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Issue Brief

Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries

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ABSTRACT: Many Medicare beneficiaries signed up for the new Part D benefit during the program's first two years. Subsequently, a significant majority of them reported that the benefit was too complicated, and some observers suggest that the complexity may have thwarted some beneficiaries from finding the plan that was best for them. Meanwhile, more than 4 million of those eligible failed to enroll at all. Although some degree of standardization may occur naturally as the market evolves, steps can be taken to simplify the program and make it easier for beneficiaries to make good choices among plans—and for them to enroll in the first place. This issue brief considers specific options for simplifying Part D in several areas: standardizing the benefit descriptions and procedures used by plans and the Medicare program; further standardization of the plan's benefit parameters, particularly the rules for cost-sharing; and changes to the rules governing plan formularies.

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Overview

The Medicare prescription drug benefit (Part D) has finished its first two years with mixed results. Although many Medicare beneficiaries enrolled in Part D drug plans, authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), a significant majority of them reported that the selection process was much too complicated.¹ Some observers have suggested that the complexity of the benefit designs, and their variations among the numerous plans offered, thwarted some people from finding the plan that was best for them—or from enrolling in Part D in the first place. Indeed, some of the estimated 4.6 million beneficiaries who still have no source of drug coverage might have enrolled had the process of choosing been less confusing.

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For those who did enroll, many discovered before long that their plan did not meet their needs particularly well and that another plan offered in their market area might have been better. This problem could be exacerbated over time as sponsors change their plan offerings from year to year.² Even though enrollees have the option of switching plans each year, the difficulty associated with researching their options and the potential disruption in making a change reinforce an underlying preference for sticking with the decision already made.³ A low rate of switching can be viewed as a sign of satisfaction. But the success of a market-based system relies on enrollees being able to reexamine their enrollment decisions in response to changes in plan offerings, plan performance, and their own circumstances, and the lack of clear and understandable information can interfere with their ability to make appropriate enrollment decisions.

To reduce the current complexity, a broad array of health care opinion leaders have suggested that Part D plans should become more standardized—that steps should be taken to simplify the program and make it easier for beneficiaries to make good choices about enrollment and among plans. Incremental changes might include requirements that plans use the same terms to describe the same benefits, while more substantial reforms might, for example, restrict some variations in the benefits that plans could offer.

Some observers contend, however, that as the market matures the program will become easier to navigate and standardization will prove unnecessary. Others want to wait and see if some degree of standardization occurs naturally as the organizations offering plans respond to market pressures. Meanwhile, many believe that continued outreach alone would convince more non-enrollees to join Part D plans.⁴

After assessing the main arguments for and against introducing more standardization into the

Medicare drug benefit, this issue brief considers specific standardization options in three areas:

1. Benefit descriptions used by plans and Medicare, and plans' procedures (such as prior authorization) for managing utilization
2. Plans' rules for cost-sharing (including deductibles, coinsurance, and copayments)
3. Rules for how formularies can be designed

The suggestions proposed in this brief for increasing standardization in Medicare Part D are intended to reduce beneficiaries' confusion and anxiety in making decisions about participation. Better information and more clearly defined choices might increase their ability to make appropriate decisions about Part D, improve their well-being, and strengthen the program.

An Array of Prescription Drug Plan Choices

To receive prescription drug coverage, a Medicare beneficiary must enroll in a private prescription drug plan (PDP); in 2008, more than 1,800 PDPs in 39 regions competed for such enrollments.⁵ Alternatively, the beneficiary may have employer-sponsored retiree coverage that qualifies for a subsidy.

In addition, Medicare Advantage (MA) organizations offer private plans that Medicare beneficiaries have the option to join instead of traditional Medicare. Such organizations are required to offer at least one plan with a qualified drug benefit (MA-PD) in each area they serve. So, if MA enrollees want a drug benefit, they must get it from their MA plan. Although availability varies geographically, more than 2,000 MA-PDs were offered in 2008 to beneficiaries across the nation. This issue brief concentrates, however, on PDPs, which provide more than two-thirds of Medicare Part D coverage.

The MMA established a standard benefit design by which the beneficiary experiences prescribed degrees of cost-sharing, at least in principle. He

or she is responsible for an annual deductible (\$275 in 2008), 25 percent of drug costs up to an initial coverage limit (\$2,510 in total costs for covered drugs in 2008), the full cost of drugs in the coverage gap after this initial coverage limit is exceeded, and only modest cost-sharing thereafter once a particular level of accumulated out-of-pocket costs (\$4,050 in 2008) has been reached. Cost-sharing at this latter stage is the greatest of \$2.25 for a generic, \$5.60 for a brand-name drug, or 5 percent of the cost of the drug.

Most PDPs, however, have benefits that either are actuarially equivalent variations on the standard benefit or are enhanced with more generous coverage. The majority of plans have eliminated the standard deductible, substituted flat copayments for coinsurance, and adopted tiered cost-sharing (whereby the beneficiary pays different amounts for different types of drugs). Most commonly, plans employ three tiers—with escalating copayments for generic drugs, preferred brand-name drugs, and nonpreferred brand-name drugs, in that order. By 2008, most plans also have added

a specialty tier for high-cost biotechnology products or injectable drugs. Relatively few plans have chosen to fill the coverage gap (sometimes referred to as the “doughnut hole”) at all, and most that do only cover generic drugs in the gap.⁶ The result is that beneficiaries face a wide variety of designs, as indicated by the sample in Table 1.

To appreciate the degree of variation, consider that a beneficiary with a prescription for a generic drug faces no copayment in one plan, a \$7 copayment in another, and 25 percent of the drug’s cost in a third. A beneficiary with a choice between a preferred brand-name drug and a generic alternative would pay \$45 more for the brand with coverage from Wellcare Signature but just \$15 more with the AARP Saver plan. The cost of a brand-name drug is only \$20 (as a preferred product) in one plan, \$107 (as a nonpreferred product) in another plan, and 75 percent of the drug’s cost in yet another.

