

# A Shot in the Arm for Medicare Part D: Four Ways for the Government to Boost its Customer Communications

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## Executive Summary

Twenty-five million elderly Americans are currently enrolled in Medicare Part D private drug plans and may choose among at least 40 options. Our research suggests that some seniors would make different choices if they were presented with personalized, comparative cost information and would enjoy substantial cost savings - and no adverse effects on quality - as a result.

In the 2006 open enrollment period, we conducted a randomized experiment in which some seniors enrolled in Medicare drug plans were mailed carefully designed personalized information on the potential cost savings from changing plans, while others received more general information not tailored to them.

Our background research found that, in general, seniors did not know much about Medicare drug plans and did not actively research them. While Medicare offered information via its help-line and website, other sources offered limited assistance and did not knowledgeably promote Medicare's services. These conditions suggest an ongoing role for an energetic public information campaign.

In the experimental study, 28 percent of the information group switched plans as opposed to 17 percent of the comparison group. The average relative savings for seniors who made different plan choices as a result of the study materials were at least \$150 per person or 9 percent of the annual drug bill. The savings were achieved without offsetting differences in plan quality.

We conclude that additional efforts to distribute personalized information would lead to significant reductions in Medicare beneficiaries' costs. In the short term, if the Medicare information campaign's goal is to help interested beneficiaries reduce their individual drug costs, then we recommend the following:

- 1) Emphasize the importance of *personalized* cost estimates;
- 2) Publicize the significant cost differences among plans;
- 3) Suggest ways to simplify the choice process; and
- 4) Seek to educate and engage additional community partners.

In the longer term, we recommend exploring more pro-active efforts to distribute personalized comparative information and ways to make information and context maximally conducive to robust choices.

## Introduction

In areas from Social Security to public schools to health insurance, policy makers are increasingly incorporating consumer choice into the provision of government services. While choice and competition have great potential to improve service quality and reduce cost, a recent body of research emphasizes the psychological and cognitive difficulty that consumers may have with complex choices. In the case of Medicare Part D, these difficulties may be acute. Research shows that a proliferation of complex alternatives can lead to suboptimal choice or procrastination. In addition, the comprehension of comparative information and the willingness to make decisions diminish with age. In fact, much of the early publicity about Medicare Part D emphasized beneficiaries' confusion about the program and its large number of options.

In *Nudge*, Thaler and Sunstein (2008) argue that by knowing how people think and acknowledging their sensitivity to environmental factors, we can design good "choice architecture" -- environments that encourage choices that increase consumer well-being without restricting individual freedom of choice. One aspect of choice architecture is the information environment, both the information that is available and the way in which it is presented.

The Medicare prescription drug benefit offered subsidized drug coverage to Americans with Medicare beginning in January 2006. Beneficiaries enroll voluntarily and choose among multiple free-standing private drug plans and multiple Medicare HMOs offering drug coverage. Most beneficiaries can only enroll or change plans during an open enrollment period, between November 15 and December 31 each year. The typical individual chooses from among 40-60 free-standing private plans differing along a variety of dimensions, including premiums, cost-sharing at the pharmacy, numbers of drug covered, and numbers of pharmacies participating. With the large number of plans and the many dimensions to consider, making an informed choice is extremely complicated. In particular, costs depend on a complex interplay between the individual's drugs and the plan's co-payment schedule.

Given the interest in choice-based public programs but also the potential challenges, our project investigated whether seniors were making well-informed choices among Medicare drug plans, how the provision of carefully designed personalized comparative information would affect these choices, and the implications of our findings for national policy.

## Consumer Knowledge, Information-Seeking, and Available Advice

In order to make well-informed choices in a complex environment, consumers must understand the markets and products, and take appropriate advantage of available information sources. To gather background on these topics, we conducted phone and mail surveys of seniors enrolled in free-standing Medicare drug plans in early 2007.

In general, seniors were not well-informed about the differences among drug plans and were quite complacent. While a significant majority of respondents to the phone survey knew that different plans were better for different people (82 percent) and that they could only change plans during open enrollment (74 percent), few had learned additional facts about the specific differences among plans, including differences that have a major effect on costs at the pharmacy. Only 37 percent knew that only some (rather than all) plans have a deductible. Only 55 percent knew that co-payments for generic drugs are different (rather than the same) in different plans. Immediately after open enrollment, more than 70 percent of the comparison group for our information study (described below) underestimated the potential savings from changing plans.

