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Benefit Design of Medicare Drug Plans: An Analysis of Ohio and the National Landscape from 2006 through 2009

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Brad Haverkos

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Abstract

Objectives: Since previous research was fragmented and incomplete, I described changes in the benefit designs of stand-alone PDPs in the United States from 2006 through 2009. In addition, I identified trends in the PDP market of Ohio and compared them to the national data. The intent was to discover changes that might only be observed during the examination of a smaller market. I then presented the enrollment data of stand-alone PDPs in Ohio and discussed the benefit designs of popular plans to help further understand the PDP market dynamics.

Methods: Each year, CMS collected and released information on benefit characteristics of stand-alone PDPs in November 2005, November 2006, September 2007, and September 2008. In this research, I reported on the number of PDPs available (dependent variable) in Ohio and the United States and the benefit characteristics of those PDPs (independent variables). I provided summary statistics on the following independent variables: type of benefit, LIS, premium, deductible, and gap coverage. Additionally, I highlighted the enrollment of PDPs and the benefit characteristics of those PDPs.

Results: I found that from 2006 to 2009, the benefit characteristics of PDPs in Ohio compared to national data were similar across all variables. Though PDP availability peaked in 2007, there remained a greater number of PDPs available in 2009 than there had been in 2006. Meanwhile, from 2006 to 2009, there was a gradual decline in plans available for low-income-subsidy. The average premium increased every year from 2006 to 2009. In 2009, the unweighted average of PDPs in Ohio was \$44.33, while the average premium of the most popular PDPs was \$32.47. From 2006 to 2009, there was an increase in PDPs offering more coverage during the gap, although, in Ohio, none of the most popular plans offered gap coverage. Gap coverage is defined by CMS as the period of time in which Part D enrollees were responsible for the full cost of their prescription medications drugs until they qualified for catastrophic coverage.

Conclusions: Results indicate that in 2009, PDP availability for beneficiaries who voluntarily chose their plan was greater than at any previous time. Additionally, disproportionate to the amount of plans offered, individuals enrolled in PDPs offering low premiums and PDPs without gap coverage. As well, a relatively small number of PDPs available nationwide dominated the market share. Research suggests possible policy changes in Part D concerning cost, benefit design, and availability.

Introduction

The Medicare Modernization Act of 2003 (MMA) established a voluntary prescription drug benefit program known as Medicare Part D for individuals eligible to receive Medicare services. Beginning in January 2006, those eligible for Part D had the opportunity to enroll via stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug plans.¹ Both of these privately sponsored prescription drug plans offered varying benefit designs so long as the plans met certain standard benefits established through the Centers for Medicare and Medicaid Services (CMS). The rationale behind this system, in which beneficiaries chose from on average greater than forty PDPs, revolved around principles of capitalism. Ostensibly, the market would drive down overall cost, and individual choice would drive which plan types endured. Ultimately, market demand would serve to simplify Medicare Part D by driving down the number of plan offerings, while simultaneously leaving the best plans available to beneficiaries (McClellan, 2006).

According to The Columbia Encyclopedia (2008), private ownership of wealth provides the basis of capitalism. Theoretically in a pure “laissez-faire” capitalist model, government plays no role in economic affairs and competition, allowing supply and demand to operate unabated. In actuality, however, the economic and political philosophies and practices of most contemporary nations created capitalistic economies containing government intervention (The Columbia Encyclopedia, 2008). According to many economists, health care goods and services do not follow typical supply and demand curves, suggesting that health care should not exist under a pure capitalistic model (Cutler, 2004; Phelps, 2003; The Columbia Encyclopedia, 2008).

¹ Medicare Advantage plans included prescription drug coverage along with other standard health insurance benefits included within Medicare Parts A and B.

Previously conducted epidemiologic studies examined benefit design utilizing only national data, and due to limitations in data availability and study design these previous reports have been fragmented and noncomprehensive. The present research study addressed these limitations by focusing on PDPs in Ohio and compared benefit characteristics of them to national data. By principally examining the smaller state level market, significant changes and trends in benefit offerings should have been more readily apparent and more quickly identifiable. Broadly, the objective of the primary research was to identify if and how market forces affected PDP availability and benefit characteristics.

Background

In 2008, the most recent year for which full reporting data is available, national Medicare Part D enrollment included 44.2 million Medicare beneficiaries, of which, 25.4 million (57%) enrolled in Part D. 11.2 million (25%) enrolled in stand-alone PDPs, 6.2 million (14%) were dual eligibles, and 8.0 million (18%) were in MA-PD plans (Kaiser Family Foundation [KFF], 2008).² Individuals enrolled in stand-alone PDPs had the opportunity to self-enroll on an annual basis, though some beneficiaries opted to allow CMS to randomly choose a plan for them. In Ohio, approximately 30% of the 1.8 million Medicare beneficiaries enrolled in stand-alone PDPs in 2008.

The voluntary self-enrollment process provided beneficiaries the option to enroll in a stand-alone PDP, a MA-PD plan, or a plan from another source that maintained a minimum standard coverage established by CMS (also known as creditable coverage).³ CMS enrolled dual eligibles as well as other low-income beneficiaries who did not choose a plan of their own, into a

² Dual eligibles were beneficiaries eligible for both Medicare and Medicaid.

³ If beneficiaries choose not to enroll, they faced a permanent penalty equal to 1% of the national average monthly premium for each month they delayed enrollment (KFF, 2008).

randomly selected pre-approved low-income subsidy (LIS) PDP. These beneficiaries then had the opportunity to change to a different LIS PDP at any time during their enrollment.

The Rational Choice Theory provides the basic tenants behind Medicare Part D. Rational Choice Theory postulates that greater numbers of varied choices benefit consumers by increasing the likelihood that a utility maximizing choice is available for selection and procurement. This theory does indicate several necessary conditions that must be met for consumers to benefit from more choice. These assumptions include consumers having sufficient information about their available alternatives, having the ability to sift through alternatives to reach a rational and utility-maximizing decision, and not regretting their choice (Scott, 2000). However, research conducted beginning in 2006 subsequent to the initiation of Medicare Part D found that many beneficiaries were unhappy with both the enrollment process and their ensuing choice of PDP (Dulio, Perry, & Cubanski, 2007). Thus, arguably, Part D does not meet the necessary suppositions for The Rational Choice Theory. In fact, throughout the last forty years numerous psychologists opposed this theory and its applicability in various settings (Iyengar, Huberman, & Jiang, 2004).

Previous studies about choice examined the relationship between the number of choices available to consumers regarding their 401(k) retirement plans and the decision to invest or not to invest in a 401(k) retirement plan. They revealed the existence of an inverse relationship; those consumers who faced a greater number of investment options tended to choose the less profitable investment option of those offered (Iyengar, Huberman, & Jiang, 2004). Though the applicability of 401(k) plans to PDPs may be debatable the underlying principles are clearly relevant to the present discussion. Thus, the results of these previous studies extended to PDPs suggest that a prescription drug program within which consumers often do not explore their plan options and frequently have regrets about their ultimate choice of PDP provides for an

unfavorable background for The Rational Choice Theory (Cummings, Rice, & Hanoch, 2008). This research on choice highlights an overall limitation in the process by which Americans choose health insurance.