Formularies also vary considerably among Part D plans. The Centers for Medicare and Medicaid Services (CMS) reviews each plan for-

Table 1. Illustrative Plan Designs Offered on National Basis, 2008

Plan	Deductible	Tier 1	Tier 2	Tier 3	Specialty tier	Gap coverage
Aetna Essentials	\$275	\$3	\$39	\$80	25%	None
Aetna Premier	\$0	\$4	\$40	\$70	33%	Generics
Humana Standard	\$275	No tiers – 25% coinsurance				None
Humana Complete	\$0	\$4	\$25	\$54	25%	Preferred Generics
Medco Medicare Choice	\$0	\$6	\$35	75%	33%	None
Sterling Rx Plus	\$100	\$0	\$25	25%	25%	None
United Healthcare/ AARP Preferred	\$0	\$7	\$30	\$74.85	33%	None
United Healthcare/ AARP Saver	\$275	\$5	\$20	\$49.68	25%	None
Wellcare Signature	\$0	\$0	\$45	\$107	33%	None

Note: Some values are median amounts for plans that use different tiered cost-sharing arrangements across regions.

Source: J. Hoadley, E. Hargrave, and K. Merrell, Methodology Appendix to the Medicare Part D 2008 Data Spotlights (Washington, D.C.: Henry J. Kaiser Family Foundation, Jan. 2008).

mulary under a number of specific guidelines designed to prevent it from discriminating against certain beneficiaries.⁷ Within these rules, plans have made significantly different decisions about the extensiveness of their formularies. Plan formularies include between 47 percent and 100 percent of eligible drugs. Plans also differ in how they assign their formulary drugs to tiers and in how often they employ cost-management tools such as prior authorization or step therapy.⁸

Plans have the option of offering enhanced packages with an actuarial value greater than the standard package. Plans use this option to reduce cost-sharing, waive deductibles, add gap coverage, or offer more extensive formularies. In 2007, CMS started labeling the packages that offered enhanced benefits, but the linkage between the enhanced value of the package and the premium is not readily apparent to the consumer.

Arguments in Favor of Standardization

Many beneficiaries and the counselors who help them navigate the array of program choices would like to see the program simplified through some degree of standardization. Although a majority of beneficiaries have found Medicare Part D helpful, 73 percent say the benefit is too complicated.⁹ Remediating this complexity was the first recommendation of a panel of State Health Insurance Assistance Program directors convened by the Kaiser Family Foundation. Panelists found that “the system was excessively complicated for the clients, with too many plans, and unnecessary variation across the plans in terms of premiums, benefits, covered drugs, rules, forms, and procedures.”¹⁰ This finding was strongly supported by a panel of counselors convened for this issue brief by its author.

Other informed observers agree. The Commonwealth Fund’s survey of health care opinion leaders strongly backed a move toward more standardization of Part D. Nearly all respondents (88%) agreed that “plans should be required to use the same terms to describe the same benefits,” while about three-fourths maintained that “benefits should be more standardized to reduce the variation among plans.”¹¹

The case for greater standardization starts with the complexity of the program, but it is reinforced by evidence that Medicare beneficiaries neither seek more choices in the program nor are skilled in dealing with a profusion of them. Over the past decade, several studies have suggested that Medicare beneficiaries are often overwhelmed by the amount of information they receive about Medicare Advantage and other options.¹² They typically cite an inability to sort through the volume of information to make informed and rational decisions.¹³ In particular, studies suggest that elderly Medicare beneficiaries have much more difficulty interpreting comparative data than do nonelderly consumers.¹⁴ Furthermore, at least one-fourth of beneficiaries have inadequate or marginal health literacy, with even higher rates of inadequate literacy among Spanish speakers and beneficiaries over age 85.¹⁵

There is also a growing body of literature, outside the Medicare world, suggesting that although people like the *concept* of choice, their decision-making ability is compromised when confronted with a large number of options, as they are in the Medicare drug benefit. For example, one study found that subjects were more likely to make a choice when offered a limited array of six choices than they were when faced with an array of 24 to 30 choices.¹⁶ A study of choice among 401(k) retirement plans found higher employee participation when employers offered 10 or fewer plan choices.¹⁷

In contrast to the Medicare Advantage program, where a beneficiary who makes no choice at all simply remains in traditional Medicare, the drug benefit requires an active choice. Because the program is voluntary, those who do not choose a drug plan receive no drug benefit. It seems likely that many of the 4.6 million beneficiaries with no apparent source of drug coverage—that is, those who did not apply—may have been discouraged by this program’s complexity. In particular, the 2.6 million beneficiaries estimated to be eligible for, but not enrolled in, the low-income subsidy appear to have failed to take up a benefit that would have been of clear value to them.¹⁸ Of course, there probably were additional reasons why some benefi-

ciaries failed to apply for the drug benefit. Shortcomings in outreach efforts and the voluntary nature of the program, requiring active enrollment decisions, were certainly important as well. But these factors would certainly be exacerbated by the program's complexity and consequent lack of clear information.

For those who did enroll, the program's complexity may have interfered with their ability to make a *good* choice. It may be rational for some to simplify their decisions by selecting a plan with a familiar name (e.g., AARP or Blue Cross) or one that is offered by a company with which they have an ongoing relationship (e.g., the sponsor of their Medigap supplemental insurance). Others may have chosen a plan solely on the basis of a lower monthly premium, the absence of a deductible, or the absence of a coverage gap. But the impressions of counselors who worked closely with beneficiaries were that many resorted to these simplifying strategies because it was too difficult to understand and sort out their options.

A move toward standardization could make it easier for beneficiaries to review options that have significant differences and to find the plan that best meets their particular needs.

