MEDICARE PART D 2008 DATA SPOTLIGHT: PREMIUMS

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NOVEMBER 2007

Since 2006, Medicare Part D has helped cover the cost of outpatient prescription drugs for beneficiaries enrolled in private stand-alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans. As of July 2007, more than 24 million beneficiaries are enrolled in a Medicare Part D prescription drug plan, of which 17 million are enrolled in stand-alone PDPs. This data spotlight examines PDP premiums in 2008 and trends since 2006. The 2008 analysis is based on data from the Centers for Medicare and Medicaid Services (CMS) on 1,824 PDPs offered around the nation, excluding territories.

The majority of Part D enrollees pay a monthly premium for Medicare drug coverage. Beneficiaries pay, on average, 25.5 percent of the cost for standard drug coverage; the federal government subsidizes the remaining 74.5 percent. In 2007, more than 9 million Part D enrollees do not pay premiums because they receive low-income assistance under Part D. In addition, some beneficiaries are enrolled in Medicare Advantage drug plans that do not charge a monthly premium for drug coverage.

2008 PDP Premiums Vary Widely

As in previous years, PDP premiums vary widely for 2008, with higher-premium plans typically offering more generous benefits. Across all 50 states and D.C., PDP premiums range from $9.80 to $107.50 per month. Overall, 40 percent of plans are priced below $30 per month, but roughly the same share (38 percent) have premiums of $40 or more.

Upward Trend in PDP Premiums, 2006-2008

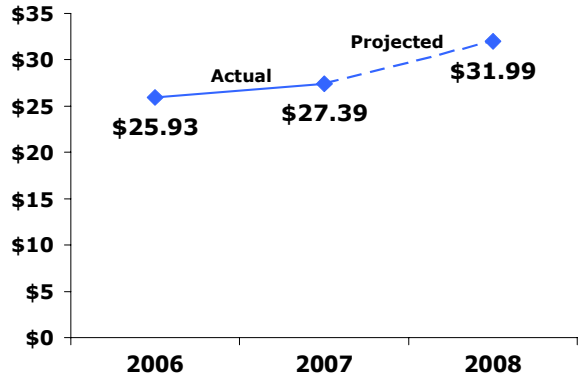
Between 2006 and 2007, average PDP premiums increased by $1.46 (weighted by each year's enrollment). According to CMS, more than 90 percent of PDP enrollees did not switch plans between 2006 and 2007. If PDP enrollees do not switch between 2007 and 2008, the average monthly premium for PDPs will rise from $27.39 in 2007 to $31.99 in 2008 (Exhibit 1).[1] This represents a 17 percent increase, or an additional $4.60 per month. By way of comparison, the standard Medicare Part B monthly premium will increase by 3.1 percent, or $2.90, from $93.50 per month in 2007 to $96.40 in 2008.

Three quarters of all PDP enrollees will face higher premiums in 2008 unless they switch to a lower-premium plan (Exhibit 2).[2] This is similar to the trend observed between 2006 and 2007 (before any switches occurred), although the magnitude of the PDP premium increases for 2008 will be larger.

Nearly one in five PDP enrollees face monthly premium increases of more than $10 in 2008 if they do not switch plans, up from 11 percent in 2007. Nearly half of PDP enrollees face monthly premium increases of more than $5, up from 30 percent in 2007. A quarter of all PDP enrollees will see lower monthly premiums if they stay in the same plan in 2008, but for most, the decrease will be no more than $5 per month. Overall, about one-fourth of PDP enrollees who have not switched plans between 2006 and 2008 will end up facing a premium increase of at least 50 percent across the three-year period.

Exhibit 1

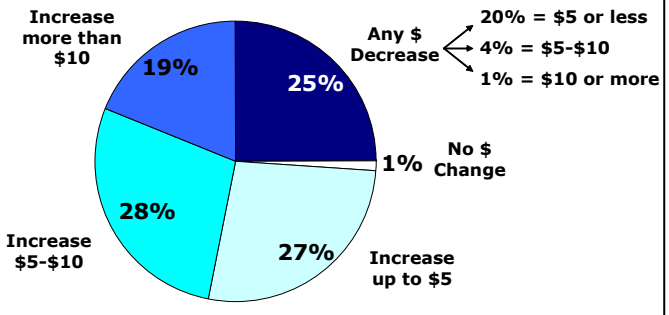
Weighted Average Monthly PDP Premiums, 2006-2008



SOURCE: Hoadley et al analysis of CMS PDP landscape files, 2006-2008, for the Kaiser Family Foundation.

Exhibit 2

Share Of PDP Enrollees Facing Monthly Premium Changes If They Do Not Switch Plans Between 2007 and 2008



NOTES: Excludes PDPs in the territories. Premium changes are estimated for PDP enrollees in plans with the same contract and plan ID in 2007 and 2008, as well as PDPs with the same plan names in each year. Changes do not apply to PDP enrollees receiving low-income subsidies. SOURCE: Hoadley et al analysis of CMS PDP landscape files, 2007-2008, for the Kaiser Family Foundation.

