MISPERCEPTION IN CHOOSING MEDICARE DRUG PLANS

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ABSTRACT

Choices increasingly abound for various government-supported services, ranging from charter schools to health plans. 24 million elderly Americans have enrolled in Medicare Part D prescription drug coverage during the past two years and may choose among at least 40 plans. Using a conceptual framework in which individuals may misperceive prices in ways that depend on environmental factors, this paper presents a randomized experiment in which one group of seniors enrolled in Medicare drug plans was presented carefully designed personalized information on the potential cost savings from changing to the lowest cost plan while another group received information about how to access the Medicare website, where essentially the same information was available. The study focuses on the 2006 open enrollment period.

In background research on the information environment, we found conditions consistent with misperception: the majority of seniors were not well-informed about drug plans, were satisfied with the plan they had chosen, and did not seek personalized comparative information during open enrollment. Medicare offered personalized information via its help-line and website, but assistance from private sources was limited.

In the experiment, the intervention group plan-switching rate was 28 percent, while the comparison group rate was 17 percent. Regression-adjusted average predicted costs for 2007 were $90 lower for the intervention group as a whole and $199 lower for those potentially affected by the intervention, with no evidence of reduced plan quality. More than 70 percent of the comparison group underestimated their potential cost savings from switching plans. We interpret these and other study results as evidence of misperceived prices.

We conclude that additional efforts to distribute simple, personalized drug plan information would lead to significant reductions in Medicare beneficiaries' costs.

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I. Introduction

Policy makers are increasingly incorporating consumer choice and competition into the provision of government services. Social security, school selection programs and prescription drug insurance are three of the most prominent examples where choice has been proposed or adopted. The rationale for including choice and competition is straightforward. Individuals have heterogeneous preferences over many basic services. Choice allows individuals to select those providers whose services best match their preferences. Competition then facilitates a menu of services being provided at the cost-efficient frontier.

This argument relies on consumers effectively choosing well, being able to consider a menu of service providers and pick the one that best matches their needs. A body of research illustrates the difficulty of choosing and the tendency to focus on easily available, invariant components of prices. For example, an experiment with mutual fund prospectuses showed that subjects overwhelmingly failed to minimize fund fees even though this choice was clearly optimal in light of the experimental setting and structure of subjects' payments (Choi, Laibson, and Madrian, 2008). In Sweden's privatized social security system, investors' choices appeared wiser and led to higher returns ex post later in the program when new participants tended to opt for the default fund than earlier in the program when an effective informational campaign encouraged participants to make their own choices (Cronquist and Thaler, 2004). In the market for credit cards, individuals appear to systematically emphasize annual fees rather than interest rates as though they were not going to borrow, yet they do tend to borrow and then pay high finance charges (Ausubel, 1991). Consumers appear to pay more for identical goods when costs are shifted into add-ons (shipping, hotel phone calls, re-stocking fees); consumers react to nominal prices more than real prices, etc; for reviews, see DellaVigna (2009) and Ellison (2006). In the case of Medicare Part D, many observers have highlighted seniors' difficulties with plan choice; further standardizing benefits and improving information are among the commonly suggested remedies. See, for example, Hoadley (2008) and Frank and Newhouse (2007).

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 average consumer surplus without restricting individual freedom of choice. Several recent studies have employed this logic in designing and testing interventions that alter choice environments and influence choice behavior. In the context of Mexico's privatized social security program, an experiment presenting fees in pesos instead of annual percentage rate to

financially illiterate workers caused much more focus on fees when selecting between hypothetical investment funds; the implied changes in demand elasticity from changing information formats could have a substantial effect on market prices (Hastings and Tejeda-Ashton, 2008). In a study of school choice, parents were more likely to choose a school with higher average test scores after receiving publicly available information about the scores of schools, and their children improved their own test scores after attending a higher-scoring school (Hastings and Weinstein, 2008). In a study of sales taxes, posting the after-tax price (as opposed to having it added at the register) significantly reduced product demand even though the after-tax prices were the same (Chetty, Looney, and Kroft, 2009). In the case of Medicare, the release of HMO report cards in 1999 and 2000 appeared to increase enrollment in higher quality plans (Dafny and Dranove, 2008).

This paper uses a conceptual framework of misperceived prices to explore the relevance of the information environment for seniors choosing Medicare Part D prescription drug insurance plans. The Medicare prescription drug benefit was established as part of the Medicare Modernization Act of 2003, with coverage first beginning in January 2006. The drug benefit was subsidized, with Medicare paying about three-quarters of the premium. Medicare beneficiaries were offered the opportunity to voluntarily enroll in drug coverage either through a free-standing plan (complementing fee-for-service health insurance through Medicare) or through a Medicare Advantage plan (often a health maintenance organization). After the introduction of the benefit, the percentage of Medicare recipients with drug coverage increased from about 67 to 90 percent, although analyses suggest that many of the remainder would also benefit if they were to enroll (Heiss, McFadden, and Winter, 2006).

Previous research looking at the health insurance components of Medicare has found that elderly beneficiaries seldom engage in the choice process (Gold, Achman, and Brown, 2003). One basic building block of informed choice is understanding differences among choices, yet comprehension of comparative information presented in the most frequently used formats of charts and tables appears to diminish substantially with age (Hibbard, 2001). Medicare beneficiaries indicate that some decisions about health plans are important and difficult, but few seek help (McCormack and Garfinkel, 2001). Interestingly, research into the decision making of older adults finds that perhaps the most important trait to emerge with age is an increased reluctance to make decisions (Mather, 2006). One study, for example, found that only 10 percent of older adults who both were willing to consider total joint arthroplasty and were perfect candidates chose to have it. Ensuing interviews revealed that, rather than actually deciding against the treatment, these older

adults had merely tended to defer the decision until some underdetermined later date (Hudak et al., 2002).

In this paper we use a randomized experiment and examine whether people respond to slight perturbations of the information environment in a way that is consistent with our concept of misperceived prices. No normative judgment is made on what constitutes a good choice, although we do collect and analyze available measures of seniors' experiences and plan quality. We focus on plan selection among those who are already enrolled in a free-standing plan, who are not receiving a low-income subsidy (where the benefits for individuals across plans are more standardized), and who are 65 years of age or more.[1] These individuals were typically choosing from among 40-60 plans, depending upon where they lived. The plans differed along a variety of dimensions, including amount paid every month (premium), how out-of-pocket expenses vary with total drug expenditures (co-payment schedule), coverage of drugs and dosages (formulary), utilization management tools (prior authorization, step therapy, quantity limitations), pharmacy accessibility, mail order discounts, customer service, and financial stability of insurer. With the large number of plans and the many dimensions to consider, making an informed choice was complicated. In particular, the costs of plans differ substantially depending upon the prescriptions that individuals may take. Medicare offered assistance with predicting costs over the internet and via telephone.

Section II provides a conceptual framework for our analysis of plan choices. Section III uses new data (two cross-sectional surveys, several audits of information sources) to briefly characterize seniors' demand for information and knowledge of Medicare drug plans as well as the supply of information and to provide context for the experimental results. Section IV describes the experiment and its results, while Section V discusses intervention costs relative to participants' savings and possible Medicare savings. Section VI concludes.

II. Conceptual framework

To highlight key aspects of the choice of prescription drug plans, we start with a Perloff and Salop (1985) model of consumer preferences for differentiated products. In the standard model, there are n plans and a finite number of consumers L, each of whom has no monopsony power. Each consumer chooses the plan that maximizes her net surplus s_{il}, $= b_{il} - p_{il}$:

[1] Other research has examined the market structure and plan dimensions, such as the factors involved in premium setting (Simon and Lucarelli, 2006) and the willingness to pay for features such as gap coverage (Heiss, McFadden, and Winter, 2007). The cost management strategies do appear to have encouraged people to switch to cheaper medications (Neuman et. al, 2007). Utilization has increased, while seniors' expenditures have decreased (Yin et al, 2008).

(1) $S_l^* = \max_i s_{il}$

s_{il} is the surplus of person l in the i-th plan, p_{il} is its price, and b_{il} is an element of the consumer's preference vector $\mathbf{b}_l = (b_{1l}, b_{2l}, \ldots, b_{nl})$. The b_{il} term measures the aggregated utility of plan-specific characteristics such as convenience and quality.

An alternative posits that individuals do not choose based on actual price p_{il} but on their perception of the price which we denote by $p'_{il}(C)$. The word "perception" is used to emphasize a process that is potentially subjective and depends on the environment. C here denotes exogenous features of the choice environment that may affect the nature and extent of misperception.[2] The choice environment captures the way information is distributed and presented, which in psychologically richer models can affect actions and beliefs even beyond their effects on the effort required to collect and process information. This may include advertising or presentations which simplify the information set. The key assumption in what follows is that we are focusing below on a specific instance of C which should not affect the choice in (1). Thus, the consumer perceives surplus to be $s'_{il} = b_{il} - p'_{il}(C)$ and maximizes this.

(2) $S_l'^* = \max_i s'_{il}$

How do we differentiate the model of misperception in (2) from the Perloff-Salop model in (1)? We form a test based on the idea that elements of C which do not affect $b_{il} - p_{il}$ cannot affect choices in (1) but could affect choices in (2). Specifically, we alter the choice environment by presenting the publicly available personalized price vector $\mathbf{p}_l=(p_{1l}, p_{2l}, \ldots, p_{nl})$ back to individuals. Presentation of this vector clearly could not affect choices if people were (pre-intervention) choosing according to equation (1) since the personalized price vector $\mathbf{p}_l$ was needed to implement that maximization in the first place. In this sense, we are simply measuring whether people were choosing coherently according to the full information price vector. We test for impact from a difference in C on the probability of any action (switching plans) and on the systematic nature of the action (specifically, the senior's predicted costs in the 2007 plan).

We put further structure on the problem by separating the true price into two components ($p_{il} = x_i + y_{il}$). x_i is the common component of the price (premium) for the i-th plan that is the same for all consumers in a market. y_{il} is the individualized component of the price (out-of-pocket costs) for the i-th plan that depends in the individual's prescription drug use. The perceived price may differ from

[2] Perloff and Salop (1985) model the difference between true and perceived product characteristics as an additive error. We are being more specific in focusing on the perception of the price and its dependence on the choice environment.

true price component x_i by the function $\varepsilon'_{il}(C)$ that depends on the choice environment, and similarly from y_{il} by $\eta'_{il}(C)$. Thus, the consumer perceives the price to be:

(3) $$p'_{il}(C) = (x_i + \varepsilon'_{il}(C)) + (y_{il} + \eta'_{il}(C)).$$

We define price misperception as having perception of the price depend on the choice environment, or $\text{Var}(\varepsilon'_{il}(C) + \eta'_{il}(C)) > 0$. Notice that price misperception here reflects an end state with no judgment passed on the process by which customers reached that end state. For example, someone who simply failed to make use of the available information and chose arbitrarily would misperceive by our definition. It is meant to capture the notion that people are choosing as if they faced a different price vector than the actual one. In the prescription drug plan choice, the information on the common component of the price is cheaper to obtain and simpler to present, since it does not depend on the multi-dimensional attributes of individual prescription use. We will therefore assume that $\text{Var}(\varepsilon'_{il}(C)) < \text{Var}(\eta'_{il}(C))$.

Thus, three tests we use to distinguish the misperception model in (2) from the basic Perloff-Salop model in (1) measure whether presenting public information back to a consumer:

- Affects choice by increasing plan switching? Since C enters equation (2) but not (1), it cannot do so in the basic model.
- Affects choice by decreasing average predicted costs of the selected plan when the choice environment emphasizes lower costs? Again, there would be no effect under the basic model in equation (1).
- Has less effect on the common component of predicted cost of the selected plan than the personalized component? Under our auxiliary assumption, $\text{Var}(\varepsilon'_{il}(C)) < \text{Var}(\eta'_{il}(C))$, the misperception model in (2) predicts it would.

An alternative to price misperception is a rational cost of thinking model, where individuals know the true distribution of prices and that they can obtain information about the personalized prices of particular plans by exerting some costly effort thinking through information acquisition and processing. The three tests above can be used to reject the basic Perloff-Salop model, but do not distinguish between price misperception and cost of thinking models. A rational thinking cost model, however, does have implications not associated with the misperception model. First, it assumes that individuals grasp the potential for differences among drug plans in terms of prices and other product features and make rational decisions about information seeking. In particular, seniors should have unbiased estimates of the potential savings from switching from their current plan to the lowest cost plan. Second, the effect of information should result in relatively greater savings

among those individuals who are dissatisfied with their drug plans, assuming that dissatisfaction is positively correlated with the expected cost gap between the current plan and cheaper plans and uncorrelated with any switching costs. Failure of these predictions would be consistent with misperception (such as when the magnitude of misperception is greater among the satisfied) as opposed to rational thinking costs.

Although additional information can only improve individual welfare in a cost of thinking model, additional information does not necessarily improve welfare in the misperception model. For example, if individuals systematically overestimate the quality of low-cost plans, then clarity about prices could lead to sub-optimal choices of low-cost, low-quality plans. While our primary analysis focuses on misperception of prices, we also examine some proxies for plan quality to interpret the practical significance of our findings.

III. Descriptive Evidence Consistent with Misperception

In a world with misperception dependent on the choice environment, seniors may not be well-informed about prices and other product specifics; they may not respond rationally to all the information that, objectively, is available; and they may fail to recognize that they are enrolled in a sub-optimal plan. To develop evidence on these points, we conducted phone and mail surveys of Medicare Part D free-standing prescription drug plan beneficiaries in early 2007. Details on survey methodology are given in Appendix A. Results from the surveys are shown in Table 1.

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. Only 37 percent knew that only some (rather than all) plans have a deductible. Only 55 percent knew that different plans have different co-payments for generic drugs, rather than all plans having the same co-payments.[3] 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

[3] In survey data collected in 2005, just prior to the beginning of the first open enrollment period, Winter et al. (2006) also found low knowledge about the structure of the benefit and the potential for differences among plans.

percent reviewed personalized plan comparisons. [4] Yet, in both surveys, we found that over 80 percent of participants were generally satisfied with their 2006 prescription drug plans. The percentage that switched plans between 2006 and 2007 was 10 and 15 percent in the phone and mail surveys respectively, slightly above the reported national rate of seven percent.[5] An additional 14 percent in the phone survey considered switching for 2007 but did not switch, which is consistent with the high levels of reported satisfaction.[6] In short, consistent with the misperception model, the majority of beneficiaries were not well-informed, appeared to be content with their plan, and did not take full advantage of available information sources.

In order to understand the information available in the existing choice environment and the costs of acquiring it, we therefore audited five potential sources of advice on choosing a drug plan: the Medicare help-line (1-800-Medicare), state health insurance assistance programs (SHIPs), senior centers, other telephone help-lines, and retail pharmacies (methodology and results of this audit are in Appendix B). In our calls to 1-800-Medicare, customer service representatives consistently made personalized plan suggestions, drawing upon Medicare's website tool, the Prescription Drug Plan Finder. This publicly available website allows input of information on prescriptions (say, those being taken currently) and preferences about pharmacy location and mail order use, and then generates a predicted annual cost for each drug plan in that person's geographic area. Our calls to SHIPs generated either referrals to Medicare or offers of similar assistance. Our visits to senior centers sometimes resulted in general discussions about the drug benefit or partial demonstrations of the Medicare website but never in comparative information in the hands of the auditor. A search for and audit of other sources of telephone advice indicated that few private-sector information sources had emerged.[7] In general, these sources were either not helpful or referred the caller to Medicare or another public-sector information source. In one noteworthy exception (a major pharmacy chain),

[4] Our results are broadly consistent with the U.S. Department of Health and Human Services (2007), which reported results from a survey in January 2007 indicating that 85 percent of seniors were aware of the open enrollment period, 50 percent reviewed their current coverage, 34 percent compared plans, and 17 percent evaluated premiums, co-payments, and coverage.

[5] The national rate is for those not receiving the Low Income Subsidy (U.S. Department of Health and Human Services, 2007).

[6] Our survey results are similar to Heiss, McFadden, and Winter (2007), who reported that 82 percent rated their 2006 plan good or better, 18 percent considered switching for 2007 but did not, and 11 percent switched plans from 2006 to 2007. Unpublished results from the same survey indicated that 60 percent did not consider switching because they were happy with their plan while 18 percent "wanted to avoid the trouble of going through the plan comparison and choice process again," a fact that is consistent with thinking costs affecting some seniors.

[7] A contributing factor may be Medicare policies, motivated by concerns about conflicts of interest, that restrict the extent to which third parties can provide advice.

the help-line offered personalized suggestions, using technology similar to Medicare's, and mailed a personalized report.[8]

A small fraction of pharmacies offered personalized in-store assistance with plan choice to auditors who walked in. In four of the 88 pharmacies audited, staff people made personalized plan suggestions based on a Plan Finder. In five pharmacies (all in one chain), a staff person offered personalized plan information about the entire universe of available plans. Sixty-nine of the 88 pharmacies provided print materials, although our user testing indicated that these materials alone were not sufficient for seniors to understand the cost implications of plan choice even in very simple 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 delivered. In conclusion, seniors could acquire personalized assistance from Medicare with minimal effort, but seniors who sought information through other channels were not consistently assisted or even consistently directed to Medicare.