Arguments Against Standardization— at Least, in the Short Term

A key argument some make against standardization is that time should be allowed for the market to stabilize. In early 2006, Medicare's administrator stated that market forces were already starting to drive toward simplification.¹⁹ As the market matures, the reasoning goes, it will become easier for beneficiaries to navigate and standardization will be less necessary. After all, in its brief history, since 2006, Part D has been a new market both for plan sponsors and beneficiaries. Stand-alone drug plans were new products for many sponsors, who had compressed time frames within which to make decisions about benefit design, formularies, and marketing strategies. For their part, beneficiaries not only had to learn about the existence of the new benefit but also needed to sort through an array of choices under looming enrollment deadlines.

Some health policy experts are absolutely against standardization, whether for a young or for a mature market, believing that plan flexibility is the key factor in driving down program costs. In this view, the considerable flexibility of Part D plans has been useful in establishing formularies and designing benefits to generate high rates of generic substitution, encourage more appropriate use of drugs, and negotiate effectively for discounted prices.

As the market matures, standardization might start to occur. Some plan sponsors will leave the market, while new ones will enter. Sponsors remaining in the market are likely to shift their arrays of offerings. As they do so, plans will tend to consider both their competitors' offerings and their own experiences with enrollment and financial results and will make adjustments that might lead to some convergence in designs. For example, plans' use of specialty tiers increased dramatically after the program's first year.²⁰ But, as the market matures, plans also may seek innovative approaches in order to distinguish themselves. In 2008, three national plans added a second tier for generic drugs in an apparent attempt to fine-tune the incentives for using generics.²¹

CMS has taken some steps in the program's first two years to direct the market toward some simplification in order to make information clearer to beneficiaries. Specifically, the agency directs plan sponsors to ensure that the plans offered provide beneficiaries with "substantially different options."²² In addition, rather than allowing each sponsor to offer three plan options, as in 2006, CMS permitted only two in 2007 and 2008, with the possibility of a third option that offers enhanced coverage (such as coverage in the gap). Many sponsors took advantage of the latter approach.

Simplification and standardization are not necessarily the same thing, however. The CMS instruction to differentiate plan options reflects the agency's goal of reducing the overwhelming arrays of similar but not identical plans originating within individual organizations. But pursuing that goal would tend to increase the overall variation in plan offerings across organizations.

The agency also has sought to improve the ways in which sponsors display comparative plan information—for example, by enhancing the online tool it makes available to beneficiaries and their advisers. The *Medicare Prescription Drug Plan Finder* includes information on all plans, as well as tools to help consumers make comparisons.

Another argument for waiting before standardizing the benefit design is that it would provide more time to examine closely the preferences that beneficiaries reveal when selecting plans. To date, beneficiaries have chosen plans with benefits structured differently from the standard benefit defined in the law; they have largely selected plans with no deductibles, fixed copayments, and access to a broad range of drugs. But to the extent that they based choices mostly on low premiums or familiar sponsors, they may not be revealing preferences for particular benefit design features.

Standardizing Part D Benefit Descriptions and Procedures

Still, despite the availability of 30 percent more plans in 2007 and the many changes to existing plan designs, most beneficiaries retained their first-

year plan selection over the next two years. CMS estimates that only 6 to 7 percent of enrollees switched plans for either 2007 or 2008. This stability may reflect satisfaction with their current plans, a general preference for staying put in the absence of major changes, or a reluctance or inability to effectively research their options.

While arguments both for and against standardization of the Medicare drug benefit need to be weighed carefully, and reconsidered in the light of program experience just starting to be accumulated, it seems important to take at least some steps toward standardization in the near term. These could help not only to reduce beneficiaries' confusion and anxiety about whether or not to participate but also to enable sound decision-making for their own particular circumstances. Six areas might profit from standardization actions taken sooner rather than later, and this section presents specific options for changes.

Labeling Cost-Sharing Tiers. Prescription drug plans have total flexibility in creating tiers. But PDPs have used up to six tiers, and their descriptions can be misleading.²³ For example, in 2006, one national organization created both a

Table 2. Distribution of Plans, by Tier Structure, 2006–2008

Tier Structure	Stand-alone PDPs 2006	Stand-alone PDPs 2007	Stand-alone PDPs 2008
Standard (25% coinsurance)	9%	14%	12%
Generic/brand (without specialty tier)	8%	<1%	<1%
Generic/brand (with specialty tier)	22%	17%	5%
Generic/preferred brand/nonpreferred brand (without specialty tier)	23%	4%	2%
Generic/preferred brand/nonpreferred brand (with specialty tier)	38%	65%	74%
Other	1%	<1%	6%

Note: PDPs exclude plans offered in U.S. territories. Numbers do not sum to 100 percent because of rounding.

Sources: Medicare Payment Advisory Commission (MedPAC), "Part D Plan Offerings," in Report to the Congress: Increasing the Value of Medicare (June 2006); "Part D Enrollment, Benefit Offerings, and Plan Payments," in Report to the Congress: Medicare Payment Policy (March 2008); and author's calculations.

Option: To improve enrollees’ ability to compare benefit packages, CMS should require sponsors to label clearly plans that have enhanced benefits and to designate the plan features that constitute the enhanced value. In that way, consumers could see more clearly what value they would receive for the higher premiums usually charged, and would be better able to make accurate comparisons when considering their options.

preferred tier and a nonpreferred tier for generic drugs, yet their cost-sharing was identical. Furthermore, whereas most plans label their preferred and nonpreferred brand-name tiers as tier 2 and tier 3, respectively, this plan called them tier 3 and tier 4. In 2008, another plan added a “value generic” tier for lower-cost generic drugs, but it is labeled in the *Drug Plan Finder* as tier 5 and so may appear to some as a high-priced tier. These descriptions can be confusing to beneficiaries when comparing plans.

