



# **Understanding Drug Spend Patterns Among Non-Low Income (NLIS) MAPD Plan Switchers**

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**Prepared By:**

ADVI Health's Strategic Analytics, Value and Economics (SAVES) Team  
In collaboration with Crabgrass & Clover, LLC

## Overview:

Each Medicare Open Enrollment Period drives meaningful member movement across Medicare Advantage Prescription Drug (MAPD) plans, and the transition from 2025 into 2026 was no exception. Major changes to medical and pharmacy benefits led many beneficiaries to shop. At the same time, many plans exited the market leaving beneficiaries with no choice but to find a new plan.

Leveraging ADVI Health's Innovator License and access to 100% Medicare Part D Event (PDE) data, ADVI partnered with Crabgrass & Clover LLC to analyze Part D claims, demographics, and switching behavior to understand how this year's enrollment patterns may influence MAPD plan performance.

A clear trend emerged across the national market for members who do not receive any extra help with Part D costs (i.e., non-Low Income Subsidy [NLIS] members): **for most MAPD organizations, the drug-spend profile of incoming NLIS members was significantly higher than the NLIS members who left.** United was the notable outlier, attracting a lower-cost NLIS cohort than the NLIS members who exited to other MAPD organizations.

As 2026 claims begin to emerge, plans must quickly assess the members they actually acquired, compare this 2026 mix with their pricing assumptions, and determine whether their 2026 earnings targets remain achievable. Plans need near-real-time insight into their emerging 2026 experience and a clear view of how these same members behaved across the broader market in 2025. With bids due by June 1, 2026, Medicare organizations are locking in their 2027 strategy with only a partial year of 2026 claims – realistically, only four months of complete Part D experience. In this compressed window, integrating internal, market, and competitive intelligence is essential for executing sustainable products and sound financial decisions.

# NLIS Plan Switchers: A Critical Indicator of Adverse Selection

Medicare’s Part D Low Income Subsidy (LIS) program reduces or eliminates Part D premiums, deductibles, and cost sharing for beneficiaries with limited income and resources. Members who do not qualify for this subsidy (e.g., NLIS beneficiaries) pay the full amount of their Part D premium, deductible, and copays or coinsurance. Because NLIS members bear the entire out of pocket burden, small shifts in premiums, deductibles, cost sharing, formulary tiers or utilization management can meaningfully affect their costs. As a result, NLIS beneficiaries are far more sensitive to year over year benefit changes and are disproportionately likely to switch plans when their pharmacy costs rise. This makes NLIS movement one of the clearest indicators of affordability pressure and potential adverse selection for MAPD organizations.

Figure 1 summarizes how NLIS members who switched into or out of select MAPD parent organizations differed in terms of gross drug spend. For each of the parent organizations listed below, actual 2025 drug spend for exiting and incoming members is compared, showing where incoming NLIS members were historically more expensive... and where they were not. The re-calculation section isolates the impact of enrollment mix changes by removing trend effects, effectively demonstrating what the 2025 PMPM would have been if the NLIS members exiting in January 2026 were removed, and if the incoming January 2026 NLIS members had been enrolled for the full year and behaved exactly as they did in their prior coverage, assuming an equivalent cost structure.

**Figure 1 - 2025 Part D Cost & Use - NLIS Individual MAPD enrollees who changed Parent Organizations from December 2025 to January 2026**