IV. Information intervention

In order to test the misperception model, we designed a randomized experiment in which the intervention was a slight perturbation of the informational environment. Members of the intervention group received a one page cover 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 comparison group received a general letter referring them to the Medicare website, and both groups received an informational booklet on how to use the site. The critical features of the intervention were that it neither contained new or difficult to acquire information nor reduced the effort required to change plans, but that it was designed using psychological principles known to promote action: a default choice (the lowest cost plan), a clear statement of that choice's benefits (potential savings), and a deadline.

Participants were University of Wisconsin Hospital patients interviewed by students in the School of Pharmacy in the fall of 2006 to elicit an inventory of prescription drug use and other

[8] In addition, a second major pharmacy chain offered an internet service in conjunction with a technology partner specializing in decision support systems. A code was developed to trigger the import of individual medications into the partner's Medicare Part D decision tool. Customers and pharmacy staff were able to produce personalized Medicare Part D Plan comparisons by entering these codes into the tool.

baseline information prior to randomization. At the time of the study interview, participants reported regularly using an average of five and half medications. The study participants were all from Wisconsin, nearly all white, with an average age of 75. About two-thirds were women, and about half were college graduates. Relative to the national population of seniors, study participants were typical in terms of age and gender but substantially better educated. A first follow-up survey, completed in early 2007, inquired about participants' plan choices for 2007 and their choice process. The final analytical sample size for this survey was approximately 400. A second follow-up survey, in early 2008, inquired about experiences in the 2007 plan and plan choices for 2008 and resulted in a sample size of approximately 300. Additional details on the experimental methodology are in Appendix C.

There were 54 Medicare prescription drug plans available to our Wisconsin sample. In order to assess the dispersion in predicted costs across plans for the same individuals, we compiled data on the predicted costs of every possible plan. Predicted cost is the estimated annual cost measure for 2007 computed by the Medicare Plan Finder for a given drug plan based on an individual's prescription drug use (as reported at the time of random assignment in fall 2006). Analysis is shown in Table 2, with separate columns for groups of low, medium, high, and very high use individuals – defined as individuals taking 0-3, 4-6, 7-10, and 11+ medications respectively. The average cost of the lowest cost plan available to low use individuals was $623, shown in column 1. The 27th least expensive plan, which is the plan at the median among the 54 available, cost an average of $1,053, or almost twice as much. For the very high use group, the average cost of the median plan was $1,153 more than the lowest cost plan, or about one-third as much higher. The plans initially enrolled in by the individuals in our sample were nearer the median plan than the lowest cost plan: the average percentile rank was between 38th and 44th for all drug use groups. Two key findings from this analysis are that, for a given individual, the cost differences among plans were substantial, and that, for most seniors, there were many plans available with similar or lower costs than those selected.[9]

The results of the information experiment, based on the first follow-up survey, are shown in Table 3, with column 1 showing estimates for the full sample of 406 participants for whom we have data on 2007 plan choice. Analysis of the probability of switching plans between 2006 and 2007 is

[9] The level of out of pocket expenditures is about 50 percent higher in our sample than in a national sample (Domino et al., 2008) and a small pharmacy sample (Appendix C), and we opt to stratify by numbers of prescriptions for this reason. However, the potential savings from changing to the lowest cost plan, as a share of current expenditure, was similar or lower than in the national pharmacy sample, which allays, to some extent, concerns about selection bias.

shown in panel A. 28 percent of those in the group receiving the letter intervention switched plans, compared to 17 percent in the comparison group. The difference of approximately 11.5 percentage points is found in a simple comparison of means and after controlling for covariates known at the time of random assignment (demographics and prescription drug information). The probability of such a large difference occurring by chance under the null hypothesis of no effect of the intervention is very small, with p-values less than .005 for both specifications. Nine percent of the intervention group switched specifically to the lowest cost plans while 20 percent switched to a different plan; in the comparison group these percentages were 2 percent (statistically significantly different from 9 percent) and 15 percent (not different from 20). This result is consistent with the idea that the intervention specifically caused seniors to consider the lowest cost plan.

Other 2007 survey results not shown in the tables shed light on seniors' choice process and knowledge. Several of the differences between the two groups support the notion that the intervention worked through cognitive channels. These include statistically significantly greater percentages of intervention respondents remembering receiving the materials, reporting that they read them, and deeming them helpful.

The average change in predicted 2007 cost between the plan chosen in 2007 (Y^{07}) and the plan chosen in 2006 (Y^{06}) is shown in panel B. This measure represents the savings from changing plans and is zero for those who remained in the same plan. The average regression-adjusted decrease in predicted cost for the entire intervention group versus the comparison group was $90. Expressed in terms of the change relative to Y^{06}, this decrease was an average of .058 log points, or about six percent. Again, the probability of such a large difference occurring by chance under the null was less than .005.

The average cost change for the entire intervention group versus the comparison group averages over people who were not affected by the intervention and those who potentially were affected, defined as those who would have changed plans either if they were assigned to the intervention group or if they were assigned to the comparison group. It is a useful estimate of the effect of the intervention itself (the intent-to-treat effect), but it is also an underestimate of the impact on those who were potentially affected. One can estimate a lower bound on the effect on the potentially affected by dividing the point estimate by the sum of the probabilities of changing plans in the intervention and comparison group. Intuitively, this estimate assumes that everyone who changed plans in the intervention group was affected and that a substantial share of the intervention group who did not change plans was also affected by because they would have switched plans if they had

been in the comparison group. A full derivation appears in Appendix D. Estimates for the full sample, controlling for background covariates, are shown in column 1 of panel C. Those potentially affected by the intervention had an average of at least 199 dollars in predicted cost savings. In relative terms, this represents predicted savings of .128 log points, or about 13 percent.

In analyses not shown in the tables, we found evidence supporting the hypothesis that the effect of information would be disproportionately concentrated in out-of-pocket costs as opposed to premium costs, because the former are more difficult to perceive. While out-of-pocket costs made up 81 percent of total costs in the 2006 plan and reductions in these costs accounted for 80 percent of the potential savings from changing to the lowest cost plan, savings in out-of-pocket costs were only 31% of the mean total savings in the comparison group. However, the treatment group achieved 84% of its mean total savings from out-of-pocket costs. The regression-adjusted effect on total costs ($90), reported in panel B of Table 3, consisted of a $14 effect on premiums (not a statistically significant change) and a $76 effect on out-of-pocket costs (a highly statistically significant change, with $p<.005$). This evidence clearly supports the misperception model as opposed to the basic Perloff-Salop model.

In the 2007 follow-up interview, we asked participants in the comparison group how much they thought they could save if they had chosen the least expensive plan. Of those who could give an estimate, more than 70 percent gave an underestimate, and the average underestimate was more than $400 in results not shown in the tables. These results cast doubt on the idea that these individuals were using a cost of thinking model for plan choice, as having biased beliefs about the distribution of plan prices is not compatible with the assumptions needed for coherent decision-making with a rational cost of thinking approach. The underestimates are consistent with misperception of prices.

Panel A of Table 4 shows results separately for groups with potential savings (the difference between the predicted 2007 cost of their 2006 plan and the least expensive plan) below and above $400, where the magnitudes in columns 3 and 4 are calculated as the lower bound for those affected by the intervention from Panel C of Table 3. The impacts on both switching probability and predicted costs were quite large when potential savings were greater than $400, as hypothesized. More surprisingly, the impact on cost for the group with lower potential savings was not trivial ($103, with a p-value of .02 on the difference) and the relative cost effect (.161 log points, with a p-value of .012) was about the same magnitude for both groups. These results are consistent with the idea that factors beyond the basic Perloff-Salop model are operating. As an alternate approach to

determining whether intervention effects varied according to baseline variables, we estimated specifications that used the whole sample but introduced interactions of the intervention indicator and baseline variables of interest. Unless otherwise noted, these results did not differ substantially from the split-sample results.

Dissatisfaction is positively correlated with potential savings, according to our baseline survey data, suggesting that one would expect the intervention effect to be relatively greater among the dissatisfied.[10] In fact, while the dissatisfied are more likely to change plans, the magnitude of the intervention effect does not differ according to baseline satisfaction as shown in Panel B. This may be related to the greater fraction of the satisfied who underestimated their potential savings, and then upon receiving the intervention realized their potential savings was large.[11] In the split-sample estimates, the intervention effect on the level of savings is actually greater for more satisfied seniors, although this result is not carried through in alternate specifications. In both the split-sample estimate and some alternate specifications, the intervention has a greater percentage effect on savings for relatively dissatisfied seniors.

We speculated that individuals who did not understand the differences among drug plans might have placed a high weight on name-recognition and popularity. (For example, the plan with the highest national enrollment in 2006 was co-branded by the AARP, formerly the American Association of Retired Persons.) We hypothesized that when the intervention made personalized cost information available to individuals in these plans, they would be relatively more likely to switch plans (although the impact on predicted costs for those affected would not necessarily be different). In Panel C, we find essentially the opposite result. Individuals in plans with market share of less than 15 percent are *more* likely to respond to the intervention by switching plans and enjoy greater cost savings among the potentially affected. Ex post, the results are more consistent with the idea that large market share plans attracted members who directly valued a trusted brand or other non-cost attributes and were relatively less sensitive to personalized cost information.

Given that our sample is much more educated than the national population, it is also notable that the impact of the intervention in panel D for those without a college degree was essentially similar to that for college graduates. This result is consistent with the notion that any limits in

[10] We did not ask directly about perceptions of potential cost savings in the baseline survey in order to avoid priming the comparison group to be particularly attuned to this issue, but dissatisfaction is likely related to these perceptions. Using baseline data, potential savings averaged $613 in the dissatisfied group and $488 in the satisfied group.

[11] The proportion underestimating potential savings in the comparison group was .75 among the satisfied and .58 among the dissatisfied, with a p-value of .11 on the difference.

comprehending information by less-educated groups are offset by the marginal value of information to these groups. Our sample also spent more on prescription drugs than a national sample; the effect of the intervention on switch rates for those with relatively lower spending was relatively lower, while the effect on the percentage reduction in predicted costs was relatively greater, as shown in appendix Table C5. We examined a variety of other subgroups in appendix Table C5 (relative cost savings > 33 percent, monthly premium > $30, 2006 premium – low-cost plan premium > $10,) and Table C6 (premium change of 2006 plan >$7 per month, number of medications > 4, married, age > 73, female). In general, results for subgroups show that the intervention effects are robust across subgroups.

As a complement to analysis of the impact of the intervention on average predicted costs, we also examined differences between the intervention and comparison groups in multivariate models of plan choice. In a conditional logit model, controlling for individual fixed effects, predicted cost, and predicted cost squared, the predicted probability of choosing a plan with the same price as that actually selected was .034. We then enriched this basic model, controlling for plan fixed effects, interactions of an intervention group indicator with predicted cost and predicted cost squared, an indicator for being the lowest cost plan for that individual, and the associated interaction. Because this model includes plan indicators, the coefficients on predicted costs exclusively reflect the response to out-of-pocket costs at the pharmacy, not premiums.

The results indicate that the intervention group is significantly more sensitive to out-of-pocket costs than the comparison group. For the intervention group, the model predicts that a twenty-five percent decrease in predicted cost (say from $2120 to $1590, which is approximately from the average cost of the plan chosen in 2006 to the lowest cost plan in 2007) increases the odds of plan selection by 2.9, i.e. it increases the probability of selection from .034 to .092. If that lower cost plan is also *the* lowest cost plan, the estimated odds ratio is 5.3, i.e. the probability of selection further rises from .092 to .35. In the comparison group, a twenty-five percent decrease in predicted cost increases the probability of plan selection only from .034 to .044. (A joint test on the two cost interactions terms yields a p value of .014; the difference between the study groups is highly significant.) In the comparison group, if the lower cost plan is also the lowest cost plan, the probability of selection further rises only from .044 to .077, with the joint test on the relevant interaction term generating an almost-significant p value of .11.

To determine whether this particular intervention was helpful or harmful to seniors, the Spring 2008 survey collected information on actual drug utilization during 2007 and experiences in the

plan. Based on actual, as opposed to predicted, drug utilization, the average regression-adjusted savings from changing plans was $82 (.039 log points) greater for the intervention group than for the comparative group. This translates to a lower bound of $152 (.09 log points) for those affected by the intervention, as shown in Table 5.

There were no statistically significant differences in self-reported 2008 switch rates, plan ratings/satisfaction, or an aggregate of measures of access to care. The fact that more seniors in the intervention than comparison group chose their plan again is consistent with, but not proof of, a welfare-improving intervention. To examine impacts on plan quality, we used an aggregate of three measures reported by Medicare: customer service, ease of prescription filling, and quality of pricing information. Our analysis found no significant differences between intervention and comparison groups on quality measures; in general, lower-cost plans were not substantially lower in measured quality. We plan to extend this analysis to include additional, alternate measures of quality, such as the prevalence of prior authorization, quantity limits, and step therapy or the quality of coverage of new or specialty drugs. Taken together, these findings of cost savings without measurable negative effects on various proxies for other aspects of plan-related utility are consistent with the ideas not only of misperception but also that this particular informational intervention increased consumer surplus.

We are also able to determine the persistence of the effects on savings. Here, our measure is the average change in predicted costs for 2008 between the plan chosen in 2006 and the plan chosen in 2008, calculated using the 2008 Medicare Plan Finder and the list of current drugs at the time of the Spring 2008 survey. In the intervention group, the average second-year savings from changing plans was $129, while this figure was $69 in the comparison group. This unadjusted difference of $60 was not statistically significant and of a lower magnitude than the comparable $90 figure for the first year; the regression adjusted difference was $38. These findings suggest that, although the intervention did not increase second-year plan switching, cost savings from plans chosen for 2007 did diminish over time.

Following a technique developed by Bernartzi and Thaler, the survey also asked seniors to evaluate the choice between several pairs of unnamed drug plans based on cost measures, plan size, and Medicare quality ratings.[12] When seniors who had not chosen the lowest cost plan were asked to compare their 2007 plan to the lowest cost plan using this set-up, 37 percent of the comparison

[12] In these questions, the cost information was similar to the information that the intervention group had received via the Medicare print-out; the enrollment and quality information were new.

group preferred their 2007 plan. Similarly, when seniors who had changed plans compared their 2007 plan to their 2006 plan, 35 percent of the comparison group preferred their 2007 plan. The fact that many seniors did not choose their 2007 plan when it was reflected back to them is consistent with ongoing misperception.

IV. Cost-benefit analysis

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. Relative 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.[13] Our results suggest that such an initiative might result in substantial savings to seniors, although the per-person savings would likely be lower than those in our study due both to population differences (study participants had relatively high drug utilization) and to differences in the intervention (it would be unlikely that a large, national initiative could generate the same level of attention as our mailing, which followed a one-on-one discussion with a pharmacy student associated with a local hospital). Also, the market for drug plans has matured since the time of our study, although it is unclear whether choices are now more or less robust as seniors' greater knowledge and experience may or may not offset errors causes by choices made early in the program that have not been re-considered and updated in light of changing drug needs and plan benefits.

In addition, an effective information intervention 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 the enrollment-weighted national average of plans' cost for offering the drug benefit, via the bid process. To the extent that plan switches represent seniors choosing plans in which the cost-sharing formula favors their individual drug profile, holding overall plan costs constant, Medicare expenditures may increase as plans' bids adjust to reflect their higher costs in the face of this type of adverse selection. (The plan bid reflects the plan's costs of offering the drug

[13] Among the challenges would be the needs to work through the relative roles of government and third party intermediaries, to minimize the potential for plans to capture the market for advice, to respect individual privacy, to provide information that balanced cost and other considerations, and to hold beneficiaries' well-being as the greatest value. Such a program could involve elements such as one-on-one counseling and the ability for beneficiaries and their advisors to manually update the automatically generated drug list.

benefit, net of beneficiary cost-sharing and reinsurance.) Alternately, plans may adjust their cost-sharing formula and other aspects of the benefit to manage these selection dynamics. An effective large-scale intervention could also potentially affect net revenues for drug plans and pharmaceutical firms, depending on the extent to which differing plan costs stem from greater efficiency, lower service quality, steering of customers by plans towards lower cost drugs, lower plan profits, and lower payments to pharmaceutical manufacturers.

In order to analyze one aspect of the effect of our intervention on Medicare expenditures, we estimated the sample-average plan bid for the intervention and comparison group. For most plans, the plan bid (and the plan's contribution to the national average bid) is related to the premium according to a simple formula (bid = premium + $53.08). For enhanced plans, the plan's contribution to the national average bid is only related to the portion of its bid which is associated with the cost of offering the standard benefit, while the full bid is reflected in the premium. In this case, we estimated the plan's contribution to the average by using the average of the sponsor's bids for its non-enhanced plans; any sponsor offering an enhanced plan must also offer at least one non-enhanced plan. Using this method, we found small differences between study groups in the average bid for 2008 associated with the 2007 plan, and could not reject the null hypothesis that plan switches did not represent choice of plans with significantly lower plan costs but also could not reject the hypothesis that a small outlay to provide personalized cost information could be recovered in the form of a lower national average bid in the future from switches to plans with lower government subsidies.