In the program’s first three years, the vast majority of plans have employed one of five basic designs, after eliminating any tiers without real distinctions:

- The standard benefit, with 25 percent coinsurance and no tiering
- A two-tier structure (generics and brands)
- A two-tier structure with an additional specialty tier

Option: To reduce confusion, plans should be required to designate only a single specialty tier and to label it accordingly on all displays, including the *Drug Plan Finder*. They should be required to label it simply as the “specialty tier,” as opposed to using a tier number. Furthermore, there should be a specific stipulation that they have no right to request a formulary exception to lower the cost-sharing paid for the drug.

- A three-tier structure (generics, preferred brands, and nonpreferred brands)
- A three-tier structure with an additional specialty tier

Only 1 percent of stand-alone PDPs used a tier structure other than these five designs in 2006 and 2007 (Table 2).²⁴ In 2008, however, plans are trending both toward and away from standardization. On one hand, there has been an increase in benefit designs that vary from the most common designs (mostly by adding a second tier for generic drugs). On the other hand, there has been a significant consolidation toward the tier structure with three standard tiers and a specialty tier, with about three-fourths of all PDPs in 2008 using the three-tier structure with an additional specialty tier.²⁵

Labeling Specialty Tiers. As shown in Table 2, most plans with any benefit design other than the standard benefit now use specialty tiers for higher-cost medications such as biotechnology products or injectable drugs. Beneficiary coinsurance for these expensive drugs is normally set by plans at anywhere from 25 to 33 percent. Because CMS guidance allows organizations to limit the ability of plan enrollees to file appeals requesting that a drug on this tier be made available at a lower level of cost-sharing, it is especially important that beneficiaries understand these tiers. They need to know that a drug is on the specialty tier and that appeal rights are limited, not just what their cost-sharing will be.²⁷

Option: To simplify tier-design options, plans should be required to adopt one of the five tier structures described above and to label tiers accordingly. In fact, given that specialty tiers have become the industry standard, three structures might be adequate. Alternatively, variations on these models could be allowed, but only if they were labeled so that cost-sharing and formulary comparisons among plans were clear.²⁶

Option: In combination with the standardized tier descriptions described above, CMS should clearly specify the cost-sharing applicable to each tier in all displays. These descriptions could be even simpler if organizations offering plans in multiple regions were required to apply the same cost-sharing rules everywhere, rather than allowing the small variations that currently exist for some organizations from region to region. This step might require a modification of the CMS interpretation of actuarial-equivalency requirements.

Currently, however, the labeling of specialty tiers is likely to confuse beneficiaries. Some plans have created two separate specialty tiers (e.g., one for biotechnology products and one for injectable drugs), but they apply the same coinsurance rate to both tiers. It is possible that one such tier is an official specialty tier for which plans claim an appeals exemption. But if this is indeed the distinction, it is unclear in either the *Drug Plan Finder* or other information provided by plans. At one point in 2007, the *Drug Plan Finder* provided improved labeling of specialty tiers, but in 2008 it has reverted to simply labeling tiers by numbers with no distinctions when two such tiers are used.

Enhanced Plan Benefits. In 2008, 51 percent of PDPs (with an estimated 21 percent of PDP enrollees) had enhanced benefits.²⁸ Because benefits with an actuarial value greater than the standard benefit could not be subsidized by federal funds, the portion of the premium corresponding to these benefits had to be fully paid by the beneficiary. There was no indicator in the 2006 *Drug Plan Finder*, however, that allowed beneficiaries to easily identify plans with enhanced benefits. This information is now displayed in CMS plan listings, but it remains difficult to determine the enhanced value of such a plan.

Adding to the confusion, the enhanced plans offered by some organizations have premi-

ums lower than those of their standard-benefit plans. For example, the Medicare Rx Value plan is an enhanced plan offered by United Healthcare with a weighted-average monthly premium of \$22.58. By contrast, United Healthcare's Medicare Rx Basic plan has an average premium of \$40.36, despite not being an enhanced plan. Because neither provides any coverage in the gap and the Basic plan waives the deductible, it is unclear even to an experienced researcher what enhanced value is provided by the Value plan.

Cost-Sharing Descriptions. Consumers using the *Drug Plan Finder* are able to identify precisely the cost-sharing they would face for each specific drug they use. But the general plan listings in the *Drug Plan Finder* and the *Medicare & You* handbook display only cost-sharing ranges. Although specific cost-sharing amounts by tier are shown in the *Drug Plan Finder* as a user clicks through to more detailed displays, the information is not easy to use.

Standard Rules and Procedures for Utilization Management. Most Part D plans apply utilization-management tools—prior authoriza-

Option: CMS should do more to encourage the use by plans of standard forms and procedures. In addition, CMS should require plans to describe the utilization management tools they use and to include such information in the *Drug Plan Finder*. Better information would give beneficiaries and providers an idea of the barriers they may face in continuing current medications. For example, it might be possible to create a set of labels to indicate which drugs must be taken first for step therapy, or what the applicable criterion is for prior authorization (e.g., safety, off-label use, or potential for payment under Medicare Part B). Alternatively, plans could be asked to make explicit general standards for prior authorization (or other restrictions) applicable to different drug classes.

Option: CMS should require standard wording for descriptions of gap coverage and precise definitions of what terms mean.

tion, step therapy, and quantity limits—to at least some covered drugs. While the presence of these requirements is relatively easy to determine using the *Drug Plan Finder*, their meaning in any given situation is unclear to beneficiaries. Beneficiaries, physicians, and pharmacists all complain that it is hard to find out what is needed to meet a particular requirement.²⁹ CMS, in the call letter for 2009 plan submissions, has told plans that they must submit standardized criteria for prior authorization and post their approved criteria on plan Web sites. It is unclear how well this new approach will meet the concerns of beneficiaries and providers. What many of them want to know is how strictly different plans enforce their utilization management rules and whether they do so on a timely basis.

