

PREMIUMS

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Medicare Part D helps cover the cost of outpatient prescription drugs for 27 million beneficiaries enrolled in private stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans. The majority of Part D enrollees pay a monthly premium for Medicare drug coverage, though some beneficiaries are enrolled in Medicare Advantage prescription drug plans that charge no additional premium for drug coverage. For low-income subsidy (LIS) recipients in Part D plans, the government pays the premium, up to a benchmark amount.

This Part D data spotlight examines PDP premiums in 2010 and trends since 2006. The 2010 analysis is based on data from the Centers for Medicare & Medicaid Services (CMS) on 1,576 PDPs offered around the nation, excluding the territories. This research is part of a broader effort analyzing Medicare Part D plans in 2010 and trends since 2006, with key findings summarized in a series of data spotlights.¹

UPWARD TREND IN PART D PREMIUMS, 2006-2010

Stand-alone prescription drug plans. Between 2006 and 2009, average PDP premiums increased 35 percent, weighted by each year's enrollment. If PDP enrollees do not switch plans between 2009 and 2010, the average monthly premium will increase another 11 percent, from \$35.09 to \$38.94 (Exhibit 1).²

Since 2006, average monthly premiums have increased dramatically for some of the most popular PDPs.

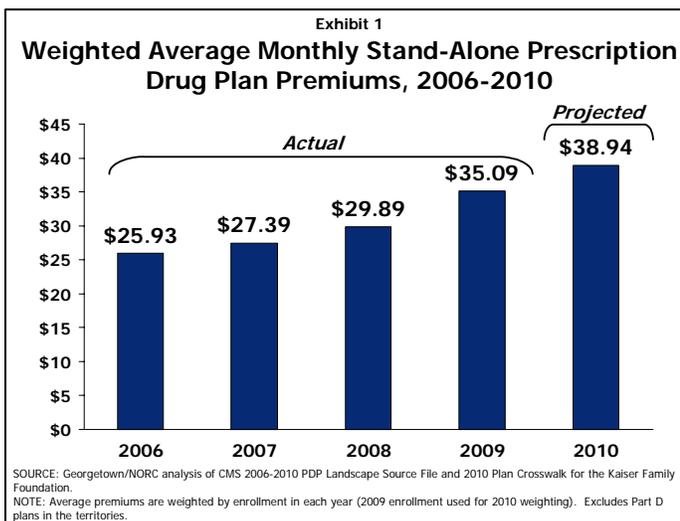
For example, the average premium for AARP Preferred, with 2.7 million enrollees in 2009, increased from \$26.31 in 2006 to \$39.39 in 2010; while the average premium for Humana Enhanced, with 1.1 million enrollees in 2009, nearly tripled from \$14.73 in 2006 to \$41.53 in 2010.

Medicare Advantage drug plans. The portion of the total premium for Medicare Advantage drug plans that is attributable to the drug benefit will remain stable between 2009 and 2010, on average, if enrollees stay in their current plans.³ Between 2006 and 2009, average monthly MA drug premiums (weighted by enrollment) increased about 21 percent. Among 1,325 Medicare Advantage drug plans offered in 2010 that can be matched to 2009 plans, the weighted average drug premium is \$14.51 in 2010, compared to \$14.59 in 2009.⁴ The average premium for MA-PD drug coverage is lower than the average premium for PDPs in part because MA plans can steer physician prescribing practices toward cheaper drugs and lower utilization. MA-PD plans are also permitted to reduce drug premiums with savings (rebates) from Medicare payments to plans for providing services under Parts A and B. In 2010, about one-third of all MA-PD plans will charge no additional premium amount for the drug benefit, similar to the 2009 level.

Average weighted Part D premiums for Medicare Advantage plans vary considerably by plan type. In 2010, average monthly drug premiums are lowest for local HMOs, representing over half of all MA-PD plans (\$11.05), and highest for local PPOs (\$29.44). The Part D portion of the total monthly premium for regional PPOs and private fee-for-service plans is \$14.44 and \$21.35, respectively.

2010 PDP PREMIUMS VARY WIDELY

PDP monthly premiums vary widely both within and across regions. To exclude variations in price that may be attributable to enhanced benefits, we examined premium variation among "basic" PDPs, which account for half of all PDPs. All basic PDPs are actuarially equivalent, meaning their benefits must have the same value as the defined standard benefit, but their premiums can and do differ substantially.



