Premiums and Cost-Sharing Features in Medicare's New Prescription Drug Program, 2006

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EXECUTIVE SUMMARY

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), beneficiaries who wish to enroll in the new Medicare prescription drug benefit must enroll either in a free-standing prescription drug plan (PDP) that complements traditional Medicare benefits or in a Medicare Advantage plan that covers prescription drugs (MA-PD). MA-PD plans, which integrate the new drug benefit into a more comprehensive package that includes Medicare Parts A and B benefits and supplemental benefits, often impose more restrictions than traditional Medicare on a beneficiary's choice of providers. Medicare policies lead to substantially higher payments in MA plans than in traditional Medicare. While allowing MA-PD plans to use savings to expand benefits or offset premiums is intended to reward efficiency, the provision also gives MA-PD plans an advantage over free-standing PDPs (and indirectly the traditional Medicare program), because they do not have access to such payments.

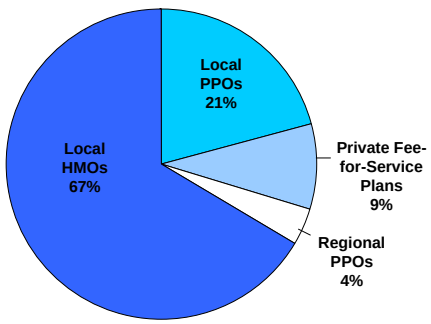
This issue brief describes the premiums and selected cost-sharing characteristics of the Medicare drug benefit offered by Medicare PDPs and MA-PD plans in 2006. The latter include health maintenance organizations (HMOs), local preferred provider organizations (PPOs), regional PPOs, and private fee-for-service (PFFS) plans. The analysis complements other reports describing the availability of diverse types of PDP and MA offerings nationwide (Gold, 2006a) and who sponsors them (Gold, 2006b). In this analysis, each plan counts equally in calculating averages-- that is, they are not weighted by enrollment because CMS had not released such data for 2006 when this analysis was conducted.

Key findings are:

- In 2006, there were 1,429 PDPs nationwide and 1,314 MA-PD plans, including 885 HMOs, 273 local PPOs, 114 PFFS plans, and 48 regional PPOs. Though the national numbers for PDPs and MA-PD plans are similar, there are substantially more PDPs available per beneficiary because service areas for most MA-PD plans are set on a county-by-county basis and there is wide variation in availability nationwide, particularly for HMOs, which account for 67 percent of all MA-PDs.

Figure ES.1

Medicare Advantage Prescription Drug Plans by Type, 2006



Total Medicare Advantage Prescription Drug Plans = 1,314

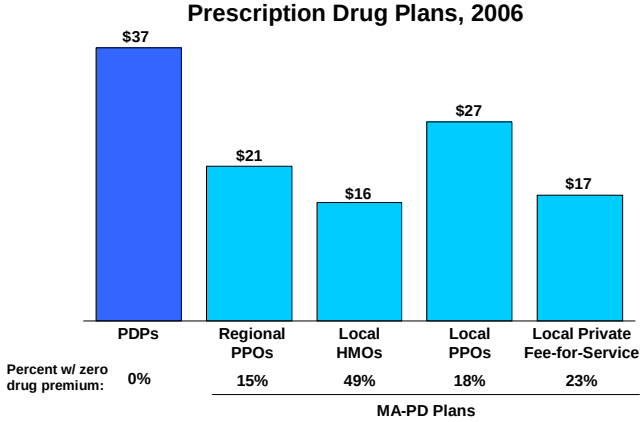
Note: Percentages exceed 100 percent due to rounding.
SOURCE: MPR analysis of CMS Landscape file. MA-PD data are from November 2005.

- Most sponsors of a given contract type (e.g., PDP, HMO) offer more than one plan of that type in areas they serve. On average, sponsors offer 2.5 PDP plans per area they serve; they offer somewhat fewer MA-PD plans per area.

- Average monthly premiums for drug coverage are substantially lower in MA-PD plans than PDPs. The average beneficiary premium in PDPs is $37 per month compared to $18 for all MA-PD plans; the average drug premium is $16 in HMOs, $17 in PFFS plans, $21 in regional PPOs, and $27 in local PPOs. Similarly, while the lowest premium for a PDP averages $29 per month, drug premiums average $10 across the lowest premium HMOs, $15 across the lowest premium regional PPOs or PFFS plans, and $21 across the lowest premium PPO. Because MA-PD plans apply savings from elsewhere in the MA benefit package, 49 percent of HMOs charge no premium for the drug component of their plan including 61 percent of lowest premium HMOs.

Figure ES.2

Average Monthly Drug Premiums for Medicare Stand-alone Prescription Drug Plans and Medicare Advantage Prescription Drug Plans, 2006



SOURCE: MPR analysis of CMS Landscape file.

- Across all MA-PD plans, average total premiums are lowest per month for HMOs where they average $50 and PFFS plans where they average $45 per month. In contrast, they are $67 for regional PPOs and $72 for local PPOs. One-third of MA-PD plans charge no monthly premium for coverage. This is mostly attributed to HMOs – 43 percent of all HMOs (and 58 percent of lowest premium HMOs) charge no premiums at all for beneficiaries enrolled in their plan. Across other types of MA-PD plans, between eight and 20 percent charge no monthly premium for coverage.

- Many PDPs and MA-PD plans have taken advantage of the flexibility inherent in the MMA to modify the standard structure of Medicare's drug benefit by offering no-deductible plans and modified cost sharing. Across all MA-PD plans, 79 percent have no deductible. Eighty-two percent of HMOs, 75 percent of local PFFS plans, 74 percent of local PPOs, and 63 percent of regional PPOs have eliminated the $250 deductible. Both PDPs and MA-PD plans typically have substituted tiered cost sharing for 25 percent coinsurance, even in their lowest premium plans. Regional PPOs appear to be the exception.

- Only a minority of PDPs and MA-PD plans have filled in the coverage gap (often called the "donut hole")—the gap between the initial coverage limit and the $3,600 out-of-pocket threshold in which beneficiaries must pay 100 percent of drug costs. Eighty-five percent of PDPs keep this feature of the standard Medicare drug benefit structure, as do 72 percent of all MA-PD plans. MA-PD plan types most likely to feature the coverage gap are regional PPOs (85 percent) and PFFS plans (100 percent). Local HMOs and PPOs are most likely to provide some coverage in this gap (32 percent and 30 percent, respectively). Such coverage typically requires enrollment in a higher premium plan and is limited to generic drugs only.

- In 2006, Medicare beneficiaries have access to a range of plan options that provide the new Medicare prescription drug benefit. There are more PDP choices but, on average, MA-PD plans have lower premiums and the structure of their cost sharing is more favorable for the average beneficiary. While this is particularly true for HMOs, it also extends to other MA plan types including non-network PFFS plans.

The analysis in this issue brief examines only the general structure of prescription drug cost sharing (not formularies, tiered copayments, or utilization management practices, each of which may also influence beneficiary's out-of-pocket costs). The analysis also focuses solely on the drug benefit offered by plans. It does not analyze the structure of cost sharing in other benefits or the characteristics of plans' provider networks and how they affect care. It should be noted that benefits offered in 2006 may be especially generous in an effort to attract enrollment and may decline in the future. High federal payments to MA plans contribute to lower beneficiary cost sharing in MA-PD benefits in 2006, a situation that could change in the future.