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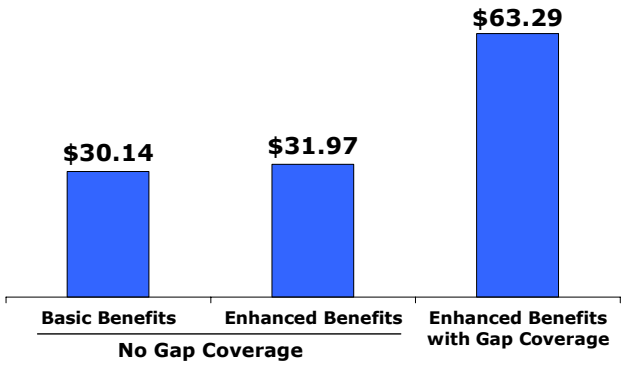
HIGHER PREMIUMS FOR GAP COVERAGE IN 2008

A key factor influencing the cost of Part D coverage is the availability of coverage for generic or brand-name drug costs in the coverage gap (sometimes called the "doughnut hole"). As in prior years, Part D enrollees will have access to PDPs offering some gap coverage in 2008, but coverage will be primarily for generic drugs only. Only one PDP in one region (Citrus Healthcare in Florida) will offer coverage of some brand-name drugs in the coverage gap, at a monthly premium of $49.40. In 2008, monthly premiums for PDPs that offer some gap coverage are, on average, twice as much ($63.29) as for PDPs with basic benefits with no gap coverage ($30.14) or with enhanced benefits but no gap coverage ($31.97) (Exhibit 3).

Although many beneficiaries are interested in purchasing coverage that offers protection against drug costs they might incur in the coverage gap, it is not clear whether the enhanced benefits offered by PDPs in 2008, covering primarily generic drugs in the gap, provide added value commensurate with their higher average monthly premiums.

Exhibit 3

Unweighted Average Monthly Premiums for PDPs, By Type of Gap Coverage, 2008



SOURCE: Hoadley et al analysis of CMS PDP landscape files, 2008, for the Kaiser Family Foundation.

PREMIUMS FOR GAP COVERAGE, 2007-2008

From 2007 to 2008, the average premium for PDPs that help cover the cost of generic drugs in the gap increased by 23 percent.[3] Conversely, the average monthly premium for PDPs offering no gap coverage has remained steady over time at about $30 per month. The average premium of the small number of PDPs that helped cover the cost of brand-name drugs in the gap in 2007 was $93.46, but most of these plans left the PDP market altogether for 2008.

PDP MARKET SHIFTS, 2006-2008

Among firms offering PDPs over time, there has been a modest decline in the offering of high-premium plans. Since 2006, some of the major PDP sponsors have scaled back or dropped their more expensive offerings that failed to attract sizable enrollment, while some sponsors have introduced new products priced below their previously lowest-cost PDP offerings. Despite the availability of new low-cost PDP options in 2008, 19 percent of all PDPs have premiums of at least $60 per month, compared to 12 percent of PDPs in 2007. Enrollment in these higher-premium PDPs was low in 2007.

PREMIUMS FOR PDPS WITH HIGH ENROLLMENT

In 2006 and 2007, the two PDPs with the highest enrollment were the lowest-premium plans offered by UnitedHealthcare (AARP MedicareRx) and Humana (Humana PDP Standard). Together these two plans accounted for approximately one-third of all PDP enrollment in 2007. High enrollment in UnitedHealthcare's PDP was likely influenced by its AARP branding, while the appeal of Humana's PDP is due in part to having been the least expensive plan available in most regions. The average annual premium for Humana PDP Standard nearly tripled (from $114 in 2006 to $310 in 2008), while for AARP MedicareRx (now called Medicare Rx Preferred), the average annual premium increased 23 percent (from $316 in 2006 to $388 in 2008).

Other companies have reduced premiums for their most popular plans since 2006 (for example, MemberHealth's Community CCRx Basic, Caremark's Silverscript, and Universal American Financial Corporation's Prescription Pathway Bronze Plan). Different pricing behaviors across organizations may reflect a combination of differing marketing strategies, PDP enrollee mix, and drug cost management practices.

DISCUSSION

The majority of Part D enrollees who do not qualify for the low-income subsidy and who do not switch plans between 2007 and 2008 will see their Part D premium increase, and nearly one in five will face premium increases of at least $120 per year.[4] In addition, Part D enrollees may experience other changes in their drug coverage that could affect out-of-pocket costs and access to needed medications. A central idea behind the structure of the part D benefit is that participants will respond to changes in the Part D marketplace to minimize out-of-pocket drug costs. However, early experience indicates that a majority of enrollees have elected to keep the coverage they have from one year to the next rather than switch plans. Measures that make it easier for beneficiaries to choose plans with optimal Part D coverage could make the market operate more efficiently and effectively for consumers.

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[1] These estimates are weighted by PDP enrollment in plans available in both years. These estimates are higher than CMS estimates because they focus exclusively on PDPs, and the weighted average calculations are based on the assumption that PDP enrollees do not switch plans between years.

[2] Premium changes discussed here and shown in Exhibit 2 do not apply to Part D enrollees receiving low-income subsidies.

[3] These estimates are not weighted by enrollment.

[4] Those who are receiving low-income subsidies will not pay the higher premiums if they switch or are switched to a cheaper plan or if the higher premium in 2008 remains below the qualifying LIS benchmark.

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