Another step forward was the release in 2006 by the American Medical Association and America’s Health Insurance Plans, in conjunction with CMS, of a standardized form designed for requests for a coverage determination, including requests for tiering or formulary exceptions, regardless of the drug plan in which the patient is enrolled.³⁰ While plans generally must accept this form, it is officially optional, and plans may request additional information. Although adoption of standard forms may not help beneficiaries directly, it should increase the willingness of physicians and pharmacists to help them get approval for drugs most appropriate to their needs.³¹

Coverage in the Gap. A subset of drug plans supplement their coverage with at least some coverage of drugs in the benefit’s coverage gap (the “doughnut hole”). In 2008, 29 percent of PDPs offered such coverage, while just over half (51 percent) of MA-PDs did so—with both rates having grown considerably since 2006. Most plans that offer some gap coverage in 2008 limit it to generic drugs, including all but one PDP and about two-thirds of the MA-PDs with some coverage.³²

Accurate labeling of gap coverage has been an ongoing problem. One plan in 2007 was inaccurately labeled with more gap coverage than was the case.³³ In 2008, the proportion of plans with gap coverage has risen, but many of them have narrowed their coverage—for example, shifting from covering all generics to covering “some generics” or “all preferred generics.” In fact, there are 12 different descriptions of gap coverage used in the *Drug Plan Finder*, without any standard definitions. It is unclear whether, for instance, “some generics” refers to more drugs than does “all preferred generics.”³⁴

Further Standardization of Plan Benefit Parameters

Even if the Medicare program takes steps to establish simpler labeling and clearer descriptions of benefit parameters, beneficiaries might still find the substantial variation in plan offerings overwhelming. In the future, it may make sense to require further moves toward standard designs, similar to what is required for Medicare supplemental (Medigap) insurance and, as described in a companion issue brief, for Medicare Advantage.³⁵ A move in this direction, however, might seem to be counter to the guidance in recent CMS call letters to potential plan sponsors. The guidance encourages plan sponsors to make sure different plans provide beneficiaries with substantially different options. In doing so, CMS has encouraged not only clear differences between the options offered by a single sponsor, but also a proliferation of plans that confront beneficiaries with a dizzying array of variations, as illustrated in Table 1.

To some extent, beneficiaries have been voting with their feet by gravitating toward certain benefit designs. The meaningfulness of these revealed preferences is limited, however, since beneficiaries appear to pick more on plan name and

Option: CMS should consider requiring that plans select between two options: use the standard deductible or eliminate the deductible entirely.

premium than on specific features, and may be led to making “wrong” choices through confusion or lack of appropriate information. As a result, plan popularity should be only one of several factors to be considered in winnowing out the options.

Deductible. A majority of beneficiaries have selected plans with no deductibles, and most of the rest have enrolled in low-premium plans with the standard deductible. Under 5 percent of beneficiaries have enrolled in the few plans that maintain a deductible but reduce it below the standard level.

Cost-Sharing Amounts. With so many cost-sharing options, beneficiaries are likely to find it hard to compare the value of one plan to that of another. Based on the examples in Table 1, it may be clear that a plan with a three-tier cost-sharing structure of \$7/\$30/\$74.85 will have higher out-of-pocket costs than one with copays of \$4/\$25/\$54. But will the plan with the latter structure have lower costs than a competing plan with copays of \$0/\$45/\$107? Or is the former plan a better deal than one with copays of \$6 and \$35, and coinsurance of 75 percent in the nonpreferred brand tier?

Given the proliferation of different cost-sharing structures and the confusion that results when trying to compare disparate designs, it might make sense for the program to restrict the range of variation in copayment amounts.³⁶ So far, beneficiaries have disproportionately selected plans with fixed copayments, as opposed to percentage coinsurance; but it is hard to tell whether, for example,

Option: Plans should be required to use the standard classification system and to display plan formularies in that framework (or a simplified version of it). This requirement would make it easier for beneficiaries to understand distinctions between plan formularies. For example, the statutory requirement that plans include at least two drugs in each category and class would mean the same thing for all plans.

Option: As a starting point, CMS should consider requiring plans to round their copayment amounts for the tiers associated with brand-name drugs to the nearest \$5 and to confine copayments for the generic tier to a modest set of options (e.g., \$0, \$2, \$5, or \$10).³⁷ Further simplification of offerings would be achieved by restricting the range of copayment amounts attached to particular tiers. For example, within the three-tier plan designs (with separate copayment levels for generic drugs, preferred brand drugs, and nonpreferred brand drugs), CMS might allow just three copayment options. One option could have only modest differences between the tiers (e.g., \$5, \$20, and \$40); the second could increase the tilt toward generic drugs (\$0, \$25, and \$50); and the third could increase the tilt toward both generics and preferred brand-name drugs (\$0, \$15, and \$60).³⁸

they would prefer narrower or wider spreads in the copayments assigned to each of the tiers.

As with any approach to limiting tier structures, plans might see such restrictions as limiting their flexibility in negotiating for discounts and rebates. Ensuring that the designated options include designs with weaker and stronger incentives for the use of generic or preferred drugs should at least partially address this concern.

Possible Standardization of Formularies

A more challenging question is whether a greater degree of standardization should be applied to plan formularies. Requirement of standard formularies would help address a major source of concern and confusion for beneficiaries, but would be opposed by plans and some others because it would tend to undermine the goals of the market-based approach adopted in the MMA. Plans are expected to enter into independent and competitive negotiations with drug manufacturers, and bargaining would

Option: With the experience gained from the first years of Medicare Part D and more clinical input, CMS should refine the two-drugs-per-class rule, the set of protected classes, and related standards to better accommodate the differences across drug classes. This could mean, for example, requiring more than two drugs in some drug classes and only a single drug in other classes.

result in a range of decisions about which drugs are on formulary and what utilization limits or cost-sharing requirements apply. One plan might negotiate a deal with one manufacturer to prefer its medication in a particular drug class in exchange for a lower price. A second plan might cut a similar deal for a competing drug. And a third plan might include both drugs, promising a broader formulary to potential enrollees in exchange for a higher premium.