As experience with the Medicare drug benefit grows, additional research is needed to provide a more comprehensive analysis of the way PDP and MA plans structure their benefits and what this means for beneficiary access to care and out-of-pocket costs; and to assess how plan benefits change over time. Such analyses rely on CMS continuing to make publicly available on a timely basis the data used in this issue brief, as well as enrollment data for individual PDP and MA plans so that beneficiary choice can be an integral part of future analyses.

INTRODUCTION

Beneficiaries deciding whether to enroll in Medicare's new prescription drug program in 2006, the first year of the program, have many private plans to consider but only two basic plan options.

- They can enroll in a stand-alone prescription drug plan (PDP) that complements the benefits offered in the traditional Medicare program; or
- They can enroll in one of several types of Medicare Advantage (MA) plans that integrate the new prescription drug benefit into a plan that also includes Medicare Part A and B benefits and supplemental coverage (MA-PD).

In most cases, MA plans have a limited provider network relative to the traditional Medicare program or charge more for beneficiaries to use those providers. The major types of MA plans are local health maintenance organizations (HMOs), local preferred provider organizations (PPOs), regional PPOs, and private fee-for-service (PFFS) plans (Gold, 2006a; see Box).[1,2] Historically, HMOs have dominated MA enrollment, but this may change as plan availability expands.

This issue brief analyzes the premiums and characteristics of cost sharing associated with the drug benefit in each of these types of plans. The analysis is based on a file of plan characteristics created from the Centers for Medicare and Medicaid Service's (CMS) Landscape Tables for MA plans (November 2005 version) and PDPs (October 13, 2005 version). The analysis of plans gives each plan equal weight regardless of their enrollment (i.e. is unweighted).

[1] The MMA also authorizes special needs plans, which can be of any type but are available only to one or more of three subgroups of Medicare beneficiaries: those dually eligible for Medicare and Medicaid, institutionalized individuals, and those with severe or disabling chronic conditions.

[2] This issue brief focuses solely on the coverage offered by plans available to all Medicare beneficiaries through the most commonly available options. Cost contracts are another type of plan available to some beneficiaries. We exclude them here to simplify discussion and because the availability of these plans reflects historical Medicare policies. These plans were to be phased out under the Balanced Budget Act of 1997 but were maintained because there were concerns about the impact on choice in an environment in which choice was dwindling in the early 2000. Under the MMA, these contracts can be maintained but, starting in 2008, only if two other MA plans are available in the area whose combined enrollment meets a minimum threshold.

This is because CMS has not released enrollment data in 2006 beyond the most aggregate levels (e.g. national PDP and MA totals). The analysis also focuses only on basic cost-sharing structures and does not analyze formularies, specific copayment levels, or the way the tiered cost sharing and the drug benefit is managed in different types of plans. All of these contribute to the out-of-pocket costs of beneficiaries, particularly for those with diverse health conditions and pharmaceutical needs.

The Appendix provides further details on the definitions used to support the analysis and includes information on MA-only plans, which do not cover prescription drugs. Many sponsors that offer MA-PD plans also offer an MA-only plan to serve those who do not seek prescription drug coverage. MA-only plans are offered by some PFFS sponsors that have decided not to provide the prescription drug benefit as part of their basic MA offering (the MMA gives them that option). Some of these sponsors (e.g., PacifiCare) offer a companion free-standing PDP that beneficiaries can select to complement their MA-only plan in 2006. When MA plans are discussed in this issue brief, they refer to MA-PD plans only.

The issue brief begins with background that provides context for understanding incentives for private plan participation, then presents a description and discussion of the premiums and cost sharing requirements charged in 2006, and concludes with implications for beneficiaries.

BACKGROUND OF MEDICARE'S PRESCRIPTION DRUG PLANS

The MMA calls for a standard Medicare prescription drug benefit that includes an annual deductible ($250), beneficiary cost sharing of 25 percent up to an initial coverage limit, and a coverage gap in which a beneficiaries pays all of the costs after the initial coverage limit until catastrophic coverage begins—which is once a beneficiary has incurred $3,600 in out-of-pocket spending (KFF, 2005). Though plans are allowed to augment that coverage within the constraints of federal requirements, all PDP and MA-PD sponsors must offer at least one

standard plan or one that is actuarially equivalent to it. Medicare beneficiaries who enroll in a plan pay a monthly premium equal to about 25 percent of the cost of standard coverage. Additional help, such as reduced premiums and cost sharing, is available to beneficiaries with limited income and assets.

While PDPs provide only the prescription drug benefit, MA-PD plans integrate such coverage into a more comprehensive benefit package that also includes coverage for Medicare Part A (hospital and other covered care in facilities) and Part B (physician and other professional services), and for selected supplemental benefits (e.g., reduced Medicare cost sharing) or additional benefits (e.g., dental, vision, chiropractic). Organizations offering MA-PD plans are required to report separately to CMS on the projected costs for each of these three parts (Medicare Parts A and B, supplemental benefits, and prescription drugs) and the relationship between costs and the premiums they propose to charge beneficiaries. Though CMS publicly posts the premium approved for the prescription drug component of the MA-PD, beneficiaries purchase the entire plan for a combined premium that reflects all three components of the benefit package. Sponsors are allowed to offset the costs of the supplemental benefits or Medicare prescription drug benefit (or enhance benefits) by using 75 percent of any savings between the sponsor's projected costs of Medicare Parts A and B benefits and the Medicare benchmark payment amount for such benefits. This benchmark, in turn, reflects a blend of county-based Medicare cost experience for beneficiaries in the traditional program and the cumulative effect of policy decisions made over time with respect to payment for MA plans and their predecessors.

Overview of Major Types of Medicare Advantage Plans

Local Plans: These plans serve defined geographical areas that consist of aggregations of counties. Authority for health maintenance organizations (HMOs) in Medicare has existed since 1982 (and earlier under demonstration authority). The Balanced Budget Act of 1997 added authority for additional types of managed care or coordinated care plans—especially preferred provider organizations (PPOs). It also authorized private fee-for-service (PFFS) plans. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), these were collectively named Medicare Advantage plans.

- **HMOs.** These typically are the most tightly managed plans. They have a defined network of providers that beneficiaries must use to receive coverage (with some exceptions, e.g., emergency care). These plans have the longest history in Medicare and account for most MA enrollment.

- **PPOs.** Like HMOs, these are network-based plans. In a PPO, enrollees generally are free to go to any provider they choose. However, if they use providers outside the network they must pay more out of pocket.

- **PFFS.** PFFS plans place no restrictions on the providers a Medicare beneficiary can use, but providers may limit their willingness to see Medicare beneficiaries in such plans. PFFS plans must pay providers willing to accept their payment on a fee-for-service basis. Payment rates do not have to match Medicare's as long as CMS concludes that the rates will provide adequate provider access. Plans also have the authority to allow providers to balance-bill beneficiaries up to 15 percent of the difference between payments and charges if they choose. (However, use of Medicare rates and billing practices is common in PFFS.)