Parent Organization	2025 Actual Baseline		Members who Exited on Dec 31 (2025 experience in baseline)		Jan 1 Incoming Members (2025 experience in their previous plan)		Incoming vs Exiting Gross Drug Spend PMPM	Theoretical Re-calculation of 2025		
	Member Count	Gross Drug Spend PMPM	Member Count	Gross Drug Spend PMPM	Member Count	Gross Drug Spend PMPM		Re-weighted Gross Drug Spend PMPM	Population Mix Change Impact %	Population Mix Change Impact PMPM
<b>United</b>	4,687,000	<b>\$382</b>	737,000	\$385	278,000	\$348	<b>-\$37</b>	<b>\$380</b>	-0.7%	<b>-\$3</b>
<b>Humana</b>	3,398,000	<b>\$345</b>	220,000	\$336	826,000	\$354	<b>\$18</b>	<b>\$348</b>	0.7%	<b>\$2</b>
<b>CVS</b>	1,890,000	<b>\$300</b>	390,000	\$282	297,000	\$349	<b>\$68</b>	<b>\$312</b>	4.0%	<b>\$12</b>
<b>Elevance</b>	1,134,000	<b>\$343</b>	280,000	\$328	55,000	\$332	<b>\$4</b>	<b>\$347</b>	1.2%	<b>\$4</b>
<b>HCSC</b>	602,000	<b>\$354</b>	126,000	\$358	83,000	\$364	<b>\$7</b>	<b>\$354</b>	0.2%	<b>\$1</b>
<b>Centene</b>	421,000	<b>\$219</b>	72,000	\$228	62,000	\$275	<b>\$47</b>	<b>\$226</b>	3.2%	<b>\$7</b>
<b>SCAN</b>	233,000	<b>\$350</b>	7,000	\$287	87,000	\$311	<b>\$25</b>	<b>\$341</b>	-2.7%	<b>-\$9</b>
<b>Devoted</b>	130,000	<b>\$184</b>	17,000	\$218	146,000	\$262	<b>\$45</b>	<b>\$226</b>	22.9%	<b>\$42</b>
<b>BCBS Michigan</b>	285,000	<b>\$367</b>	69,000	\$395	12,000	\$358	<b>-\$36</b>	<b>\$358</b>	-2.4%	<b>-\$9</b>
<b>Corewell (Priority)</b>	200,000	<b>\$298</b>	5,000	\$255	22,000	\$379	<b>\$124</b>	<b>\$307</b>	3.1%	<b>\$9</b>

PMPM = Per Member Per Month. Member Count average based on 12 months. Table above represents a subset of parent organizations offering MAPD. Results are rounded. See Appendix for detail.

Across most large MAPD organizations, incoming NLIS members were more expensive than those who exited, often by a wide margin, indicating that 2026 growth through switching was accompanied by higher gross drug-spend risk. Notable findings include:

- Most plans: incoming NLIS members are higher-cost than those that exited
- United: notable exception with incoming NLIS members being ~10% lower-cost than those who exited
- Magnitude of PMPM spending differential of incoming versus exits varies from -\$49 to +\$124
- Scale allows larger plans to dilute PMPM cost pressure from membership mix changes across a wider base

United was the sole significant national organization where NLIS incoming members were *less* costly than the NLIS members who exited, to the tune of **\$37** PMPM, making it the clear outlier in the national pattern. United changed most Non-SNP MAPD benefits from co-pays in 2025 on Tier 3 and Tier 4 (subject to a maximum of \$47 and \$100 respectively) to coinsurance in 2026, which may help to explain why higher cost brand-utilizing members shopped and left.

CVS added NLIS members with substantially higher PMPM spend, **\$68** PMPM higher than their NLIS members that left. Over a third of the members that switched to CVS for 2026 came from United, with 2025 drug spend of \$381 PMPM. CVS made no substantial changes to Non-SNP MAPD benefits in 2026, including coinsurance on Tiers 3, 4 and 5 for both 2025 and 2026.

Humana's NLIS incoming members were also more expensive, **\$18** PMPM higher than the NLIS members that left. Humana remains the largest carrier that continues to broadly offer fixed copays on Tier 3 and 4 in 2026. Humana was also the clear leader in membership growth. Of the members that switched to Humana, nearly 40% came from United with 2025 drug spend of \$401 PMPM and over 20% came from CVS with 2025 drug spend of \$283 PMPM.

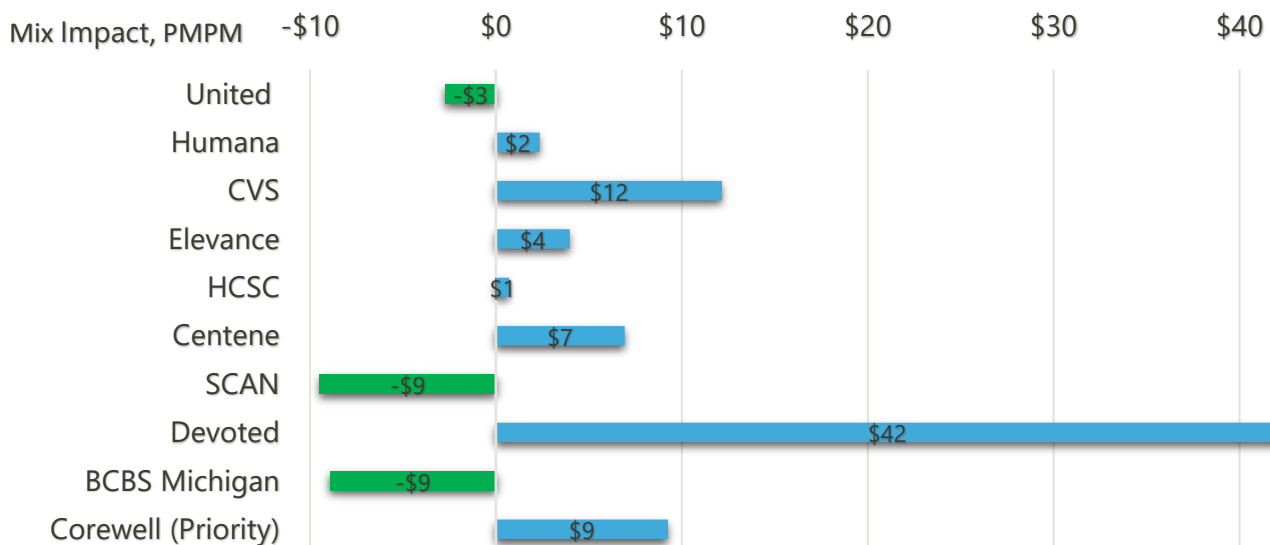
Corewell (Priority) experienced a dramatic NLIS differential, with gross spend of incoming members **\$124** PMPM higher than the PMPM spend of the NLIS members that left. Over two thirds of Corewell's incoming members switched from BCBS of Michigan where their 2025 gross drug spend was \$386 PMPM.