According to both surveys, the leading sources of information that participants used to learn about drug plans were mailings from plans and mailings from Medicare; such material is not personalized and does not convey transparent information about out-of-pocket costs. The phone survey also indicated that more interactive forms of information gathering, such as in-person, phone, or internet, were each used by less than 15 percent of respondents. Less than 20 percent reviewed personalized plan comparisons. Yet, in both surveys, we found that over 80 percent of participants were generally satisfied with their 2006 prescription drug plans. Only 10 percent of phone survey respondents and 15 percent of mail survey respondents had switched plans (slightly above the reported national rate of seven percent), and only 14 percent of phone survey respondents had considered switching plans without doing so.

In order to understand whether consumers are taking full advantage of available information sources and to consider new policies, it is useful to understand the information that is currently available. We therefore audited the Medicare help-line, 88 pharmacies, and several other potential sources of advice on choosing a Medicare drug plan. In these audits, a researcher posed as a Medicare beneficiary or a helpful relative and requested advice on plan choices.

This investigation indicated that personalized, comparative information was available from Medicare but not from other sources, and that other sources were not particularly effective advocates of what Medicare had to offer. Medicare's website tool, the Prescription Drug Plan Finder (available at <http://www.medicare.gov/MPDPF>), generates personalized, comparative information. After the user enters information on prescriptions and other preferences, the tool calculates an estimated total annual cost for each plan. While using the Plan Finder may challenge some people who are less familiar with technology or with the Medicare drug benefit, calls to 1-800-MEDICARE indicated that personalized, comparative information was readily available from this source with minimal effort on the part of the caller.

The audit further indicated that few private-sector information sources had emerged. A small fraction of pharmacies offered personalized in-store assistance with plan choice, but the majority offered only vague general guidance. About half mentioned Medicare as an information source, but few could confidently state what services were available. Our user testing of popular written materials indicated that they were not sufficient for seniors

to understand the cost implications of plan choice even in straightforward cases. Even the simple message, “Choice among drug plans has significant cost implications, and personalized help is available from Medicare,” was not clearly and consistently articulated. These survey and audit results show the need for more active policies.

### Seniors’ Response to Personalized, Comparative Information

The main component of the study was a randomized experiment, designed to explore whether seniors were already making well-informed choices, defined as choices that they themselves would not change in the face of additional information, and the specific effects of carefully designed information on choices. Half of study participants, selected at random, received a letter showing the individual’s current plan and its predicted annual cost, the lowest cost plan and its predicted annual cost, and the potential savings from switching to the lowest-cost plan, as well as a printout from the Medicare Plan Finder including costs and other data on all available plans. The other half received a general letter referring them to the Medicare website, and both groups received an informational booklet on how to use the site. The predicted costs measures used in these letters and subsequent analyses were calculated using the Medicare Plan Finder and the senior’s drug use as reported at the time of the baseline interview. These predicted cost measures include the premiums paid to the insurer and out-of-pocket payments made at the pharmacy.

Given the research interest in whether seniors were making well-informed decisions and in the importance of information design, the essence of the intervention was to present information that was already available in a format conducive to action. The letter neither contained new or difficult-to-acquire information nor reduced the effort required to actually enroll in a new plan, but it was designed using psychological principles known to facilitate action: a default choice (the lowest cost plan), a clear statement of that choice’s benefits (potential savings), and a deadline. The letter focused on cost because the Medicare Plan Finder focuses primarily on costs, not because the researchers believed that cost was, necessarily, the most important plan feature. While the letter clearly identified Medicare as the source of study information, it was printed on the stationery of a local university hospital, which may have led to increased attention or credibility.

Participants were 406 patients of the University of Wisconsin Hospitals and Clinics, who were already enrolled in a free-standing Medicare drug plan, not receiving subsidies, and over age 65. Baseline data collection and the intervention occurred in the fall of 2006. Follow-up interviews were conducted in the spring of 2007 and the spring of 2008. Members of our sample could choose among 54 plans.