Regional PPOs. These PPOs serve large areas defined by 26 regions that include one or more states. Regional PPOs must offer the same plan with the same benefits and premiums across the entire region. Benefits must be structured to integrate cost sharing across traditional Medicare benefits (Parts A and B) and to include an annual out-of-pocket limit on cost sharing for these benefits, a feature not in traditional Medicare. (Local plans may set such a limit but are not required to). To encourage regional plans, the MMA allows Medicare to share financial risk with sponsors in 2006 and 2007, creates selected provisions to make it easier to establish networks in rural areas, and establishes a regional stabilization fund starting in 2007 to encourage entry of new plans and retention of existing ones.

Medicare Payment Rates. All local plans are paid the same way, with a risk-based monthly capitated payment that is set on a county-by-county basis. Originally based on historical fee-for-service costs for similar beneficiaries in the traditional program in that county, these rates have been modified over time to allow floor payments for rural counties (1998) and urban counties (2001), risk adjustment (being phased in), and minimum update amounts annual (1998, revised 2004). In 2006, competitive bidding was added and rates derived from these policies serve as benchmarks for evaluating sponsor bids, which separate out the expected costs associated with traditional Medicare benefits, supplemental benefits, and the new prescription drug benefit. If a bid for traditional Medicare benefits (Parts A and B) is below the benchmark, sponsors can use 75 percent of the savings to offset the costs elsewhere in the benefit package or reduce premiums. Regional plans are paid similarly, but the methods used take regional PPO bids (not just traditional Medicare costs) into account in setting benchmarks and other modifications consistent with the regional focus.

NOTE: These different types of plans are available to all beneficiaries but may be modified and approved as special needs plans (SNPs) to serve one or more of three subgroups of beneficiaries: dual eligibles, institutionalized individuals, and those with serious chronic or disabling conditions. Cost contracts and various demonstrations also may be offered in particular locales. For more information on available types of plans see Gold, 2006a.

For a variety of reasons, intended and not, MA benchmark payments in 2006 yield, on average, substantially higher payments than CMS estimates it costs the Medicare program to deliver benefits in the traditional fee-for-service program (MedPAC, 2005; Biles et al., 2004; Berenson, 2004). Two notable reasons for higher payments relate to historical rate history and the structuring of risk adjustment in calculating payment rates. The Balanced Budget Act of 1997 (and its subsequent refinements) established county-based minimum payment amounts (rural and urban floors) to encourage plans to locate in less populated and/or lower cost counties. These payment floors, often substantially higher than what Medicare pays for similar beneficiaries in the traditional program, contribute to higher payment levels under the MMA in affected counties. MA plans also, on average, have benefited from the phase in of risk-adjustment for differences in health status (and likely future health care costs) between those choosing MA plans and those staying in the traditional program. CMS has indicated that most MA plans have, on average, favorable risk (CMS, 2005). Because of phase in, only 75 percent of this difference in risk was included in payment rates for 2006. As in prior years, CMS also held the MA sector harmless in 2006 for favorable risk, which in effect raises average payment rates to all plans.

Thus, while allowing MA-PD plans to use savings to expand benefits or offset premiums is intended to reward efficiency, the provision also gives MA-PD plans an advantage over free-standing PDPs (and indirectly the traditional Medicare program), which do not have access to such payments. Though the Medicare Payment Advisory Commission recommended that such disparities in payment levels be eliminated to level the playing field (MedPAC, 2004), the policies have been maintained as a vehicle for moving Medicare to a more competitive, private sector model (Iglehart, 2004; Gold, 2005).

PDPS AND MA-PD PLANS OFFERED IN 2006

Prescription Drug Plans

There are 1,429 prescription drug plans available in 2006, each serving one of 34 regions defined by CMS that consist of one or more states. Though firms can sponsor plans in multiple regions—10 sponsor them in all 34—plans are defined at the regional level because CMS requires firms to offer the same benefits and premiums to all Medicare beneficiaries *within* a region. In 2006, the number of plans per region varies from 27 in Alaska to 56 in West Virginia and Pennsylvania (KFF, 2005). In most regions, at least 40 plans are available; these plans are sponsored by at least 15 firms (Gold, 2006b).[3] Sponsors tend to offer multiple plans in each region they serve, with the average being 2.5 plans.

TABLE 1

NUMBER OF PDP AND MA-PD PLANS OFFERED BY TYPE, 2006

	Total Plans	Lowest Premium Plans[a]	Other Plans[b]	Plans/Sponsoring Firm
PDP	1,429	583	846	2.5
All MA-PDs	1,314	775	540	1.7
Regional PPO	48	26	22	1.8
HMO	879	468	411	1.9
Local PPO	273	188	85	1.5
PFFS	114	92	22	1.6

Source: MPR analysis of CMS Landscape file. MA-PD data are from November 2005. PDP data are from October 13, 2005.

[a] This represents the plan that has the lowest premium available from a given sponsor for that plan type in that geographical area. By definition, when a sponsor offers only a single plan of a given type in an area, it will be considered "lowest premium."

[b] "Other plans" are defined as additional plans of the same type by a sponsor in an area whose premiums are higher than the reference "lowest premium" plan of that sponsor.

[3] These include the 10 national firms and others (see Gold, 2006b). Exceptions are Alaska, where only 11 firms offer plans and Hawaii where only 12 do.

Public data on PDP benefits do not indicate whether a plan is standard (i.e., equal to Medicare's standard benefit or actuarially equivalent) or enhanced (i.e., additional benefits).[4] Our analysis reports on characteristics of all plans of a type but it also distinguishes between the lowest premium plan and any other plans offered in a region by a given sponsor. We make this distinction because, in the absence of information on whether plans are standard or enhanced, it provides an efficient way to compare offerings across plan types. Depending upon the beneficiary's health status and drug needs, the lowest premium plan may not be the same as the plan that results in the lowest total out-of-pocket costs for drugs since the latter will vary with use and associated cost sharing for particular prescriptions purchased.

Medicare Advantage-Prescription Drug Plans

There are 1,314 MA-PD plans available in 2006. Although there are almost as many MA-PD plans as PDPs, the number of MA-PD plans available to any given beneficiary typically is substantially less than the number of PDPs. This is because service areas for MA plans (with the exception of regional PPOs) are typically much smaller than the area served by PDPs and because MA plans are unevenly distributed across areas of the country.[5] HMOs account for 67 percent of all MA-PD plans (see Table 1). There are 879 MA-PD plans under HMO contracts, 273 under local PPO contracts, and 114 under local PFFS contracts. There are fewer regional PPO plans (48), which probably is a function of their larger service area and the limited number

[4] The plan filings that indicate this are considered proprietary. However, it would be useful for analysts and beneficiaries if CMS would add an indicator on the public files noting whether a plan is standard, actuarially equivalent to standard, or enhanced.