As a solution, after the enactment of Medicare Part D, researchers suggested that the simplification and standardization of Medicare Part D could improve the process by creating an environment where beneficiaries would more easily choose a utility maximizing option. By this rationale, Medicare Part D could then operate optimally under the Rational Choice Theory. This subsequent literature review highlights pertinent research on the simplification and standardization of Medicare Part D along with research specific to stand alone PDPs.

Literature

Research on stand-alone PDPs was mostly cross-sectional and speculative in nature. Additionally, there were no published studies examining enrollment in PDPs nor were there any studies that used inferential statistics to evaluate benefit characteristics of Part D plans. Studies used descriptive statistics alone to identify trends from 2006 to 2008. Other studies obtained information through surveys. These surveys described beneficiaries' experiences from 2006 and early 2007 and provided the only research that drew attention to beneficiaries' ability to choose an optimal plan. There was no research that specifically addressed the effect of the private PDP market. Furthermore, research specific to individual states did not exist. In summary, no research was able to provide a major conclusion or trend about the PDP market. In general, Medicare Part D intended to lower costs, improve efficiency, and increase access to prescription medications. Understandably then, there was an abundance of research in business and health care that focused on the cost effectiveness of the program and out-of-pocket expenditures. These studies, while noteworthy, were not the focus of this current research. The purpose of this research was to

identify trends in the availability of stand-alone PDPs, which would help contribute to understanding the direction of Medicare Part D and the effect of the private market on Medicare Part D. This current study could further implicate methods to improve the voluntary self-enrollment process.

In 2006, beneficiaries had concerns about the enrollment process questioning how to enroll, who to call or trust for help enrolling, and even if they wanted to enroll (Kaiser Family Foundation [KFF], 2006). After two years of the program, participants indicated a general level of contentment, but a significant majority of these individuals also reported the program was too complicated (Dulio, Perry, & Cubanski, 2007). Psychological theory suggests that when individuals have more than ten choices they are more attracted to the initial decision making process, enjoy the process of choosing more, and have greater satisfaction in their choice as compared to individuals that choose amongst less than ten options. When examining these individuals' choices, research showed that they made a better decision when faced with fewer options (Iyengar & Lepper, 2000). With regards to Medicare Part D, this research suggested that there was not a relationship between beneficiaries' initial satisfaction and the actual quality of their PDP.

Hibbard, Slovic, and Peters (2000) found that consumers' skill in using comparative data to make choices declined with age. Their research showed that the majority of individuals over 65 years of age had difficulty correctly interpreting even simple displays of Medicare health plan information, and many seniors demonstrated high error rates in accurately using information to make informed choices on health plan options (Hibbard, Slovic, and Peters, et al., 2000). While, vulnerable populations were the greatest risk for choosing sub-optimal health plans given their low levels of health literacy (Hall, Kurth, & Moore, 2007). Despite the fact that many

beneficiaries had a poor understanding of the plans, most beneficiaries cited that they did not seek help in choosing a plan. Surveys showed that only a few beneficiaries spent much time contemplating their choices, and most beneficiary counselors observed that beneficiaries focused solely on the differences in monthly premiums, rather than any of the other benefit characteristics (Gold, Achman, & Brown, 2003).

Surveys found the amount of information beneficiaries received was overwhelming, and beneficiaries frequently cited an inability to sort through the volume of information to make informed and rational decisions (Hibbard & Peters, 2003). Mobley, McCormack, and Wang (2005) found the increasing number of plans and unnecessary variations further complicated the health plan decision-making process for beneficiaries. This suggested that beneficiaries needed more help in interpreting this information to find the utility maximizing choice. One solution included further standardizing and simplifying Part D to maximize health literacy (Hoadley, 2008). A study by the Medicare Payment Advisory Commission (MedPAC) in 2004 found individuals more likely to make a choice when offered a limited array of six choices rather than when faced with an array of 24 to 30 choices. Surveys noted that somewhere between 65 and 80 percent of individuals believed that Medicare Part D was too complicated (Cummings & Rice, 2008; KFF, 2006; Winter, Balza, Caro et al., 2006). Since the institution of the program in 2006, these percentages changed minimally.

The continued high uptake rates of this voluntary program demonstrated seniors' desire for a prescription drug plan, but as shown in the research many beneficiaries wanted reform of the program. The Commonwealth Fund (2006) stated that 88% of individuals agreed that "plans should be required to use the same terms to describe the same benefits," and three-fourths agreed, "Benefits should be more standardized to reduce the variation among plans." More than

two thirds suggested that the government should simplify the number of Part D plans (Cummings & Rice, 2008). From these findings it seems clear that beneficiaries had difficulty selecting an optimal plan. Nevertheless, beneficiaries who went through the process once had no interest in doing it again, thus demonstrating beneficiaries' reluctance to change plans once enrolled (Dulio, Perry, & Cubanski, 2007). Other beneficiaries felt they were already in the best available plan and therefore had no need to change plans. Those same individuals believed switching to a different plan would not improve their coverage, because they thought all plans were essentially the same (Dulio, Perry, & Cubanski, 2007). These findings were concerning and warranted a close look at possible modifications to the process. Many researchers, including Frank and Newhouse (2007) concluded that simplification would result in more effective consumer choice and a more competitive system.

Limited knowledge was a problem for Medicare in 1965 and was similarly a shortcoming of Part D (Hibbard, Greene, & Tusler, 2006; Sing, Stevens, Cook et al., 2001). Consumer Union found that an inexpensive plan in 2007 was often more expensive the following year, sometimes by more than \$1000. This was not often easily detectable, as premiums did not necessarily rise, consequently making it difficult for consumers to understand the cost burden of their plan. Domino, Stearns, Norton, and Yeh in 2008 reported that during a 1-year period 43% of beneficiaries could have saved money by switching to a different plan. On average, these individuals paid \$500 more by not switching to a different plan. In spite of this, two national studies found that at most, only 10% of PDP beneficiaries planned to switch coverage during open enrollment (Campbell & Morgan, 2007; Domino, Stearns, Norton, & Yeh, 2008). Additionally, Hsu, Fung, Price et al. (2008) estimated that only 40% of beneficiaries were aware

that their drug plan included a coverage gap. These studies raised serious questions about beneficiaries' knowledge of their PDP and the corresponding benefit costs.

In summary, a sizeable, consistent amount of research justified simplification and standardization of Medicare Part D, but this research had limitations. The major limitation of survey data is that it relies on self-report. Questions of validity, reliability, poor memory, and misunderstanding of the questions are all shortcomings of self-reported surveys. In addition, there could be a selection bias in the individuals that choose to respond to a survey. Additionally, surveys are descriptive, not explanatory, and therefore cannot offer any insights into cause-and-effect relationships. On the contrary, surveys are useful in situations where one is interested in collecting data on aspects of behavior that are difficult to observe directly. They provide a descriptive analysis of a large number of opinions, because researchers are capable of surveying large numbers of individuals due to the ease of distribution. Lastly, considering most of the Part D surveys were from 2006 or early 2007 after only one full year of the program, it is possible the data was out-dated.