Formularies have been a major source of plan variability, and one that is difficult to describe clearly to beneficiaries.³⁹ The *Drug Plan Finder* is a good tool for allowing beneficiaries to identify the placement and cost-sharing for their particular drugs on a plan’s formulary. But beneficiaries trying to calculate future drug needs have no helpful means of identifying which plan formularies are the most complete and which are the most restrictive.

Some beneficiary advocates would prefer less-restrictive formularies, envisioning a system where CMS requires plans to cover a set of drugs for which there are clear clinical indications. Plans might still be allowed to offer incentives to use preferred products (e.g., through tiered cost-sharing) while still including all required drugs on formulary. Some plans essentially have open formularies in which all drugs are available (though beneficiaries may find it hard to identify these plans using the *Drug Plan Finder*). The current system of exceptions and appeals offers beneficiaries and physicians a way to obtain drugs not listed on a

plan’s formulary, but they often find these procedures difficult to use.

Even if standard formularies were not required, several steps could be taken to make it easier for beneficiaries to compare the formularies offered by different plans.

Standard Classification System. In accordance with the law, CMS adopted a model classification system, but does not require its use. The classification system not only helps standardize the way formularies are presented and organized, but also provides a framework for the statutory requirement that plans list on formulary at least two drugs for each therapeutic category and pharmacologic class. CMS guidelines for 2006 and 2007 also required that plans cover at least one drug in each formulary key drug type (a third level of the classification system). There were other provisions in the guidelines as well, with some exceptions allowable on clinical grounds.⁴⁰ About one-fourth of plans, however, substituted their own classification system in 2006, and according to CMS that number has increased to over half in 2008.⁴¹

Standards for Formulary Review. Even if formularies were not standardized, the guidance for formulary review could be strengthened. CMS guidance has been modified each year to date, but it starts with the statutory requirement that two drugs be on formulary from each category and class. It has also mandated nearly complete coverage of the drugs in a set of protected drug classes, including immunosuppressant drugs used by transplant recipients and drugs used to treat mental health conditions, HIV/AIDS, and cancer.

Option: Summary measures on plan formularies should be displayed in the *Drug Plan Finder*. Such measures should focus on both the completeness and the restrictiveness of formularies, and if possible should also incorporate the ease of obtaining access to off-formulary or restricted drugs.

Summary Measures for Formularies.

Currently, the *Drug Plan Finder* includes no summary measures for plan formularies. In 2006, the share on formulary of the most commonly prescribed drugs was displayed, but this type of measure focuses solely on a particular subset of drugs and does not reveal whether less commonly prescribed drugs are also listed. Summary measures of the completeness or restrictiveness of formularies have been plagued by methodological issues. For example, there is no agreement on how to count different forms and strengths of a given drug or varying generic versions made by different manufacturers.⁴²

Expected Impact on the Plan Market and Beneficiary Access

Clearer descriptions and some reduction in the proliferation of options should make it easier for beneficiaries to choose plans. Furthermore, if good information constitutes one underpinning of an effective market, this market would operate more efficiently with plans competing on clearly defined dimensions of quality, service, and access rather than on a broad range of characteristics that are poorly defined and hard to understand.

In 2006, many beneficiaries simply selected plans with the most familiar names or with the lowest overall premiums. While this may have seemed a valid strategy at the time, better information and a clearer set of choices could make it possible for some to see that a plan with, for example, a higher premium might be a good buy because of lower cost-sharing or a more inclusive formulary.

Most beneficiaries have remained with the same plan they chose in the program's first year. Their decisions could reflect satisfaction with their current plans, but they could also indicate that beneficiaries were unwilling or unable to research options to make a change even when plan premiums and benefits were substantially modified. Many observers speculate that few even considered making a change in the absence of compelling circumstances. A shift toward greater simplicity and more standardization would have the potential to improve beneficiaries' ability to choose plans that suit their needs. They would then be making the most of their Medicare drug benefit, while plans would be encouraged to compete in a market that is more responsive to beneficiaries' preferences.

ABOUT THIS STUDY

This issue brief and the companion Commonwealth Fund brief, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*,[\[LINK\]](#) are based on our research team's analysis of plan offerings under the new Medicare Part D drug benefit, a review of the literature on beneficiaries' knowledge and understanding of their benefits, and a review of the more general issues surrounding benefit standardization.

The briefs also reflect the significant input of two panels of Medicare experts. The first panel, which we convened in December 2005, included professionals from health plans and beneficiary organizations as well as highly regarded scholars in the field. We convened a second panel, in September 2006, made up of beneficiary counselors from state health insurance assistance programs (SHIPs) and private organizations involved in counseling beneficiaries. Both sets of panelists discussed, over the course of a day, broad issues regarding standardization of Medicare Advantage and Medicare Part D benefits, and they were given the opportunity to comment on the draft briefs as well.

This paper has benefited greatly from the input of these panelists, although it does not represent any consensus or endorsement by them.