In future work, we plan to supplement this analysis by examining the effect of the intervention on total drug costs paid by the plan, using the negotiated prices published on the Medicare website (the senior's cost in the coverage gap). This analysis will allow us to analyze the role of off-formulary drugs and differential cost-sharing in generating seniors' cost-savings. However, the analysis' shortcoming will be that negotiated prices do not represent plans' actual net acquisition costs, since they do not reflect rebates (retrospective payments from drug manufacturers to plans based on volumes) and other price concessions, which may be as significant as negotiated prices in driving differences in net acquisition costs among plans.

VI. Conclusion

This study analyzed the choice among Medicare drug plans using a conceptual framework of misperceived prices, which was contrasted with a simple Perloff-Salop model of rational choice and

a model of rational thinking costs incorporating imperfectly estimated prices due to costs of acquiring and analyzing price information. The misperception model permits consumers to be sensitive to the choice environment and to the subtle ways that information is presented, which go beyond the content of the information or the costs of acquiring it. Unlike the Perloff-Salop model, the misperception model predicts that consumers may respond to presentations of publicly available drug plan price information by changing plans and reducing their costs, and it further predicts that any reductions in costs will likely be concentrated in hard-to-perceive out-of-pocket payments at the pharmacy rather than the easier-to-perceive premium costs. A model in which individual's make rational choices in the presence of thinking costs, which assumes consumers have some unbiased information about products, can also generate these three predictions. In addition, a thinking cost model also predicts that the provision of information will have the greatest effect on those who estimate that they have the greatest cost potential savings.

This study used data from phone and mail surveys of seniors, an audit of sources of drug plan information, and an experiment in which a randomly selected group of seniors received carefully designed letters based on information available on the Medicare website while another randomly selected group was simply referred to the site. Three main results of the experiment were consistent with the misperception model, as opposed to the Perloff-Salop model. Relative to the comparison group, the intervention group had higher rates of changing plans (28 percent vs. 15 percent) and lower predicted costs ($90 for the sample as whole, $199 as a lower bound for those potentially affected), with the cost savings relatively concentrated in the less-obvious out-of-pocket costs rather than the more transparent premium costs.

The audit confirmed that the effort required to acquire cost comparative price information from Medicare was indeed minimal, reinforcing the notion that the savings generated by the experiment were large relative to the costs of acquiring the information. The independent phone and mail surveys of seniors indicated that the majority of seniors were not particularly well informed about drug plans or particularly diligent users of information sources but were content with their choices nonetheless. In our comparison group, more than 70 percent underestimated their potential savings. In the experiment, the effects of information were not greater among the dissatisfied. We interpret this pattern of results as being more consistent with a misperceived price model than a rational cost of thinking model. An alternate rational explanation is that information on the letterhead of the University of Wisconsin was deemed different and more relevant than the same information from CMS, even when Medicare was cited as the source. While not trivial, the likely magnitude of this

potential effect seems small relative to the realized cost savings. Yet another rational model could involve switching costs, and the magnitude of savings in the comparison group of about $100 from switching may not be larger than the switching costs. However, our intervention essentially held switching costs constant relative to the comparison group, so switching costs cannot explain the intervention effect.

Inducing seniors to focus on prices might cause them to make choices that under-weighted other non-pecuniary benefits. The second follow-up survey sought to collect a variety of proxies for consumer welfare, and based on available measures, the effects of the study information were consistent with improvements in welfare. Realized (as opposed to predicted) costs were $82 lower in the intervention group, with a lower bound of $152 for those potentially affected; there were no measurable effects on plan-related utility and plan quality.

Our preferred explanation emphasizes the potential for altering price perceptions through changes in the choice environment. We hypothesize that, for seniors in the spring of 2006, Medicare drug plans were complex and unfamiliar products, leading to the potential for misperception both of prices and of the differences among plans. More generally, study results seem consistent with a situation in which seniors under-invest in information-seeking in part because they under-estimate the potential for differences among plans. Once choices had been made, not only did misperception of prices persist, but confirmation bias (the tendency to stick with one's existing opinions and choices) and transactions costs, albeit low, 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 confirmation bias (by showing the savings available), and providing an alternative default (the lowest cost plan). Because of the fragility of initial choices, this small, behaviorally sensitive intervention had a large effect.

Together with an emerging body of work on fragile choices and the importance of context, this study underscores that policy makers seeking to utilize choice and competition in provision of services must also direct careful attention to the design of the environment in which individuals seek information and make choices. In the case of Medicare drug plans, if the goal is to maximize seniors' private welfare, it remains important for Medicare to continue to communicate the potential for differences among plans; to provide personalized, comparative information; and to publicize the availability and value of this information. However, given the observed reluctance of most individuals to reassess their choices, engaging a larger share of Medicare enrollees may require more pro-active efforts. 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. The apparent presence of misperception and the potential impact of information also call for a vigilant attitude toward information in areas that are deemed socially important. Information presenting choices should be thoughtfully designed, and alternative presentations should be carefully tested to determine the formats that lead to the most robust choices.

This study highlights four areas for further research. One is very concrete work on the design of clear, actionable information about Medicare drug plans or other health coverage choices. This preliminary work shows the potential for information to have an effect, but the study intervention incorporated multiple features including the partnership with a trusted hospital, the priming effect of an in-person interview, the behaviorally sensitive letter, the full Medicare print-out, and a mailing that both communicated personalized information about potential savings and raised general awareness about the potential for savings and the nature of the variation among plans. Additional work could unbundle these effects, with potential implications for the design of larger scale programs, and could explore the effects of quality as well as cost information. Tools for creating more sophisticated price information could also be developed that would incorporate forecasts of changes in drug use, rather than simply assuming that next year's use will be the same as last year's use.

Another area is the role of product and information markets in misperception. It is striking that, despite the apparent value of personalized comparative information, few third parties emerged to provide it, or even to highlight its potential value and steer seniors towards Medicare and its local partners. The actual provision of information may have been impeded by CMS regulations that constrained the role of third parties and by the effort involved in working with seniors one-on-one, although third parties with access to drug histories can provide personalized information relatively efficiently.

A third area involves the potential response of insurance firms to broader provision of personalized price information. For example, if the information assumed last year's drug use is the same as next year's drug use, then firms would have strong incentives to cut prices on drugs used for short periods and increase prices on drugs used for long periods in order to encourage individuals to perceive their prices to be lower than a rational cost forecast would be. Within increased salience of prices, there would also be incentives for firms to cut costs which could lead to lower overall quality of service.

A fourth area for more conceptual research is the interaction between misperception and other forms of market failure at both the theoretical and the more practical level. In the case of Medicare drug plans, the private and public optima may differ, and misperception may actually counteract market failure by reducing the extent of adverse selection and contributing to the success of the voluntary insurance market. The market functioning could be harmed if all plans with more than basic coverage attract only those who most benefit from them (with these plans then becoming too expensive and being dropped), or if all individuals chose one low-cost provider who then obtained enough market power to keep out new entrants and also set monopolist prices in future periods. Alternatively, as noted above, misperception may unambiguously reduce social welfare if its practical result is that seniors to choose plans that, on average, have higher costs than those they would have chosen if more informed, thereby increasing the overall cost of the Part D program.

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Table 1. Information on choices from representative samples, early 2007

	Phone Survey (1)	Mail Survey (2)
At least somewhat satisfied with 2006 plan	.85	.83
Switched plans from 2006 to 2007	.10	.15
Read at least some of Annual Notice of Change	.57	.86
Ever reviewed mailings for plan choice	.53	
Ever had in-person contact for plan choice	.14	
Ever had phone contact for plan choice	.07	
Ever used internet for plan choice	.04	
Ever reviewed side-by-side comparison for choice	.34	
Ever reviewed personalized information for choice	.18	
Knows that not all plans have a deductible	.37	
Knows plans have different co-payments for generics	.55	
Sample size	348	1430

Notes. National phone and mail survey data collection is described in Appendix A.

Table 2. Distribution of predicted plan costs, by number of medications taken

	Medications as of 2006			
2007 Predicted Total Costs	0-3 (1)	4-6 (2)	7-10 (3)	11+ (4)
Average cost of least expensive plan	$623	$1,417	$2,580	$3,635
Average cost of 27th least expensive (median) plan	$1,053	$2,019	$3,383	$4,788
Average cost of plan selected for 2006	$958	$1,932	$3,303	$4,540
Average percentile rank of plan selected for 2006	38th	44th	43rd	37th
Sample size	142	128	78	43
Fraction of total sample	0.36	0.33	0.20	0.11

Notes. Wisconsin plan cost data collection is described in Appendix C.

Table 3. Analysis of switching plans between 2006 and 2007

A. Probability of switching between 2006 and 2007	
$E[S \mid Z=1]$	.282
$E[S \mid Z=0]$	.168
$E[S \mid Z=1] - E[S \mid Z=0]$	.115*
	(.041)
$E[S \mid Z=1,X=x] - E[S \mid Z=0,X=x]$	.096*
	(.042)
B. Average predicted cost change	
$E[Y^{07} - Y^{06} \mid Z=1,X=x] - E[Y^{07} - Y^{06} \mid Z=0,X=x]$	-90*
	(28)
$E[\ln(Y^{07}/Y^{06}) \mid Z=1,X=x] - E[\ln(Y^{07}/Y^{06}) \mid Z=0,X=x]$	-.058*
	(.017)
C. Average predicted cost change lower bound for those affected by the intervention	
$\{E[Y^{07} - Y^{06} \mid Z=1,X=x] - E[Y^{07} - Y^{06} \mid Z=0,X=x]\}$	-199*
$/ \{E[S\|Z=1]+E[S\|Z=0]\}$	(62)
$\{E[\ln(Y^{07}/Y^{06}) \mid Z=1,X=x] - E[\ln(Y^{07}/Y^{06}) \mid Z=0,X=x]\}$	-.128*
$/ \{E[S\|Z=1]+E[S\|Z=0]\}$	(.038)
Sample size	406

Notes. S: switched plans between 2006 and 2007. Z: indicator of assignment to intervention group. X: vector of covariates (indicators for gender, married, high school graduate, college graduate, post-graduate, age<70; age<75; drug insurance rated fair or poor in 2006; sixth-order polynomial predicted potential savings of 2006 plan versus lowest-cost plan; sixth-order polynomial of the log of the ratio of predicted potential savings to lowest-cost plan). |X=x: conditional expectations are approximated using linear regression. Y^{07}: predicted 2007 cost of plan chosen in 2007. Y^{06}: predicted 2007 cost of plan chosen in 2006. Standard errors in parentheses. * = p-value <.05.

Table 4. Analysis of switching plans between 2006 and 2007, by subgroups

	Switching probability		Lower bound impact on predicted cost		N
	Comparison	Intervention	Dollars	Log points	
	(1)	(2)	(3)	(4)	(5)
A. Dollar potential savings					
≤ $400	.145	.217	-103*	-0.161*	216
			(44)	(.064)	
> $400	.195	.350~	-260*	-.120**	190
			(105)	(.047)	
B. Satisfaction rating of 2006 plan					
Fair, Poor, or unknown	.235	.370	-88	-.150*	124
			(90)	(.064)	
Good, Very good, or Excellent	.144	.235~	-212*	-.108*	282
			(75)	(.050)	
C. Sponsor share of sample in 2006					
≤ .15	.141	.333~	-463*	-.290*	142
			(133)	(.064)	
> .15	.180	.252	-75	-.063	264
			(61)	(.047)	
D. Education					
Not college graduate	.154	.284~	-172	-.117*	213
			(99)	(.056)	
College graduate	.183	.280	-182*	-.134*	193
			(75)	(.054)	

Notes. All subgroups are defined on characteristics known prior to random assignment. Dollar potential savings = predicted 2007 cost of plan chosen in 2006 – predicted 2007 cost of least expensive plan. ~ = p-value <.05 on difference between columns 1 and 2. Column 3 estimated using method in Table 3, panel C, row 1. Column 4 estimated using method in Table 3, panel C, row 2. Standard errors in parentheses. * = p-value <.05.

Table 5. Analysis of plan experience in 2007

	Comparison	Intervention	Difference	Regression-adjusted difference
	(1)	(2)	(3)	(4)
A. Average realized cost change				
Entire sample				
Dollars	$5	-$77	-$82*	-65*
			(28)	(24)
Log points	-.004	-.05	-.046*	-.039*
			(.018)	(.019)
Potentially affected - lower bound				
Dollars				-$152*
				(56)
Log points				-0.090*
				(.044)
B. Probability of switching for 2008				
Probability	.23	.20	-.03	-.01
			(.05)	(.05)
C. Plan rating and experience				
Rate plan as fair or poor	.14	.14	.00	-.01
			(.04)	(.04)
Dissatisfied with drug costs	.20	.23	.03	.02
			(.05)	(.05)
Dissatisfied with quality, non-cost features	.06	.10	.03	.05
			(.03)	(.03)
Any access problems (7 items)	.52	.52	-.01	-.01
			(.06)	(.06)
D. Prefer 2007 plan in blinded comparison				
Relative to least expensive plan	.37	.47	.11	.11
(N comparison=102, N intervention=105)			(.07)	(.07)
Relative to 2006 plan	.35	.84	.49*	.60*
(N comparison = 18, N intervention = 37)			(.12)	(.12)
E. Plan quality				
Plan rating from Medicare.gov (average of 3 items)	3.66	3.70	.04	.04 (.03)
			(.03)	

Notes. N=305 unless otherwise noted. Average realized cost change = estimated 2007 cost of plan chosen in 2007 – estimated 2007 cost of plan chosen in 2006 (both costs conditional on drugs taken in 2007). Standard errors in parentheses. *= p-value <.05.

Appendix A: Survey Methods

A-1. National Phone Survey

The national phone survey asked 400 seniors enrolled in Part D about their information-seeking behavior and plan knowledge in February and early March 2007. Deft Research, LLC, a market research firm specializing in health care markets and Medicare conducted the survey on our behalf. The initial sample frame consisted of 10,000 phone numbers, which, based on market research data bases, were likely to reach households containing at least one senior. To be eligible for the survey, a potential respondent must be 65 or older, receiving Medicare benefits, and enrolled in a private drug plan at the time of the survey. As part of initial screening, interviewers confirmed that participants were not enrolled in a Medicare HMO or receiving drug benefits from a former employer or the military.

Survey staff attempted to call 4383 numbers of which 710 (16 percent) did not work, were not residences, or had other problems. In 2733 cases (62 percent), the potential respondent declined to participate; in 464 (11 percent), no-one in the household was eligible for the survey; in 76 (2 percent), the respondent did not complete the survey, and, in 400 cases (9 percent), an interview was completed.

Survey participants answered approximately 35 questions concerning the name of their drug plan in 2006 and 2007, their process for choosing their 2006 and 2007 drug plans, including sources of information, their activities during open-enrollment period, their information sources and preferences, their knowledge of Part D (with emphasis on knowledge of the extent of variation among Part D drug plans), and their knowledge of benefits in their own plans. The majority of these questions were multiple-choice; however, questions concerning information sources were "open response." The survey also included an additional 11 questions about basic individual characteristics, including eligibility for subsidies.

To create the analytic file, we eliminated 49 participants from analyses of 2007 data because, although these participants reported being enrolled in private drug plans, when they were asked to name their plan, they named an employer-based plan or a Medicare HMO. We also removed three people from the 2007 sample because they were not on 2006 plans, and one additional person in a 2006 plan for whom we did not have data for a 2007 plan, leading to final sample sizes of 351 or 349 for most analyses.

Analyses of plan knowledge required us to match survey data with plan data. Although the survey instrument contained a complete list of plans and 130 participants named a plan on this list, many participants named a sponsor but not a plan (141) or gave an open-ended response (78). We imputed the plan name in these cases when we could do so with confidence, for example, when a named sponsor had only one plan or when an open-ended response matched a known plan. As a result of these efforts, 273 observations included a specific plan name and approximately half of these (127) could be matched to CMS data on plan features.

The main source of plan data was CMS' list of Medicare Stand-Alone plans, which we supplemented by using the Plan Finder to view plans available in a representative zip code in each plan region and manually entering co-payments.

Members of this sample were more likely to be relatively young, female, and college educated than the national population of seniors. Fifty-eight percent of the sample was between 65 and 74 years of age; 33 percent between 75 and 84; and 8 percent over 85; the corresponding national percentages in 2005 were 51, 36, and 14. Seventy-one percent of the sample was female (59 percent). Five percent lacked a high school degree (17 percent), while 27 percent had some college (18 percent) and 25 percent had a college diploma or more (18 percent). Note that one component of these differences may be differences between the population of seniors with Medicare drug plans and the general population of seniors, the other component being differences between the project sample and the national Part D population.

A-2. National Written Survey

The national written survey asked 11,541 seniors enrolled in Medicare a few questions about Medicare drug plan choice in January 2007. These questions were appended to an existing national written survey of 33,571 pharmacy customers conducted in January 2007 by WilsonRx, a consumer research organization that specializes in the retail pharmacy sector, in partnership with a national research panel. This survey, which was mailed to 67,028 households, had a 50 percent response rate across all age groups.

