

## **Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?**

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## **Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?**

The Medicare Modernization Act of 2003 (P.L. 108-173), the legislation that added the Part D prescription drug benefit to the Medicare program, represents the single most significant expansion of a public insurance programs in the U.S. in the past 40 years. A key, and controversial, feature of this legislation was the use of multiple private insurance providers to deliver this new public insurance product. Under the Part D program, dozens of private insurers offer a wide range of drug plans with varying prices and benefit design features. This represents a departure from the traditional model of government-mandated uniform benefits and fee-for-service reimbursement for other Medicare-covered benefits.

This unprecedented privatization of the delivery of a public insurance product raises a host of important policy questions. A key question is whether Medicare beneficiaries are making economically optimal decisions about which plan to enroll in, based on their expected premiums and out-of-pocket costs for the prescription drugs they take. While other factors could be important to beneficiaries in choosing a Part D plan, such as the reputation of the insurance company or the extent to which the plan restricts access to medications, 72 percent of seniors reported that the amount the plan charges for each prescription was a very important factor in deciding upon which drug plan to enroll in.<sup>1</sup> This issue brief explores the financial implications of actual Part D plan choices made by Medicare beneficiaries enrolled in Part D plans in 2006, the first year of the program's operation.

### **Background**

The Medicare Part D benefit is delivered through two types of private plans: stand-alone prescription drugs plans (PDPs) for beneficiaries who wish to remain in traditional fee-for-service Medicare, or Medicare Advantage Prescription Drug (MA-PD) plans, such as HMOs, PPOs, or private fee-for-service plans, which provide all Medicare benefits, including prescription drugs. Despite initial uncertainty about whether insurance companies would be willing to participate in the new Part D drug plan market, the industry response has far exceeded expectations. In 2006, there were a total of 1,429 stand-alone PDPs offered throughout the nation, with about 40 PDPs available in most states. The number of PDPs increased by about 30 percent in 2007, from 1,429 plans to 1,875 plans, remained at this level in 2008, and was somewhat lower in 2009.<sup>2</sup> The majority of PDPs are offered by a dozen national or near-national companies. In addition, there were 1,333 MA-PD plans available throughout the U.S. in 2006, and the number of MA-PD plans has also increased over time.<sup>3</sup> By November 2006, every county in the nation had at least 27 plans available and the typical county had 48 plans, while some counties featured more than 70 choices, primarily due to a high number of MA plans.<sup>4</sup>

With the proliferation of private plan choices under Medicare Part D, government officials and other proponents of the market-based approach used to deliver the Medicare drug benefit suggested that beneficiaries would have an opportunity to choose among competing plans to

identify the specific plan that would best meet their needs, based on each individual's prescription drug regimen. Medicare created a web-based tool that allows beneficiaries to input detailed information about their drug regimen, including specific drug, dose level and frequency, and other preferences, such as pharmacy location, to narrow down the list of drug plans available in their area (both PDPs and MA-PD plans) and identify the best plan according to their total expected costs of enrolling, including monthly premiums and prescription drug cost-sharing amounts.<sup>5</sup>

As of June 2006, after the first open enrollment period for Part D, a total of 22.5 million Medicare beneficiaries were enrolled in Part D plans, including 10.4 million people who chose to enroll in stand-alone PDPs, 6.0 million people who enrolled in MA-PD plans, and 6.1 million dual eligibles (beneficiaries eligible for both Medicare and Medicaid) who were automatically enrolled in stand-alone PDPs.<sup>6,7</sup> Although voluntary enrollment in Part D plans was greater than many anticipated for the new public program, survey results indicated that many beneficiaries were confused by their enrollment options. Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors.<sup>8</sup> When asked if they agree with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative.<sup>9</sup>

### **Data for This Analysis**

The primary data source for this analysis is a longitudinal sample of prescription drug records from the Wolters Kluwer (WK) company. WK is the largest "switch" operator in the prescription drug market, collecting electronic claims from retail pharmacies and passing them on to pharmacy benefit managers (PBMs) and insurance companies that pay the claims. After claims are adjudicated, they are passed back through the "switch" to the pharmacy. WK performs this function for a large sample of retail pharmacies throughout the U.S.<sup>10</sup> On average the claims captured by the WK system represent almost 31 percent of all third-party prescription claims filled in the U.S.<sup>11</sup> The geographic distribution of these data is very closely representative of the geographic distribution of third-party claims as well; the correlation between the WK market share and the overall third-party market share across each of the states is 0.86. The WK dataset excludes Part D claims filled by beneficiaries in a subset of Medicare Advantage plans that operate their own retail pharmacies, prescription filled through mail order, and prescriptions filled in institutions.