Devoted more than doubled their 2025 NLIS membership and the new members' gross spend was **\$45** PMPM higher than those who exited. Devoted has the highest overall population mix change impact of **\$42** PMPM, given the relatively low membership and PMPM spend in the 2025 baseline.

## Assumptions vs Actual Outcomes

The difference between drug spend of exiting members and incoming members is just part of the story. Figure 2 (derived from the last column of Figure 1) summarizes the impact of the population mix change on the overall PMPM, assuming the negotiated drug costs and formulary management is comparable across parent organizations.

**Figure 2 – Population impact using 2025 re-calculation (PMPM) of select Parent Organizations**



*Mix Impact PMPM = { [ (2025 Baseline Member Count \* Gross Drug Spend PMPM) – (Exiting Member Count \* Gross Drug Spend PMPM) + (Incoming Member Count \* Gross Drug Spend PMPM) ] / (2025 Baseline Member Count – Exiting Member Count – Incoming Member Count) } – 2025 Baseline Gross Drug Spend PMPM. See Appendix for detail.*

In the absence of actual data, MAPD organizations may have anchored their 2026 PMPM expectations to historical performance, implicitly assuming that the impact of enrollment changes through switching would be broadly cost-neutral, i.e., there would be minimal disruption to overall drug spend PMPM.

Actual switching outcomes challenge that view. For most parent organizations, incoming NLIS members carried meaningfully higher spend profiles than the NLIS members who left, creating immediate upward pressure on PMPM costs. These results raise a critical strategic question: to what extent were bids, benefit designs, and earnings targets adequately priced for the risk embedded in this switching behavior - and where may plans now be exposed as 2026 experience emerges while 2027 strategies are being finalized? Even modest PMPM increases driven by switching can materially affect margins when applied across large and growing member populations.

## From National Signals to Deeper Insight

This analysis highlights a clear signal: for most MAPD organizations, growth driven by NLIS switching was not cost-neutral. Incoming members often carried higher historical drug-spend profiles than those who exited, creating early cost pressure that may not have been fully anticipated in 2026 pricing and bid strategies.

At the same time, national averages at the parent organization level provide only a partial view. Switching dynamics, utilization profiles and their financial implications vary meaningfully by state, plan, benefit design, formulary structure and competitive landscape. Understanding where cost pressure is surfacing, and whether it reflects transient enrollment behavior or durable adverse selection, requires a more granular view of member movement informed by both full-year historical experience and early 2026 utilization as it comes into focus.

Using real-time Medicare Part D event data, member level enrollment files and advanced analytics, ADVI Health works with Medicare stakeholders to go several layers deeper: examining who switched, where they came from, what they cost, and how those dynamics align with pricing assumptions and forward-looking strategy. As data continues to emerge, this level of insight can help organizations identify risk early, test assumptions, and make more informed product and pricing decisions.