Of this sample, 4,646 seniors (40 percent of seniors with Medicare) had a separate Medicare drug plan in 2007. These participants answered seven multiple-choice questions concerning the name of their drug plan, their process for plan choice, and their activities during the open-enrollment period. The survey also included many other questions, including basic individual characteristics. For these analyses of plan choice, data from the written survey was merged with plan data. The written survey contained check boxes for the top eleven plans in terms of 2006 enrollment, and only individuals who checked one of these boxes were included in the merged sample.

Table A1a. National Phone and Written Surveys: Choice Process and Knowledge

National Phone Survey	Percent of Sample	***National Written Survey*** *(Compared to Phone Survey where applicable)*	Percent of Sample – Unrestricted [h]	Percent of Sample – Restricted [h]
2006 Plan Choice [a], N=348		**2007 Plan Choice**	**N=2423**	**N=1430**
Chose 2006 plan after considering several plans	.49	Chose 2007 plan after considering several plans	.69	.77
Chose 2006 plan without considering other plans	.20	Chose 2007 plan without considering other plans	.12	.12
Assigned to 2006 plan, did not make a choice	.31	Put in 2007 plan, did not make a choice	.15	.08
Don't know/refused	.01	Don't know/Refused	.03	.02
Features Reviewed for 2006 Plan | Not Assigned to a Plan in 2006, N=238		**Features reviewed for 2007 Plan | Not Assigned to a Plan in 2007**	**N=2048**	**N=1317**
Cost and coverage of current drugs	.69	Cost and coverage of current drugs	.83	.86
Premium	.58	Premium	.76	.80
Trusted company	.57	Trusted company	.48	.50
Access to a preferred pharmacy	.46	Access to a preferred pharmacy	.58	.62
Coverage of drugs possibly need in future	.30	Coverage of drugs possibly need in future	.39	.41
		Most important feature reviewed for 2007 Plan | Not Assigned to Plan in 2007	**N=2048**	**N=1317**
		Cost and coverage of current drugs	.43	.44
		Premium	.17	.19
		Trusted company	.09	.09
		Access to a preferred pharmacy	.04	.04
		Coverage of drugs possibly needed in the future	.04	.05
		Other/don't know/refused	.22	.18
Sources of Information Reviewed for 2007 Plan, N=351		**Sources of Information Reviewed for 2007 Plan**	**N=2423**	**N=1430**
Mailings from a plan (own or other)	.47	Mailings from current plan	.64	.67
Mailings from Medicare	.27	Mailings from Medicare	.26	.26
Mailings from AARP	.17	--		
Phone calls with a plan (own or other)	.06	Phone calls / internet site of current plan	.12	.14
Internet sites of a plan (own or other)	.03	Phone calls / internet site of other plans	.10	.11
-		Phone calls / internet site of Medicare	.07	.07
Information Types Reviewed for 2007 Plan, N=351				
Mailings	.53			
In-person contact	.14			
Phone Calls	.07			
Internet	.04			
Review of Comparative Info, N=351				
Reviewed information comparing plans	.34			
Reviewed personalized plan comparisons	.18			
Activities During Open Enrollment for 2007, N=349		**Read mailings from Drug Describing Changes between 2006-2007**	**N=2423**	**N=1430**
Read ANOC [c] thoroughly	.27	Read Thoroughly	.53	.56
Read some parts of ANOC [c]	.30	Read Some Parts	.28	.30
Did not read ANOC [c]	.17	Did not read	.06	.04
Did not receive / do not remember receiving ANOC [c]	.26	Did not receive / do not remember receiving	.08	.07
Don't know	.01	Don't know/refused	.05	.03

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Table A1b. National Phone and Written Surveys: Plan Information

National Phone Survey	Percent of Sample	***National Written Survey*** *(Compared to Phone Survey where applicable)*	Percent of Sample – Unrestricted [h]	Percent of Sample – Restricted [h]
2006 Plan Satisfaction, N=349		**2006 Plan Satisfaction**	**N=2423**	**N=1430**
Very satisfied	.64	Highly satisfied	.24	.23
Somewhat satisfied	.22	Satisfied	.56	.60
Neither satisfied nor dissatisfied	.03	--		
Somewhat dissatisfied	.06	Dissatisfied	.11	.11
Very dissatisfied	.03	Highly dissatisfied	.04	.04
Don't know	.02	Refused	.04	.02
Considered Changing Plans from 2006-2007 [a], N=348		**Switched Plans from 2006-2007**	**N=2423**	**N=1430**
Yes, considered changing plans	.14	Did not switch plans from 2006-2007	.86	.85
No, did not consider changing plans	.73	-		
Did not know I had a choice	.02	-		
N/A, Switched plans from 2006-2007	.10	Switched plans from 2006-2007	.14	.15
Don't know	.01			
Hypothetical Sources of Information Respondents Would Use, N=351 [b]				
Mailings from a plan (Own or Other)	.23			
Mailings from Medicare	.14			
Phone calls to/from a plan	.11			
Mailings from AARP	.08			
In-person contact with friends/family	.07			
In-person contact with plan representatives	.07			
Medicare website	.06			
Plan website	.06			
Phone calls to/from Medicare	.06			
Hypothetical Types of Information Respondent Would Review, N=351				
Mailings	.27			
In-person contact	.23			
Phone calls	.19			
Internet	.14			
Hypothetical Reports Medicare or a senior center could offer, N=351				
Three-page report on the seven cheapest available plans	.34			
Detailed report focused on quality of service / plan features, less focused on cost	.23			
Half-page report on the three cheapest available plans	.17			
No report – rather receive information from other sources	.27			

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Table A1c. National Phone and Written Surveys: Plan Knowledge

National Phone Survey	Percent of Sample	***National Written Survey*** *(Compared to Phone Survey where applicable)*	Percent of Sample – Unrestricted [h]	Percent of Sample – Restricted [h]
Medicare Knowledge Questions [d], N=351				
Knows some Medicare plans have a deductible (not all plans)	.37			
Knows some plans offer coverage in the gap (not none of the plans)	.37			
Knows plans have different co-payments for generic drugs (not the same co-payments)	.55			
Knows plans may choose not to cover some drugs (not that they must cover all drugs)	.63			
Knows different plans are better for different people (not some plans are better than others)	.82			
Knows you can only change plans during open enrollment (not any time)	.74			
Plan Knowledge Questions [e], N=127				
Knows level of plan premium	.56			
Knows whether plan premium changed 2006-2007 [f]	.50			
Knows level of plan deductible	.52			
Knows level of plan co-payment/cost-sharing	.39			
Knows whether plan co-payment/cost-sharing changed 2006-2007 [g]	.41			

[a] One respondent did not know his/her plan in 2006 and is considered part of the 2006 Part D universe, but was not asked choice process questions.
[b] Those on Part D in 2007 include the 348 respondents who were on Part D in both 2006 and 2007 and 3 respondents who were not enrolled in 2006. (There was one respondent enrolled in 2006 who was not enrolled in 2007.)
[c] ANOC refers to the Annual Notification of Changes sent by Part D plans to members of their plan during open enrollment.
[d] All respondents were given the choice of two answers or “don’t know”. Percentages shown are the number who answered correctly.
[e] All respondents were asked what they believed were the levels of their plan characteristics and whether any changes had occurred to these plan characteristics. Percentages shown are the number who were correct in their beliefs of plan levels and changes.
[f] 6 people for whom 2007 plan data is available, had unidentified 2006 plans so N=121.
[g] 14 people had unidentified co-payment/cost-sharing data for either 2006 or 2007.
[h] The unrestricted sample includes all individuals who reported that they had "a separate Medicare drug plan" as opposed to "drug coverage from a current or former employer, a union, the VA, or TRICARE." The restricted sample eliminates individuals who reported any health insurance from a source other than self-purchase and Medicare to address the concern that the unrestricted sample might include individuals who had a separate Medicare drug plan that had been paid for and chosen by a third party.

Table A2. National Phone and Written Surveys: Demographics

National Phone Survey (N=352 on Part D in 2006 or 2007)	Percent of Sample	***National Written Survey*** *(Compared to Phone Survey where applicable)* (N=2423, Unrestricted; N=1430, Restricted)	Percent of Sample – Unrestricted [a]	Percent of Sample – Restricted [a]
Age				
65-69	.31			
70-74	.27			
75-79	.22			
80-84	.13			
85+	.08			
Gender				
Male	.29			
Female	.71			
Education				
Less than high school	.05			
High school diploma or equivalent	.41			
Some college	.27			
College diploma or more	.25			
Don't know/refused	.03			
Income		**Income**		
$20,000 or less	.25	$19,999 or less	.08	.08
$20,001 to $50,000	.31	$20,000 to $49,999	.56	.57
$50,001 to $80,000	.14	$50,000 to $84,999	.23	.22
More than $80,000	.05	More than $85,000	.13	.13
Don't know/refused	.26	-		
Number of Prescription Drugs – Total		**Number of Prescription Drugs – Total**		
None	.09	None	.01	.01
1 to 2	.19	1 to 2	.10	.11
3 to 5	.37	3 to 5	.29	.30
6 to 9	.25	6 to 9	.29	.30
10 or more	.09	10 or more	.31	.28
Don't know/refused	.01	**-**		
Number of Generic Prescription Drugs				
None	.14			
1 to 2	.32			
3 to 5	.26			
6 to 9	.11			
10 or more	.02			
Don't know/refused	.14			
Receives Extra Help or Partial Help		**On Medicaid**		
Yes	.03	Yes	.02	N/A
No	.93	No	.98	N/A
Don't know/refused	.04	-		
Has Supplemental Health Insurance				
Yes	.62			
No	.36			
Don't know/refused	.02			

[a] The unrestricted sample includes all individuals who reported that they had "a separate Medicare drug plan" as opposed to "drug coverage from a current or former employer, a union, the VA, or TRICARE." The restricted sample eliminates individuals who reported any health insurance from a source other than self-purchase and Medicare to address the concern that the unrestricted sample might include individuals who had a separate Medicare drug plan that had been paid for and chosen by a third party.

Appendix B: Audit Methods

The information audit collected one-on-one advice about drug plan choice from 125 organizations that provided personal, apparently unbiased information about the Medicare drug benefit during the 2006 Open Enrollment period. Specifically, the final audit sample consisted of 12 calls to 1-800-Medicare (Medicare's national source of help and information), five calls to SHIPs (Medicare's network of locally based counselors), 88 in-person visits to Boston-area pharmacies, seven in-person visits and one phone call to Boston-area senior centers, and 12 calls to other telephone help-lines. The audit placed particular emphasis on pharmacies because of our interest in third-party private-sector information sources. These five information sources represent four of seniors' most common sources of information about Medicare prescription drug coverage (pharmacies, the Medicare help-line, senior centers, and senior organizations, which were well-represented in the calls to other phone lines).14 Other common sources of information were excluded because they did not offer one-on-one help (publications, the media, the Medicare web-site), were not apparently unbiased (insurance companies offering drug plans or administering other Medicare benefits), or could not be audited effectively (friends and family).

The calls to SHIPs were based on a random sample of states and contact information provided by Medicare. The pharmacy sample was constructed via a two-step process. First, we chose 18 Boston-area communities creating a purposive balance between urban and suburban locations and levels of median income. Within each community, to the extent possible, we sampled equal numbers independent, chain, and mass-merchandiser pharmacies. The final sample consisted of 100 pharmacies in 18 communities. Seven of these pharmacies were later deemed ineligible for the study because they had closed or were overly specialized, and auditors could not locate five, leading to a final total of 88 pharmacies audited.

For the audit of senior centers, we created a sample of 11 locations which were listed as senior centers in the yellow pages and responded by phone that services were available for seniors who were choosing a Medicare drug plan. Due to time limitations, auditors only attempted to visit four of these locations and called one. To broaden the sample, we encouraged one surveyor (a long-time Boston resident) to visit other senior or community centers in her neighborhood, leading to an additional three completed surveys and raising the final total to eight.

The sample of other telephone help-lines was based on a keyword search, "Medicare drug plan help" (7 leads), recommendations from pharmacists (3 leads), and referrals/recommendations from the help-lines themselves (2 leads). The final total of 12 help-lines included three plan sponsors with national foundations/advocacy groups, one pharmacy help-line, two state-sponsored help-lines, two federal agencies, three national non-profit/advocacy organizations, and one independent rating organization.

For the phone calls to CMS, SHIPs, and other help-lines, research assistants placed the calls and used the following introduction, "I'm helping my aunt to choose a Medicare drug plan and it's hard

[14] Source: CMS, Medicare Current Beneficiary Survey, 2005 Access to Care: Survey KN Supplement (Knowledge and Information Needs) Codebook, published 2005.
http://www.cms.hhs.gov/MCBS/Downloads/A05%20Ric%20KN.pdf
Most common sources of information are based on unweighted tabulations of data collected in January-April 2006.

to figure out which one would be best. Can you offer advice?" From that point forward, the research assistants listened and asked neutral follow-up questions. For the calls to 1-800-Medicare, the research assistants used actual Medicare numbers provided by two volunteers; in the other calls, the research assistants did not use the Medicare numbers.

A physician developed two different medication lists for use in the information audit. One was a "high cost" drug list, which consisted of six brand name drugs, and the other was a "low-cost" drug list, which consisted of three generic drugs. Both were intended to seem unremarkable to a pharmacist and suitable for a relatively young, apparently healthy Medicare beneficiary. Neither was necessarily typical of the Medicare population. The two lists differed substantially. For the low-cost list, among the 51 health plans available in Cambridge MA, the mean estimated annual cost was $664, while for the high-cost list, this figure was $4,950. The set of low-cost plans differed for the two drug lists, and each list was used for a randomly selected half of the audit's calls and visits.

Temporary workers, trained by the researchers, made the in-person visits to pharmacies and senior centers using a survey guide. To start the interview, the auditor (1) introduced herself and asked for advice in choosing a Medicare Part D plan. The auditor then followed-up with three focused questions to ask (2) if the individual could recommend a plan, (3) what decision process to use to choose a plan, and (4) which plan features are most important. At this point, the auditor pulled out a fictional drug list on an index card, and (5) expressed concern about choosing a plan that made sense for her drug needs. To close the interview, the auditor would (6) ask where she could go for more help choosing a plan, (7) ask the individual how important the differences between plans are, and (8) ask for written materials about Medicare Part D. In the pharmacies, auditors spoke to the person who seemed most immediately available behind the pharmacy counter and collected all available print materials.

Auditors took comprehensive notes. All data were coded for certain basic outcomes, such as whether a plan was suggested, whether a plan finder was used, whether the auditor was referred to Medicare, etc. The audit data were linked to data on the set of plans available in the Boston area and the associated costs to permit us to analyze whether the plans suggested were, in fact, low cost plans. For the audit of pharmacies, we created and coded for a list of interview themes and coded print materials for source, type of item, and content.

In addition to this coding, researchers directly measured the effectiveness of certain print materials. In July of 2007, we tested the Medicare knowledge of a group of 39 seniors at a senior center in Cambridge MA before and after they reviewed selected informational materials collected as part of the pharmacy audit. For this exercise, we selected four items that were widely available, reflected diverse sources, and had the apparent purpose of communicating basic information about Part D.

As a final component of the information audit, we collected and reviewed several Annual Notices of Plan Changes (ANOCs), official communications between plans and their enrolled members.

Table B1. Responses to Request for Assistance

	Total Sample	Pharmacies	Medicare Help-Line	SHIP Help-Lines	Other Help Lines	Senior Centers
Total Contacts Made	*125*	*88*	*12*	*5*	*12*	*8*
Final Relevant Outcome (most helpful action scored)						
Personalized plan suggestions made	19	4	12	-	3	-
Personalized plan information given w/o specific plan suggestions	5	5	-	-	-	-
Non-personalized plan suggestions made	17	16	-	-	-	1
Referral to Medicare	39	32	-	1	3	2
Referral to other source offering personalized assistance	3		-	0	1	0
Offer of appointment-declined				4		
Other Outcomes						
Identification of Plans and/or Plan Sponsors During Contact						
Plan sponsor selectively named, not based on drug list	19	16	-	-	2	1
Specific plan selectively named	17	3	11	-	3	-
Quality of Plan Suggestions						
Lowest cost plan available (for given drug list) named	10	1	8	-	1	-
High drug list	4	-	3	-	1	-
Low drug list	6	1	5	-	-	-
Referrals to Other Sources of Assistance						
To Medicare	54	43	-	4	4	3
To other public-sector source	20	12	-	2	2	4
To plan sponsor	13	11	-	0	1	1

Notes. This table represents key outcomes from the audit of information sources.

Table B2. Effectiveness of Print Materials

A. Demographic Information	
Mean: Female	.60
Mean: Ages 65-74 (as opposed to 75+)	.54
Mean: On Medicaid	.49
Mean: Has Prescription Drug Coverage	.90
Mean: Has neither Prescription Drug Coverage nor is on Medicare	.08
B. Pre- and Post-Test Means: "Medicare Knowledge Questions"	
Pre-Test Mean [Q1-12]	6.05
(Standard Error)	(.48)
Post-Test Mean [Q1-12]	7.90
(Standard Error)	(.41)
Difference in Pre- and Post-Test Means	1.85***
(Standard Error)	(0.39)
C. Pre- and Post-Test Means: "Application/Calculation Questions"	
Pre-Test Mean [Q13-15]	.36
(Standard Error)	(.11)
Post-Test Mean [Q13-15]	.51
(Standard Error)	(.12)
Difference in Pre- and Post-Test Means	.15
(Standard Error)	(.09)

Notes. This table presents demographic information and results from the "User Testing of Print Materials" experiment conducted at the Cambridge Senior Center with 39 seniors. ***Significant at 1% level.