NOTES

- ¹ Kaiser Family Foundation, *Chartpack: Seniors and the Medicare Prescription Drug Benefit* (Washington, D.C.: Henry J. Kaiser Family Foundation, 2006).
- ² J. Hoadley, E. Hargrave, K. Merrell, J. Cubanski, and T. Neuman, *Benefit Design and Formularies of Medicare Drug Plans: A Comparison of 2006 and 2007 Offerings—A First Look* (Washington, D.C.: Henry J. Kaiser Family Foundation, Nov. 2006); J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: Benefit Design* (Washington, D.C.: Henry J. Kaiser Family Foundation, Dec. 2007).
- ³ A survey sponsored by the Kaiser Family Foundation and the Harvard School of Public Health in November 2006 found that most beneficiaries did not intend to switch plans. While the most common reason cited was satisfaction with their plan, over one-third cited that “it’s too much trouble to compare and choose another.” Kaiser Family Foundation, *Chartpack: Seniors and the Medicare Prescription Drug Benefit*. CMS reports that about 6 percent of nonsubsidized enrollees switched plans in the fall 2007 open season (about 7 percent did so in fall 2006).
- ⁴ Beneficiaries deemed eligible for the low-income subsidy may enroll outside the open season without penalty.
- ⁵ These numbers and those presented elsewhere in this issue brief exclude plans offered solely to employer groups. In general, the discussions of standardization do not apply to these plans. Typically, employers offer their retirees a limited set of options for drug benefits and supplemental health coverage.
- ⁶ J. Hoadley, E. Hargrave, J. Cubanski, and T. Neuman, *An In-Depth Examination of Formularies and Other Features of Medicare Drug Plans* (Washington, D.C.: Henry J. Kaiser Family Foundation, April 2006); J. Hoadley et al., *Benefit Design and Formularies of Medicare Drug Plans*; J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: Benefit Design*; E. Hargrave et al., *Medicare Part D 2008 Data Spotlight: Specialty Tiers* (Washington, D.C.: Henry J. Kaiser Family Foundation, Dec. 2007); J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: The Coverage Gap* (Washington, D.C.: Henry J. Kaiser Family Foundation, Nov. 2007).
- ⁷ J. Hoadley, *The Effects of Formularies and Other Cost Management Tools on Access to Medications: An Analysis of the MMA and the Final Rule* (Washington, D.C.: Henry J. Kaiser Family Foundation, March 2005).
- ⁸ MedPAC (Medicare Payment Advisory Commission), “Part D Enrollment, Benefit Offerings, and Plan Payments,” in *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2008). Data reported are for 2007, but unpublished analysis of 2008 shows similar results.
- ⁹ Kaiser Family Foundation, *Chartpack: Seniors and the Medicare Prescription Drug Benefit*.
- ¹⁰ J. James, T. Neuman, and M. K. Strollo, *Early Experiences of Medicare Beneficiaries in Prescription Drug Plans* (Washington, D.C.: Henry J. Kaiser Family Foundation, 2006).
- ¹¹ Commonwealth Fund, *The Commonwealth Fund Health Care Opinion Leaders Survey: Medicare Part D* (New York: The Commonwealth Fund, 2006). Frank and Newhouse also reach the conclusion that simplification would likely result in more effective consumer choice and a more competitive system. R. G. Frank and J. P. Newhouse, *Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing*, Discussion Paper 2007-03 (Washington, D.C.: The Brookings Institution).
- ¹² J. H. Hibbard and E. Peters, “Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches That Facilitate the Use of Information in Choice,” *Annual Review of Public Health*, 2003 24:413–33.
- ¹³ Studies that address these questions include J. H. Hibbard and E. Peters, “Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches That Facilitate the Use of Information in Choice”; J. H. Hibbard et al., “Can Medicare Beneficiaries Make Informed Choices?” *Health Affairs*, Nov./Dec. 1998 17(6):181–93; M. Sing et al., *Educating New Members of Medicare+Choice Plans About Their Health Insurance Options: Does the National Medicare Education Program Make a Difference?* Final report submitted to CMS (Washington, D.C.: Mathematica Policy Research, 2001); Frederick Schneiders Research, *Lessons from the Front Line: Focus Group Study of Medicare Insurance Counselors* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 1998); and G. Dallek and C. Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, Oct. 2001).
- ¹⁴ J. H. Hibbard et al. *Older Consumers’ Skill in Using Comparative Data to Inform Health Plan Choice: A Preliminary Assessment* (Washington, D.C.: AARP Public Policy Institute, 2000).
- ¹⁵ J. Dubow, *Adequate Literacy and Health Literacy: Prerequisites for Informed Health Care Decision Making* (Washington, D.C.: AARP Public Policy Institute, 2004); J. A. Gazmararian et al., “Health Literacy Among Medicare Enrollees in a Managed Care Organization,” *Journal of the American Medical Association*, Feb. 10, 1999 281(6):545–51; D. W. Baker et al., “The Association Between Age and Health Literacy Among Elderly Persons,” *Journal of Gerontology: Social Sciences*, Nov. 2000 55(6):S368–74.
- ¹⁶ S. S. Iyengar, and M. R. Lepper, “When Choice is Demotivating: Can One Desire Too Much of a Good Thing?” *Journal of Personality and Social Psychology*, Dec. 2000 79(6):995–1006.
- ¹⁷ S. Sethi-Iyengar, G. Huberman, and W. Jiang. “How Much Choice Is Too Much? Contributions to 401(k) Retirement Plans,” in *Pension Design and Structure: New Lessons from Behavioral Finance* (O.S. Mitchell and S. Utkus, eds.) (New York: Oxford University Press, 2004), pp. 83–95.