Against Standardization and Simplification

As mentioned, surveyed beneficiaries frequently claimed general contentment with the program. Without looking further into the complexity of this finding, many policymakers concluded that changes in Part D were unnecessary. Other than this survey finding, arguments against standardization and simplification come from expert opinion. The opposing theory to standardizing and simplifying Medicare Part D through governmental involvement was that the market unabated would simplify and standardize to the extent needed. In theory, individuals chose PDPs that resulted in the least amount of out of pocket spending and in doing so chose their individual optimal plan. This process would drive out unnecessary and unneeded plans, as a

result simplifying Part D. Similarly, the market would undergo standardization when consumers demanded it. Other health policy experts were absolutely against standardization, believing that plan flexibility was the key factor in driving down program costs (Hoadley, 2008).

Some Medicare administrators pointed out market forces have already started to drive towards simplification (McClellan, 2006). One example was the increase in use of specialty tiers after the programs first year (Hoadley, 2008). Further evidence included plans creating innovative approaches to drug coverage during the gap (Hargrave, 2008). Also, in response to beneficiaries enrolling in fewer plans with standard benefit design, the market offered more PDPs with enhanced benefit designs. An additional argument from experts suggested that waiting to standardize the benefit design would provide more time to closely examine the preferences that beneficiaries reveal when selecting plans (Hoadley, 2008).

In defense of policymakers, individuals have commonly noted general contentment with individual plans. This, in combination with individual reluctance to change PDPs, provided the illusion that individuals chose optimal plans, were generally happy with their plans, and did not feel it necessary to change plans. Even as recently as 2009, the Pharmaceutical Research and Manufacturers of America (PhRMA) noted that the competitive market approach to the Medicare drug benefit worked well as it was saving beneficiaries and taxpayers more than expected (Carey, 2009).

The major limitations to the arguments against standardization and simplification included unreliable survey data and a lack of data to back-up expert opinion. In fact, most of the arguments against standardization and simplification were based solely on theories. For these theories to be legitimate, the basic constructs and assumptions of the theories must be valid and verified, and as shown, previous studies casted doubt upon many of these assumptions. Since

previous studies already insinuated that beneficiaries were not choosing their optimal plan, this present study will not further evaluate this supposition. Specifically, this present study highlighted changes and trends in the benefit characteristics of plans since 2006. Overall, it aimed to provide a broad view of the stand-alone market's response to consumer demand. The information discovered in this current study provided further data to reinforce or refute invalidated expert opinions.

Stand-alone PDPs

While there was a significant amount of research on Medicare Part D, only one major group of researchers focused on stand-alone PDPs. Since 2006, Kaiser Family Foundation (KFF) produced numerous reports on benefit design and enrollment. In addition, Hoadley, Hargrave et al. published a report comparing benefit designs in 2006 and 2007.

Since 2006, the number of stand-alone PDPs increased in the United States. The number of PDPs increased by 30% from 2006 to 2007, from 1,429 to 1,875. Every state noted an increase. Alaska, Arkansas, and Ohio had the largest increases (Hoadley, Hargrave et al., 2006).⁴ In 2008, there were 1,824 stand-alone PDPs followed by 1,689 in 2009 (KFF, 2008). In November of 2007, KFF estimated that sponsors serving almost all regions of the country offer 85% of all stand-alone PDPs (Hoadley, Hargrave et al., 2006). In addition, the market appeared dominated by a small number of organizations where 15 organizations represent 88% of all PDPs (Hoadley, Hargrave et al., 2007).

The benefit design of PDPs was either basic or enhanced. The basic plan offered a standard benefit design established by CMS annually. Enhanced plans offered a benefit design

⁴ Alaska, Arkansas and Ohio each increased by 18 PDPs from 2006 to 2007.

that surpassed CMS' minimum benefit requirements.⁵ Plans offering enhanced benefits increased from 43% in 2006 to 47% in 2007 while only accounting for around 17% of enrollees in 2006. Basic plans increased from 9% in 2006 to 12% in 2007. Low-income subsidy eligible plans carried more than three-fourths of enrollment in 2006, while only constituting 28.6% of PDPs (Hoadley, Hargrave et al., 2006). In 2009, approximately half of enrollees were in LIS PDPs with about a quarter of stand-alone PDPs qualifying as LIS-eligible (Hoadley, Hargrave, & Cubanski, 2008).

The major benefit characteristics included were premium variability, deductible variability, and type of coverage in the gap. In 2006, the majority of individuals (48%) enrolled in plans with premiums between \$20 and \$30, dissimilar to the distribution of plans offering premiums from \$20 to \$30 accounting for 22% of plans (Hoadley, Hargrave et al., 2006). The weighted average monthly premium in 2006 was \$25.93 and climbed steadily since then to the projected total of \$37.29 in 2009. In 2009, premiums ranged from \$10.30 to \$136.80, a contrast to 2006 where only one plan had a monthly premium more than \$100 (Hoadley, Thompson et al., 2008).

The standard deductible, as established by CMS, rose annually from \$250 in 2006 to \$295 in 2009. The number of PDPs available that offer the standard deductible, less than the standard deductible, or no deductible remained relatively unchanged from 2006 to 2007. Since 2006, the number of plans offering no deductible continued to stay around 60%, while the proportion of plans offering the standard deductible remained at about a third (Hoadley, Hargrave et al., 2006). In 2009, 45% of PDPs charged a deductible with 34% charging the

⁵ A proportion of these enhanced plans were actuarially equivalent to basic plans. CMS established a standard benefit design annually. CMS allowed sponsors to offer PDPs that were actuarially equivalent to the basic plans. Sponsors could also offer PDPs with an increase in benefits. CMS determined what benefits were actuarially equivalent. One can obtain these actuary tables through CMS.

standard amount. On the other hand, the percentages of plans that offer some type of gap coverage increased slightly since 2006 from 15% to around 30% in 2008 but have since dropped back down to 25% in 2009 (KFF, 2008).⁶

However, there were several limitations to these reports. For one, the data was all cross-sectional in nature. As a result, there were no cause-and-effect inferences. Also, these data reports used descriptive statistics alone, rather than making any correlative or inferential conclusions. Lastly, the cross-sectional data on stand-alone PDPs both nationally and locally was scattered among many different reports from 2006 through 2009 making the data collection process tedious and lengthy. Fortunately, Hoadley et al. published a report near the end of 2006 combining 2006 and 2007 data, but since then, no reports have been as cumulative or comprehensive. This research was the first since 2006 to have such a large and inclusive scope on stand-alone benefit characteristics.

Previous data on stand-alone PDPs suggested minimal change in the PDP market from 2006 to 2009. It appeared there was a larger initial change in benefit offerings from 2006 to 2007, but subsequent data reports from 2008 and 2009 suggested that this was overly inflated. The majority of the literature warranted simplification and standardization of Medicare Part D. A lesser amount of research favors the fact that the market responded adequately to consumer demand. This review of the literature helped to elicit the direction of the program and provided a sense of what changes may have been beneficial to the program. This past research was fragmented, noncomprehensive, and accumulative. This present study aimed to identify trends in the PDP benefit design providing further evidence for or against the standardization and simplification of Medicare Part D. In part, this current analysis underscored the role of the free

⁶ CMS defined the gap in coverage also known as the “doughnut hole” as the period of time in which Part D enrollees were required to pay the full cost of their drugs until they qualified for catastrophic coverage, in which case they would then be reimbursed for drug purchases again.

market on Medicare Part D, but most importantly, the results provided a general direction for the program and implicated certain policy changes.