Appendix C: Experimental Methods

This information experiment collected baseline data on drug utilization and Medicare drug plan enrollment from 550 seniors via a telephone interview in the fall of 2006. Half of these study participants, selected at random, received a personalized mailing highlighting the potential savings from changing plans, while the other half received a more general mailing. A second telephone interview, in the spring of 2007, inquired whether the participant had changed plans for 2007 and about the process of plan choice. A third interview, in the spring of 2008, collected information about plan experience during 2007, the full drug utilization history for 2007, and identified the plan for 2008.

Patients who were over 65 and seen at the University of Wisconsin Hospital and Clinics made up the sample frame for the study. Patients were eligible for the study if they were enrolled in Medicare and in a stand-alone Medicare drug plan. Project staff attempted to contact 14,183 individuals, of whom 5,014 (35 percent) had moved, died, or were never reached; 5,024 (35 percent) were ineligible; 3,595 (25 percent) chose not to participate; and 550 (3 percent) were interviewed.[15]

In the baseline interviews, pharmacy students from the University of Wisconsin collected the drug utilization and other information needed to generate personalized reports using the Medicare Plan Finder as well as the name of the participant's current Medicare drug plan and other basic personal information. The Medicare Plan Finder was used to estimate annual costs for 2008 in all available plans. These estimates were generated using the "general search" feature of the Plan Finder and thus did not utilize participants' Medicare numbers or the Plan Finder's capability to link to Medicare enrollment databases. Like all estimates provided by the Plan Finder, these estimates were based on current drug utilization and assumed that drug utilization would not change during the year.[16]

Study participants were randomized into two groups. Members of the comparison group received a general letter and an informational brochure about how to use the Medicare website created by a reputable organization for seniors, while members of the intervention group

[15] The randomized experiment potentially provides strong internal validity but not necessarily external validity. Patients with recent hospital and clinic visits (especially to an academic medical center) may be more likely than the general population to have experienced recent changes in their health status and drug utilization and to benefit from effort and information directed at Medicare drug plan choice. In addition, the requirement for informed consent and the low participation rates may make the study population unrepresentative of the overall Medicare population. Seniors who were willing to join the study may be more likely than the general population to believe they could benefit from information about drug plan choice and may be correct in this belief, leading the study to potentially over-estimate the magnitude of impacts if the intervention were received by the general population. As reported in the main text, the potential cost savings of current plan relative to the lowest cost plan in our sample was proportional to that found in administrative pharmacy records not subject to survey attrition. Our comparison group is roughly twice as likely to switch plans as a national sample, suggesting that our sample may have a greater dissatisfaction with their plans than a national sample. The results, however, do not suggest that the impact of our intervention differs sharply by dissatisfaction reported in the baseline interview, providing some evidence that the low response rate for partipation in our study may not imply that our results would differ substantially if the response rate had been higher.

[16] The Plan Finder's measure of estimated annual cost is not the same as an ideal measure of expected annual costs because it does not capture expected changes in drug utilization stemming either from changes in seniors' drug needs or from changes induced by the plan.

received a personalized letter that presented their estimated annual costs for 2008 in the current and lowest cost plan and the savings from making the change. (Exhibit C1-C3.) The letter was accompanied by the full print-out from the Medicare website, which showed, in cost order, the names of all 54 plans in the participant's zip code along with the associated costs and four other plan features. (See Exhibit C4 for an example.) Absent the intervention, seniors could have acquired the print-out by using the website themselves, calling Medicare, or visiting some senior centers; the information in the letter came directly from the print-out.[17] All letters were printed on the stationery of the University of Wisconsin Hospital and Clinics, mailed in December 2007, contained identical introductory and concluding paragraphs, and included the internet address of the Medicare Plan Finder.

In the spring, all participants received a follow-up phone call to determine whether they had changed plans and the name of the new plan. In this call, interviewers also asked about 20 additional questions covering participants' activities during the open-enrollment period, including sources of information; perspectives on drug plan choice and drug plan information; and knowledge of the potential savings from changing plans.[18]

Baseline interviews for study participants were completed with 451 individuals. The main analytic file of 406 observations contained data from the baseline and follow-up interviews plus the estimated annual cost in the 2006, 2007, and lowest cost plan as estimated by the Plan Finder. There were several sources of study attrition. 13 individuals could not identify their 2007 plan. 6 individuals dropped Part D coverage for 2007. 26 could not be interviewed because they withdrew consent, could not be located, died, or could not respond for other reasons. Combining all sources of attrition, 8.3 percent of study participants in the intervention group had missing data in our analyses, and 11.6 percent had missing data in the comparison group. The difference of 3.3 percentage points was not large enough to reject with confidence the null hypothesis of equal attrition in the two groups.

Note that some additional individuals, not included in the counts above, were removed from the study based on information collected in the baseline survey. 17 were removed because their 2006 plan was not offered in 2007. An additional 64 were eligible for subsidies and hence faced a different choice process and set of plan options. 10 were not residents of Wisconsin.

For 391 of the 406 observations, we augmented the file by entering costs for all of the 54 available plans; for 15 observations, some 2007 plan cost data on paper forms were lost after 2007 Plan Finder information was not longer available. The data on costs for all plans were used

[17] Our auditors, who called Medicare in late December, were not offered personalized print-outs by mail, presumably because these print-outs might not arrive before December 31. A pilot auditor, who called earlier, was offered and did receive a print-out by mail. Our auditors who visited senior centers were sometimes shown how to use the website but were never given print-outs; however some of our calls to SHIPs suggested that a print-out might have been available from this source if a senior had made an appointment and/or had provided a Medicare number.

[18] The question on potential savings was: "Our final two questions ask about your expectations for 2007. … About how much money do you think you could save if you switched to the least expensive Medicare drug plan?" a. Less than $100; b. $100-$199; c. $200-$500; d. More than $500; e. I already have the cheapest plan." Calculation of underestimation was predicted cost for 2007 minus lower bound imputed expected savings equal to zero for (e), 100 for (a), 200 for (b), and 500 for (c). A potentially offsetting factor in this lower bound calculation was the possibility that individuals lowered their expected savings estimates assuming they would switch at the time of the interview in the spring of 2007 rather than hypothetically switching at the beginning of 2007.

for analyses of the variation in costs among plans and to create the plan-level variables that were then appended back on to the main analytic file.

Relative to the national population of seniors, study participants were typical in terms of age and gender but substantially better educated. Table C1 shows that 53 percent of the sample was between 65 and 74 years of age; 36 percent between 75 and 84; and 11 percent over 85; the corresponding national percentages were 51, 36, and 14.[19] Sixty-three percent of the sample was female; 65 percent were married; 5 percent lacked a high school degree; 48 percent had a college diploma or more. These figures were 59 percent female, 58 percent were married, 27 percent with no high school degree, and 19 percent with a college degree or more in the national population ages 65 and over.[20]

Seniors were randomly assigned to intervention and comparison group and, as expected, the study data suggested the measured characteristics of the two groups were generally similar with one important exception: at baseline, members of the intervention group were more likely to rate their prescription drug coverage as poor or fair and hence, might be expected to have greater rates of plan-switching. Multivariate analyses included this variable.

Table C2 provides additional detail on the dispersion of predicted costs. Table C3 provides additional detail on switching and predicted savings. Table C4 provides additional detail on the plan choice process in 2006. Tables C5 and C6 provide additional results on switching impacts by subgroup.

In order to compare our sample to data on individuals who did not elect to participate in research study, we obtained data on prescriptions filled by a sample of CVS/pharmacy customers. We selected 110 customers who were over 65, had PDP-paid prescriptions in 2006, had no Medicaid-paid prescriptions in either 2005 or 2006, had the majority of their prescriptions paid either by a PDP or by self, and did not appear to be receiving Extra Help subsidies, based on co-payments. For these customers, we created profiles, intended to represent drugs taken on a regular basis (the same standard used in Wisconsin); these profiles included drugs for which the senior had four or more fills during the last six months of 2006. In a manual review, we excluded 13 because they were not on a Medicare plan, 23 because they appeared to be receiving a subsidy and 15 because we were unable to identify specific plans. The final sample of 59 included 41 for whom we identified a sponsor but not a plan. For these individuals, we made two calculations: one in which we identified the lowest cost plan from those offered by the sponsor and the other in which we identified the highest cost plan from those offered by the sponsor. The pharmacy data is likely missing some data on prescriptions that the individual filled at other pharmacies; a countervailing factor is that some individuals with insurance but without prescription use are omitted from the sample by construction.

We also compared the predicted 2007 costs in the lowest cost plan for our sample to results shown in Domino et al., 2008, in which the authors applied the Medicare Plan Finder to data on prescriptions for a national sample of seniors in the 2003 Medicare Expenditure Panel Survey.

[19] Source: US Census Bureau, "Age and Sex for States and Puerto Rico: April 1, 2000 to July 1, 2000," published August 4, 2006. http://www.census.gov/popest/states.asrh/SC-EST2005-02.html.
[20] Source: US Census Bureau, "Educational Attainment in the United States: 2004, Detailed Tables," published March 2005.

Roughly speaking, the level of out of pocket expenditures is about 50 percent higher in our sample than in these samples. Specifically, based on using the more expensive plans, in the pharmacy data, the 2007 average predicted cost in the plan chosen was $1,382; in our sample, it was $2,119, or 53 percent higher. In the Domino study, the average 2006 predicted cost in the lowest cost plan was $1114; in our sample, the corresponding 2007 predicted cost was $1594, or 43 percent higher. These differences are probably due to a combination of our sample being drawn from a universe of hospital patients, comprised of individuals who voluntarily participated in a study involving discussion of prescription drugs, and more recent than the MEPS data. However, the potential savings from changing plans, as a share of current expenditure, was similar or lower in our sample than in the national pharmacy sample (30 percent in our sample, between 24 and 41 percent in the pharmacy sample, depending on the method used), suggesting that the study did not disproportionately attract those who stood to benefit financially from changing plans.

A third telephone interview was conducted in the spring of 2008. Prior to the interview a letter was sent to all participants indicating the upcoming call and containing a one-page handout with information to be referred to in the subsequent interview. These interviews were again conducted by pharmacy students from the University of Wisconsin. The interviews asked whether the participants had changed plans in 2008, and the names of their 2008 plans. The interviews also asked about 35 additional questions covering the participants' activities during the open-enrollment period in fall 2007; knowledge of the potential savings from changing plans; and experiences during 2007 with their drug plans. Finally, the interviews collected detailed drug utilization histories for 2007 and a current list of drug utilization as of spring 2008. Information drawn from these interviews is presented in Table 5.

Of the 406 participants whose data is reported in the original set of interviews, 331 were able to be re-interviewed in spring 2008, of whom 305 provided a complete set of data which is analysed and presented here. There were several sources of attrition. 75 individuals could not be interviewed because they withdrew consent, could not be located, died, or could not respond for other reasons. 10 individuals were unable to identify their 2008 plan. 3 individuals were newly eligible for extra subsidies in 2008. 18 individuals gave responses to the 2008 survey which were unreconcilable with their responses to the 2007 survey. Combining all sources of attrition, 21.2 percent of study participants in the intervention group had missing data in our 2008 analyses, and 28.8 percent had missing data in the comparison group. The difference is statistically significant at the $p<.10$ level, however the 2008 sample is similar to the 2007 sample in terms of key demographic characteristics and implied estimates of critical study outcomes.

The detailed drug utilization histories collected in this interview were used to retrospectively estimate the actual costs which would have been experienced in 2007 by participants in all 54 drug plans available to them. An archived version of a Medicare Part D prescription drug plan cost comparison webtool (Plan Presciber) with 2007 premiums and drug prices was provided by Experion Systems. This program mimics the Medicare Plan Finder available at the CMS website and was found to generate cost estimates which differed on averge by about 4% from those generated by the Medicare Plan Finder. The Medicare Plan Finder itself could not be used for this retrospective cost analysis, since it only provides current year cost data. The complete list of prescription drugs reported as utilized by study participants was entered into the Plan Prescriber

webtool and the estimated 2007 costs based on actual 2007 drug utilization for all 54 plans available to the participants in 2007 were retrieved. The following conditions apply to these data: 1) for the 30% of the prescriptions which were only used for a few months, filling frequencies and/or monthly supply levels were altered upon entry into the webtool in order to approximate the costs experienced for these durations; 2) in cases (less than 3% of prescriptions) where a medication was only used for a very brief duration, i.e. less than 2 weeks, the drug was not entered (these were essentially all short courses of generic, low-cost antibiotic treatment); and 3) in a small number of cases the reported drug names were ambiguous or otherwise unavailable in the Plan Prescriber database (about 1% of prescriptions) and were not included in cost estimates. These estimates of 2007 experienced costs, based on 2007 reported drug utilization, are used to generate the plan cost changes reported in Table 5, panel A.

Predicted costs for 2008 were based on the drugs reported as current at the time of the 2008 interview and the Medicare Plan Finder.

Table C1. Experiment Demographics

	Mean (SE in Parentheses)			Difference in means: (SE)	Significance of the difference in means: t-statistics
	Overall (N=406)	Comparison (N=197)	Intervention (N=209)		
	(1)	(2)	(3)	(4)	(5)
Female	.63 (.02)	.63 (.03)	.64 (.03)	.01 (.05)	.14
Age	75.16 (.32)	74.64 (.46)	75.65 (.43)	1.01 (.63)	1.60
High school or equivalent	.95 (.01)	.94 (.02)	.95 (.01)	.01 (.02)	.58
College diploma	.48 (.02)	.47 (.04)	.48 (.03)	.01 (.05)	.13
Graduate degree	.18 (.02)	.20 (.03)	.16 (.03)	-.05 (.04)	1.18
White	.97 (.01)	.98 (.01)	.96 (.01)	-.02 (.02)	1.07
Married	.65 (.02)	.67 (.03)	.63 (.03)	-.04 (.05)	.81
Mean Number of Medications	5.46 (.18)	5.28 (.25)	5.62 (.26)	.34 (.36)	.94
<=3 Medications	.36 (.02)	.39 (.03)	.34 (.03)	-.04 (.05)	.86
4-6 Medications	.32 (.02)	.32 (.03)	.32 (.03)	.00 (.04)	.09
7+ Medications	.31 (.02)	.29 (.03)	.33 (.03)	.05 (.05)	.99
2006 Plan Rated Very Good/ Excellent	.38 (.02)	.41 (.04)	.34 (.03)	-.07 (.05)	1.39
2006 Plan Rated Poor/ Fair	.31 (.02)	.26 (.03)	.35 (.03)	.09 (.05)	1.98**
Predicted cost of 2006 Plan in 2007	$2119.54 (87.20)	$2125.95 (122.64)	$2113.49 (124.10)	-$12.46 (174.69)	.07
Predicted cost of Lowest-Cost Plan in 2007	$1593.03 (72.67)	$1606.23 (102.55)	$1580.59 (103.11)	-$25.64 (145.57)	.18
Potential Savings [a]	$526.51 (31.02)	$519.73 (44.46)	$532.90 (43.40)	$13.18 (62.14)	.21

Notes. This table displays descriptive statistics for the overall sample as well as by both experimental groups (columns 1, 2, 3) and reports differences and associated t-statistics between group means (columns 4, 5). Figures may not sum to do rounding. [a]"Potential savings" is defined as the difference between predicted cost of the 2006 plan (in 2007 terms) and the identified lowest-cost cost plan. *Significant at the 10% level. **Significant at the 5% level. ***Significant at 1% level.

Table C2. Additional Detail on Predicted Cost

N=406	Mean	Median	Minimum	Maximum	Standard Deviation
Predicted cost of 2006 Plan (in 2007 terms)	$2120	$1356	$178	$9630	$1757
Predicted cost of Lowest-Cost Plan in 2007	$1593	$856	$178	$7989	$1464
Predicted cost of 2007 Chosen Plan	$2043	$1336	$178	$9007	$1677
Potential Savings [a]	$527	$381	$0	$4946	$625
Predicted Savings [b]	$76	$0	-$744	$4825	$378

Notes. This table displays detailed summary statistics on predicted annual cost variables in the information experiment. [a] "Potential savings" is defined as the difference between 2006 plan cost (in 2007 terms) and the identified lowest-cost plan. [b] "Predicted savings" is defined as the difference between the cost of 2007 chosen plan and the cost of the 2006 plan in 2007 terms.