- ¹⁸ The most recent enrollment numbers are available in Centers for Medicare and Medicaid Services, “Medicare Prescription Drug Benefit’s Projected Costs Continue to Drop,” press release, Jan. 31, 2008.
- ¹⁹ M. McClellan, Centers for Medicare and Medicaid Services, testimony before the House Committee on Energy and Commerce, March 1, 2006.
- ²⁰ E. Hargrave et al., *Medicare Part D 2008 Data Spotlight: Specialty Tiers*.
- ²¹ J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: Benefit Design*.
- ²² CMS, “2009 Call Letter”; available at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>.
- ²³ One report on the program’s first year offerings emphasizes the number of plans with four or more tiers. E. Heaton, T. Carino, and H. Dix, *Assessing Medicare Prescription Drug Plans in Four States: Balancing Cost and Access* (New York: The Commonwealth Fund, Aug. 2006).
- ²⁴ MedPAC (Medicare Payment Advisory Commission), “Part D Plan Offerings,” in *Report to the Congress: Increasing the Value of Medicare* (Washington, D.C.: MedPAC, June 2006).
- ²⁵ J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: Benefit Design*.
- ²⁶ A recent report by the American Academy of Actuaries included an option for limiting designs to no more than three or four tiers. American Academy of Actuaries, “Medicare Part D—Lessons Learned,” letter to Abby Block, Centers for Medicare and Medicaid Services, March 21, 2007.
- ²⁷ J. Hoadley, E. Hargrave, J. Cubanski, and T. Neuman, *An In-Depth Examination of Formularies and Other Features of Medicare Drug Plans*; E. Hargrave et al., *Medicare Part D 2008 Data Spotlight: Specialty Tiers*. CMS guidance says that coinsurance for a specialty tier should be 25 percent, but plans are allowed to increase the coinsurance rate on an actuarially equivalent basis. For example, some plans increased the coinsurance to anywhere from 30 to 33 percent in exchange for eliminating the deductible.
- ²⁸ MedPAC, “Part D Enrollment, Benefit Offerings, and Plan Payments.”
- ²⁹ E. Hargrave et al., “Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists,” contractor report submitted to the Medicare Payment Advisory Commission, May 2008; available at http://www.medpac.gov/documents/May08_PartDFocusGroup_CONTRACTOR_JS.pdf.
- ³⁰ M. McClellan, Centers for Medicare and Medicaid Services, testimony before the House Committee on Ways and Means, June 14, 2006.
- ³¹ L. Summer et al., *Improving the Medicare Part D Program for the Most Vulnerable Beneficiaries* (New York: The Commonwealth Fund, May 2007). This report notes the value of more standardization of the procedures and criteria used for exceptions and appeals.
- ³² J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: The Coverage Gap*.
- ³³ In 2007, this organization was listed in the Medicare & You handbook as covering both generics and preferred brands. It turned out that the particular plan only covered a small handful of brands that were listed on its generic tier (probably so-called “branded generic drugs”). While corrections were made by the plan and on the online *Drug Plan Finder*, it was too late to correct the handbook that was mailed to all beneficiaries.
- ³⁴ J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: The Coverage Gap*.
- ³⁵ E. O’Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice* (New York: The Commonwealth Fund, April 2008). Frank and Newhouse recommend development of a set of seven to nine standardized PDPs. R. G. Frank and J. P. Newhouse, *Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing*.
- ³⁶ A recent report by the American Academy of Actuaries suggests the option of restricting cost-sharing levels to certain ranges. American Academy of Actuaries, “Medicare Part D—Lessons Learned.”
- ³⁷ Taking this step might require some flexibility in interpreting the actuarial equivalence rules.
- ³⁸ More analysis would be required in designing these options so as to ensure that they were actuarially equivalent.
- ³⁹ J. Hoadley et al., *Medicare Part D 2008 Data Spotlight: Formularies* (Washington, D.C.: Henry J. Kaiser Family Foundation, Jan. 2008). MedPAC, *Part D Enrollment, Benefit Offerings, and Plan Payments*.
- ⁴⁰ J. Hoadley, *The Effects of Formularies and Other Cost Management Tools on Access to Medications: An Analysis of the MMA and the Final Rule*.
- ⁴¹ “Part D Plans Are Getting Compliance Message, but CMS Still Intends to Ramp Up Its Oversight Efforts,” *AIS’s Health Business Daily*, March 6, 2008; available at <http://www.aishealth.com/Bnow/hbd030608.html>.
- ⁴² MedPAC, *Part D Plan Offerings and Part D Enrollment, Benefit Offerings, and Plan Payments*.

Appendix: Expert Panel Members

(Note: Members' affiliations were recurrent at time of panel meeting)

Expert Panel, December 2005

John Bertko

Vice President and Chief Actuary
Humana

Bonnie Burns

Training and Policy Specialist
California Health Advocates

Bryan Dowd

Professor
University of Minnesota School of Public Health

Joyce Dubow

Senior Policy Advisor
AARP

Jorge Gomez

Insurance Commissioner, Wisconsin

Bob Hurley

Associate Professor
Department of Health Administration
Medical College of Virginia

Marilyn Moon

Vice President and Director of the Health Program
American Institutes for Research

Mary Beth Senkewicz

Senior Counsel for Health Policy
National Association of Insurance Commissioners

George Strumpf

Director, Federal Relations
HIP Health Plans

Expert Panel, September 2006

Bonnie Burns

Training and Policy Specialist
California Health Advocates

Chris DeYoung

Community Outreach Coordinator
Iona Senior Services
Washington, D.C.

Lisa Federico

Coordinator
GeorgiaCares
Atlanta Regional Commission Area Agency
on Aging

Ellen Frazier

Elder Information Specialist
East Providence (Rhode Island) Senior Center

Bill Lardy

Director
Senior Health Insurance Counseling
North Dakota Insurance Department

Vicki Mikels

Director
GeorgiaCares
Georgia Division of Aging Services

Beverly Roberts

Director of Mainstreaming Medical Care
The Arc of New Jersey

Stephanie Sue Stein

Director
Milwaukee County Department on Aging

ABOUT THE AUTHORS

[Jack Hoadley, Ph.D.](#), is a research professor in the Health Policy Institute at Georgetown University, where he leads research projects on Medicare, Medicaid, and other health financing topics (with a particular focus on prescription-drug issues). Recent projects have included studies of: the use of formularies by Medicare drug plans; approaches used by Medicare beneficiaries to make choices relating to the Medicare drug benefit; the use of evidence-based medicine to manage pharmacy costs for Medicaid; and the effects of recent changes to Florida's Medicaid program. Hoadley received his M.A. and Ph.D. in political science from the University of North Carolina at Chapel Hill.

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