WK maintains a longitudinal database that tracks prescription drug use for more than 100 million people in the U.S. For this analysis, WK provided a longitudinal sample of prescription claims for individuals ages 65 and over in 2005, excluding Medicare beneficiaries who are under age 65 (roughly seven million beneficiaries). The data cover the 24-month period from January 2005 through December 2006. This dataset is valuable for research because it contains information both on specific drug utilization by seniors in Part D plans and that can be used to identify plan enrollment. Information about specific drug utilization is critical because plan costs vary tremendously based on drug utilization, as discussed below.

The other major source of data for this analysis is information on the availability of Part D plans and specific plan features directly from four files provided by CMS: the plan information file, the beneficiary cost file, the formulary file and the geographic locator file. The plan information file lists plan names and identifiers, and regions/counties in which plans are offered. The beneficiary cost file contains copayments and coinsurance rates for different tiers of each plan. The formulary file contains a list of all the drugs that are included on the formulary for each plan. The geographic locator file was used to identify all of the Social Security Administration (SSA) counties that correspond to different PDP and MA regions.

The final sample for the analysis includes 55,000 individuals who had a Part D claim in 2006, were enrolled in a stand-alone PDP, were not employer-insured, dual eligibles, or eligible for Part D low-income subsidies/partial subsidies, were in the dataset for both 2005 and 2006, and were able to be matched to a specific PDP in the CMS plan information file.<sup>12</sup> The WK data report each patient's county and the name of the company that provides the Part D plan that is covering each prescription, but not specifically which Part D plan offered by that company is covering the prescription. For this analysis, beneficiaries were matched to specific PDPs using a combination of county code, company name, and copayment structure. Beneficiaries receiving Part D low-income subsidies were excluded from this analysis because they are not required to pay the full premium or cost-sharing requirements and typically do not choose a Part D plan on their own because they are assigned to a plan by the government.

### **Modeling Plan Choice**

I estimate for each Medicare beneficiary in the WK dataset the cost of enrolling in each PDP available to them in their particular state. I do so by replicating the plan calculator available on the Medicare Prescription Drug Plan Finder website, which takes as inputs specific prescription drug names and amounts, and outputs the out-of-pocket costs to the enrollee of enrolling in each plan in their option set. The total cost includes *both* premium costs and expected out-of-pocket costs for prescriptions, obtained by running a measure of the individual's prescription drug use (described below) through the plan calculator for each plan available to them. I then assess the actual choices made by individuals relative to this opportunity set.

This analysis is designed to answer the question: Do seniors choose the PDP which has the lowest costs (both premiums and out-of-pocket drug costs) among the PDPs that are available in their state? The analysis does not account for other reasons why enrollees might choose higher-cost plans, such as brand preference or plan quality differences.

### **Models of Expectations**

A key issue for modeling whether individuals are choosing the lowest-cost plan available to them is assessing their expectations for their prescription drug use in the coming year. Without knowing how individuals form those expectations, this analysis considers two different models and assesses the robustness of the findings to their chosen plan. The two models are:

- **Model 1: Backwards-Looking:** Assume that individuals expect to use the same prescriptions in 2006 that they used in 2005, and model plan choice using 2005 prescriptions. This approximates the rationale behind the Medicare plan finder tool, where the user can enter in the medications they are currently taking in order to compare the total cost to them of plans offered in their area.
- **Model 2: Perfect Foresight:** Assume that individuals know when they choose a Part D plan for 2006 exactly what drugs they will use throughout the year in 2006, and model plan choice using 2006 prescriptions.

## **Results**

Regardless of which model of expectations is used to assess plan choice, this analysis suggests that remarkably few Part D enrollees in the WK dataset chose the lowest-cost stand-alone PDP available to them in 2006. Table 1 presents the findings from which this conclusion is drawn, including the percent of enrollees choosing the lowest-cost plan under each model of expectations and the foregone monetary amount (expressed both in dollars and as a percent of actual spending) that results from choosing a higher-cost plan (at the mean and 95<sup>th</sup> percentile).