To assess the range of costs faced by participants, we compiled data on the predicted costs for 2007 of every possible plan for each individual. This data showed that there were significant differences in costs among plans, and that many seniors could potentially save significant amounts of money by changing plans. For example, based on predicted costs, a typical senior with between four and six prescriptions could have saved about \$500 by changing from his/her current plan to the lowest cost plan. Moreover,

approximately 80 percent of total costs and 80 percent of the potential savings from changing plans resided in the difficult-to-calculate out-of-pocket costs at the pharmacy as opposed to the more transparent premiums.

Seniors' choices reported in the spring of 2007 indicated that, absent the informational letters, seniors were not making fully informed decisions, and that seniors would change their choices if presented with additional information. In addition, these choices suggested that the alternate choices were a thoughtful response to the information presented. Specifically, 28 percent of seniors in the information group switched plans, compared to 17 percent in the comparison group. Furthermore, 9 percent of the information group switched to the lowest cost plan, while 2 percent of the comparison group made this change. In the information group, greater percentages of seniors remembered receiving the materials, reported reading them, and deemed them helpful.

Based on drugs used at the time of plan selection, the decrease in predicted cost for the entire information group relative to the comparison group was \$90 or six percent of the baseline total drug bill. The decrease in predicted costs was larger if one only considers those seniors who made different choices as a result of the intervention; this decrease was between \$200 and \$320 or between 13 and 21 percent of the baseline drug bill.

The bulk of the information group's relative savings came in the form of out-of-pocket costs, not premiums. For this group, 81 percent of the predicted savings from changing plans came in the form of lower costs at the pharmacy, while, for the comparison group, only 31 percent of predicted savings came from this source. Pharmacy costs are virtually impossible to calculate without the Plan Finder or a comparable tool, and the observed discrepancy suggests that the information group had a stronger grasp of this aspect of costs than the comparison group. All of these differences were found in a variety of statistical models and for a variety of sub-populations.

Seniors' experiences over the year, as reported in the spring of 2008, indicated that seniors in the information group had, indeed, enjoyed significant savings without any apparent negative effects on quality. Based on the actual set of drugs used over the year, as opposed to drugs known at the time of selection, the decrease in realized costs for the entire information group as opposed to the comparison group was \$65 or 4 percent of the total drug bill, which translates into average savings of at least \$152 or at least 9 percent for those who made different choices. We also found some evidence that savings for the information group continued into 2008, not because this group was more likely to change plans a second time, but because of ongoing savings in the plan chosen for 2007.

There were no apparent differences between the two groups in plan satisfaction or medication access as reported by the study participants or in plan quality as reported by Medicare. These last findings are important because of the concern that an informational mailing that emphasized the predicted cost of current drugs might lead seniors to focus overly on costs or on the specific drugs they were taking and thereby make choices they would later regret, due either to differences in non-cost aspects of plan quality or to the costs of new medications.

## Potential for National Implementation

The average realized cost savings for participants in the study was \$65 in the first year, with modest additional saving projected to persist for additional years. In response to these savings, Medicare or another organization with access to individual drug profiles could potentially combine drug use data with information about plan enrollment and subsidy eligibility to directly implement an intervention similar to ours at low cost – say, less than \$5 per person. For example, together with Experion Systems, a technology company, CVS/pharmacy is offering offers a service whereby 500,000 customers enrolled in private drug plans can directly import their prescription history in Experion’s drug plan choice tool to create personalized, comparative information; arrangements like this may prove cost-effective and reach seniors who might not pursue information from Medicare.

In addition, an effective information provision on a large scale could potentially affect Medicare expenditures. To the extent that plan switches represent seniors’ choosing plans with lower costs overall, then Medicare expenditures would presumably be reduced because Medicare subsidies are tied to average plan costs. To the extent that plan switches represent seniors choosing plans in which the cost-sharing formula favors their individual drug profile, then the effect on Medicare is ambiguous, because it is difficult to forecast how plans and plan costs would respond to this type of sorting.

## Discussion and Implications for Policy

The essential finding of our study is when seniors were presented with personalized, comparative information on their costs in different drug plans, they made different plan choices that led to lower costs. Importantly, the bulk of the savings came from the harder-to-perceive out-of-pocket costs at the pharmacy rather than the easier-to-grasp premiums, underscoring the value to seniors of acquiring personalized information based on one’s own drugs rather than relying on generic information sources. Equally importantly, despite this same information’s availability from Medicare by web and phone, seniors who were not mailed the information did not independently acquire it and make these same changes, underscoring the likely value to seniors of public sector strategies intended both to boost both information supply and demand and to facilitate action.