Methods

Data on Medicare Part D from Centers for Medicare and Medicaid Services (CMS) was available since January 2006. The following research focuses on the characteristics of stand-alone PDPs, as part of Part D. This research utilizes data on the characteristics of plan benefits from the CMS “landscape” files. Centers for Medicare and Medicaid Services annually release this file. It contains information on every state and every available stand-alone PDP.⁷ CMS collected the data and released the “landscape” files in November of 2005, November of 2006, September of 2007, and September of 2008. CMS’ plan finder and Kaiser Family Foundation provided data verification in several instances. However, only the CMS landscape files contained all data on PDP availability and Ohio enrollment for 2009. Kaiser Family Foundation provided national enrollment data of PDPs for 2009. This information was also available through CMS.

Variables:

Using the four CMS landscape files, this research reports on the number of PDPs available (dependent variable) with the specified benefit characteristics (independent variables) of stand-alone PDPs in Ohio and the United States as a whole. This research presents summary statistics on each of the following independent variables on a state and national level.

- Type of Benefit
 - o The benefit type variable was either basic or enhanced. CMS established the minimum benefits for PDPs annually. Basic PDPs offered the minimum benefits established by CMS. Enhanced plans offered additional benefits.

⁷ This research focuses solely on stand-alone prescription drug plans. It does not include Medicare Advantage plans nor does it include employer sponsored stand-alone PDPs.

Some plans offered a different set of benefits that were actuarially equivalent to basic PDPs. CMS regarded these plans as enhanced. When available, this research separated the actuarially equivalent plans from the enhanced plans.

- Low-Income Subsidy Plan Availability
- Monthly premium amount
- Deductible
 - o None, Less than Standard Deductible, or Standard Deductible
- Type of drug coverage within the coverage gap
 - o None, Generics, Many Generics, Some Generics, Preferred Generics, and Generics & Brands

This analysis examines PDP availability for each of these independent variables from 2006 through 2009 using the four aforementioned “landscape” files. This analysis demonstrates the similarities and differences in availability from year to year along with a comparison between the United States and Ohio. In addition, this research presents plans in Ohio with the highest enrollment in 2009 along with the monthly premiums and the deductibles of these plans. Also, this research compares the national sponsors with the highest enrollment to PDPs in Ohio with the highest enrollment.⁸ All summary statistics, tables, and figures were created using Microsoft Excel 2004.

Results

PDP Availability

Table 1 summarizes the distribution of stand-alone PDPs in the United States from 2006 to 2009. From 2006 to 2009, the number of PDPs nationwide ranged from a low of 1,429 in 2006

⁸ Enrollment data on stand-alone PDPs incorporated both individuals enrolled automatically as part of the LIS program and individuals that enrolled in a stand-alone PDP, rather than a MA-PD plan or a plan with creditable coverage.

to a high of 1,875 in 2007. There was a 31% increase in available plans from 2006 to 2007. Plan availability was relatively unchanged from 2007 to 2008. Subsequently, from 2008 to 2009, there was a 7% decline in plan availability from 1,824 to 1,689. In comparing benefit design in 2006 and 2007, there was a 4% increase in PDPs with enhanced design in 2007 (from 43% to 47%). CMS established PDPs as either basic or enhanced. PDPs that offered the standard benefit design, as established by CMS annually, were termed basic. CMS classified all other PDPs as enhanced. There were a proportion of enhanced plans that were actuarially equivalent to the standard benefit design. Centers for Medicaid and Medicare Services deemed benefit designs actuarially equivalent when their value was the same based on CMS' actuarial assumptions. Benefit design in 2008 and 2009 was not available.

Table 2 summarizes the distribution of PDPs in Ohio from 2006 to 2009. In Ohio the number of available stand-alone PDPs between 2006 and 2009 ranged from a minimum of 43 in 2006 to a maximum of 60 in 2007. In 2008 and 2009, the amount of available plans declined. There were 49 available plans in 2009. In terms of benefit type, the proportion of PDPs that offer enhanced benefits increased from 2007 to 2009 (from 45% to 53% of available plans), although the absolute number of plans in Ohio stayed about the same.

Tables 3 and 4 provide the sponsors with the highest national enrollment and the PDPs in Ohio with highest enrollment in 2009, respectively. In 2009, 72% of beneficiaries enrolled in 10 PDPs, and 89% of beneficiaries enrolled in 20 PDPs. Nearly 23% of individuals in Ohio enrolled in the AARP preferred plan sponsored by United Health Care. The PDP with the second highest enrollment, Humana Enhanced, had only 9% of the market share. In 2009, only one of the ten most highly enrolled PDPs in Ohio was not also one of the top enrolling sponsors nationally. This PDP sponsored by First Health Part D carried 3% of the market share in Ohio. In 2009,

organizations that offered at least one plan in all fifty states and the District of Columbia sponsored 47 of the 49 PDPs in Ohio. UPMC and Bravo were the only two organizations not available nationwide.

As shown in Table 5, after 2006, there was a steady decline in PDPs available for low-income-subsidy (LIS) in the U.S. from 29% in 2006 to 18% in 2009.⁹ Table 6 demonstrates the distribution of LIS PDPs. In 2009, the proportion of PDPs in Ohio available to LIS beneficiaries was 12%. This demonstrates an 11% decline since 2006. The number of LIS plans has ranged from a minimum of 6 in 2009 to a maximum of 22 in 2007.

PDP Premiums and Deductibles

Table 7 summarizes the distribution of stand-alone PDPs in the United States by monthly premium from 2006 to 2009. In 2009, 76% of PDPs had premiums between \$20 and \$50. In 2006, 82% of PDPs had premiums between \$20 and \$50. The proportion of plans in 2009 with above \$60 was much larger compared to 2006. In 2006, 5% of plans had premiums above \$60. This percentage rose to 23% in 2009. The proportion of plans with premiums above \$50 increased from 16% in 2006 to 30% in 2009. The average (unweighted by enrollment) monthly premium in 2009 was \$45.45 up from \$37.43 in 2006.

Table 8 displays the premium distribution of stand-alone PDPs in Ohio. The majority of premiums fall in the range of \$20 to \$50. In 2009, 69% of PDPs had premiums between \$20 and \$50, and in 2006, 74% had premiums in that range. A higher proportion of plans in 2009 were in the \$60 to \$100 range compared to 2006. The proportion of plans with premiums over \$50 increased from 20% in 2006 to 29% in 2009. There were never any plans in Ohio with premiums

⁹ Medicare beneficiaries who qualified for full Medicaid benefits (dual eligibles), those enrolled in Medicare Savings Programs (MSP), and those who received the Supplemental Security Income (SSI) were automatically qualified for the LIS. Other beneficiaries qualified for full or partial subsidies if they met certain income and asset standards (KFF, 2008).

over \$100 per month. The average premium of PDPs increased between \$8 and \$10 since 2006. In 2009, the average unweighted premium in Ohio is \$44.33. Table 9 illustrates the premiums of the most highly enrolled PDPs in Ohio. The average monthly premium of these plans is \$32.47. The monthly premium of the AARP enhanced plan was \$38.20. This plan has a strong influence on the weighted average premium because of it encompasses nearly one-fourth of the market share.

