October 2003).

marketing oversight. Some combination of these may be needed, because each contains loopholes and is focused on different aspects of risk selection.

Guaranteed-Issue. Guaranteed-issue regulations prohibit insurance plans from denying coverage to eligible applicants based on health status or any other underwriting factor. This provision (included in both 2003 drug bills) is designed to create a level playing field such that a plan must take all comers and may not explicitly refuse enrollment to people with expensive health problems.

Although guaranteed-issue provisions are necessary, they are not sufficient for reducing adverse selection. For example, the Medicare+Choice program, which contains guaranteed-issue provisions, has been found to cover a healthier-than-average set of beneficiaries, leaving traditional Medicare with a more costly population.[3] Indeed, experts on the insurance industry often argue that guaranteed-issue provisions actually could increase a plan's incentive to find more implicit ways to risk select, such as marketing techniques, arbitrary "capacity limits," and benefit designs (all discussed further in this brief).

Delayed enrollment penalties. Another method to reduce individual risk selection allows the imposition of a financial penalty on individuals who enroll after an established initial enrollment period. This penalty can be a useful mechanism for encouraging beneficiaries to enroll in a plan as soon as possible—when their expenses are likely to be the lowest—rather than waiting until they need several medications.[4] It has worked well in Medicare Part B, in which almost all beneficiaries enroll during their initial enrollment period.[5] For Part B, late enrollees' premiums are permanently increased by 10 percent for each year individuals delay enrollment.

Both the House and the Senate bills include provisions that allow drug benefit plans to impose financial penalties on beneficiaries who delay enrollment past their initial enrollment period (corresponding to their Part B initial enrollment period). The House bill permits plans to vary the penalty for individual applicants based on health status and other demographic characteristics. This underwriting practice (used by many Medigap insurers) may result in extremely high penalties that could effectively eliminate some beneficiaries' access to drug coverage, particularly those with health problems. This is

[3] U.S. General Accounting Office, *Medicare+Choice: Payments Exceed Cost of Fee-For-Service Benefits, Adding Billions to Spending* (Washington, D.C.: GAO, August 2000).

[4] The lack of information and resulting uncertainty about benefits that will likely occur in the first year of a plan's operation may cause at least some beneficiaries to delay enrollment.

[5] The Medicare Part B initial enrollment period is a seven-month window of time, usually beginning three months before beneficiaries turn 65. Under certain special circumstances, this penalty may be waived.

especially true with respect to the House bill because it does not establish limits on the penalties that plans may impose.

The Senate bill includes more oversight on the amount plans may charge late enrollees. It calls for the penalties to be standardized across all enrollees, based on a specified amount for each year of delayed enrollment, similar to the method currently used to determine Part B penalties.

Standardized benefit design. If insurance plans are able to vary their benefits, there is great potential for plans to design benefit packages that do not suit beneficiaries with chronic illnesses, particularly those treatable by expensive drug regimens. For example, plans that limit coverage to just one brand-name drug on their list will be less likely to attract people who take other brand-name drugs in that therapeutic category. Additionally, plans that offer generous coverage for those with spending under $1,000 but create a hole in coverage for those who spend, say $2,000 to $4,000, may encourage healthier beneficiaries to enroll.[6]

The more that benefits are similar among different plans, the less reason there is for beneficiaries to sort themselves by risk categories, and the easier it is for them to make price comparisons among plans. The House and Senate bills establish a "standard" benefit package but allow plans to vary its actual structure, providing it is at least actuarially equivalent to the standard benefit package outlined in the bill. Therefore, plans have the ability to manipulate benefit details, such as copayments, to attract healthier beneficiaries, even though the total value of the benefit is standardized. Indeed, the House bill does not specifically require plans to offer the standard benefit, instead allowing them to offer what they determine to be richer coverage in lieu of standard coverage. In contrast, the Senate bill requires that if plans want to offer a richer benefit package, it must be in addition to and separate from the standard benefit. The Senate bill also sets a limit above which catastrophic coverage must begin, regardless of income.

Service area requirements. To prevent plans from navigating around geographic areas with disproportionately high prescription drug needs, it can be useful to establish minimum service area requirements. In some cases, a state may be a natural separation point, but in many regions it is much less appropriate. For example, being able to separate beneficiaries living in the District of Columbia from those living in neighboring Montgomery County could present an opportunity for adverse selection because the

[6] For further discussion of the proposed "donut hole" in coverage, see Cristina Boccuti, Marilyn Moon, and Krista Dowling, *Chronic Conditions and Disabilities: Trends and Issues for Private Drug Plans* (New York: The Commonwealth Fund, October 2003).

overall health status of beneficiaries in these two regions (of the same metropolitan area) varies considerably. The Senate bill generally would not allow such an area to be split into separate service areas, but does allow for loopholes. Neither the House nor the Senate bill allows plans to split up a state's service area. Both bills also prohibit plans from using service areas to risk select, but relevant oversight mechanisms are not prescribed in the bills.