[5] For historical reasons and because they are built on networks and county-based pricing, MA sponsors typically have different contracts for each service area or at least state. Sponsors of local plans must offer the same prescription drug benefit across all parts of the region included in the service area for that contract. However, this requirement does not apply to the rest of the benefit package, and some firms historically have subdivided their service area into segments or subgroups of counties covered under the contract, particularly when county-based payment rates vary extensively across the area. Though the prescription drug benefit may be the same across the contract, the premium for the prescription drug plan may differ because more or less savings are available from elsewhere in the benefit package to offset the costs of the benefit.

of firms offering them (Gold, 2006a,b). MA sponsoring firms offer, on average, fewer plans per region than do PDP sponsoring firms. Local HMO and regional PPO sponsors offer just under two plans per area served; sponsors of other MA-PD plan types offer fewer.

Regional PPOs and local PFFS plans are heavily influenced by Humana's presence. Humana offers regional PPOs in 14 regions and accounts for 28 of the 48 regional PPO MA-PD plans. Humana also accounts for 69 of the 114 PFFS MA-PD plans. (See Appendix Table A-2 for data comparing Humana's offerings for these types of plans to other sponsors.)

PDP AND MA-PD PREMIUMS

Prescription Drug Premiums. Premiums for Medicare's new prescription drug coverage vary substantially across plans of different types though they also vary geographically and by plan (see Table 2). Overall, the average prescription drug premium is $37 across all PDPs, compared to $18 across all MA-PD plans. Average drug premiums are $16 across HMOs, $17 across PFFS plans, $21 across regional PPOs and $27 across local PPOs. Among lowest premium plans only, premiums average $29 per month in a PDP, compared to $10 in HMO plans, $15 in the regional PPOs or PFFS plans, and $22 in local PPO plan. If a beneficiary chooses a plan that costs more than the lowest premium plan available, it costs them an average of $43 for a PDP and $40 for a local PPO, but only $28 for a regional PPO, $26 in a PFFS, and $22 for a local HMO. By applying savings, 39 percent of all MA-PD plans charge no premium for the drug benefit. By plan type, nearly half of local HMOs (49 percent) charge nothing for the prescription drug portion of the benefit (61 percent of lowest premium plans and 35 percent of others). Such options are more limited in other types of MA plans but they exist in about a fifth to a quarter of the lowest premium MA-PD plans of other types.

TABLE 2

PDP AND MA-PD PLAN AVERAGE PREMIUM AND DISTRIBUTION, LOWEST PREMIUM, AND OTHER, BY SELECTED CONTRACT TYPE, 2006

				MA-PD Plans											
	PDPs			Regional PPO			Local HMO			Local PPO			Local PFFS		
	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other
Number of Plans	1,429	583	846	48	26	22	879	468	411	273	188	85	114	92	22
Rx Premium															
Mean	$37	$29	$43	$21	$15	$28	$16	$10	$22	$27	$22	$40	$17	$15	$26
Distribution															
0	0	0%	0%	15%	23%	5%	49%	61%	35%	18%	21%	12%	23%	28%	0%
<$20	6	12	3	33	58	5	11	12	10	13	17	5	22	24	18
$20 - $29	22	42	8	31	4	64	17	15	19	22	28	7	42	42	46
$30 - $39	32	38	28	8	12	5	13	9	18	26	29	18	13	5	36
$40 - $49	23	2	38	8	4	14	5	1	8	11	3	29	0	0	0
$50 - $74	16	6	23	4	0	9	4	1	8	8	1	25	0	0	0
$75 - $99	0	0	0	0	0	0	1	0	1	2	1	4	0	0	0
$100 +	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0
Premium Other Than Rx															
Mean		NA	NA	$46	$38	$55	$34	$18	$53	$45	$38	$57	$28	$26	$32
Distribution															
0		NA	NA	10%	19%	0%	51%	66%	34%	14%	18%	6%	31%	38%	5%
<$20		NA	NA	15	15	14	11	9	13	18	20	15	19	17	27
$21 - $30		NA	NA	13	12	14	5	4	6	10	13	2	4	4	0
$31 - $50		NA	NA	15	19	9	11	8	14	18	18	20	29	21	64
$51 - $75		NA	NA	29	23	36	9	7	12	21	18	27	11	14	0
$76 - $100		NA	NA	15	8	23	8	4	14	11	9	16	4	3	5
$101 +		NA	NA	4	4	5	5	2	9	7	5	13	3	2	0
Total Premium															
Mean		NA	NA	$67	$53	$83	$50	$28	$76	$72	$60	$97	$45	$41	$58

	PDPs			MA-PD Plans											
				Regional PPO			Local HMO			Local PPO			Local PFFS		
	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other
Distribution															
0		NA	NA	8%	15%	0%	43%	58%	26%	10%	13%	1%	20%	25%	0%
<$20		NA	NA	2	4	0	4	6	2	4	5	1	15	16	14
$21 - $30		NA	NA	4	8	0	5	5	4	8	10	5	5	4	9
$31 - $50		NA	NA	21	23	18	13	9	17	14	14	12	13	14	9
$51 - $75		NA	NA	23	19	27	11	9	14	20	22	16	25	21	41
$76 - $100		NA	NA	21	19	23	11	8	14	20	18	25	15	13	23
$101 +		NA	NA	21	12	32	14	5	23	24	17	40	7	6	5

Source: MPR analysis of CMS Landscape file. MA data are from November 2005. PDP data are from October 2005.

Note: MA plans are defined by contract segments reflecting aggregations of counties in the service area with a uniform benefit package and premiums. PDPs are defined by offerings in each of 34 regions.

Total Premiums in MA-PD Plans. The amount of premium paid by enrollees in MA-PD plans is based on the difference between (1) the costs that plans estimate are associated with their benefits and (2) CMS's payments to them for Medicare covered benefits. If plans can provide Medicare benefits for less than what Medicare pays them, they can apply 75 percent of the difference to expand other benefits or offset the premium costs associated with such benefits. They also can provide a rebate to offset the cost of the Part B premium, which beneficiaries still are responsible to pay. The shift to a bidding approach starting in 2006 also gives firms the ability to raise their premiums to the extent that their costs for Medicare benefits are higher than the benchmark. In the first year, this was not relevant since 95 percent of all bids in 2006 were below the relevant benchmark for Medicare Parts A and B services (MedPAC 2006).