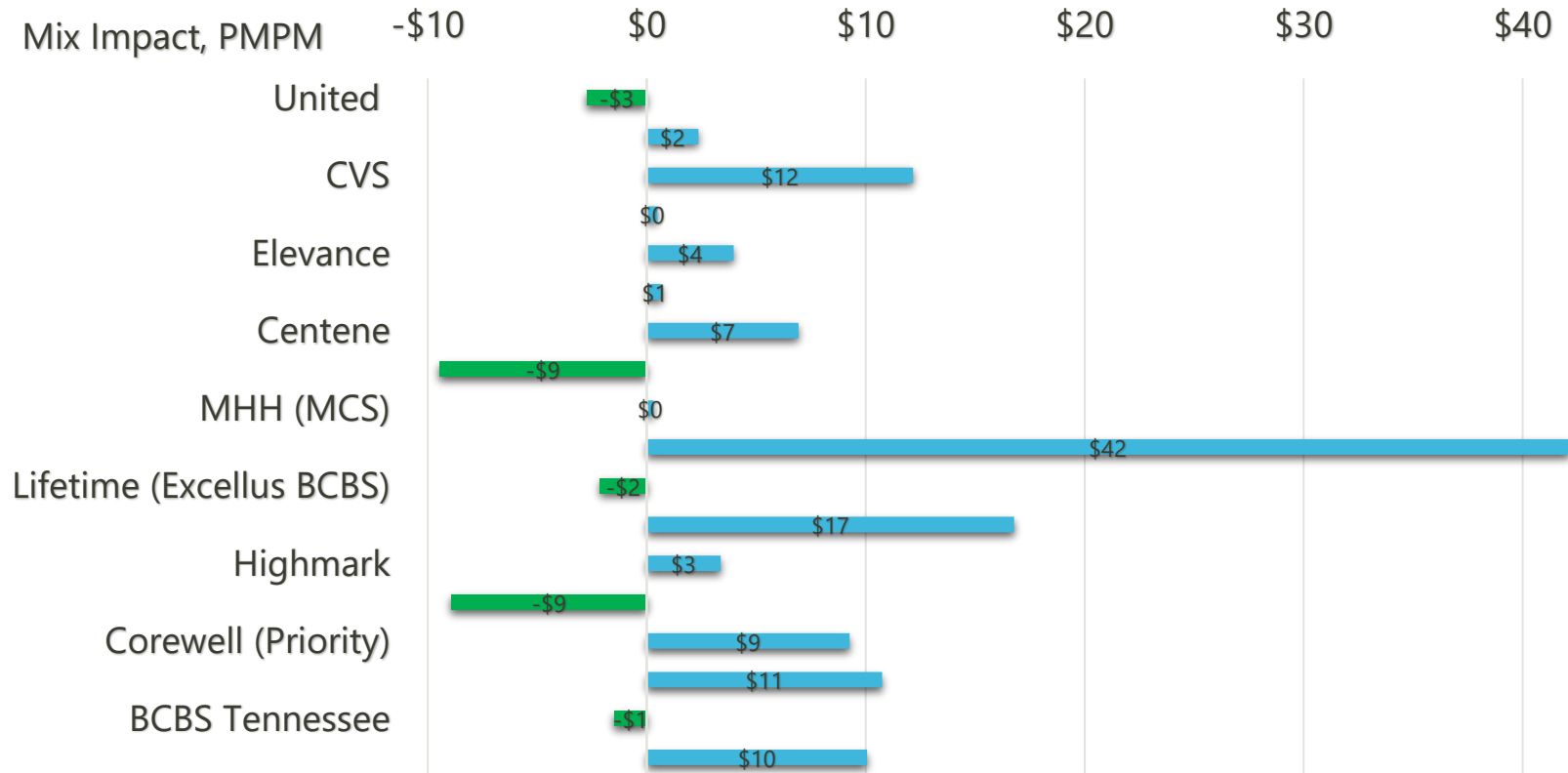
## Appendix

ADVI additionally evaluated switching behavior of patients diagnosed with COVID-19 versus those without. The COVID-19 findings showed slight variation between plans with no clear patterns. Full results can be made available upon request.

**Figure A1 - 2025 Part D Cost & Use - NLIS Individual MAPD enrollees who changed Parent Organizations from December 2025 to January 2026**  
**Expanded list of organizations including 30 day equivalent scripts and average 30 day cost per script**