Table C3. Experiment Outcomes

	Comparision		Intervention		Difference in means: (SE)	Significance of the difference in means: t-statistics
	N	Mean (SE)	N	Mean (SE)		
	(1)	(2)	(3)	(4)	(5)	(6)
Switched plans from 2006 to 2007	197	.17 (.03)	209	.28 (.03)	.11 (.04)	2.78***
Switched to lowest-cost plan	197	.02 (.01)	209	.09 (.02)	.07 (.02)	2.95***
Switched to other plan	197	.15 (.03)	209	.20 (.03)	.05 (.04)	1.30
Mean predicted savings [a] | switched plans	33	$97.36 (60.68)	59	$469.37 (112.13)	$372.01 (156.94)	2.37**
Mean predicted savings [a] | *switched to lowest-cost plan*	4	$308.75 (147.42)	18	$713.00 (190.50)	$404.25 (416.70)	.97
Mean predicted savings [a] | *switched to other plan*	29	$68.21 (64.94)	41	$362.41 (136.11)	$294.21 (171.08)	1.72*
Mean predicted savings [a] | all respondents	197	$16.31 (10.37)	209	$132.50 (34.70)	$116.19 (37.14)	3.13***
Predicted cost of 2006 plan | *all respondents*	197	$2125.95 (122.64)	209	$2113.49 (124.10)	-$12.46 (174.69)	.07
Potential savings [b] | *all respondents*	197	$519.73 (44.46)	209	$532.90 (43.40)	$13.18 (62.14)	0.21
Predicted cost of 2007 plan | *all respondents*	197	$2109.64 (121.47)	209	$1980.99 (114.29)	-$128.65 (166.63)	.77

Notes. This table displays key switching and cost statistics for the overall sample by experimental group post-intervention (columns 1, 2, 3, 4) and reports the differences and associated t-statistics between group means (columns 5, 6). Figures may not sum due to rounding. [a] "Mean predicted savings" is defined as the difference between the cost of 2007 chosen plan and the cost of the 2006 plan in 2007 terms. [b] "Potential savings" is defined as the difference between 2006 plan cost (in 2007 terms) and the identified lowest-cost plan. *Significant at the 10% level. **Significant at the 5% level. ***Significant at the 1% level.

Table C4. Choice Process

	Comparison		Intervention		Difference in means: (SE)	Significance of the difference in means: t-statistics
	N	Mean (SE)	N	Mean (SE)		
	(1)	(2)	(3)	(4)	(5)	(6)
Considered Changing Plans [a]	164	.31 (.04)	150	.35 (.04)	.04 (.05)	.67
Average time spent deciding on 2007 plan in 2006 (hours) [b]	193	2.97 (.33)	201	3.69 (.31)	.72 (.45)	1.61
Spent enough time deciding?	197	.72 (.03)	209	.75 (.03)	.04 (.04)	.81
Read project materials thoroughly	197	.26 (.03)	209	.45 (.03)	.19 (.05)	3.96***
Do not remember receiving materials	197	.34 (.03)	209	.24 (.03)	.10 (.04)	2.14**
Found materials somewhat or very helpful	197	.09 (.02)	209	.20 (.03)	.11 (.03)	3.14***
Received other information in fall 2006	197	.53 (.04)	209	.56 (.03)	.03 (.05)	.64
Percent overestimating potential savings [c]	109	.09 (.03)	129	.12 (.03)	.02 (.04)	.61
Percent underestimating potential savings [c]	109	.72 (.04)	129	.54 (.04)	- .17 (.06)	2.77***

Notes. This table displays other follow-up variables for the overall sample post-intervention as well as by both experimental groups (columns 1, 2, 3, 4) and reports differences and associated t-statistics between group means (columns 5, 6). Figures may not sum due to rounding. [a] 92 respondents not applicable as they did change plans. [b] 12 respondents unable to estimate time spent deciding on 2007 plan in 2006. [c] Overestimation and underestimation figures determined by subtracting potential savings from response to question: “About how much money do you think you could save if you switched to the least expensive Medicare drug plan?” 168 respondents were unable to estimate potential savings.

Table C5. Analysis of switching plans between 2006 and 2007, by cost subgroups

	Switching probability		Lower bound impact on predicted cost		N
	Comparison	Intervention	Dollars	Log points	
	(1)	(2)	(3)	(4)	(5)
A. Relative potential savings					
≤ 33%	.193	.276	- 78	- .046	230
			(58)	(.027)	
> 33%	.133	.290~	- 547 *	- .272 *	176
			(160)	(.083)	
B. Predicted 2007 cost of 2006 plan					
≤ $1500	.125	.221	- 97 *	- .158 *	217
			(49)	(.075)	
> $1500	.215	.354~	- 353 *	- .121 *	189
			(121)	(.038)	
C. 2007 Monthly premium of 2006 plan					
≤ $30	.085	.292~	-142	-.139*	190
			(73)	(.056)	
> $30	.243	.274	-138	-.095	216
			(72)	(.050)	
D. Difference in 2007 monthly premium between 2006 plan and low cost plan					
≤ $10	.115	.280~	-224*	-.139*	202
			(73)	(.051)	
> $10	.226	.284	-239*	-.136*	204
			(114)	(.053)	

Notes. All subgroups are defined on characteristics known prior to random assignment. Relative potential savings = 1 – (predicted 2007 cost of least expensive plan / predicted 2007 cost of plan chosen in 2006). ~ = p-value <.05 on difference between columns 1 and 2. Column 3 estimated using method in Table 3, panel C, row 1. Column 3 estimated using method in Table 3, panel C, row 2. Standard errors in parentheses. * = p-value <.05.

Table C6. Analysis of switching plans between 2006 and 2007, by additional subgroups

	Switching probability		Lower bound impact on predicted cost		N
	Comparison	Intervention	Dollars	Log points	
	(1)	(2)	(3)	(4)	(5)
A. Premium increase for 2006 plan between 2006 and 2007					
≤ $7 per month	.130	.260~	-332*	-.168*	188
			(135)	(.061)	
> $7 per month	.200	.301	-222*	-.132*	218
			(87	(.049)	
B. Number of medications taken					
≤ 4	.160	.250	-138*	-.194*	195
			(56)	(.072)	
> 4	.175	.310~	-326*	-.101*	211
			(124)	(.037)	
C. Marital status					
Not married	.154	.169	-108	-.135	142
			(107)	(.086)	
Married	.174	.348~	-281*	-.147*	264
			(88)	(.042)	
D. Age					
≤ 73 years old	.151	.247	-243*	-.143	195
			(96)	(.063)	
> 73 years old	.187	.308~	-191	-.109*	211
			(104)	(.045)	
E. Gender					
Male	.164	.342~	-260*	-.199*	149
			(88)	(.062)	
Female	.169	.248	-259*	-.106*	257
			(109)	(.047)	

Notes. Same as Table C5.

Appendix D: Derivation of Upper and Lower Bounds on Effects on the Potentially Affected

The notion of being affected by the intervention involves an unobserved counterfactual of what would have happened if an individual had been randomly assigned to the other group. To be precise, it is helpful to use some notation. Define C as an indicator of being potentially affected by the intervention, where C involves the counterfactual and cannot be directly observed. Define S as an observed indicator for switching plans, and Z as an indicator for assignment to the intervention group. Define $Y = Y^{07} - Y^{06}$, Y_1 as the potential outcome if an individual were assigned to the intervention group, Y_0 as the potential outcome if an individual were assigned to the comparison group. The causal effect of the intervention is then Y_1-Y_0**.**

There would be a causal effect for any individual who would have chosen a plan with a different predicted cost in the intervention group than in the comparison group. These situations include having the intervention cause someone to switch to a lower cost plan ($Y_1<0$; $Y_0=0$), having the intervention cause someone who was going choose a more expensive plan to not switch ($Y_1=0$; $Y_0>0$), and other cases (anytime $Y_1 \neq Y_0$). A special case is when someone would not switch plans regardless of the intervention, so there is no effect on cost. The upper bound on probability of this special case occurs when everyone who switches plans in one group would have switched if assigned to the other group (1- max{E[S | Z=1], E[S | Z=0]}). The lower bound on the probability of this special case occurs when no one who switches plans in one group would have switched if assigned to the other group (1- {E[S | Z=1] + E[S | Z=0]}). Intuitively, we can use the lower bound on the fraction of zeros included in the estimate of the average cost change for the entire intervention group versus the comparison group in order to calculate a lower bound on the average cost change for those who potentially were affected by the intervention. This bound is based on the derivation in equation (D1).[21]

(D1) $E[Y^{07} - Y^{06} \mid Z=1] - E[Y^{07} - Y^{06} \mid Z=0]$

$= E[Y_1 \mid Z=1] - E[Y_0 \mid Z=0]$

$= E[Y_1-Y_0]$

$= E[Y_1-Y_0 \mid C=1]Pr(C=1) + E[Y_1-Y_0 \mid C=0]Pr(C=0)$

$= E[Y_1-Y_0 \mid C=1]Pr(C=1) + 0$

$\leq E[Y_1-Y_0 \mid C=1]\{E[S \mid Z=1] + E[S \mid Z=0]\}$

We can now calculate an expression based on (3) for a lower bound on the average cost change for those who were potentially affected by the intervention, shown in equation (D2).[22]

[21] The first line of equation 3 is the difference in observed outcomes between the intervention and comparison groups. The second line uses the definition of potential outcomes. The third line uses the independence of potential outcomes from randomly assigned groups. The fourth line uses the definition of conditional expectation. The fifth line uses the definition of C, where $Y_1-Y_0= 0$ when C=0. The sixth line uses the lower bound described in the text, where Pr(C=0) = 1-Pr(C=1) <= 1- {E[S | Z=1] + E[S | Z=0]}.

[22] This approach is similar to that used by Imbens and Angrist (1994) to estimate a local average treatment effect (LATE), where those who did not comply and take up the treatment offer are assumed to have been unaffected. However, LATE also involves an assumption of monotonicity and an exclusion restriction, and neither of these are needed for (3). If being treated were defined as being caused to switch plans, then monotonicity would be violated if the intervention caused some people to not switch who would have otherwise switched and the exclusion restriction would be violated if those in the comparison group who would have switched without the intervention nevertheless had their plan choice affected by the intervention. Our intuition is that the exclusion restriction does not hold in this application but monotonicity probably does. If we were to assume monotonicity holds but not impose the exclusion

(D2) $E[Y_1-Y_0|C=1] \geq \{E[Y^{07}-Y^{06} \mid Z=1]- E[Y^{07}-Y^{06} \mid Z=0]\} / \{E[S \mid Z=1] + E[S \mid Z=0]\}$

In this paper's application, the point estimates and standard errors use the estimates from Table 3, panel B, and are simply rescaled by $1/\{E[S \mid Z=1] + E[S \mid Z=0]\}$. There is a small amount of negative covariance between the estimation of average cost differences and switching rates, and accounting for this slightly reduces the standard errors in panel C; for simplicity, this adjustment is not included in the results shown[23]

restriction, then panel C would rescale the results by $1/E[S \mid Z=1]$ instead of $1/\{E[S \mid Z=1] + E[S \mid Z=0]\}$, and would result in point estimates about 1.6 times larger in column 1.

[23] Both the point estimates and standard errors use the estimates from panel B and are simply rescaled by $1/\{E[S \mid Z=1] + E[S \mid Z=0]\}$. There is a small amount of negative covariance between the estimation of average cost differences and switching rates, and accounting for this slightly reduces the standard errors in panel C; for simplicity, this adjustment is not included in the results shown.

Exhibit C1: Comparison Group Letter

December 2006

Dear UWHC Patient:

Thank you for participating in our Medicare Part D prescription drug plan study. I hope the information you received on the phone recently was helpful to you.

As you were told, you can find additional information regarding the plans available to you by accessing the Medicare Prescription Drug Plan Finder web site at: http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/SearchOptions.asp.

You can use the enclosed document from AARP to assist you in using the web site.

Please remember that later this coming spring, we will call again to find out what plan you chose and how satisfied you are with your choice; that call will take about 10 minutes.

If you have any questions or concerns about this study or the information you have received, please feel free to contact me at 608-262-7537. Thank you for your kind consideration!

Sincerely,

Lee Vermeulen, R.Ph., M.S., FCCP
Director, Center for Drug Policy
UW Hospital and Clinics
Clinical Associate Professor
UW- Madison School of Pharmacy

Exhibit C2: Intervention Group Letter

December 2006

«First_Name» «Last_Name»
«Street»
«City», «State» «Zip»

Dear UWHC Patient:

Thank you for participating in our Medicare Part D prescription drug plan study. I hope the information you received on the phone recently was helpful to you.

Please find enclosed a summary of the information that you received during the interview. As you can see from the Medicare web site, you may have an opportunity to save on your prescription drug costs by changing plans for 2007.

The plan you reported being in for 2006:	«M_06_PLAN»
The estimated cost of that plan for 2007:	$«ANNUAL__OF_PTS_CURRENT_PLAN_06»
The lowest cost plan available to you for 2007:	«LEAST_EXPENSIVE_PLAN_07»
The estimated cost of that plan for 2007:	$«ANNUAL__07»
Your potential savings for 2007 if you choose the lowest cost plan:	$«POTENTIAL_SAVINGS»
Comments:	«COMMENTS_TO_SUBJECTS»

Note that even if you have already chosen a plan for 2007, you can still change your mind and choose a different plan until December 31, 2006! If you do choose to change plans, you can access the Medicare web site at:
http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/SearchOptions.asp

Please remember that later this coming spring, we will call again to find out what plan you chose and how satisfied you are with your choice; that call will take about 10 minutes. If you have any questions or concerns about this study or the information you have received, please feel free to contact me at 608-262-7537. Thank you for your kind consideration!

Sincerely,

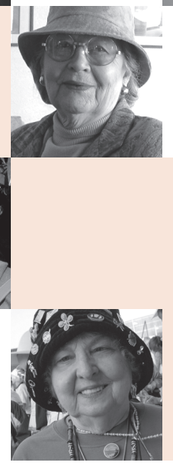
Lee Vermeulen, R.Ph., M.S., FCCP
Director, Center for Drug Policy
UW Hospital and Clinics
Clinical Associate Professor
UW- Madison School of Pharmacy

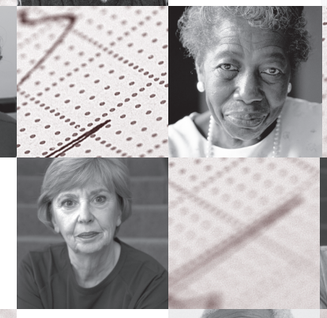
The New Medicare Prescription Drug Coverage

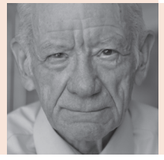
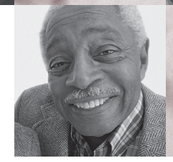
Using the Medicare Prescription Drug Plan Finder







AARP®

601 E Street, NW
Washington, DC 20049

For more information about Medicare's prescription drug coverage, visit AARP's website at www.aarp.org/medicarerx, or call 1-888-OUR-AARP (1-888-687-2277).

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Contents

Introduction

In this booklet you will find information about how to use the tools available to help you make a decision about a Medicare prescription drug plan. For those who have access to a computer and/or assistance from a computer user, Medicare has developed the Medicare Prescription Drug Plan Finder. In this booklet you will find a step-by-step guide on how to do a "General Search" of prescription drug plans. There are various other kinds of searches that can be done, but our goal was to familiarize you with the tool itself—enabling you to move on to other searches yourself later. For those who do not have access to a computer and/or who are uncomfortable working with this kind of a tool, there is also information about how to enroll in a Medicare prescription drug plan using the telephone. Either way, we hope you will explore the new Medicare prescription drug coverage options available to you—to see if it will help you save on your drug costs. Finally, if you need more information before making a final decision, see the "Other resource information" column on page 9.

Using the Medicare Prescription Drug Plan Finder

Preparing for Your Drug Plan Search

Before using the Medicare Prescription Drug Plan Finder, you should collect the following information (see worksheet on page 11):

1. **A List of the Prescription Drugs You Take:**
   - Name of each drug*
   - Dosage or strength of the drug you take (e.g., 20 mg)
   - Number of times you take each drug each day or per week

*Prescription drugs are dispensed in a variety of ways—tablets, capsules, patches, time-released, etc. Often this information is entered in coded language on your pill container. The names of some drugs may also be abbreviated because they are so long. Thus, your pill container may not give you everything you need for your drug list. It therefore might be a good idea to talk with your pharmacist when making your list—and if you get all your drugs from one place, your pharmacist may be willing to provide you with a printout of your drug list.

2. **Information about Your Current Insurance Coverage (if any)** such as a Medicare supplement, retiree coverage, Medicare Advantage (managed care) plan, VA, TRICARE, or FEHB.

For Help on the Computer:

- **Ask a family member or friend to help you.**
- **Contact the State Health Insurance Assistance Program (SHIP). Call 1-800-633-4227** to learn the number for your state's SHIP. SHIP trains volunteers to help people with their Medicare issues. Most are computer savvy. Or,

Current coverage

If you have VA, TRICARE, or FEHB, your drug coverage may already be as good as the new Medicare Rx coverage. Your medical plan provider should have sent you information by now about whether your coverage is as good as Medicare's.

If you were in a Medicare Advantage Plan with prescription drug coverage prior to 2006, your plan should have informed you that you would be enrolled in their Medicare prescription drug plan.

If you had retiree drug coverage through a former employer or union, or a Medicare supplemental plan with drug benefits, prior to 2006, you should have been notified by your plan provider if your coverage is as good as Medicare's drug coverage.