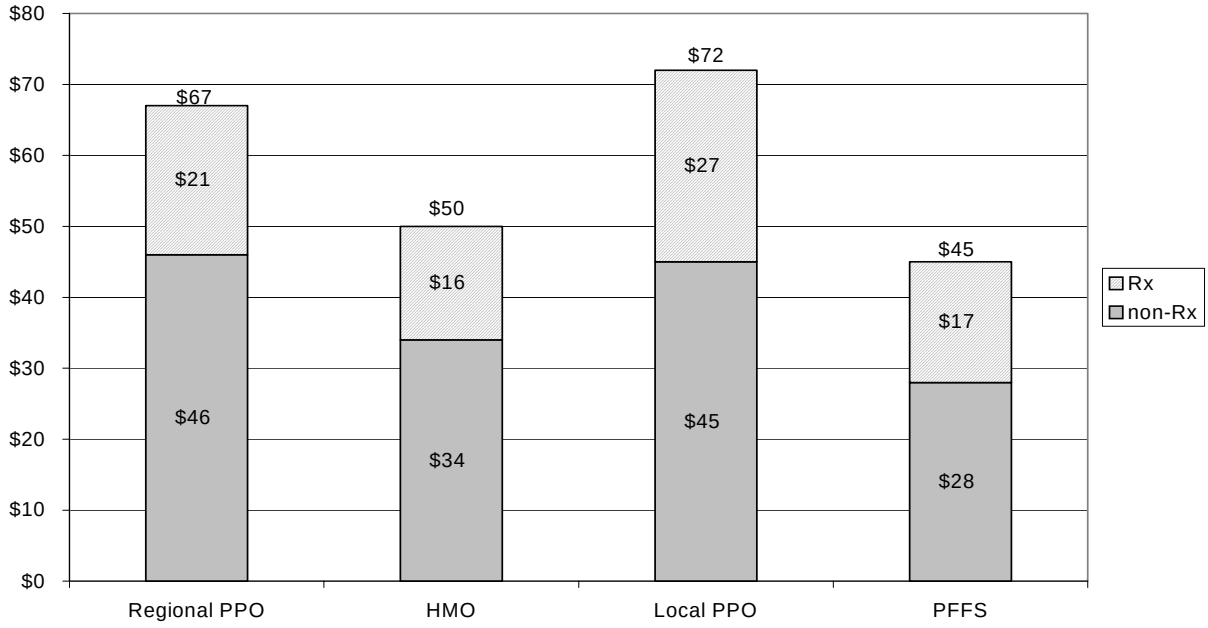
Average total premiums vary by product in much the same way that they do in the prescription drug premiums (see Figure 1). Across all MA-PD plans, average total premiums are lowest per month for HMOs where they average $50 and PFFS plans where they average $45. In contrast, total premiums average $67 for regional PPOs and $72 for local PPOs. Premiums are by definition lower in the lowest premium plan offered by sponsors in an area, but there are similar differences across plan types. Considering only the lowest premium plans of each type, HMOs also have the lowest average total premium—$28 per month versus $41 for PFFS, $53 for regional PPOs, and $60 for local PPOs.

Premiums on average in "other" MA-PD are substantially higher than they are for lowest premium plans. Higher premiums are driven particularly by higher premiums in the non-drug component. Higher premium plans are not as common in PFFS as elsewhere, and the differential between them and lowest premium plans is smaller than with other plan types. The highest average monthly premiums are in other local PPOs ($97). We currently are analyzing the way

MA plans structure their hospital and physician benefits, which may shed more light on the premiums of diverse plan types and the way they are positioned in the marketplace.[6]

FIGURE 1

TOTAL AVERAGE MONTHLY PREMIUMS AND COMPONENTS, MA-PD PLANS BY TYPE 2006



Source: MPR analysis of CMS November 2005 Landscape file.

Availability of Zero Premium Offerings. MA plans available for no additional premium beyond that which is charged for Part B have been important in attracting beneficiaries to MA and particularly important for those beneficiaries whose incomes, assets, and other characteristics lead them to be most price sensitive (Gold, 2004). The availability of zero premium options declined in the early 2000s when increases in federal payments to MA plans were small (Gold, 2001, 2004).

In 2006, zero premium MA plans are again common with a third of all MA-PD plans charging nothing (see Table 3). Such offerings are especially common in HMOs. Forty-three percent of all HMOs charge no premium—including 58 percent of lowest premium HMOs and

[6] Forthcoming late spring 2006 from the AARP Public Policy Institute.

26 percent of other HMOs. Some of those charging premiums provide part of the benefit package (either the drug component or the non-drug component) at what effectively is zero premium. However, even beneficiaries who want a different type of plan option that may provide them with broader provider choice often have access to such a plan, depending upon their location. The most common other source of such plans is among PFFS plans. Twenty percent of all PFFS plans (and 25 percent of lowest premium PFFS plans) charge no premium to enroll in the plan. [7]

[7] The data source used here does not provide information on Part B premium rebates, though we intend to examine this in other analyses.

TABLE 3

PERCENTAGE OF MA PLANS BY TYPE AVAILABLE FOR NO PREMIUM, 2006

	Regional PPO			Local HMO			Local PPO			Local PFFS		
Percentage with	All	Lowest	Other	All	Lowest	Other	All	Lowest	Other	All	Lowest	Other
No Premium at All	8%	15%	0%	43%	58%	26%	10%	13%	1%	20%	25%	0%
No Premium for RX Component Only	6	8	5	6	3	9	8	7	11	3	3	0
No Premium for Non-Rx Component Only	2	4	0	8	8	8	4	4	5	11	13	5
Premium Both for Rx and Non-Rx Part	83	73	95	43	31	57	78	75	84	67	59	95

Source: MPR analysis of CMS Landscape file. MA-PD data are from November 2005. PDP data are from October 2005.

Note: MA plans are defined by contract segments reflecting aggregations of counties in the service area with a uniform benefit package and premiums. PDPs are defined by offerings in each of 34 regions.

DRUG BENEFITS OFFERED BY PLAN TYPE

In 2006, many plans have modified the structure of Medicare's standard drug benefit to eliminate deductibles and modify cost sharing. Such features are available even in many of the lowest premium plans' sponsors offer of any given type in an area (see Table 4)

Initial deductible. While the standard Medicare drug benefit includes an initial $250 annual deductible, there is no front end deductible in 79 percent of all MA-PD plans, and slight variation by plan type: HMOs (82 percent), PFFS plans (75 percent), local PPOs (74 percent), and regional PPOs (63 percent). By comparison, 58 percent of PDPs have no drug deductible.

No deductible plans are the norm even in the lowest premium plans—absent in 80 percent of the lowest premium HMOs, 71 percent of the lowest premium PFFS, and 68 percent of the lowest premium local PPOs. The deductible is less likely to be eliminated in the lowest premium regional PPOs (35 percent) or PDPs (31 percent). For these plan types, beneficiaries likely could get such a benefit but not in the lowest premium plan. For the most part, sponsors seem either to have kept the deductible or eliminated it entirely; plans with a reduced deductible are not common in 2006.

Tiered Copayments. Though the standard Medicare benefit includes 25 percent coinsurance after the initial deductible until the coverage gap, most plans substitute tiered copayments that involve levels of fixed-dollar copayments that vary with the specific drug and its place in the plan formulary. In general, such tiered copayments create an opportunity for beneficiaries to save, but they also could result in higher out-of-pocket costs on any individual drug purchase than a fixed 25 percent coinsurance.[8] For example, a drug that costs $100 for a 30-month supply would cost a beneficiary $25 under Medicare' traditional coinsurance

[8] Whether out-of-pocket costs are higher or lower for a beneficiary with tiered copayments than standard cost sharing depends on the plan's formulary, how tiers are set, what a beneficiary needs, and how a beneficiary's physician responds to the incentives behind the tiered copayments in ordering drugs.

arrangements. Copayments might be $10, $25, $35, or even $75 under tiered cost sharing depending on the tier and level of copayment. Such tiered copayments aim to provide beneficiaries an incentive to choose certain drugs in a class over others.

Tiered cost sharing is included in 92 percent of MA-PD plans. Broken out by plan type, tiered cost sharing is a feature of 94 percent of local PPOs, 93 percent of HMO plans, 91 percent of PDPs, 89 percent of PFFS plans, and 71 percent of regional PPOs. Similarly, it is also a common feature of the lowest premium plans of each type. The only exception to this pattern is regional PPOs, where tiered copayments are used in only 46 percent of lowest premium plans even though it is used in all the other (higher premium) regional PPO plans.