Parent Organization	2025 Baseline		Members who Exited on Dec 31 (2025 experience; in baseline)				Jan 1 Incoming Members (2025 experience in their previous plan)				Incoming vs Exiting Gross Drug Spend PMPM	Theoretical Re-calculation of 2025		
	Member Count	Gross Drug Spend PMPM	Member Count	Gross Drug Spend PMPM	30 Day Equivalent Scripts PMPM	Avg 30d Cost per Script	Member Count	Gross Drug Spend PMPM	30 Day Equivalent Scripts PMPM	Avg 30d Cost per Script		Re-weighted Gross Drug Spend PMPM	Population Mix Change Impact %	Population Mix Change Impact PMPM
United	4,687,000	<b>\$382</b>	737,000	\$385	4.5	\$86	278,000	\$348	4.4	\$78	<b>-\$37</b>	\$380	-0.7%	<b>-\$3</b>
Humana	3,398,000	<b>\$345</b>	220,000	\$336	4.6	\$72	826,000	\$354	4.3	\$82	<b>\$18</b>	<b>\$348</b>	0.7%	<b>\$2</b>
CVS	1,890,000	<b>\$300</b>	390,000	\$282	4.0	\$71	297,000	\$349	4.3	\$81	<b>\$68</b>	<b>\$312</b>	4.0%	<b>\$12</b>
Kaiser	1,122,000	<b>\$194</b>	9,000	\$113	3.0	\$38	13,000	\$180	3.1	\$59	<b>\$67</b>	<b>\$194</b>	0.3%	<b>\$0</b>
Elevance	1,134,000	<b>\$343</b>	280,000	\$328	4.6	\$71	55,000	\$332	4.5	\$73	<b>\$4</b>	<b>\$347</b>	1.2%	<b>\$4</b>
HCSC	602,000	<b>\$354</b>	126,000	\$358	3.8	\$94	83,000	\$364	4.4	\$84	<b>\$7</b>	<b>\$354</b>	0.2%	<b>\$1</b>
Centene	421,000	<b>\$219</b>	72,000	\$228	3.9	\$58	62,000	\$275	4.2	\$65	<b>\$47</b>	<b>\$226</b>	3.2%	<b>\$7</b>
SCAN	233,000	<b>\$350</b>	7,000	\$287	3.8	\$75	87,000	\$311	4.0	\$79	<b>\$25</b>	<b>\$341</b>	-2.7%	<b>-\$9</b>
MHH (MCS)	291,000	<b>\$460</b>	9,000	\$338	5.4	\$62	20,000	\$410	5.4	\$75	<b>\$72</b>	<b>\$461</b>	0.1%	<b>\$0</b>
Devoted	130,000	<b>\$184</b>	17,000	\$218	3.5	\$62	146,000	\$262	3.9	\$68	<b>\$45</b>	<b>\$226</b>	22.9%	<b>\$42</b>
Lifetime (Excellus BCBS)	207,000	<b>\$400</b>	16,000	\$365	4.2	\$86	53,000	\$380	4.0	\$94	<b>\$15</b>	<b>\$398</b>	-0.5%	<b>-\$2</b>
Aware (BCBS MN)	183,000	<b>\$282</b>	6,000	\$341	5.7	\$60	66,000	\$349	4.0	\$87	<b>\$7</b>	<b>\$298</b>	6.0%	<b>\$17</b>
Highmark	303,000	<b>\$353</b>	75,000	\$346	4.3	\$81	15,000	\$374	4.4	\$85	<b>\$28</b>	<b>\$356</b>	1.0%	<b>\$3</b>
BCBS Michigan	285,000	<b>\$367</b>	69,000	\$395	4.5	\$88	12,000	\$358	4.4	\$82	<b>-\$36</b>	<b>\$358</b>	-2.4%	<b>-\$9</b>
Corewell (Priority)	200,000	<b>\$298</b>	5,000	\$255	4.1	\$62	22,000	\$379	4.0	\$94	<b>\$124</b>	<b>\$307</b>	3.1%	<b>\$9</b>
Guidewell (Florida Blue)	222,000	<b>\$435</b>	32,000	\$359	4.3	\$83	13,000	\$415	5.4	\$77	<b>\$56</b>	<b>\$446</b>	2.5%	<b>\$11</b>
BCBS Tennessee	155,000	<b>\$423</b>	4,000	\$463	5.0	\$92	9,000	\$414	4.9	\$85	<b>-\$49</b>	<b>\$421</b>	-0.4%	<b>-\$1</b>
Alignment	136,000	<b>\$292</b>	10,000	\$251	3.3	\$76	32,000	\$329	4.0	\$83	<b>\$78</b>	<b>\$302</b>	3.4%	<b>\$10</b>

**Figure A2 – Population Impact using 2025 re-calculation (PMPM) of select Parent Organizations**  
**Expanded list of organizations**



$$\text{Mix Impact PMPM} = \left\{ \left[ (2025 \text{ Baseline Member Count} * \text{Gross Drug Spend PMPM}) - (\text{Exiting Member Count} * \text{Gross Drug Spend PMPM}) + (\text{Incoming Member Count} * \text{Gross Drug Spend PMPM}) \right] / (2025 \text{ Baseline Member Count} - \text{Exiting Member Count} - \text{Incoming Member Count}) \right\} - 2025 \text{ Baseline Gross Drug Spend PMPM}$$