As displayed in Table 10, the percentages of plans offering the standard deductible in the U.S. were relatively unchanged since 2006. The standard deductible, indexed to grow annually with per capita Part D spending, increased from \$250 in 2006 to \$295 in 2009. About a third of all PDPs offered the standard deductible from 2006 through 2009. In 2009, the majority of PDPs (56%) did not have a deductible, as was the majority in 2006 (58%). Additionally, there was only a small change in the percentage of plans offering less than standard deductible (from 8% in 2006 to 11% in 2009).

Table 11 displays the distribution of PDPs in Ohio by deductible amount from 2006 to 2009. Ohio follows the same overall national trends with about a third of all PDPs offering the standard deductible from 2006 through 2009. In 2009, the majority of PDPs (57 percent) did not have a deductible, similar to 2006. Five percent of plans had a deductible lower than the standard amount in 2009, compared to 3 percent in 2006. Table 12 lists the ten PDPs with the highest enrollment in Ohio for 2009 with their corresponding deductible amount. Among these ten PDPs, four have no deductible and five have the standard deductible.

PDP Gap Coverage

Since 2006, sponsors offered a mixture of different types of gap coverage including covering all generics, covering few too many generics, and covering certain “preferred”

generics.¹⁰ Table 13 demonstrates the national distribution of PDPs by type of gap coverage from 2006 to 2009. Since 2006, a 10% increase occurred in amount of plans offering some type of gap coverage. In 2009, 24% of plans offered some coverage. Fourteen of the twenty four percent covered the majority of generics during the coverage gap. There were only three plans in 2009 that covered any brand name drugs. These three plans covered only a small fraction of brand name drugs. In 2006 and 2007, a larger share of the PDP market covered brand name drugs. In general, since 2006, there was an overall decline in PDPs covering all generics during the gap. In 2009, only 6% of plans covered all generics during the gap.

Table 14 demonstrates the distribution of PDPs in Ohio by type of gap coverage from 2006 to 2009. The number of PDPs with any type of gap coverage increased from 7 in 2006 to 12 in 2009. This was an increase from 16% in 2006 to 24% of available plans in 2009. The only PDPs that offered gap coverage in 2008 and 2009 offered generic-only coverage. In 2006 and 2007 one plan offered coverage of brand-name drugs. In 2009, none of the ten most popular PDPs in Ohio offered gap coverage. Overall, only 7% of enrollees in Ohio enrolled in plans with gap coverage. Figure 1 compares the average premium for plans by type of gap coverage. The average monthly premium for plans with some type of gap coverage in 2009 is \$67.50 compared to a premium of \$35.89 in plans without gap coverage.

Discussion

This analysis highlighted valuable information about the direction of Part D. From 2006 to 2009, the largest changes in Ohio occurred in overall PDP availability, plans available for subsidy, and plans offering gap coverage. Additionally, from 2006 to 2009, there was a gradual increase in the unweighted average monthly premium, but there were only minimal changes in

¹⁰ CMS defined gap coverage as the period of time in which Part D enrollees were required to pay the full cost of their drugs until they qualified for catastrophic coverage. Sponsors began offering plans that helped mediate this otherwise 100% out of pocket cost by offering varying degrees of gap coverage.

the percentages of PDPs offering the standard deductible. Overall, this research identified the same trends at the Ohio statewide level and the United States' national levels.

PDP Availability

During the first two years of the program, surveys suggested the enrollment process was too complicated and many beneficiaries desired simplification (KFF, 2006; Dulio, Perry, & Cubanski, 2007). Despite this, in 2007, PDP availability increased in Ohio and on a national level by 40 and 31 percent respectively. Availability remained unchanged in 2008. Additionally, the results indicated a decline in availability from 2008 to 2009, however, there were still more PDPs available in 2006 than in 2009. The decline from 2008 to 2009 suggests that the market responded to beneficiary demand by dropping their unpopular plans. However, the only decline in availability was from 2008 to 2009, which makes it difficult to conclude that this is a definitive trend in the market.

Interestingly, from 2006 to 2009, the results demonstrate that PDP availability increased for non-LIS beneficiaries. Since 2006, the proportion of PDPs eligible for LIS declined significantly in both the U.S. and Ohio. Therefore, despite the overall decline in PDPs from 2008 to 2009, there was an increase in PDPs available to non-LIS beneficiaries. These results suggest a lack of choice for non-LIS beneficiaries in both Ohio and on the national level. Previous survey data suggests beneficiaries believe there are too many PDPs to choose from. Additionally, previous research on human behavior suggests that beneficiaries are not capable of choosing their individual best plan when faced with so many options. (Cummings & Rice, 2008; Dulio, Perry, & Cubanski, 2007; Hibbard, Slovic, Peters et al., 2000; Hoadley, 2008; Iyenger, Huberman, & Jiang, 2004; O'Brien & Hoadley, 2008; Schwartz, 2004; Scott, 2000).

In Ohio 96% of beneficiaries enrolled in plans that were available to all beneficiaries nationwide. The remaining 4% enrolled in plans only available to beneficiaries within the state of Ohio. In 2008, Ohio had only two PDPs that were not available nationwide. Only one of these plans carried noteworthy enrollment (3.6%) and ranking eighth in total Ohio enrollment. In Ohio, 72% of individuals enrolled in 10 of the 58 PDPs. One PDP in Ohio, the AARP Medicare Preferred plan, captured 23% of the market share. These results reveal a PDP market dominated by larger nationally run corporations perhaps with added advantages over smaller state run organizations.¹¹

PDP Premiums

The results illustrate a consistent increase in the average of prescription drug plan premiums both statewide in Ohio and on the national level since 2006.¹² The results also show that the average premium of the most popular PDPs in Ohio (accounting for 2/3 of enrollees) was significantly lower than the average of all PDPs in 2009. These results suggest that beneficiaries enrolled in plans with lower premiums. National studies also demonstrated that beneficiaries chose plans with lower premiums more frequently (Hoadley, Hargrave et al., 2006). Based on these findings, beneficiaries continue to demand and enroll in plans with lower premiums despite sponsors offering increasingly more plans with higher premiums. Previous studies examined this discrepancy and concluded that beneficiaries focus on monthly premium over other benefit characteristics (Gold, Achman, & Brown, 2003).

PDP Gap Coverage

The percentage of plans offering gap coverage increased 10% over the past four years in Ohio and the U.S. Despite this, 93% of individuals in Ohio enrolled in plans without gap

¹¹ This idea is also known as economies of scale.

¹² The health care inflation rate for 2006 was 6.7% and in 2007 it was 6.1% (Hartman et al, 2007)

coverage—a figure unchanged since 2006 (Hoadley, Hargrave et al., 2006). Contrary to enrollment data, previous surveys suggested an overwhelming desire for increased coverage during the coverage gap (Dulio, Perry, & Cubanski, 2007). Previous studies also demonstrated that adherence to medications declines during the coverage gap (Yin, Basu et al., 2008; Lichtenberg, Frank, & Sun, 2007; Madden, Graves et al. 2008). In this example, it seems the PDP market responded to both consumer desire and consumer need, but consumers appeared disinterested in plans with gap coverage. Results reveal that PDPs with gap coverage have significantly higher monthly premiums than plans without. This increase in premium could be one reason why sponsors have not seen more beneficiaries enrolled in PDPs with gap coverage. As previously mentioned, Gold, Achman, & Brown (2003) suggest this to be the case.