Typically, formularies have multiple tiers of coverage that are separately defined within each class of drug (e.g., generics only, most preferred drugs, preferred drugs, drugs only available under exception policies). Even if covered, cost-sharing amounts for drugs vary and some covered drugs may come at a high price, depending on the tier they are assigned and the amount charged for drugs in that tier.[9]

The Coverage Gap. What is commonly referred to as the "donut hole" is that feature of Medicare's standard drug benefit that requires a beneficiary to pay 100 percent of the costs for drugs after reaching the initial coverage limit, but before reaching $3,600 in out-pocket-costs, at which time Medicare's catastrophic benefit applies and beneficiaries are responsible for only 5 percent of covered drug costs. Of all features of the Medicare drug benefit, this one probably has been most criticized, particularly for its impact on sick or chronically ill beneficiaries who use

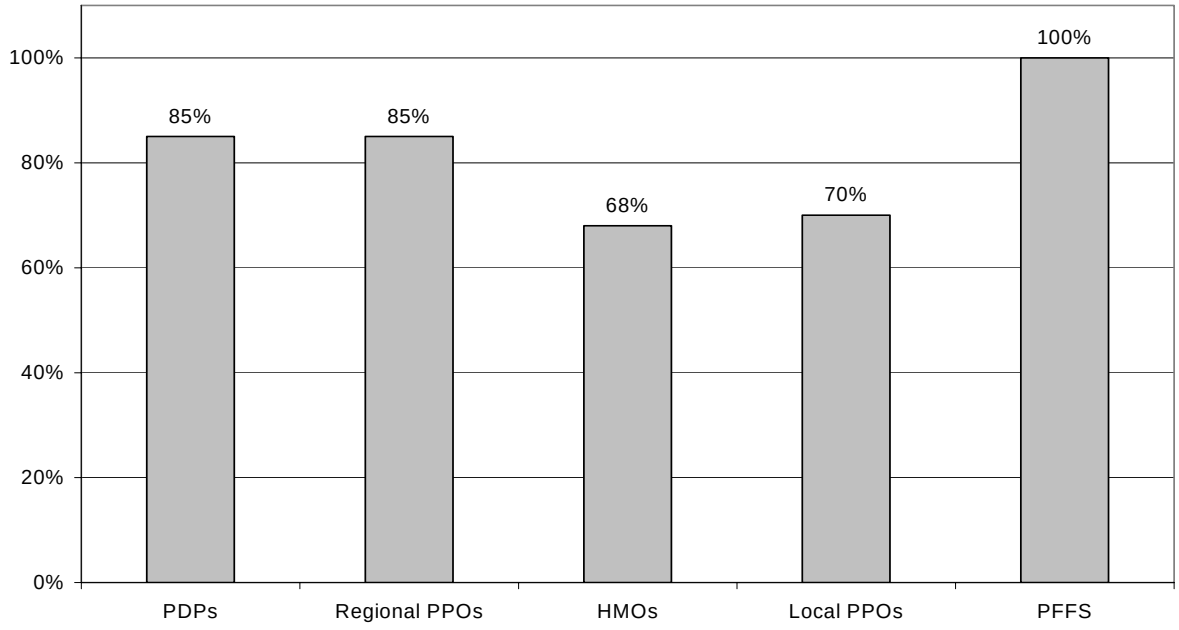
[9] Jack Hoadley et al. for the Kaiser Family Foundation (April 2006) found at: http://www.kff.org/medicare/upload/7489.pdf.

many drugs and do so consistently over time (Rosenthal 2004; Safran et al 2005; Stuart et al 2005; Gellad et al 2005; Rector and Venus 2004).

Beneficiaries seeking coverage that eliminates the coverage gap have limited options (see Figure 2). Most plans maintain this gap. The MMA actually gives plans incentives to do so because in most cases extra coverage delays the trigger for catastrophic benefits and federal reinsurance. Across all MA-PD plans, 72 percent maintain the coverage gap.

FIGURE 2

PERCENTAGE OF PLANS WITH MEDICARE'S STANDARD "COVERAGE GAP," BY TYPE, 2006



Source: MPR analysis of CMS Landscape file. MA data are from November 2005. PDP data are from October 2005.
Note: Few plans offering coverage include brand name drugs. Beneficiaries seeking such coverage can find them in 2 percent of PDPs, 7 percent HMOs and 3 percent of local PPOs. (No regional PPOs or PFFS plans provide such coverage.)

By plan type, 100 percent of PFFS plans and 85 percent of both PDPs and regional PPOs maintain the standard structure of the coverage. Local HMO and PPO plans are most likely to provide some coverage in this gap (32 percent and 30 percent, respectively), with some of the higher-priced PPO plans potentially structured to attract beneficiaries seeking such coverage. In

most cases, coverage in the gap is limited to generic drugs. Because generics are not available for some commonly used drugs and drug classes, this is an especially important limitation.

Availability of Mail Order. The option for mail order service, particularly for maintenance drugs used over long periods of time, can be a source of savings for beneficiaries because services often provide a 90-day drug supply versus 30-day supply for a lower copayment than the latter would entail over the same period. Mail order options also can be convenient for geographically isolated beneficiaries and for those with mobility or transportation problems. More than 90 percent of PDPs and MA-PD plans of all types offer the mail order option. The exceptions (a small group of HMOs and PDPs) likely are dominated by organizations owning retail pharmacies. Mail order options are common and their availability does not seem to vary across lowest premium and other plans.[10]

[10] The fact that percentages differs between categories in some plan types likely reflects differences in the number of plans offered by firms with and without mail order options among PDPs and local HMOs.

TABLE 4

SELECTED CHARACTERISITCS OF PDP AND MA-PD PLAN PRESCRIPTION DRUG BENEFITS
LOWEST PREMIUM AND OTHER PLANS BY SELECTED CONTRACT TYPE, 2006

				Medicare Advantage											
	PDPs			Regional PPO			Local HMO			Local PPO			Local PFFS		
	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other	Total	Lowest	Other
Number of Plans	1,529	583	846	48	26	22	879	468	411	273	188	85	114	92	22
Initial Deductible															
None	58%	31%	77%	63%	35%	95%	82%	80%	84%	74%	68%	88%	75%	71%	91%
Reduced	8	7	9	0	0	0	3	3	4	6	6	6	2	2	0
$250	34	62	14	38	65	5	15	17	12	20	27	6	24	27	91
Tiered Copayments															
Yes	91%	81%	98%	71%	46%	100%	93%	93%	94%	94%	92%	99%	89%	87%	95%
No	9	19	2	29	54	0	7	7	6	6	8	1	11	13	5
Benefits in Coverage Gap															
None	85%	100%	74%	85%	92%	77%	68%	73%	63%	70%	82%	44%	100%	100%	100%
Generic Only	13	0	22	15	8	23	25	19	31	27	16	51	0	0	0
Brand	2	0	4	0	0	0	7	7	6	3	2	6	0	0	0
Percent with Mail Order	91%	90%	92%	100%	100%	100%	93%	93%	92%	98%	98%	98%	100%	100%	100%

Source: MPR analysis of CMS Landscape file. MA data are from November 2005. PDP data are from October 2005.
Note: MA plans are defined by contract segments reflecting aggregations of counties in the service area with a uniform benefit package and premiums. PDPs are defined by offerings in each of 34 regions.