The three columns in the table correspond to the backwards-looking model, the perfect foresight model, and a “best match” model, which assumes that individuals employ whichever model of expectations leads to the best match with their chosen plan. That is, evaluating the lowest-cost plan under each model of expectations, if the individual’s chosen plan matches the lowest-cost plan under either model, the “best match” model would indicate that the lowest-cost plan was indeed chosen.

The table of results is divided into four panels from top to bottom. The first panel examines the propensity of beneficiaries to choose the one lowest-cost plan available to them in their state under each of the three models of expectations.

- In 2006, between 6 percent and 9 percent of seniors chose the lowest-cost plan.
- *Among those who did not choose the lowest-cost plan*, enrollees would have saved between \$360 and \$520 on average if they had chosen the lowest-cost plan, based on their actual prescription drug use in 2006.
- At the 95<sup>th</sup> percentile, savings would have been as much as \$1,360 – that is, using the backwards-looking model of expectations, 5 percent of Part D enrollees in this analysis could have saved \$1,360 or more by choosing the lowest-cost plan.
- Under the “best match” model, enrollees who did not choose the lowest-cost plan would have saved an average of 30 percent if they had chosen the lowest-cost plan, and 5 percent of enrollees would have saved 58 percent or more.

Reading down the table, the next three panels model looser definitions of “lowest cost.” The second panel examines the propensity of beneficiaries to choose one of the plans that is among the 5 percent with lowest costs. That is, in a state with 40 PDPs, choosing among the 5 percent with the lowest costs would mean choosing either one of the two lowest-cost plans.

- Results show that that 10 percent to 13 percent of seniors chose one of the lowest-cost 5 percent of PDPs available in their state, and savings among those who did not choose from among this lowest-cost set of plans would have been considerable.
- For example, using the perfect foresight model of expectations, enrollees who did not choose one of the lowest-cost plans would have saved \$350 (or 28 percent of their actual spending in 2006) by choosing a plan in the lowest 5 percent of total costs.

The third panel presents an even more expansive definition: choosing a plan in the lowest 25 percent of plan costs. That is, in a state with 40 PDPs available, the lowest-cost 25 percent of plans would amount to 10 plans.

- Results show that roughly half of enrollees chose plans in the lowest 25 percent of total costs in 2006, and that even relative to this loose standard of “lowest cost”, the savings that would have been achieved from choosing one of the lowest-cost plans are non-trivial.

The fourth panel models enrollment choices where the target is choosing from among plans in the lowest 50 percent of the total cost distribution.

- Even using this very expansive definition of lowest cost, between 14.1 percent and 24.7 percent of individuals did not choose one of the lowest-cost plans, depending upon which model of expectations is assumed.

## **Conclusion**

The unprecedented privatization of a public insurance function embedded in the Medicare Part D program provides an excellent opportunity to understand how well individuals handle choice in their public insurance options. The results presented here suggest that the answer is “not very well” in terms of maximizing savings to the consumer; most seniors in this analysis did not choose the lowest-cost Part D plan available to them in 2006.

It is important to acknowledge that there could be factors other than savings that drive Part D plan enrollment decisions. Some beneficiaries may choose to pay more for a plan with a strong brand name or a good reputation. Others may be willing to pay more for a plan that has fewer utilization restrictions, such as prior authorization requirements or step therapy limits. And some beneficiaries may choose to pay more for a plan that contracts with a convenient pharmacy that is not in the network of the lowest-cost plan. A detailed analysis that controls for these other factors substantiates the fundamental conclusion of the present analysis: many Part D enrollees are not financially optimizing in their choice of a Medicare drug plan.<sup>13</sup>

The findings of this analysis suggest that choice across such a wide range of Part D plan options may not be in the best interest of beneficiaries who are looking to maximize their savings. Future research may want to consider the long-term costs for seniors, who tend to stick with their Part D plan from year to year rather than assess alternatives that might better meet their prescription drug needs.