Policy Implications

Both survey data and research on human behavior recognized a benefit to beneficiaries choosing from a limited number of PDPs (Hibbard & Peters, 2003; Iyengar & Lepper, 2000; Mobley, McCormack, & Wang, 2005). The results of this current study demonstrated that since 2006, PDP availability increased for beneficiaries who did not participate in auto-enrollment. Based on this finding, it would be beneficial for CMS to consider methods limiting the number of choices to beneficiaries. It would also be beneficial to simplify the selection process in a manner that allows for optimal plan selection. In 2008, CMS allowed beneficiaries to sort plans based upon gap coverage, annual deductible, drug cost sharing, summary rating of PDP quality (customer satisfaction rating), national availability, formulary, and coverage of brand name medications. This provides opportunity for individuals to simplify their available choices, however, this analysis and previous research suggest that beneficiaries placed a heavy priority on choosing a plan with a low premium and one that was available nationwide. As a result, CMS

may want to consider different modes of simplification whereby beneficiaries incorporate other benefit characteristics into the decision making process.

CMS and policymakers should consider continued promotion of plans that offer coverage during the gap. The literature suggests that during the coverage gap beneficiaries skip doses, choose not to refill medications, and self-prescribe in ways that are not conducive to their health (Yin, Basu et al., 2008; Lichtenberg, Frank, & Sun, 2007; Madden, Graves et al., 2008). Previous research also suggests that these habits may cause increased costs to Medicare A and B by increasing disease exacerbations and hospitalizations (Yin, Basu et al., 2008; Lichtenberg, Frank, & Sun, 2007; Madden, Graves et al., 2008). More importantly, previous surveys suggested that many more than the 5-7% of beneficiaries in PDPs with gap coverage wish to be in plans with coverage during the gap (KFF, 2008). Policymakers should consider the low enrollment in PDPs offering gap coverage as problematic and as an opportunity where Part D can be improved. Future research should also continue to examine the effect of this gap in coverage.

Previous research has not identified an association between the quality of the PDP and monthly premium, so it is unknown if choosing a plan with the lowest monthly premium is beneficial to beneficiaries. However, typically the increase in monthly premium dictates an increase in coverage. As mentioned, an absence of coverage during the gap often necessitates poor compliance with prescription medications (Yin, Basu et al., 2008; Lichtenberg, Frank, & Sun, 2007; Madden, Graves et al., 2008). Based on this research, it appears unlikely that choosing a plan with the lowest premium is a prudent selection. Future research examining monthly premium as a predictor of beneficiary enrollment is important for future policymaking decisions. Using enrollment data from 2006 through 2009, researchers need to identify which benefit characteristics have the strongest association with enrollment. In addition, researchers

should look for associations between enrollment and formulary, customer satisfaction, gap coverage, deductible, LIS, and nationwide availability. These associations will provide further insight into which factors are most important to beneficiary plan choice. Finally, future research should examine which factors, besides coverage during the gap, positively or negatively affect health outcomes. Then, policymakers will be able to reinforce systems that do not allow beneficiaries to make decisions based on superfluous factors.

Limitations

This current study has a number of limitations. First, the nature of this data does not allow one to determine causality. Second, complete enrollment data was unavailable. By obtaining state enrollment in Ohio along with national enrollment from 2006 through 2009, more clearly defined relationships and trends could be identified. It would also be advantageous to have individual enrollment data to help identify which plans beneficiaries choose to switch to and from. Third, it took a longer than expected amount of time to sort through the raw data. If more time were available, other benefit characteristics could be analyzed. The exclusion of formulary and customer satisfaction as variables are recognized limitations. Researchers hypothesized that a significant factor in beneficiary choice was based on which brand name medications were included on the plan's formulary. Fortunately, this previous research supplies a template whereby one identifies how many of the ten most prescribed brand-name medications are on each PDP's formulary. Using this information, a researcher could correlate enrollment with number of medications on the formulary. Preliminary data reveals that plans with higher enrollment often list all ten of the most prescribed medications on their formulary. Researchers could use a similar model for customer satisfaction ratings. Despite this limitation, the

conclusions about the studied variables are still noteworthy. It should just be noted that this analysis does not include all factors that influence the decision to enroll in a specific PDP. It should also be mentioned that previous national studies support the same trends identified in this current study. So despite its limitations, this current study replicated the findings of previous studies.

Conclusions

This current research hypothesized that the smaller market of Ohio would reflect changes and trends in benefit characteristics not seen on the national level due to its size. However, this research identified the same state trends also observed nationally. The striking similarities between the U.S. and Ohio are likely a product of national sponsorship dominating the market. In general, the similarities between Ohio and the U.S. suggest that conclusions made about Ohio's enrollment in 2009 are applicable nationally.

This research provides a cumulative and comprehensive view of the PDP market. There are several key conclusions based on the snapshots and comparisons of benefit characteristics. Despite the overall decline in PDP availability from 2008 to 2009, the evidence shows that PDP availability is increasing for beneficiaries that do not enroll in LIS PDPs. Evidence also suggests that beneficiaries are choosing to enroll in PDPs with the lowest monthly premium. This appears to be an important factor in the process of choosing a PDP.

In concluding, it is important to discuss the general direction of Medicare Part D. This current analysis revealed that a small number of national sponsors dominated the market, and one PDP controlled 23% of the market share. While, sponsors continued to offer more plans with gap coverage, 93% of beneficiaries enrolled in plans without gap coverage. Previous research on

patient adherence to prescription medications suggests that beneficiaries need to enroll in plans that offer coverage during the gap. So, in general, this analysis demonstrated that market forces might be capable of responding in a fashion that best serves Medicare beneficiaries, but this can only occur when beneficiaries choose optimally. Currently, there is no evidence to suggest that the process has led beneficiaries to choose the utility maximizing plan.

Based on previous and this current research, there is still some uncertainty which direction the free market model will drive Part D. The only evidence of simplification was the decline in overall availability from 2008 to 2009. So, to state this decline implies simplification would simply be incorrect. In the future, it is imperative that policymakers and CMS continue to evaluate the enrollment process to ensure that the assumptions behind The Rational Choice Theory are being met. In the end, policymakers must realize that the aim of Part D is to improve health outcomes for beneficiaries, and if future research suggests that beneficiaries are not choosing plans that promote health, the program should be re-evaluated.

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Appendix

Table 1
Distribution of stand-alone PDPs in U.S., by type of benefit, 2006-2009

Benefit Type	2006 Plans		2007 Plans		2008 Plans	2009 Plans
	Number	Percent	Number	Percent	Number	Number
Basic	132	9.2%	228	12.2%	n/a	n/a
Actuarially Equivalent ^a	689	48.2%	760	40.5%	n/a	n/a
Enhanced	608	42.5%	887	47.3%	n/a	n/a
Total	1429	100.0%	1875	100.0%	1824	1689

Note. In 2008 and 2009, the benefit type of PDPs was not easily identified and therefore excluded. This information is in the CMS landscape files. ^aCMS establishes a standard benefit design annually. CMS allowed sponsors to offer PDPs that were actuarially equivalent to the basic plans. Sponsors could also offer PDPs with an increase in benefits. CMS determined what benefits were actuarially equivalent. One can obtain these actuary tables through CMS.