IMPLICATIONS FOR BENEFICIARIES

In 2006, Medicare beneficiaries have access to a range of plan options that provide the new Medicare prescription drug benefit. There are more PDP choices but, on average, MA-PD plans have lower premiums and some features which may reduce cost sharing more than free-standing PDPs. Though HMOs typically have the lowest premiums on average, other MA-PD plan types also have lower premiums and make more use of selected features than PDPs. As a trade-off of these features, enrollees in most types of MA-PD plans have limits on the providers they can use, particularly if they want to limit out-of-pocket spending.[11] PFFS plans, which might be expected to cost more because they lack the potential of tightly managed care to generate savings through their relationships with physicians and care management, are more similar in their characteristics to other MA-PD types, including HMOs, than one might have expected.

Private-sector plans offer a range of structures that depart from the standard Medicare drug benefit design. However, despite the range of choice, beneficiaries in 2006 have limited access to plans structured to fill the coverage gap. The plans offered typically include coverage for generic drugs only in the donut hole. However, some of the drugs commonly used by Medicare beneficiaries are relatively new and have no generic option. As a result, Medicare beneficiaries enrolling in either PDPs or MA-PD plans still may accrue substantial out-of-pocket expense, particularly if they have chronic illnesses or conditions that result in heavy medical expense.

There are many limitations to the analysis. First, we have not been able to assess the way formularies are structured across diverse types of plans, how tiers are defined and copayments assessed across tiers, and how the drug benefit is managed in each type of plan, all of which are important features of drug coverage that affect out-of-pocket costs to beneficiaries and overall

[11] PFFS plans are not allowed to limit availability of providers and must take all providers who agree to the payment levels they offer. However, some providers may still be reluctant to participate in such plans.

access to pharmaceuticals under Medicare's new drug benefit. Second, we have not examined the way MA-PD plans have structured their cost sharing for Medicare Parts A and B benefits and supplemental services and therefore do not know how these compare to prior years' MA offerings or the kind of coverage available through Medigap policies. Third, we do not address the issue of provider choice and how that factors into beneficiaries decision making. And fourth, the analysis reflects the first year of the drug benefit under the MMA and plan interest in attracting members. The 2006 profile may not necessarily reflect the pattern of offerings over time as firms learn more about the costs of offering prescription drug ability and challenges of managing the benefit. Because statistics are not weighted by enrollment, the profile also is limited in the insight it can provide on how average coverage across plan types varies because of the kinds of choices beneficiaries are making in enrollment.

Finally, the analysis focuses only on the first year of drug coverage in Medicare. It should be noted that firms, especially in MA, may be offering particularly generous benefits in 2006. MA plans may be artificially keeping premiums low in 2006 as a way to attract new business just when the new benefit is coming on line and beneficiaries are choosing a plan. Firms have an incentive to do this since history suggests limited movement once beneficiary choices are established. Equally important is the way payments are structured in 2006—with rates substantially higher than in traditional Medicare. This also encourages generous benefits in 2006 because, in effect, firms are being paid to do so. Even without legislative changes, such overpayments may be reduced in the future. For example, CMS indicates that in 2007 the average rate of increase in MA will be only 4.4 percent in 2007 because of the phase out of the "budget neutrality" adjustment that aims to protect the MA sector from reduced revenue as a

result of risk adjustment (CMS April 4, 2006).[12] In addition, risk adjustment also is being recalibrated in 2007 for MA vis-à-vis traditional Medicare (referred to by CMS as "fee-for-service normalization"). CMS therefore anticipates that plans with the same risk score in 2007 as 2006 would receive only a 1.1 percent increase in 2007.

As experience with the Medicare drug benefit grows, additional research is needed to provide a more comprehensive analysis of the way PDP and MA plans structure their benefits and what this means for beneficiary access to care and out-of-pocket costs; and to assess how plan benefits change over time. Such analyses rely on CMS continuing to make publicly available on a timely basis the data used in this issue brief, as well as enrollment data for individual PDP and MA plans so that beneficiary choice can be an integral part of future analyses.

[12] CMS has been phasing in enhanced risk adjustment factors, a process completed in 2007. In prior years, average rates in the MA sector were increased by a factor designed to maintain the total share of Medicare funds available to the MA sector. This will no longer be the case in 2007 when CMS will protect the MA sector from only 55 percent of what they otherwise would receive from risk adjustment that is budget neutral on the MA sector.

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APPENDIX

DEFINING THE UNIT OF ANALYSIS

The analysis in this report is based on plans that are defined using a combination of contract and county codes. The package offered by each plan has a unique set of benefits that are available for a specified premium to beneficiaries in all or part the full geographic area included within the contract. Defining the unit of analysis is particularly complicated for local MA plans whose features may vary on a county-by-county basis.

Contracts are specific formal written agreements CMS establishes each year with sponsors of private plans; contracts authorize sponsors to offer a particular MA product type (e.g., HMO) in a specified location defined by counties (for local plans) or regions (for PDPs and MA regional PPOs). The same sponsor may have multiple contracts covering diverse products and/or areas. Contracts are renewed or terminated on an annual basis and include the legal requirements related to each offering.

Contract Segments. Contracts may be subdivided into non-overlapping and unique contract-segments that are defined on a geographical basis. Segmentation historically occurred when HMOs divided their local service area under a contract into subgroups of counties (segments) so that they could vary the generosity of the package between counties that may have been close to one another geographically within a metropolitan area but were paid at very different levels by CMS (e.g., New York City boroughs versus the adjacent Nassau and Suffolk Counties in Long Island) (MedPAC, 2004). Local MA plans retain authority to segment their service areas for purposes of defining plan benefits. CMS requires that drug coverage be consistently defined within any contract in a given MA region. However, drug premiums may differ to the extent that savings to offset costs differ across segments and other features vary.

Under the MMA, newer types of MA plans—particularly regional PPOs and local PFFS plans—often involve contracts that may cover large parts of the country. For example, Humana has only 3 regional PPO contracts nationally though it offers plans across 14 MA regions and has authority under the MMA to vary the structure of benefits and premiums in each. Similarly, while there are only 22 PFFS contracts, these reflect 115 geographically defined PFFS entities and, because more than one plan is offered by some entities in a given area, 163 distinct plans.

MA-PD versus MA-Only Plans. HMOs and local PPOs are required to offer at least one plan that includes prescription drugs; regional PPOs are required to offer only such plans. In addition to MA-PD plans, MA organizations may offer MA-only plans that do not include prescription drugs. MA-PD offerings are optional for PFFS plans.