**Table 1: Modeling Enrollment in Lowest-Cost Stand-Alone Prescription Drug Plans and Foregone Monetary Amounts Associated with Plan Choices in 2006**

	<b>Backwards-Looking Model: Using 2005 Prescriptions to Assess 2006 Plan Choice</b>	<b>Perfect Foresight Model: Using 2006 Prescriptions to Assess 2006 Plan Choice</b>	<b>Best Match Model</b>
<b>Choice of Lowest-Cost PDP</b>			
<b>Percent Choosing</b>	<b>6%</b>	<b>7%</b>	<b>9%</b>
<b>Foregone Amount In Dollars:</b>			
Mean	\$520	\$470	\$360
95 <sup>th</sup> Percentile	\$1,360	\$1,190	\$870
<b>As a % of Actual Spending:</b>			
Mean	46%	37%	30%
95 <sup>th</sup> Percentile	99%	64%	58%
<b>Choice of Lowest-Cost 5 Percent of PDPs</b>			
<b>Percent Choosing</b>	<b>10%</b>	<b>11%</b>	<b>13%</b>
<b>Foregone Amount In Dollars:</b>			
Mean	\$400	\$350	\$280
95 <sup>th</sup> Percentile	\$1,050	\$880	\$720
<b>As a % of Actual Spending:</b>			
Mean	35%	28%	24%
95 <sup>th</sup> Percentile	82%	54%	50%
<b>Choice of Lowest-Cost 25 Percent of PDPs</b>			
<b>Percent Choosing</b>	<b>53%</b>	<b>49%</b>	<b>64%</b>
<b>Foregone Amount In Dollars:</b>			
Mean	\$220	\$180	\$150
95 <sup>th</sup> Percentile	\$640	\$510	\$450
<b>As a % of Actual Spending:</b>			
Mean	18%	13%	11%
95 <sup>th</sup> Percentile	50%	33%	31%
<b>Choice of Lowest-Cost 50 Percent of PDPs</b>			
<b>Percent Choosing</b>	<b>78%</b>	<b>75%</b>	<b>86%</b>
<b>Foregone Amount In Dollars:</b>			
Mean	\$190	\$150	\$140
95 <sup>th</sup> Percentile	\$580	\$450	\$410
<b>As a % of Actual Spending:</b>			
Mean	15%	10%	9%
95 <sup>th</sup> Percentile	43%	28%	26%

SOURCE: Author's analysis of Wolters Kluwer prescription drug claims data, 2005-2006, for the Kaiser Family Foundation, 2009.

## ENDNOTES

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<sup>1</sup> Kaiser Family Foundation, Seniors' Early Experiences with Their Medicare Drug Plans (conducted June 8-18, 2006), June 2006.

<sup>2</sup> Hoadley J, Thompson J, Hargrave E, Cubanski J, Neuman T, "Medicare Part D 2009 Data Spotlight: The Coverage Gap," Kaiser Family Foundation, November 2008.

<sup>3</sup> Hoadley et al, 2008.

<sup>4</sup> Author's analysis of number of plans in a median county obtained from Prescription Drug Plan Formulary and Pharmacy Network Files for 2006, provided by CMS.

<sup>5</sup> Centers for Medicare & Medicaid Services, Medicare Prescription Drug Plan Finder:  
<http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp>

<sup>6</sup> Enrollment data taken from CMS, State Enrollment Data spreadsheet at  
[http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02\\_EnrollmentData.asp#TopOfPage](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage). Enrollment numbers also available at <http://www.kff.org/medicare/upload/7453.pdf>.

<sup>7</sup> Prior to 2006, dual eligibles received drug coverage from state Medicaid programs. When Medicare Part D went into effect in January 2006, dual eligibles were automatically enrolled in stand-alone PDPs.

<sup>8</sup> Kaiser Family Foundation/Harvard School of Public Health, The Public's Health Care Agenda for the New Congress and Presidential Campaign (conducted November 9-19, 2006), December 2006; Kaiser Family Foundation, National Surveys of Pharmacists and Physicians, Findings on Medicare Part D (conducted April 25-July 8, 2006), September 2006.

<sup>9</sup> Kaiser Family Foundation/Harvard School of Public Health, December 2006.

<sup>10</sup> Once pharmacies are in the WK sample, there is a 93 percent chance that they remain enrolled, so this is effectively a longitudinal sample of pharmacies.

<sup>11</sup> Figure based on data provided by WK for Q3:2006.

<sup>12</sup> A number of other restrictions were imposed for data consistency, such as removing observations with missing claims information. Full details available from the author.

<sup>13</sup> Abaluck, Jason and Jonathan Gruber, "Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," Working Paper, MIT Department of Economics, January 2009.



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