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Variation across regions. In just over half of the 34 PDP regions, most on the east and west coasts, the average premium for a basic PDP is between \$35 and \$40 per month (Exhibit 2). The New Mexico region in the southwest has the lowest average monthly basic PDP premium (\$27.15), and other southern states also have relatively low average monthly premiums for basic PDPs. The highest average monthly basic PDP premium is in the Idaho/Utah region (\$44.83). All states with average basic PDP premiums above \$40 are west of the Mississippi River.

Variation within regions. Variations across regions mask wide premium variation *within* regions. In almost every region, the monthly premium for the most expensive basic PDP is at least double the premium of the least expensive basic PDP; in many regions, the difference is greater (Exhibit 3). For example, the difference between the lowest and highest premium for a basic PDP is more than three-fold in Florida (\$23.10 to \$72.00) and more than four-fold in Arizona (\$10.30 to \$49.10).

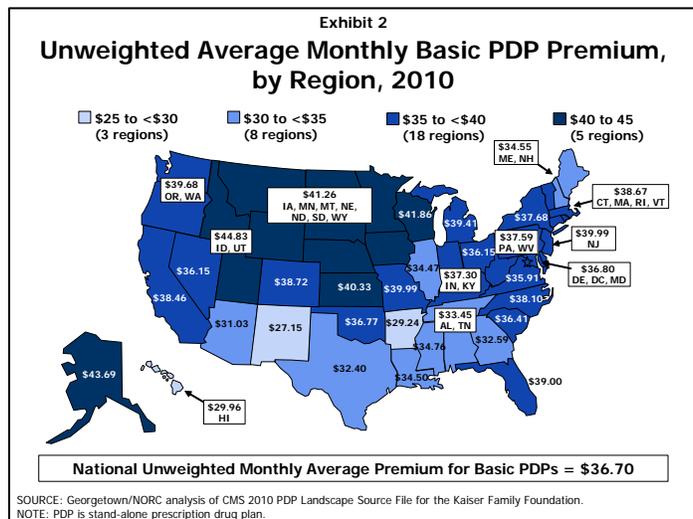
Variation for the same PDP across regions. Plan sponsors typically charge different premiums for the identical plan in various regions across the country, often twice as much in one region as another (Exhibit 4). For example, the monthly premium for CCRx Basic is \$53.30 in California, more than twice the monthly premium for the same plan in Texas (\$25.70) or Pennsylvania/West Virginia (\$20.60). Furthermore, among insurers, there is no consistent pattern of more or less expensive regions. The monthly premium for AARP Preferred is highest in Arkansas (\$47.00) and lowest in New Hampshire/Maine (\$32.50), with California and Texas in between.

MANY PDP ENROLLEES FACE HIGHER PREMIUMS UNLESS THEY SWITCH PLANS

The majority of PDP enrollees who are not receiving the low-income subsidy (87 percent) will pay a higher monthly premium in 2010 (typically an increase of less than \$5 per month) unless they switch to a lower-premium plan (Exhibit 5). More than one-fourth of PDP enrollees (27 percent) face premium increases of at least \$5 per month if they do not switch plans, with increases for some as high as \$40 per month. Thirteen percent face lower premiums in 2010 if they do not switch plans.

Changes in benchmark plan availability

could mean some LIS recipients will incur monthly costs for premiums in 2010. About one-fifth of all PDPs in 2010 (19 percent, or 307 plans) will be “benchmark” plans – that is, plans available for no monthly premium to LIS enrollees, down from a high of 630 benchmark PDPs in 2007. Many LIS