Marketing oversight. In an effort to minimize insurers' ability to promote their plans only to healthy enrollees, advertising and marketing regulations could be included in private drug plan proposals. Plans that advertise their products only to seniors involved in golf and sports clubs, for example, clearly would be strategizing to select the healthiest enrollees possible. A plan that requires applicants to climb a flight of stairs to reach the enrollment office can effectively prevent people who use wheelchairs as well as people taking expensive arthritis medications from joining. Additionally, because a 1998 study by the Kaiser Family Foundation found that inadequate government oversight of Medicare managed care plans resulted in misleading and inaccurate advertising claims, specifications on marketing oversight should be included in private plan prescription drug proposals.[7]

Techniques Requiring Federal Subsidies to Reduce Adverse Selection

In addition to regulatory controls, financial subsidies may be used in a Medicare drug benefit plan to reduce adverse selection, or at least minimize its effects. In addition to a general premium subsidy, which can encourage beneficiary participation, further government subsidies can help to compensate plans when they enroll beneficiaries with high drug costs. In most cases, such differential subsidies can be applied either proactively, at the time each beneficiary enrolls in the plan, or retroactively, after the plan has incurred particularly high costs.

General premium subsidies. Using federal subsidies to lower premiums is an important feature of a voluntary drug benefit and makes enrolling in a plan a good deal, regardless of drug spending. In particular, beneficiaries with lower expected drug costs are more likely to enroll when the purchase price of drug coverage is reduced. With more beneficiaries purchasing insurance, the financial risk of unexpected health problems is spread among a larger, somewhat healthier, pool of people. The House and the Senate bills both include general premium subsidies to plans.

[7] Patricia Neuman, Ed Maibach, Katharine Dusenbury, Michelle Kitchman, and Pam Zupp, "Marketing HMOs to Medicare Beneficiaries," *Health Affairs* 17 (July/August 1998): 132–39.

Risk-adjustment subsidies. To reduce a plan's incentive to avoid high-risk beneficiaries, the federal government can pay higher subsidies to plans based on the health status of their enrollment pool. The goal is to provide appropriate compensation to insurers so they have no incentive to discourage sicker enrollees from joining their plans. Currently, there are no known risk-adjustment mechanisms developed specifically for prescription drug utilization. The correlation between drug use and other health care expenditures is low, suggesting that risk adjusters developed for other use may not be well suited for drug-only plans.

The House and Senate bills allow for risk-adjustment subsidies but fail to outline the exact methodology. It is important not to assume that an untested, not-yet-designed drug risk adjuster will be a panacea, because researchers have struggled with risk-adjustment formulas for Medicare plans for years. Given the predictability of drug spending from year to year, however, researchers may find that risk adjustment for drug-only coverage might be more accurate than risk adjustment for a comprehensive set of health services.

Reinsurance. Both the House and Senate bills include provisions for the federal government to make additional payments to plans that experienced high enrollee drug costs in the previous year. Under this framework, the federal government is "reinsuring" the private plans, thus decreasing their risk of covering people who require expensive drug therapies. Theoretically, reinsurance should increase the number of plans willing to participate in the uncharted market of stand-alone drug plans. Consequently, under reinsurance, beneficiaries would have access to a greater number of plans.

Determining the level of government reinsurance of plans can have major effects on whether these goals are met in conjunction with keeping overall costs down. On the one hand, the lower the share of government reinsurance, the greater the financial incentive for the plans to risk select, to employ tactics to attract healthier-than-average enrollees. On the other hand, the greater the share of government reinsurance, the lower the financial incentive for the plans to control spending. The structure of the payments also can affect plan incentives to risk select.

The House bill includes reinsurance provisions directing Medicare to partially reimburse plans for each of their high-cost enrollees. The level of reimbursement to plans varies by the level of beneficiary cost. That is, the greater the beneficiary's drug costs, the greater the share retroactively reimbursed by Medicare. This bill requires Medicare to subsidize 80 percent of the costs of covering each enrollee after stop-loss begins (i.e.,

once the enrollee reaches the dollar threshold after which the risk is borne by or shared with the government), and 20 percent of the costs of covering each enrollee with spending between $1,000 and $2,000. (Beneficiaries pay in full for costs between $2,000 and $3,500.) This means that plans would be fully at risk for only $750 of spending. This generous reinsurance may ensure participation by plans but reduce their interest in monitoring use of drugs by those with high expenditure levels.