Table 2
Distribution of stand-alone PDPs in Ohio, by type of benefit, 2006-2009

Benefit Type	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Basic	n/a		33	55.0%	29	50.0%	23	46.9%
Enhanced	n/a		27	45.0%	29	50.0%	26	53.1%
Total	43		60	100.0%	58	100.0%	49	100.0%

Note. In 2006, the benefit type of PDPs was unable to be found.

Table 3
PDP Offerings among sponsors with highest enrollment nationally in 2009

Organization Name	Plan Name
Humana	Humana PDP Complete
Humana	Humana PDP Enhanced ^a
Humana	Humana PDP Standard ^a
United Health Care	AARP MedicareRx Preferred
United Health Care	AARP MedicareRx Enhanced
United Health Care	AARP MedicareRx Saver ^a
United Health Care	United Health Rx Basic
Universal American	Community CCRx Basic ^a
Universal American	Community CCRx Choice
Universal American	Community CCRx Gold
WellCare	WellCare Classic ^a
WellCare	WellCare Signature
UniCare	MedicareRx Rewards Standard
SilverScript Insurance Co.	SilverScript Complete
SilverScript Insurance Co.	SilverScript Plus
SilverScript Insurance Co.	SilverScript Value ^a
Anthem Blue Cross and Blue Shield	Blue MedicareRx Plus
Anthem Blue Cross and Blue Shield	Blue MedicareRx Premier
Anthem Blue Cross and Blue Shield	Blue Medicare Rx Value ^a
Health Net	Health Net Orange Option 1
Health Net	Health Net Value Orange Option 2
RxAmerica	Advantage Freedom Plan by RxAmerica
RxAmerica	Advantage Star Plan by RxAmerica

Note: Enrollment data on national sponsors found through Kaiser Family Foundation. ^a Denotes a PDP in the top ten most highly enrolled PDPs in Ohio

Table 4
Most highly enrolled stand-alone PDPs Ohio and corresponding sponsor in 2009

Organization Name	Plan Name	Enrollment	Percentage of Total Enrollment
United Health Care	AARP MedicareRx Preferred	119642	22.7%
Humana Insurance Company	Humana PDP Enhanced	47428	9.0%
Universal American	Community CCRx Basic	45890	8.7%
Humana Insurance Company	Humana PDP Standard	31436	6.0%
SilverScript Insurance Company	SilverScript Value	29426	5.6%
Anthem Blue Cross and Blue Shield	Blue MedicareRx Value	26171	5.0%
WellCare	WellCare Classic	25064	4.8%
First Health Part D	First Health Part D-Premier ^b	18997	3.6%
WellCare	WellCare Signature	15804	3.0%
United Health Care	AARP MedicareRx Saver	13963	2.6%

Note. Enrollment data obtained through CMS. ^b Denotes only plan in Ohio's top enrolled PDPs that is not in top nationally enrolled PDPs

Table 5
Distribution of stand-alone PDPs in the U.S., by eligibility for enrollment of low-income subsidy beneficiaries for zero premium, 2006-2009

Eligible for Subsidy	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number ^a	Percent ^b
Yes	409	28.6%	483	25.7%	442	24.2%	~304	18%
Yes, with premium waiver			157	8.4%	53	2.9%		
No	1020	71.4%	1235	65.9%	1329	72.9%	~1385	82%
Total	1429	100.0%	1875	100.0%	1824	100.0%	1689	100%

^a In 2009, the number of PDPs with LIS subsidy was based on percentages provided by Kaiser Family Foundation. Approximations are denoted by ~. ^b Percentages were not provided to the tenth decimal place as is written in other tables. ^c A CMS policy put in place in 2007 allowed LIS beneficiaries that were already enrolled in a PDP to stay in that plan in 2007 if the monthly premium exceeded the low-income benchmark by no more than \$2. In 2009, it is unknown how many PDPs fell into this group.

Table 6
Distribution of stand-alone PDPs in Ohio, by eligibility for enrollment of low-income subsidy beneficiaries for zero premium, 2006-2009

Eligible for Subsidy	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Yes	10	23.3%	22	36.7%	15	25.9%	6	12.2%
No	33	76.7%	38	63.3%	43	74.1%	43	87.8%
Total	43	100.0%	60	100.0%	58	100.0%	49	100.0%

Table 7

Distribution of stand-alone PDPs in U.S., by monthly premium, 2006-2009

Monthly Premium	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under \$20	90	6.3%	104	5.5%	132	7.2%	58	3.4%
\$20-\$30	313	21.9%	619	33.0%	613	33.6%	322	19.1%
\$30-\$40	459	32.1%	503	26.8%	385	21.1%	496	29.4%
\$40-\$50	334	23.4%	432	23.0%	298	16.3%	313	18.5%
\$50-\$60	160	11.2%	74	3.9%	63	3.5%	115	6.8%
\$60 and up	73	5.1%	143	7.6%	333	18.3%	385	22.8%
Total	1429	100.0%	1875	100.0%	1824	100.0%	1689	100.0%

Table 8

Distribution of stand-alone PDPs in Ohio, by monthly premiums, 2006-2009

Monthly Premium	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under \$20	3	7.0%	2	3.3%	2	3.5%	1	2.0%
\$20-\$30	10	23.3%	21	35.0%	20	34.5%	10	20.4%
\$30-\$40	13	30.2%	16	26.7%	14	24.1%	14	28.6%
\$40-\$50	9	20.9%	14	23.3%	11	19.0%	10	20.4%
\$50-\$60	6	13.9%	3	5.0%	1	1.7%	3	6.1%
\$60 and up	2	4.7%	4	6.7%	10	17.2%	11	22.5%
Total	43	100.0%	60	100.0%	58	100.0%	49	100.0%

Table 9

Premiums of plans in 2009 with highest enrollment in Ohio

Organization Name	Plan Name	Premium
UnitedHealthcare	AARP MedicareRx Preferred	\$38.20
Humana Insurance Company	Humana PDP Enhanced	\$39.50
Universal American	Community CCRx Basic	\$27.90
Humana Insurance Company	Humana PDP Standard	\$42.70
SilverScript Insurance Company	SilverScript Value	\$25.10
Anthem Blue Cross and Blue Shield	Blue MedicareRx Value	\$32.00
WellCare	WellCare Classic	\$37.00
First Health Part D	First Health Part D-Premier ^b	\$23.00
WellCare	WellCare Signature	\$33.50
UnitedHealthcare	AARP MedicareRx Saver	\$25.80

Note: ^b Denotes only plan in Ohio's top enrolled PDPs that is not in top nationally enrolled PDPs

Table 10
Distribution of stand-alone PDPs in U.S., by deductible amount, 2006-2009

Deductible	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
None	834	58.4%	1127	60.1%	1069	58.6%	939	55.6%
Less than Standard Deductible	112	7.8%	157	8.4%	148	8.1%	186	11.0%
Standard Deductible	483	33.8%	591	31.5%	607	33.3%	564	33.4%
Total	1429	100.0%	1875	100.0%	1824	100.0%	1689	100.0%

Note. Standard deductible as follows: \$250 in 2006, \$265 in 2007, \$275 in 2008, and \$295 in 2009