Tips on using the Medicare Speech Automated System

It will ask you a series of questions about what kind of information you need. The basic questions you will need to answer are as follows:

1. If you are calling about the new Medicare drug coverage, say: "Drug Coverage."
2. For information on how the new prescription drug plans work, say: "Plan Choices."
3. Do you have your Medicare Card?
4. Please tell me your Medicare Claim Number, including any letters (it's on your Medicare card).
5. May I have your last name, without spelling it?
6. What is your date of birth?
7. What was the starting date of your Medicare coverage? (This is on your Medicare card.)
8. Our records show that you are... (enrolled or not enrolled in Medicare prescription drug plan).
9. If would like to speak with an agent, you will need your drug list and Medicare card. Say: "Agent." This will bring a customer service representative from Medicare on to the line.

- **Call your local Area Agency on Aging at 1-800-677-1116** to learn which office is the closest to you.

If You Don't Have Computer Access:

- **Call MEDICARE at 1-800-633-4227.** Customer service representatives will walk you through the Plan Finder. If you request it, they will send you a "Customized Print on Demand" booklet of the prescription drug plans that might work best for you.

Tips for calling Medicare:

- Medicare's toll-free number is currently available 24 hours a day, 7 days a week. Try to call during non-peak hours such as evenings or weekends, and try to avoid Monday mornings.
- You will need to have your list of drugs and dosages, your Medicare card, your date of birth, and the date you originally enrolled in Medicare (the date is on your Medicare card) available when you call.
- Write down any specific questions you have before calling, and check your questions off as they are answered when you call.
- When you make the call, you may first get a "Speech Automated System" (a computer) that will instruct you to say your answers. If you decide to use this system, you will need to speak slowly, distinctly, and loudly enough for the computer to understand you. Also, try to minimize any background noises that might make it hard for you and the computer to hear.
- If the response from the Medicare automated system is that you are not enrolled in a plan, it will ask you to please check back later because Medicare is updating its records daily. So if you have enrolled already, wait about a week and call Medicare back. If you haven't enrolled yet, and want to get Medicare drug coverage, you will need to make a choice and enroll in a plan. Say: "Enroll."
- **If you dislike or have difficulty using a speech automated system, you can press zero (0) on your telephone to bypass the automated system**. This may or may not get you to a customer service operator right away—depending upon how busy they are. **It's important to know, however, that calls are taken in the order they are received—so hanging up and calling back only puts you at the back of the line!**

If You Do Have Computer Access:

Once you have gathered your drug information, you are ready to begin your prescription drug plan search, using the Medicare Prescription Drug Plan Finder.

To keep your initial search simple, this tool focuses on "Stand Alone" prescription drug plans associated with the traditional Medicare fee-for-service program. By working through a "General Search," you will become better acquainted with the information available through the Plan Finder.

To start your prescription drug plan search:

1. On the computer, go to the Internet, type: **www.medicare.gov**, hit enter, and log onto the Medicare website.
2. Click on **Compare Medicare Prescription Drug Plans**.
3. Scroll down to where you see (in blue) **Where Would You Like to Begin?** Then, where you see, **Find a Medicare Prescription Drug Plan**, click on the orange arrow to the right.
4. Scroll down to the lower half of the page until you see a button that says **General Search** and click on that button.
5. Enter your **Zip Code** in the box that is provided. **Do not hit enter**.

Note: In some cases, when you enter your zip code, you will get another box that asks you to select your county. Click on the drop down arrow and select your county, then click on **Continue**.

Extra Help for those with limited income

Extra Help is available if your income and assets are below these figures:

- Income eligibility for Extra Help is $14,355 (single) or $19,245 (couple).*
- Asset eligibility is $11,500 (single) or $23,000 (couple).

If it looks like your income is less than these figures, even if you have some doubts, it is a good idea to apply for this benefit, since it could provide:

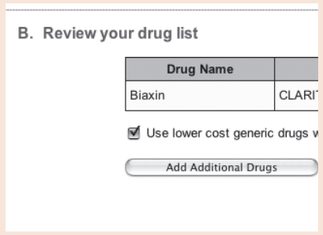
- Unlimited drug coverage (no coverage gap).
- Greatly reduced (or even zero) monthly premiums.
- Greatly reduced (or even zero) annual deductible.
- Co-pays of $1 to $5 or 15% of the cost of each drug—depending on income and asset levels.

*Income figures will go up for 2006.

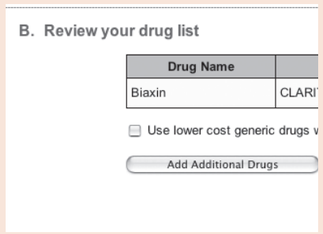
Generic check box

When you enter a drug name, the computer automatically checks to see if a generic drug is available.

Generics will automatically come up on your list of drugs



—unless you uncheck the box first (below).



Because generics are usually less expensive than their brand name equivalents, the computer will also factor the generics listed into the plan costs. Therefore, the cost quotes might be misleading, if you intend to stay with a brand name as opposed to a generic.

You will have another chance to do this kind of cost comparison later, so we suggest you uncheck the box at this point in your search.

6. On the same page, scroll down and click on the box that best describes your **Current Prescription Coverage**. If you don't know, click "**None of the Above**."

7. On that same page, scroll down and select "**yes**" or "**no**" to the question **Eligible or Qualify For Additional Help**, then scroll down and click the **Continue** button. (**If you are not sure if you will qualify for the Extra Help, check the eligibility information in the box in the shaded area on page 3.**)

8. This will bring up the next window **Decide on Your Plan Options**. At the bottom of the page, click on **Choose a Drug Plan Type**.

9. Near the bottom of the page, click on the gray button **Search for Medicare Prescription Drug Plans**.

10. Scroll down to **Enter Your Medications**, and click on the gray button. Using the list of drugs you made earlier, type the name of your drug in the box that appears, and click **Search for Drug**. Scroll down to **Review Your Drug List** to see that drug name has been entered. If you have more than one drug to enter, click on **Add Additional Drugs** and enter the next drug. Repeat for each drug used, clicking **Add Selected Drug to My List** each time after typing in the name of your drug. Don't panic when the screen appears to go blank—the computer is just doing its work.

Note 1: If you type the drug name incorrectly or just type in the first few letters, the program will give you a drop-down screen with a list of drugs to choose from that are close to what you've entered—select the correct drug and then click on **Add the Drug to My List**. You can also enter just the first letter of the drug name (such as "L" for Lovastatin) and you will get a complete listing of all drugs that start with that letter. If you find your drug on this list, you then need to select it and click on **Add the Drug to My List**.

Note 2: When all your drugs are listed, click on the little box below the list. This will remove the check mark (see explanation in the shaded box) from the box that says: "Use lower cost generics when available."

Note 3: If a particular drug does not appear on the Medicare Plan Finder list, it is probably not covered by Medicare and you will have to pay for the drug yourself—unless you qualify for another program such as Medicaid or a state pharmacy assistance program

11. When you have completed entering your list of medications, click on **Continue with Selected Drugs**.

12. Next click on **Change/Update My Drug Dosage**. **This is one of the most important steps in the whole process!** You will get a more precise plan comparison if you take the time to enter exact dosages and quantities. For example, if two pills are taken per day, change the 30-day quantity to 60. To change the dosage, click the drop-down arrow to the right of the drug name, and then click **Update Dosage/Quantity** to make sure all your changes have been registered. You next need to click on **Continue with Selected Drugs**.

13. Scroll down to **Choose How You Want to View Your Plan**. Click on **Continue to Plan List** rather than **Select My Preferred Pharmacy**. You will have another chance to do this later. You will then see a screen titled **Find a Medicare Prescription Drug Plan**. Scroll down to the **Prescription Drug Plan Comparison** multi-colored chart that gives you plans for the zip code you entered, starting with the one that is estimated to be least expensive overall calculated for 30-day supplies from local "preferred" pharmacies (those that are in the plan's network). You still need to compare plans, however, because there are other factors to think about.

Note: In order to view the information about the various plans, you will click on the words in the column that are underlined (Plan Information, Plan Name, # of Pharmacies, etc.). This will bring up more detailed information about each plan. In order to move back and forth between these columns, you should scroll down to the bottom of the screen and click on the buttons that may say **Return to Personalized Search**, **Close Window**, or **Return to Previous Page**. You can also use your "back" button on your computer in most cases to move back and forth between the various windows.

Getting the answers you need from the Medicare Rx Plan Finder

What will my detailed cost be under this plan?
See **View Cost Details**.

What are my 90-day mail order options?
See **View Cost Details**.

Are there ways of paying less under a prescription drug plan? See **Lower My Cost Share**.

How can I tell whether all my drugs are covered?
See **View Cost Details**.

How can I tell what my drug costs will be in the "gap in coverage?" See **View Cost Details/Show Details** or **Plan Name/Show Details** (if it says **Hide Details** click on it to bring up the **Show Details**).

Note: A Double Asterisk (**)—to the right of a drug's name (in **Show Details**) means it is not part of a plan's preferred drug list, or formulary, and therefore will be more costly to you.

How can I tell whether I can get my prescription drugs in other parts of the country under this plan, if I'm traveling? See **View Plan Notes**.

Which pharmacies can I go to under this plan? Click on the number in the **# of Pharmacies** Column.

14. Scroll down about halfway until you see a multi-colored chart. Look for the heading **More About this Plan**.

    Then, starting in the **Plan Information** column on the topmost plan, click on the **Select Below** arrow that will provide a drop-down menu with the following selections:

    - **Enroll in this Plan**
    - **View Cost Details**: This gives you what you need to compare plans properly. Some of the things it shows include: (see box to the right also)
        > An estimate of your total annual costs (including premiums, deductibles and co-pays) for all of 2006.
        > Your fixed costs —monthly premiums and annual deductible (if any).
        > Your co-pays in the initial coverage period.
        > If or when you might reach the "gap in coverage" and what your drugs will cost you when you do.
    - **Lower My Cost Share**: This is where you can check to see what savings might be available through the use of a similar drug or generic equivalent.
    - **View Notes**: This will give you information about whether the plan is regional or national, as well as information about where you might obtain your drugs (pharmacy networks, etc.)

15. In the **Plan Name Column**, click on the name of the plan to get detailed information about your specific drug costs, including:
    - Your monthly premium and deductible (if any).
    - Your specific co-pay or co-insurance for each drug you listed earlier.
    - The "tier" your drug(s) are in for that plan (remember tiers won't necessarily be the same for all plans).
    - The cost for a 90-day mail order supply.
    - If and when your costs are estimated to reach the "gap in coverage" or catastrophic level, and your estimated monthly cost during the "gap" period.
16. In the **Select to Compare** column, click in the boxes to the left of the plan names (up to three at a time) you are interested in, and then scroll down and click the button that says **Compare Three Plans**. Repeat for more comparisons.
17. In the **# of Pharmacies column**, click on the **#** to get a list of the pharmacies that are preferred by that particular plan.

By now you should be getting a feel for how the Medicare Prescription Drug Plan Finder works. There is a lot of information available at your fingertips—but it takes a little practice to become comfortable using it—so take your time and don't be afraid to explore some of the other search possibilities available. There will be times when "traffic" is heavy on the Plan Finder. You may have to try at another non-peak time, but don't get discouraged. As the "traffic jam" begins to break up, you'll have access when you want it.

Some other things to be aware of when using the Medicare Prescription Drug Plan Finder:

1. **Restrictions on certain drugs**—Watch for a single asterisk (*) to the right of a drug name in the "View Cost Details" page. It means there are special rules that apply, such as:
    - **Prior Authorization**: This means that you or your doctor must obtain the plan's approval before it will cover a particular drug (often a high-priced one). The physician generally has to document why this specific medication is needed.
    - **Step Therapy**: This is a variation of prior authorization. It requires the physician to use a similar but

Exploring similar drugs to treat a particular condition

AARP has developed an online consumer guide to help you find the most effective and affordable drugs. The guide provides unbiased information on drug safety, effectiveness, and cost. It's based upon an independent review and assessment of the available medical evidence.

The guide shows how the most expensive drugs are not necessarily the best, and that consumers willing to consult with their doctor or pharmacist, can often find similar safe and effective lower cost drugs. To learn more about AARP's prescription drug consumer's guide, visit the AARP website listed below.
www.aarp.org/comparedrugs

Other types of searches

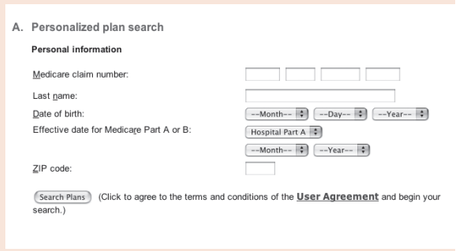
Formulary Search:

Each plan has a formulary, or its preferred list of drugs.

To do a Formulary Search, go to **www.medicare.gov**, click on **Formulary Search**. Enter your state, then your list of drugs. When the list of plans is displayed, click on the name of each plan to see in which tier each of your drugs falls. This won't give you co-pays, however, so you'll need to go to "View Cost Details" (see page 6) for that.

Personalized Search:

Start at **www.medicare.gov** again. Click on **Compare Medicare Prescription Drug Plans**. Click on **Find a Medicare Drug Plan**. Enter your personal information in the boxes, then click on **Personalized Search**. From there, follow the same basic steps as for the "**General Search**."



less expensive "preferred" drug to treat a condition before being allowed to use the one originally prescribed.

2. **Quantity Limits: This does NOT mean that your supply of drugs will be cut off after a certain time—or restricted to a particular number of prescriptions per year**. It does mean that your doctor must follow your plan's guidelines when prescribing drugs for a current condition. If, for instance, your doctor writes a prescription that falls outside your drug plan's quantity limit, he or she must get prior authorization from your plan before the plan will agree to pay for the prescription. For example, prescriptions for sleeping pills need to be monitored very closely by your doctor and therefore most will have a quantity limit associated with them. In other words, if the normal course of treatment calls for a 10-day supply of pills, then your doctor can't write the prescription for more than that—unless he or she has prior approval from the drug plan to do so.

3. **Co-payment/Coinsurance**: This is the amount you pay for each prescription after you have paid the deductible. In some plans, you pay the same co-payment (a set amount) or coinsurance (a percentage of the cost) for any prescription. In other plans, there might be different levels or "tiers," with different costs, depending on which tier a particular drug is assigned. Some plans may have co-payments for some drugs and coinsurance for others.

4. **"Tiered" co-payment levels**: Typically, less expensive drugs are assigned to lower tiers, with lower co-pay amounts. Brand-name drugs may be further divided into "preferred" and "non-preferred" tiers as well. Further, some plans may dedicate another tier for less common and/or very expensive drugs. With these kinds of variations, it's a good idea to compare not only the monthly premium and annual deductible—but also co-payments—when calculating your total costs.

5. **Premiums and Deductibles**: Keep in mind that some plans will not require a premium or a deductible—but you still need to compare total costs for the plan as a whole to see which plan makes the most dollar sense. While your premiums and deductible (if any) cannot increase in the calendar year, your co-pays or co-insurance may. Such changes, though not expected to happen frequently, can raise or lower your estimated annual drug costs.

6. **Types of Medicare Plans**:

   - **"Stand alone" plans** that offer only drug coverage. Such a plan may be for you if you wish to stay in the traditional Medicare fee-for-service program for other medical coverage.
   - **Medicare Advantage (MA) plans** that cover both medical services and prescription drugs. Such a plan may be for you if you can accept restrictions on your choice of health care providers, and you prefer managed care.

7. **Call and Confirm Plan Information**: Prior to enrolling in any prescription drug plan, it's important to call the Prescription Drug Plan sponsor (or check their website) to confirm the information that you have gotten from the Plan Finder. The plans are able to make changes on a daily basis—and many have, as they try to be more competitive with the plans they only saw for the first time on November 15, 2005.

8. **Changing Plans**: Medicare beneficiaries who qualify for Extra Help have the option of changing their prescription drug plan at any time. If you do not qualify for Extra Help you can change your plan once between now and May 16, 2006. Thereafter, changes can be made during the annual enrollment period which is typically November 15 to December 31 of each year.

Other resource information

On the AARP Medicare website **www.aarp.org/medicarerx** you will find a host of helpful information (in English and Spanish), including:

The New Medicare Prescription Drug Coverage: What You Need to Know

The New Medicare Prescription Drug Coverage: Extra Help for People with Limited Incomes

The New Medicare Prescription Drug Coverage: A Glossary of Terms

The New Medicare Prescription Drug Coverage: Drug Formularies, Exceptions, & Appeals

The New Medicare Prescription Drug Coverage: More Information for People with Medigap

The New Medicare Prescription Drug Coverage: More Information for People with Retiree Coverage

The New Medicare Prescription Drug Coverage: How to Ask the Right Questions & Get the Most from Your Medicines (includes My Medication Record)

The Medicare website **www.medicare.gov**, features more than the plan finder. On their home page, click on **Other Resources** for fact sheets, things to consider, etc.