It is difficult to explain these findings using rational theories of decision making. Across a variety of measures, we found no evidence that seniors’ savings were offset by reductions in plan quality. The intervention consisted of information that was already free and easy to acquire. Much of the power of intervention seems to stem from the behaviorally sensitive design of the informational letter. To a degree, the intervention may have reduced the effort of acquiring information, but this reduction seems small relative to the realized savings of at least \$150 per person for those who made different choices as a result of the study mailing. In addition, seniors may have valued the

information differently because it came from a hospital rather than from CMS, but this difference is, itself, essentially psychological.

We interpret these findings as evidence that seniors were confused about drug costs. In the initial enrollment in spring 2006, Medicare drug plans were complex and unfamiliar products, making it difficult for seniors to grasp both their own predicted costs and the potential for differences among plans. Study results seem consistent with a situation in which seniors under-invested in information-seeking in part because they underestimated the potential for differences among plans or over-estimated the difficulty of learning about them. In the second open enrollment period in the fall of 2006, not only did this confusion persist, but status-quo bias (the tendency to stick with existing opinions and choices) led to high rates of satisfaction and low rates of change. Our intervention, while small, challenged these tendencies by altering price and market perceptions, countering status quo bias (by showing the savings available), and providing an alternative default (the lowest cost plan). As a result, this small, behaviorally sensitive intervention had a large effect.

We conclude that additional efforts to distribute personalized information would lead to significant reductions in Medicare beneficiaries' costs. Based on our research, if a goal is to help interested beneficiaries reduce their individual drug costs, then we recommend four ways for Medicare and its community partners to enhance their information campaign:

1. Emphasize that careful evaluation of all drug costs, and not premium alone, is essential to maximizing Medicare drug plan savings and value. Strongly encourage Medicare beneficiaries to seek personalized, comparative information. Increases in seniors' premiums may raise cost awareness or generate interest in changing plans, but seniors who focus exclusively on premium miss three-quarters of the cost story.
2. As part of the general information campaign, describe and quantify the average potential savings from changing plans, given that these savings are not widely understood. Statements like: "A typical senior with four to six prescriptions can save \$500 by changing plans" may motivate beneficiaries to consider changing plans and pursue more accurate personalized information.
3. Offer a first step to beneficiaries who may be overwhelmed by the full Medicare print out. Suggest that they structure and simplify their decision by first noticing costs in the current plan, costs in the lowest cost plan, and the potential savings from the change. Our study results suggest that this simplification is potentially useful in promoting action, and that, on the margin, it does not lead to seniors' choosing plans of lower measured quality.
4. Continue to engage trusted partners, including pharmacists and hospitals, and give them the tools to confidently describe the availability and value of the information available from Medicare.

In the longer term, given the observed reluctance of most individuals to reassess their choices, we recommend that Medicare explore more pro-active efforts to engage a larger share of Medicare beneficiaries. As described above, Medicare itself could potentially generate letters based on seniors' drug claims history at costs lower than the expected savings for seniors, although the long term impacts on the Medicare program require further study. As an alternative, while careful regulation would be needed, we are intrigued by the idea of the government facilitating a private market for comparative information as a way to reach additional seniors and to foster innovation.

More generally, based on this and other research, we recommend that Medicare and other public organizations charged with implementing choice-based policy pay close attention to the psychology of choice and the subtleties of information design. Behavioral research highlights two important factors, intention and action, in the take-up of benefit programs. Informational and consciousness-raising campaigns can impact intention; the design of helpful access and clever decision-aids can impact action. As scientists, we recommend the testing of alternative presentations of information to determine the formats that lead to the most robust decisions to act as well as the testing of alternative context designs to determine those that promote the most robust choices, ideally defined as choices that are most satisfactory to the affected individuals themselves. In addition, we see a need for additional research on the participation of third parties in information markets, the response of plan sponsors to broader information provision, and the interaction between customer confusion and other complex aspects of insurance markets, such as adverse selection.