Table 11
Distribution of stand-alone PDPs in Ohio, by deductible amount, 2006-2009

Deductible	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
None	25	58.1%	38	63.4%	34	58.6%	28	57.1%
Less than Standard Deductible	3	7.0%	5	8.3%	4	6.9%	5	10.2%
Standard Deductible	15	34.9%	17	28.3%	20	34.5%	16	32.7%
Total	43	100.0%	60	100.0%	58	100.0%	49	100.0%

Note. Standard deductible as follows: \$250 in 2006, \$265 in 2007, \$275 in 2008, and \$295 in 2009

Table 12
Deductible amount of ten PDPs with highest enrollment in Ohio, 2009

Organization Name	Plan Name	Deductible
UnitedHealthcare	AARP MedicareRx Preferred	\$0
Humana Insurance Company	Humana PDP Enhanced	\$295
Universal American	Community CCRx Basic	\$295
Humana Insurance Company	Humana PDP Standard	\$295
SilverScript Insurance Company	SilverScript Value	\$130
Anthem Blue Cross and Blue Shield	Blue MedicareRx Value	\$295
WellCare	WellCare Classic	\$0
First Health Part D	First Health Part D-Premier ^b	\$0
WellCare	WellCare Signature	\$295
UnitedHealthcare	AARP MedicareRx Saver	\$0

Note: ^b Denotes only plan in Ohio's top enrolled PDPs that is not in top nationally enrolled PDPs

Table 13

Distribution of stand-alone PDPs in U.S. by type of coverage in the gap, 2006-2009

Gap Coverage	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent ^c	Number	Percent ^c
None	1209	84.6%	1337	71.3%	~1295	71%	~1266	75%
Generics	187	13.1%	511	27.3%	~255	14%	~101	6%
Many Generics (>65%)							~236	14%
Some Generics (10-64%)					~274	15%	~83	5%
"Few" brand name drugs ^a							3	0.2%
Generics & Brands ^b	33	2.3%	27	1.4%				
Total	1429	100.0%	1875	100.0%	1824	100%	1689	100%

^a "Few" brand name drugs is defined as less than 10% of brand name drugs on the formulary. ^b Of the 27 PDPs in 2007 covering brand-name drugs in the coverage gap, 25 cover all formulary drugs and 2 cover brands and preferred generics. The assumption is that in 2006, the 33 PDPs covering generics and brand-name drugs covered all generics and an unidentified amount of brand-named drugs. ^c Data from 2008 and 2009, the number of PDPs offering varying types of gap coverage from 2008 and 2009 was based on percentages provided by KFF. Approximations are denoted by ~. Percentages were not provided to the tenth decimal place as is written in other tables.

Table 14

Distribution of stand-alone PDPs in Ohio, by type of coverage in the gap, 2006-2009

Type of Gap Coverage	2006 Plans		2007 Plans		2008 Plans		2009 Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
None	36	83.70%	43	71.6%	41	70.7%	37	75.5%
Generics	6	14.00%	16	26.7%	9	15.5%	3	6.1%
Many Generics (>65%)							7	14.3%
Some Generics (10-64%)					2	3.5%	2	4.1%
All Preferred Generics					6	10.3%		
Generics & Brands	1	2.30%	1	1.7%				
Total	43	100.00%	60	100.0%	58	100.0%	49	100.0%

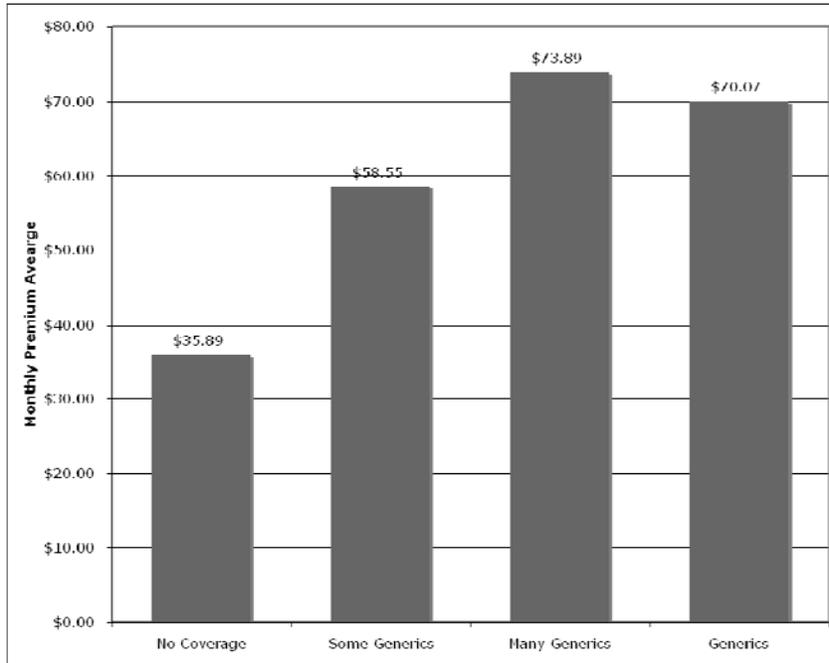


Figure 1: Average monthly unweighted premiums for all PDPs in Ohio by type of gap coverage, 2009

Glossary

MMA – Medicare Modernization Act of 2003

PDP – Prescription Drug Plan

CMS – Centers for Medicaid and Medicare Services

Dual eligibles - Beneficiaries eligible for both Medicare and Medicaid have become known as dual eligibles.

Creditable coverage - The voluntary enrollment process provides beneficiaries the option to enroll in either a MA-PD plan, stand-alone PDP, or from another source that maintains a minimum coverage standard established by CMS (known as creditable coverage).

Benchmark plan – Plans having only the basic benefit characteristics as established by CMS and also eligible to LIS beneficiaries.

KFF – Kaiser Family Foundation

LIS – Low-Income Subsidy

Public Health Competencies Achieved:

Domain #1: Analytic Assessment Skill

- Defined a problem
- Identified relevant and appropriate data and quality sources of information
- Evaluated the integrity and comparability of data and identified the gaps in the data
- Recognized how the data illuminated ethical, political, scientific, economic, and overall public health issues

Domain #2: Policy Development/Program Planning Skills

- Collected, summarized, and interpreted information on a relevant issue
- Articulated the health, fiscal, administrative, legal, social, and political implications of each policy option
- Stated the feasibility and expected outcomes of each policy option

Domain #3: Communication Skills

- Communicated effectively both in writing and orally
- Effectively presented accurate demographic, statistical, programmatic, and scientific information for professional and lay audiences
- Listened to others in an unbiased manner, respected the points of view of others, and promoted the expression of diverse opinions and perspectives

Domain #5: Community Dimensions of Practice Skills

- Described the role of government in the delivery of community health services

Domain #6: Basic Public Health Sciences Skills

- Identified the individual's and organization's responsible within the context of the Essential Public Health Services and core functions
- Defined, assessed, and the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
- Understood the historical development, structure, and interaction of public health and health care systems
- Identified and applied basic research methods used in public health
- Identified and retrieved current relevant scientific evidence
- Identified the limitations of research and the importance of observations and interrelationships
- Developed a lifelong commitment to rigorous critical thinking

List of public health competencies obtained from the "Competencies Project" at

http://trainingfinder.org/competencies/list_levels.htm