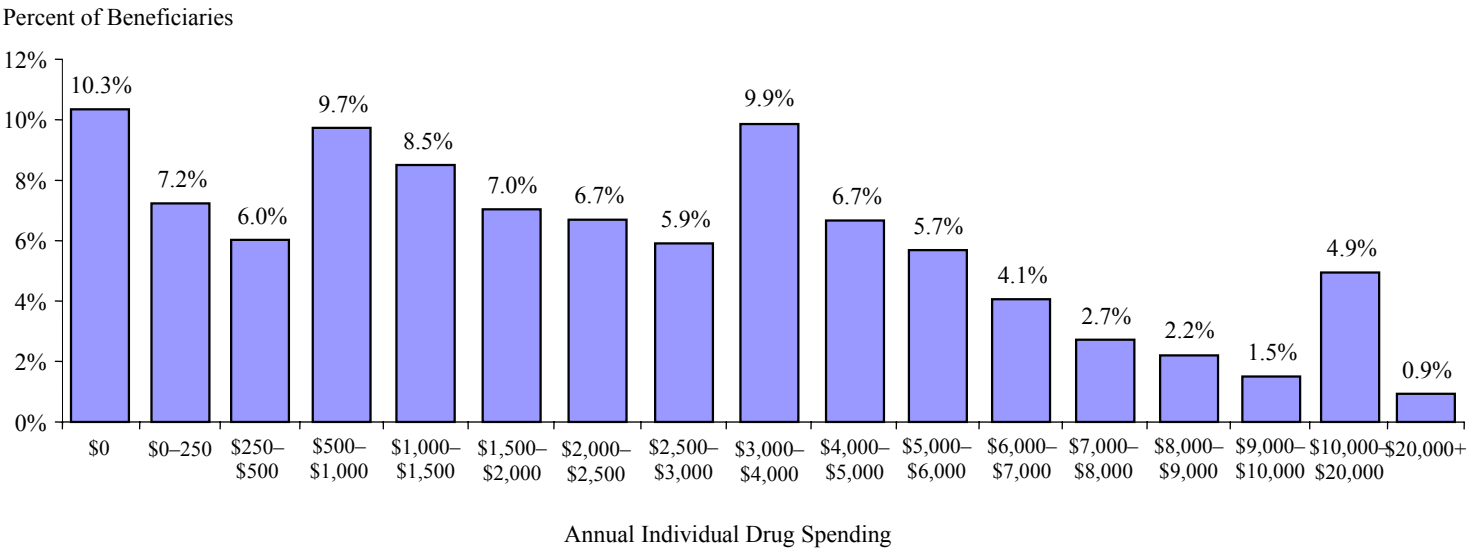
In addition to reinsuring 80 percent of plans' costs for covering individuals after stop-loss begins, the Senate plan includes an alternative method of reinsurance, based on a plan's aggregate claims. In general, this reinsurance method reimburses a specified portion of a plan's costs once their total expenses reach a predetermined amount. Aggregate reinsurance provides plans with a clearer picture of limits on future expenses, compared with individual enrollee claims review. Determining a plan's true total drug expenses may be extremely difficult, however. For example, plans are expected to negotiate rebates and discounts through multiple arrangements with drug manufacturers and pharmacy benefit managers. Yet tracking and calculating these rebates with respect to a plan's total expenses may not be possible, particularly within a tight timeframe.

Also proposed in the Senate bill are "risk corridors," whereby Medicare would reinsure for plans' losses but also would recover a portion of plan profits if expenses were lower than a predetermined amount. In other words, thresholds—floors and ceilings—are established that determine levels of both government reimbursement and plan profit sharing (with the government). Establishing risk corridors simplifies the government's ability to modify reinsurance rates in the future. That is, the share of reimbursement and profit sharing can be adjusted as well as the thresholds for triggering them.

Conclusions

Current congressional proposals that rely on the private market to offer individual, stand-alone drug coverage will need to include generous plan subsidies to encourage plans to enter a new market in which the highest-risk beneficiaries are the ones most likely to apply for coverage. Even with risk adjustment and federal reinsurance, plans are less likely to compete in terms of benefit generosity because that may attract applicants with the greatest prescription drug needs. Therefore, along with insurer subsidies, the federal government will need to allocate resources for oversight to ensure that those who are the most vulnerable have adequate access to drug coverage.

Figure 1
Distribution of Beneficiaries by Level of Prescription Drug Spending, 2006



Note: Excludes beneficiaries living in long-term care facilities.
Source: Urban Institute analysis of the 1999 Medicare Current Beneficiary Survey, adjusted for Congressional Budget Office estimates on 2006 prescription drug spending.