Need for an Annual Checkup: Lowering Medicare Beneficiaries' Out-of-Pocket Prescription Drug Costs by Part D Plan Optimization

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BACKGROUND

Medicare Part D, first available in 2006, is the outpatient prescription drug benefit.

Medicare Drug Plans[1]

- **Medicare Advantage Prescription Drug Plan (MA-PD)** — Covers Original Medicare benefits and prescription drugs
- **Stand-alone Prescription Drug Plan (PDP)** — Only provides drug coverage; roughly 2/3 of beneficiaries' chose this route[1]

PDP offerings

- In 2018, **782 PDPs** are offered across the 34 Part D Regions nationwide.[2] (5%↑ from 2017)
- Average # of PDP offerings in 2007 vs. 2018 were 55 and 23, respectively.[3]
- Each PDP has a different formulary and beneficiary cost-sharing structure.

PDP selection

- Beneficiaries can select (using the online Medicare Plan Finder Tool) the lowest cost PDP based on their individual needs (e.g., drug regimen); but, there are multiple barriers to widespread use of the Tool.[2]
- Despite the decrease in PDP offerings since the early years of the benefit, beneficiaries still have difficulty selecting the lowest cost Part D plan.[4]
- Studies report that as few as 5.2%-25% of beneficiaries are in the lowest cost PDP.[2,5]

Beneficiary out-of-pocket (OOP) spending

- $368 — Average annual overspending on unnecessary higher premiums for underutilized plan features[6]
- 15% — Potential OOP cost reduction by switching to lowest cost plan[2]

Health/behavioral implications

- ~11% of beneficiaries with multiple chronic disease states can experience cost-related medication nonadherence.[7]
- A study of beneficiaries with diabetes, heart failure, and COPD found that those with higher medication costs were less likely to be medication adherent.[7]
  - Beneficiaries with poor medication adherence had higher ($49-$840/month) Medicare costs.[8]

OBJECTIVES

1. To determine potential out-of-pocket cost savings opportunities through Medicare Part D plan optimization.
2. To evaluate potential Part D out-of-pocket cost savings as a function of sociodemographic and health-related characteristics.

METHODS

Mobile Medicare Clinics

- Fourteen community-based clinics targeting Medicare beneficiaries were held across northern and central California during fall 2017.
- Trained student pharmacists from the University of the Pacific provided Medicare Part D assistance.

Part D Plan Optimization

Plan Finder Tool

Student pharmacists used the online Plan Finder Tool (www.medicare.gov) to guide each Part D intervention

- Information recorded from Tool included:
  - Drug information (drug name, dosage, quantity, and frequency)
  - Preferred pharmacy(ies)
  - Subsidy-status (e.g., Medicaid)
  - Cost of current plan and lowest cost plan in 2018
  - Formulary status of each drug under current and lowest cost 2018 plan

OOP Cost Savings Calculated

OOP Cost Savings = (Cost of Current Plan in 2018 – Cost of Lowest Cost 2018 Plan)

Data Collection

Demographic, disease state, and drug data were collected via a standardized data collection tool

- IRB approval for data collection was obtained from the University

Statistical Analyses

- Descriptive statistics were used to summarize cost data.
- Normality of cost savings data were tested via the One-sample K-S statistic.
- Inferential statistics (Mann-Whitney and Kruskal-Wallis) tested for differences in OOP cost savings as a function of beneficiary factors.
- Spearman's correlation examined the relationship between potential OOP savings and beneficiary factors.
- Alpha (Type 1 error) was set a-priori to 0.05.
- All statistics were performed via IBM SPSS Statistics 24 (IBM, Armonk, NY).