Don't Give Out

Final Note: Protect yourself against fraud

- **Applying is free**. The forms are free, and there's plenty of free help in your community to fill them out.
- **Don't give out bank or credit card account numbers**. You will have to give some personal information about your income and resources if you apply for Extra Help, but not your banking, checking or credit card information!
- **Talk to the right person.** If you have sent information to Social Security to apply for Extra Help, they may call you, but if the caller asks for your Social Security number, hang up! They probably aren't from the Social Security Administration!
- **By law, Medicare plans cannot come to your door** to sell their product, unless you have invited them. If you experience this kind of activity, contact your state attorney general. Look in the blue pages of your telephone directory for state government listings, then look for "Attorney General."
- **Don't be pressured**. Companies can call you to tell you about their drug plans, but they can't sign you up over the phone. In addition, organizations must:
  - Comply with the National-Do-Not-Call Registry
  - Honor "do not call again" requests, and
  - Abide by federal and state calling hours.
- **Take your time. You have until May 15 of this year to enroll without incurring a late penalty.**

List of Medications for Medicare Plan Finder Search	What I pay now monthly for the drugs I take	Plan 1	Plan 2	Plan 3
Monthly Premium	$	$	$	$
Deductible	$	$	$	$

Name of the drug (including strength/numbers; e.g., Lipitor 20mg, 30 tab or Metformin HCL tab 500mg)

#1				
#2				
#3				
#4				
#5				
#6				
#7				
#8				
#9				
#10				
#11				
#12				
Total Monthly Cost				
Does this plan have a gap in coverage?				
If so, when does the gap begin?				
When does the gap end?				
Can I use the plan at the pharmacy? Do I have to go to a different pharmacy?				
Does the plan give me discounts on all the drugs I currently take?				
If I currently buy a 90-day supply, what is the price difference? Do I have to utilize mail order?				
If I live in another state for part of the year, can I get my drugs in that state?				

List of Medications for Medicare Plan Finder Search	What I pay now **monthly** for the drugs I take	Plan 1	Plan 2	Plan 3
Monthly Premium	**$**	**$**	**$**	**$**
Deductible	**$**	**$**	**$**	**$**

Name of the drug (including strength/numbers; e.g., Lipitor 20mg, 30 tab or Metformin HCL tab 500mg)

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If I currently buy a 90-day supply, what is the price difference? Do I have to utilize mail order?				
If I live in another state for part of the year, can I get my drugs in that state?				

AARP is a nonprofit, nonpartisan membership organization that helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We produce *AARP The Magazine*, published bimonthly; *AARP Bulletin*, our monthly newspaper; *AARP Segunda Juventud*, our bimonthly magazine in Spanish and English; *NRTA Live & Learn*, our quarterly newsletter for 50+ educators; and our website, www.aarp.org. AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. We have staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Medicare

The Official U.S. Government Site for People with Medicare

Medicare Prescription Drug Plan Finder

Find and Compare Plans

Your Personalized Plan List

Print This Page

54 Medicare Prescription Drug Plans in ZIP code [redacted] [View 11 Medicare Health Plans in ZIP code [redacted]] [View 3 Special Need Plans in ZIP code [redacted]]

Click on column titles to sort. Click on plan names to view more information about each plan. If you're interested in any plans but not ready to make a decision, click "Add" to put the plan in a list of Your Favorite Plans so you can save them for later.

Note that 2007 plan data is displayed by default. Click here to display 2006 plan data.

Click here for information about Ways to Lower Your Costs During the Coverage Gap.

Get Plan Performance Information

Compare up to 3 Plans Compare (Clear Selections)

	Plan Name and ID Numbers	Estimated Annual Cost	Monthly Drug Premium	Annual Deductible	Coverage in the Gap	Number of Network Pharmacies	Favorites	Enroll
☐	**Health Net Orange Option 1** **Health Net** (S5678-038) *Approved by Medicare* *Available nationwide ‡*	$872 Lower this cost	$24.30	$265.00	No gap coverage	9	Add	Enroll
☐	**Community Care Rx BASIC** **MEMBERHEALTH** (S5803-085) *Approved by Medicare* *Available nationwide ‡*	$1,090 Lower this cost	$27.70	$265.00	No gap coverage	9	Add	Enroll
	Community Care	$1,104	$44.30	$0.00	Generics	9	Add	Enroll

☐	**Rx GOLD MEMBERHEALTH** (S5803-233) *Approved by Medicare Available nationwide ‡*	**Lower this cost**						
☐	**DeanCare Rx Enhanced Dean Health Insurance, Inc.** (S5954-005) *Approved by Medicare*	$1,193 **Lower this cost**	$48.90	$0.00	Generics and Preferred Brands	9	Add	Enroll
☐	**Sterling Rx Plus Sterling Life Insurance Company** (S4802-049) *Approved by Medicare*	$1,215 **Lower this cost**	$57.00	$100.00	Generics	9	Add	Enroll
☐	**SilverScript Complete SilverScript Insurance Company** (S5601-087) *Approved by Medicare Available nationwide ‡*	$1,228 **Lower this cost**	$35.80	$0.00	Generics	9	Add	Enroll
☐	**First Health Select First Health Part D** (S5768-063) *Approved by Medicare*	$1,237 **Lower this cost**	$35.30	$0.00	No gap coverage	9	Add	Enroll
☐	**CIGNATURE Rx Value Plan CIGNATURE Rx** (S5617-078) *Approved by Medicare Available nationwide ‡*	$1,238 **Lower this cost**	$28.60	$265.00	No gap coverage	8	Add	Enroll
☐	**Community Care Rx CHOICE MEMBERHEALTH** (S5803-153) *Approved by Medicare Available nationwide ‡*	$1,248 **Lower this cost**	$35.70	$0.00	No gap coverage	9	Add	Enroll
	HealthSpring	$1,258	$26.50	$265.00	No gap	9	Add	Enroll

	Prescription Drug Plan-Reg 16 **HealthSpring Prescription Drug Plan** (S5932-015) *Approved by Medicare* *Available nationwide ‡*	**Lower this cost**			coverage			
☐	**DeanCare Rx Classic** **Dean Health Insurance, Inc.** (S5954-004) *Approved by Medicare*	$1,268 **Lower this cost**	$25.90	$250.00	No gap coverage	9	Add	Enroll
☐	**UnitedHealth Rx Basic** **UnitedHealthcare** (S5921-072) *Approved by Medicare* *Available nationwide ‡*	$1,284 **Lower this cost**	$27.60	$0.00	No gap coverage	9	Add	Enroll
☐	**Aetna Medicare Rx Plus** **Aetna Medicare** (S5810-152) *Approved by Medicare* *Available nationwide ‡*	$1,292 **Lower this cost**	$42.70	$0.00	No gap coverage	8	Add	Enroll
☐	**WPS MedicareRx Plan 2** **WPS Health Insurance** (S5753-007) *Approved by Medicare*	$1,301 **Lower this cost**	$42.50	$0.00	Generics	9	Add	Enroll
☐	**SAMAscript** **SAMAscript** (S7950-016) *Approved by Medicare* *Available nationwide ‡*	$1,306 **Lower this cost**	$44.60	$265.00	No gap coverage	8	Add	**Contact Plan to Enroll**
☐	**Medco YOURx PLAN** **Medco YOURx PLAN** (S5660-016) *Approved by Medicare*	$1,328 **Lower this cost**	$35.80	$100.00	No gap coverage	9	Add	Enroll
	Prescription	$1,330	$43.50	$0.00	Generics	9	Add	Enroll

☐	**Pathway Platinum Plan Reg 16** **Pennsylvania Life Insurance Company** (S5597-213) *Approved by Medicare*	**Lower this cost**						
☐	**WPS MedicareRx Plan 1** **WPS Health Insurance** (S5753-006) *Approved by Medicare*	$1,339 **Lower this cost**	$37.30	$0.00	No gap coverage	9	Add	Enroll
☐	**CIGNATURE Rx Plus Plan** **CIGNATURE Rx** (S5617-080) *Approved by Medicare* *Available nationwide ‡*	$1,339 **Lower this cost**	$37.50	$0.00	No gap coverage	8	Add	Enroll
☐	**Health Net Orange Option 2** **Health Net** (S5678-037) *Approved by Medicare* *Available nationwide ‡*	$1,349 **Lower this cost**	$29.00	$0.00	No gap coverage	9	Add	Enroll
☐	**AARP MedicareRx Plan - Saver** **UnitedHealthcare** (S5921-071) *Approved by Medicare* *Available nationwide ‡*	$1,357 **Lower this cost**	$20.80	$265.00	No gap coverage	9	Add	Enroll
☐	**AdvantraRx Premier** **Coventry AdvantraRx** (S5670-082) *Approved by Medicare*	$1,359 **Lower this cost**	$34.20	$0.00	No gap coverage	9	Add	Enroll
☐	**SilverScript Plus** **SilverScript Insurance Company** (S5601-033) *Approved by Medicare* *Available*	$1,376 **Lower this cost**	$31.70	$0.00	No gap coverage	9	Add	Enroll

	nationwide ‡							
☐	**CIGNATURE Rx Complete Plan** **CIGNATURE Rx** (S5617-186) *Approved by Medicare* *Available nationwide ‡*	$1,381 **Lower this cost**	$48.90	$0.00	Generics	8	Add	**Contact Plan to Enroll**
☐	**Aetna Medicare Rx Premier** **Aetna Medicare** (S5810-186) *Approved by Medicare* *Available nationwide ‡*	$1,386 **Lower this cost**	$72.20	$0.00	Generics	8	Add	Enroll
☐	**Prescription Pathway Gold Plan Reg 16** **Pennsylvania Life Insurance Company** (S5597-048) *Approved by Medicare*	$1,394 **Lower this cost**	$23.00	$0.00	No gap coverage	9	Add	Enroll
☐	**SilverScript** **SilverScript Insurance Company** (S5601-032) *Approved by Medicare* *Available nationwide ‡*	$1,426 **Lower this cost**	$23.40	$265.00	No gap coverage	9	Add	Enroll
☐	**UnitedHealth Rx Extended** **UnitedHealthcare** (S5820-119) *Approved by Medicare*	$1,436 **Lower this cost**	$40.60	$0.00	No gap coverage	9	Add	Enroll
☐	**AdvantraRx Premier Plus** **Coventry AdvantraRx** (S5670-084) *Approved by Medicare*	$1,453 **Lower this cost**	$48.30	$0.00	Generics	9	Add	Enroll
☐	**Health Net Orange Option 3** **Health Net** (S5678-088) *Approved by Medicare* *Available*	$1,461 **Lower this cost**	$44.10	$0.00	Generics	9	Add	Enroll

	nationwide ‡							
☐	**UA Medicare Part D Prescription Drug Cov** **United American Insurance Company** (S5755-019) *Approved by Medicare*	$1,464 **Lower this cost**	$39.90	$0.00	No gap coverage	9	Add	Enroll
☐	**AARP MedicareRx Plan** **UnitedHealthcare** (S5820-015) *Approved by Medicare*	$1,484 **Lower this cost**	$26.10	$0.00	No gap coverage	9	Add	Enroll
☐	**AdvantraRx Value** **Coventry AdvantraRx** (S5670-081) *Approved by Medicare*	$1,502 **Lower this cost**	$23.40	$0.00	No gap coverage	9	Add	Enroll
☐	**Sterling Rx** **Sterling Life Insurance Company** (S4802-027) *Approved by Medicare*	$1,503 **Lower this cost**	$31.70	$100.00	No gap coverage	9	Add	Enroll
☐	**UA Medicare Part D Rx Covg - Silver Plan** **United American Insurance Company** (S5755-054) *Approved by Medicare*	$1,555 **Lower this cost**	$30.60	$265.00	No gap coverage	9	Add	Enroll
☐	**EnvisionRxPlus Gold** **EnvisionRx Plus** (S7694-050) *Approved by Medicare* *Available nationwide ‡*	$1,570 **Lower this cost**	$69.00	$0.00	Generics	8	Add	Enroll
☐	**AARP MedicareRx Plan - Enhanced** **UnitedHealthcare** (S5921-073) *Approved by Medicare* *Available*	$1,597 **Lower this cost**	$44.00	$0.00	Generics	9	Add	Enroll

	nationwide ‡							
☐	**Blue MedicareRx Plus** **Blue Cross Blue Shield of Wisconsin** (S5596-022) *Approved by Medicare*	$1,600 **Lower this cost**	$34.60	$0.00	No gap coverage	9	Add	Enroll
☐	**Blue MedicareRx Value** **Blue Cross Blue Shield of Wisconsin** (S5596-021) *Approved by Medicare*	$1,607 **Lower this cost**	$27.50	$250.00	No gap coverage	9	Add	Enroll
☐	**Prescription Pathway Bronze Plan Reg 16** **Pennsylvania Life Insurance Company** (S5597-081) *Approved by Medicare*	$1,609 **Lower this cost**	$25.00	$265.00	No gap coverage	9	Add	Enroll
☐	**Blue MedicareRx Premier** **Blue Cross Blue Shield of Wisconsin** (S5596-023) *Approved by Medicare*	$1,626 **Lower this cost**	$45.40	$0.00	Generics	9	Add	Enroll
☐	**MedicareRx Rewards Premier** **Unicare** (S5960-086) *Approved by Medicare* *Available nationwide ‡*	$1,650 **Lower this cost**	$47.40	$0.00	Generics	9	Add	Enroll
☐	**Humana PDP Complete S5884-044** **Humana Insurance Company** (S5884-044) *Approved by Medicare*	$1,801 **Lower this cost**	$80.30	$0.00	Generics	9	Add	Enroll
	NMHC Medicare PDP Gold **NMHC Group Solutions**	$1,824 **Lower this cost**	$29.30	$0.00	No gap coverage	7	Add	Enroll

☐	(S8841-016) *Approved by Medicare Available nationwide ‡*							
☐	**WellCare Signature** **WellCare** (S5967-050) *Approved by Medicare Available nationwide ‡*	$1,833 **Lower this cost**	$24.50	$0.00	No gap coverage	9	Add	Enroll
☐	**Humana PDP Enhanced S5884-014** **Humana Insurance Company** (S5884-014) *Approved by Medicare*	$1,848 **Lower this cost**	$23.50	$0.00	No gap coverage	9	Add	Enroll
☐	**Aetna Medicare Rx Essentials** **Aetna Medicare** (S5810-050) *Approved by Medicare Available nationwide ‡*	$1,900 **Lower this cost**	$29.20	$200.00	No gap coverage	8	Add	Enroll
☐	**MedicareRx Rewards Value** **Unicare** (S5960-016) *Approved by Medicare Available nationwide ‡*	$1,920 **Lower this cost**	$26.20	$265.00	No gap coverage	9	Add	Enroll
☐	**WellCare Classic** **WellCare** (S5967-153) *Approved by Medicare Available nationwide ‡*	$2,051 **Lower this cost**	$15.90	$265.00	No gap coverage	9	Add	Enroll
☐	**WellCare Complete** **WellCare** (S5967-084) *Approved by Medicare Available nationwide ‡*	$2,085 **Lower this cost**	$45.50	$0.00	Generics	9	Add	Enroll
	Humana PDP Standard S5884-	$2,134 **Lower**	$14.80	$265.00	No gap coverage	9	Add	Enroll

☐	**074 Humana Insurance Company** (S5884-074) *Approved by Medicare*	**this cost**						
☐	**Advantage Freedom Plan by RxAmerica RxAmerica** (S5644-177) *Approved by Medicare Available nationwide ‡*	$2,415 **Lower this cost**	$34.00	$265.00	No gap coverage	6	Add	Enroll
☐	**Advantage Star Plan by RxAmerica RxAmerica** (S5644-191) *Approved by Medicare Available nationwide ‡*	$2,461 **Lower this cost**	$29.30	$265.00	No gap coverage	6	Add	Enroll
☐	**EnvisionRxPlus Standard EnvisionRx Plus** (S7694-016) *Approved by Medicare Available nationwide ‡*	$3,136 **Lower this cost**	$45.00	$265.00	No gap coverage	8	Add	Enroll

Plans per page: All

Compare up to 3 Plans Compare **(Clear Selections)**

‡The organization that offers this plan offers at least one plan in all fifty states and the District of Columbia. Note: The specific plan(s) offered by this organization may differ from state to state.

The drug costs displayed above are estimates based on your current drug use and preferred pharmacies. These estimates may vary based on the specific quantity, strength, and/or dosage of each medication, the order in which you purchase your prescriptions, and the pharmacy you use. You may wish to revise your Drug & Pharmacy List below in order to get the most accurate cost estimates.

My Drug & Pharmacy List

Review the dosage and quantity information displayed below for each of your drugs and update if necessary. If you take more than one dose of the same drug, click "Add Doses."

Note that if you change the strength of a drug using a dropdown menu in the "Drug Name" column, you then need to make sure the information in the "Quantity & Days Supply" column is still correct.

My Drugs

Drug Name	Quantity/Days Supply	Actions
Celebrex CAP 200mg	30 per Month	Add Doses Remove
LISINOPRIL TAB 10MG	30 per Month	Add Doses Remove
Lunesta TAB 2MG	30 Per year	Add Doses Remove
SIMVASTATIN TAB 20MG	30 per Month	Add Doses Remove
TRIAMTERENE/HCTZ CAP 37.5-25	30 per Month	Add Doses Remove

Add More Drugs | Print My Drug List | Update Dosage/Quantity

My Pharmacies

No pharmacies selected. Click the **Change Pharmacy Selection** button to add pharmacies.

Selected Pharmacies **Remove**

Change Pharmacy Selection

Page Last Updated: October 31, 2006

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