TABLE A-1

NUMBER OF MA CONTRACTS AND CONTRACT SEGMENTS, BY WHETHER OR NOT A MA-PD PLAN IS OFFERED, TYPE AND NUMBER, 2006

	Regional PPO	Local HMO	Local PPO	Local PFFS
Number of MA Contracts	11	207	113	22
Contract Segments				
All	26	471	189	115
Only MA-PD plans	22	164	111	70
Both MA-PD & MA- Only Plans	4	304	77	22
Only MA-Only Plans	0	3[b]	1[b]	23
Plans				
All	70	1,185	351	163
MA-PD	48	879	273	114
MA-Only	22	306	78	49
Mean				
Number of Plans/Plans per Contract Segment				
All	2.7	2.5	1.9	1.4
MA-PD Plans per Contract Offering MA-PD	1.8	1.9	1.5	1.6
MA-Only Plans per Contract with MA-Only Plans	5.5[c]	1.0	1.0	1.1

Source: MPR analysis of CMS November 2005 Landscape file. These data are designed for administrative purposes and may have coding or other errors.

[a] Segments are geographical areas in which the firm offers the same benefit package. Firms serving more than one region with a regional PPO may have a single contact but offer different regional PPO plans in each region (the segment). Local MA plans define their service areas by counties and my offer distinct plans in subsets of the counties they service.

[b] These are likely to be special cases since CMS restricts MA-only offerings in local HMOs or PPOs under the same contract.

[c] This figure appears high relative to other types of contracts and possibly could be an error.

APPLICATION OF CONCEPTS TO 2006 OFFERINGS

Table A-1 shows the number of MA contracts by type and the number of contract segments into which they are divided for each type of MA plan. The table also shows which of these segments offer only MA-PD plans, which offer both MA-PD and MA-only plans, and which offer just MA-only plans, as well as the number of associated plans in aggregate and per segment.

HMOs are the most common type of contract. For example, there are 207 separate HMO contracts in 2006 but the number of distinct geographical areas for purposes of defining plans is more than twice as many (471); in 65 percent of these segments both an MA-PD and an MA-only plan is offered. On average, there are 2.5 MA plans per segment for each HMO sponsor. Typically, only one MA-only plan is offered but there are two MA-PD plans. MA-only plans are less likely to be offered in local PPOs and, consistent with federal law, mostly absent from regional PPOs.

Because MA-PD offerings are not mandated for PFFS sponsors, we were interested to see that sponsors still have chosen to offer them in most contract segments where such plans are offered. Only 23 PFFS contract segments of the 115 total PFFS segments involve just MA-only plans. An example is PacifiCare, which offers PFFS as an MA-only plan; the firm also offers a national PDP and beneficiaries may be urged to select both.

Very little is known about the role of MA-only plans in a sponsor's portfolio of MA plans. Further, unless CMS releases enrollment data at the plan level (which it historically has not), it will not be possible to know how many individuals are enrolled in MA-only versus MA-PD plans. Presumably, MA-only offerings target those who do not want to enroll in Medicare's prescription drug benefit but still wish to enroll in an MA plan.. In addition, an unknown share of MA-only offerings could be geared primarily for employers seeking to build on the Medicare benefit.

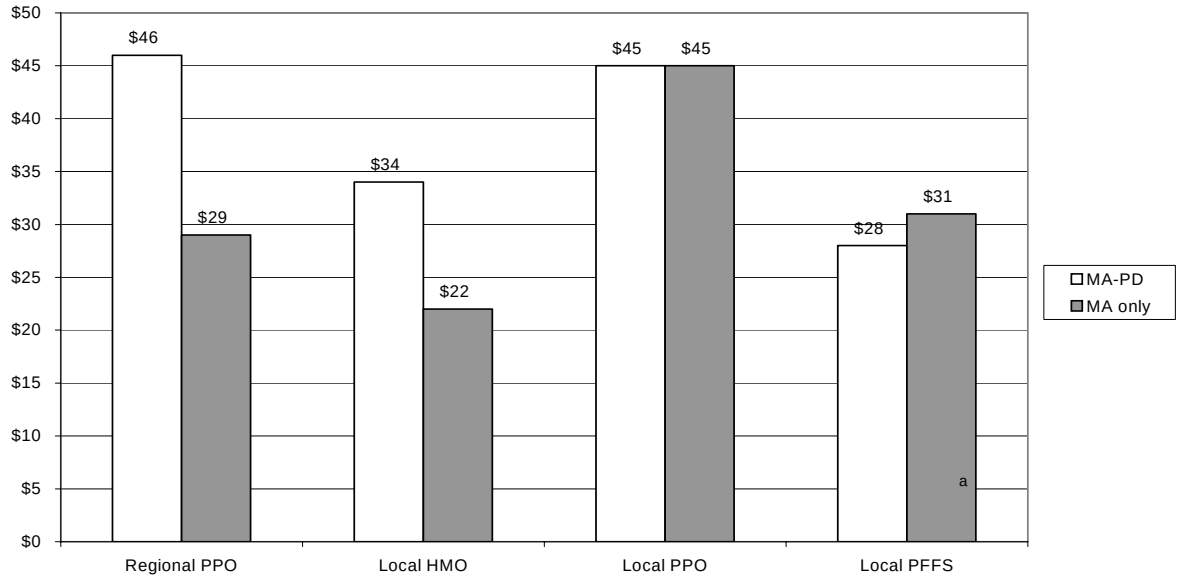
On average, premiums in MA-only plans are lower than the non-drug portion of the premium in MA-PD plans, particularly for local HMOs or regional PPOs (see Figure A-1). Lower MA premiums would be consistent with plans designed for employer wrap-arounds or very price sensitive beneficiaries who do not seek drug coverage.

THE EFFECT OF HUMANA ON REGIONAL PPO AND PFFS PLANS

Table A-2 profiles Humana versus non-Humana-affiliated regional PPOs and PFFS plans. Humana plays a dominant role in offerings of both types so it is valuable to know whether any idiosyncratic features of their offerings have affected the overall averages for each of these types of plan. The table shows differences between Humana's offerings and others. For example, in their lowest premium regional PPO offerings, Humana is less likely to modify the standard benefit feature than are others, but the premiums they charge are higher. Distinctions are less pronounced in lowest cost PFFS plans. Without further analyses that adjust for location (which influences Medicare payments), it is difficult to fully interpret the differences between Humana's approach and others.

FIGURE A-1

AVERAGE PREMIUMS FOR BENEFITS OTHER THAN PRESCRIPTION DRUGS, MA-PD VERSUS MA ONLY PLANS BY TYPE, 2006



Source: MPR analysis of CMS November 2005 Landscape file.
a MA-only plans average premium is $34 in PFFS contract segments where the organization also offers an MA-PD versus $28 in MA-only segments.

TABLE A-2

CHARACTERISTICS OF HUMANA-AFFILIATED VERSUS OTHER MA-PD REGIONAL PPOS AND PFFS PLANS, 2006

	Regional PPOs				PFFS			
	Lowest Premium		Other		Lowest Premium		Other	
	Humana	Other	Humana	Other	Humana	Other	Humana	Other
Number of Plans	14	12	14	8	63	29	6	16
Percent with No Deductible	0%	75%	100%	88%	94%	21%	83%	94%
Percent with Coverage in Gap	0%	17%	0%	63%	0%	27%	0%	0%
Percent with Tiered Copayment	0%	100%	100%	100%	94%	72%	83%	100%
Average Total Premium	$67	$36	$77	$94	$45	$32	$47	$62

Source: MPR analysis of CMS November 2005 Landscape file.

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