Figure 1: Potential Out-of-Pocket (OOP) cost savings opportunities through Part D plan optimization

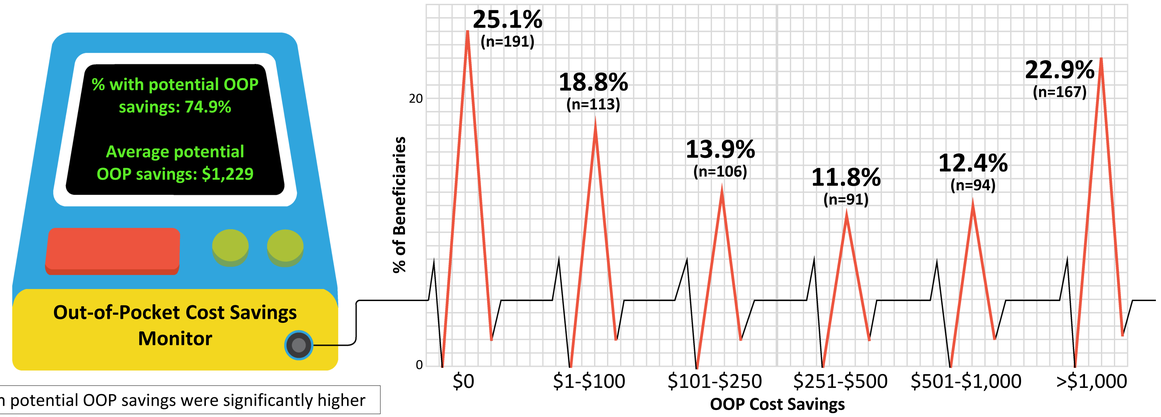


Figure 2: Disease states in which potential OOP savings were significantly higher

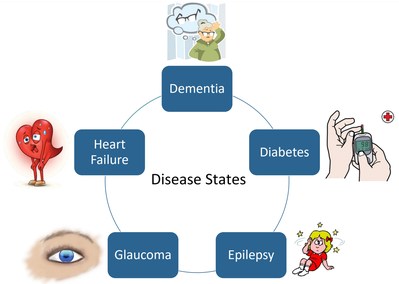
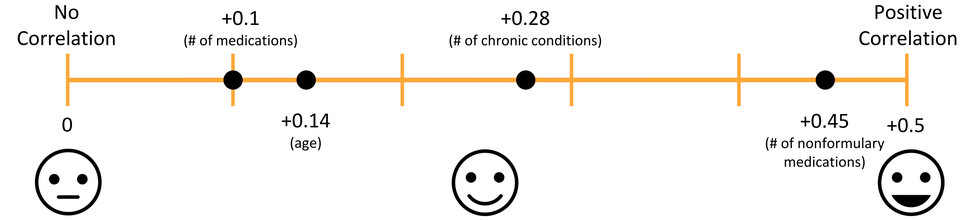


Figure 3: Correlation Scale between potential Out-of-Pocket Cost Savings and other examined variables



RESULTS

- **Figure 1** highlights the % of those with potential OOP cost-savings and the stratified OOP savings data.
  - In total, 762 assisted beneficiaries could have saved $936,522 in potential OOP costs.
  - >⅓ beneficiaries had ≥ $501 in potential OOP cost-savings.
- **Figure 2** identifies disease states in which potential OOP cost savings were significantly higher in those with the disease state.
  - Potential OOP cost savings was also significantly greater for subsidy recipients than non-subsidy recipients ($1,705 vs. $1,124, respectively).
- **Figure 3** depicts a correlation scale between potential OOP costs savings and significant examined variables.

DISCUSSION

- Trained pharmacy professionals can help lower beneficiaries' OOP drug costs.
  - Previous research showed that a pharmacist-initiated teleservice program was able to identify a lower cost plan for 75% of patients (avg. savings of $833/year).[9]
  - We also found that ~75% of beneficiaries could save money by switching to a new Part D plan in the upcoming year; average potential OOP cost savings = $1,229.
- Part D plan optimization may help decrease cost-related medication nonadherence.
  - Those with certain disease states (likely due to use of brand-name medications) were more likely to have potential OOP cost savings.
  - Potential OOP cost-savings was most strongly correlated with number of non-formulary medications. Community pharmacists are ideally positioned to address this finding.
- We recommend beneficiaries reevaluate their Medicare Part D plan at least annually ('annual checkup') as doing so may help minimize unnecessary OOP drug costs.

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