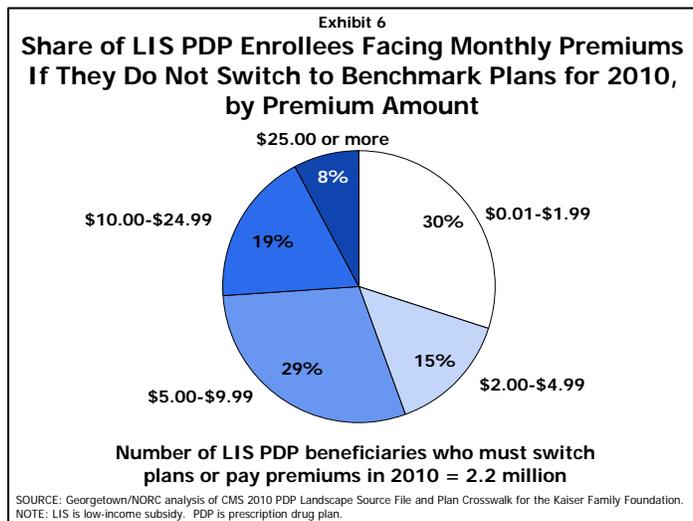
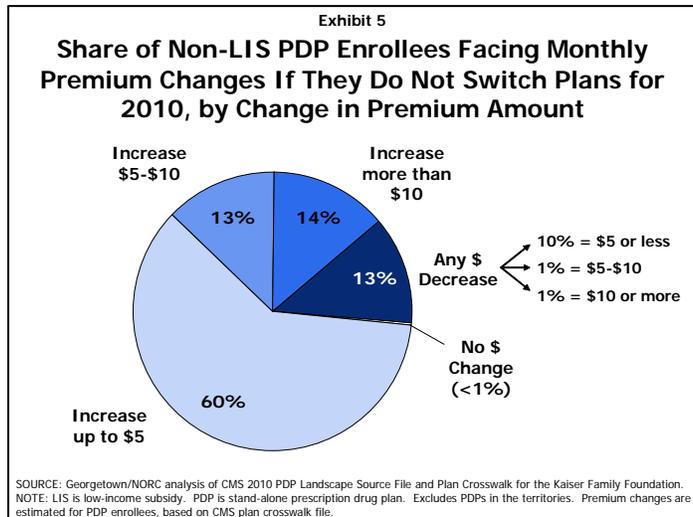
enrollees (4.6 million) are enrolled in PDPs that are designated as benchmark plans for 2010. Of the 3.3 million LIS enrollees in PDPs not designated as benchmark plans, CMS will assign one third of them to a new (benchmark) plan. The remaining two-thirds (2.2 million) will need to switch plans on their own or will pay higher premiums equal to the amount of the basic premium that exceeds the benchmark (subsidy) amount, plus the value of any enhanced benefits. Just over a quarter of these LIS recipients (27 percent) will pay \$10 or more per month, including 8 percent who will pay \$25 or more (Exhibit 6).

LIS enrollees, unlike other Part D enrollees, are permitted to switch plans at any time. Some may choose to stay in a plan, even if it is not a benchmark plan, if they are satisfied with their coverage and will face relatively low premiums. Others, however, may not know they can switch plans, although all received a notification letter from CMS this fall. In 2009, two million beneficiaries were enrolled in non-benchmark PDPs and paid unsubsidized premium amounts ranging from less than \$1 to more than \$100 per month. Had they switched to a benchmark plan, they would have paid no premium at all.

DISCUSSION

Part D enrollees have faced relatively steep drug plan premium increases over time, including those in the most popular plans. If no beneficiaries change plans for 2010, the weighted average monthly premium will be 50 percent higher in 2010 than in 2006. In addition, annual changes in the PDP marketplace present challenges for low-income beneficiaries who may face monthly premiums unless they change plans, despite qualifying for zero-premium coverage. Despite appeals by government officials to compare Part D plans annually, CMS reports that most beneficiaries do not switch plans during the annual open enrollment period.

PDP premiums vary considerably both across and within regions. Average monthly PDP premiums in the most expensive region are over 50 percent higher than in the least expensive region. Within any region, monthly premiums for PDPs of identical actuarial value can range by two-fold or more. The most expensive regions for some plan sponsors are among the less expensive regions for some of their competitors. More research is required to understand whether these geographic variations in Medicare Part D premiums are influenced by variations in health status, market dynamics, prescribing practices, or consumer preferences across regions.



¹ Other Medicare Part D 2010 Data Spotlights, based on the authors' analysis of CMS data, are available at <http://www.kff.org/medicare/med110909pkg.cfm>.

² These estimates incorporate CMS plan crosswalks where relevant. They are higher than CMS estimates because they focus only on PDPs and assume that most enrollees do not switch plans. According to CMS, more than 90 percent of PDP enrollees did not switch in past years.

³ Medicare Advantage plan analysis excludes employee-only plans, Special Needs Plans, cost plans, demonstration plans, and those offered in the territories. For additional information on 2010 MA plan availability and premiums, see *Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums in 2010*, Kaiser Family Foundation, November 2009. Analysis of MA-PD drug plan premiums for 2006 to 2009 is from the Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program* (June 2009).

⁴ The average premium for unmatched plans is about \$19. If many beneficiaries choose to switch to less expensive plans, the average premium weighted by actual 2010 enrollment could be lower.