GoodRx

Unrealized Savings in Medicare

Enrolling in the Wrong Medicare Part D Plan Could Cost Patients Over $800 Every Year

DECEMBER 2022

The GoodRx Teams

RESEARCH

Amanda Nguyen, PhD

Tori Marsh, MPH

Diane Li, BA

Lauren Chase, BS

Trinidad Cisneros, PhD

Sasha Guttentag, PhD

Jeroen van Meijgaard, PhD

CREATIVE

Creative Direction by Dennis Huynh

Designed by Chelsea Pyne

Table of Contents

Overview

How much is lost, in both dollars not saved and underuse of services, when patients don't have the awareness or ability to price shop or pick the best insurance plan?

These are questions our team here at GoodRx has pondered for years. And after nearly a year of work, we have quantified how much a patient's cost burden can differ simply based on the prescription drug plan they enroll in. This is a phenomenon we call **unrealized savings.**

Our analysis highlights just how important healthcare literacy and shopping for the best price can be, not only for patients' pocketbooks, but for their health in general.

Our five key findings

Under original Medicare, patients can get prescription drug coverage by enrolling in a standalone Part D plan. But with so many options to choose from and confusing, hard-to-predict drug pricing, people may find it difficult to select the right Medicare Part D plan for their prescription drug needs. The plan you choose, however, can make a big difference when it comes to out-of-pocket costs for medications.

Below, we discuss our five key findings from analyzing the difference in patients' costs between Medicare drug plans:

1

OUT-OF-POCKET COSTS VARY WIDELY ACROSS MEDICARE PART D PLANS, EVEN FOR THE SAME PATIENT.

We estimate that the average Medicare patient enrolled in the average Part D plan overspends on their prescription drugs by **$840** every year by not enrolling in the cheapest plan for their medication needs. The worst Medicare Part D plan for the average Medicare patient can cost them nearly **$3,200** more per year than the best plan.

2

PATIENTS WITH COSTLIER MEDICATION NEEDS FACE EVEN HIGHER UNREALIZED SAVINGS IF THEY AREN'T ENROLLED IN THE BEST PLAN FOR THEM.

The majority of patients taking prescription medications face unrealized savings of at least **$450** per year if they're enrolled in the average Part D plan. High-cost patients (in the 90th percentile of unrealized savings) stand to lose over **$6,200** every year if they enroll in the most expensive Part D plan for their medication needs.

3

CHRONIC CONDITIONS NOT ONLY RESULT IN GREATER MEDICATION NEEDS FOR PATIENTS, BUT ALSO WIDER VARIATION IN OUT-OF-POCKET COSTS ACROSS MEDICARE PRESCRIPTION DRUG PLANS.

Patients diagnosed with chronic conditions like lung cancer, cervical cancer, chronic obstructive pulmonary disease (COPD), diabetes, and high blood pressure could save hundreds if not thousands of dollars if they enrolled in the cheapest plan for their medication needs. The average Medicare patient with one of these conditions could save from **$905** to **$1,703** every year by switching from the average Part D plan to their optimal plan.

4 OUT-OF-POCKET COSTS FOR PATIENTS WHO TAKE BRAND-NAME DRUGS WILL DEPEND GREATLY ON THE PLAN THEY ENROLL IN.

Patients who take brand drugs that have been identified as potential candidates for Medicare price negotiation, such as Xarelto, Jardiance, Januvia, Myrbetriq, Victoza, or Levemir, could save anywhere from **$1,700** to nearly **$3,500** per year if they switched from the average Part D plan to their optimal plan.

5 OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUGS VARY WIDELY ACROSS PART D PLANS FOR BOTH ORIGINAL MEDICARE AND MEDICARE ADVANTAGE.

Not enrolling in the cheapest prescription drug plan available can cost original Medicare enrollees **$878** per year and Medicare Advantage enrollees **$808** per year, on average.

Higher prices can cause people to skip, delay, or ration their medications, leading to potentially serious consequences for their health. More needs to be done to ensure that patients understand their costs under Medicare and are able to enroll in the best plan for their healthcare needs.

What causes unrealized savings in Medicare?

Navigating healthcare in the U.S. can be complicated. Even under a national government health insurance program like Medicare, patients have to consider an overwhelming amount of information throughout their healthcare journey: what type of plan to enroll in, what's covered, and how much needs to be paid out of pocket. Each of these considerations affects the cost and, ultimately, the amount of care that patients receive.

But even though these decisions are critically important, there are many barriers that prevent people from making the best decision for their healthcare needs. One of these barriers is "inertia," or the tendency to do nothing. It has been well documented in the context of choosing health insurance plans, and it often results in patients overpaying for their health coverage. Many people wind up defaulting to a less-than-optimal insurance plan, whether they get their insurance from their job, the commercial marketplace, or even Medicare.

7 out of 10 Medicare enrollees don't compare plans during open enrollment. At least **79%** of enrollees stay in their prescription drug plan.

The average Medicare beneficiary has to choose between 54 Part D plans for their prescription drug coverage, so it's no surprise that **7 out of 10** people don't compare plans during Medicare open enrollment. This results in less than a quarter of Medicare patients switching plans during open enrollment.

Inertia in health insurance can be due to a number of reasons, such as complex insurance pricing rules and a general lack of health literacy, especially when it comes to medical finances. The majority of Americans report difficulty estimating their out-of-pocket costs across a wide range of healthcare settings.

Another obstacle for patients is that prescription drug pricing is notoriously opaque and confusing, with prices varying across pharmacies. And coverage is increasingly subject to restrictions like prior authorization and step therapy. Medicare drug coverage adds another layer of complexity due to the phased structure of Medicare drug benefits, which makes coverage dependent on how much a patient spends in a given year.

Timing of diagnosis may also play a role. If a patient's medication needs change, their optimal plan may also change in between enrollment periods. To make matters worse, Medicare drug formularies — which determine whether a medication is covered and how much it costs the patient — change year to year. This makes it even more difficult to predict out-of-pocket costs, let alone identify the plan with the lowest out-of-pocket costs.

Altogether, these barriers make it harder for patients to select the best plan with the best prices for their healthcare needs.

How much unrealized savings are Medicare patients losing out on?

To understand the extent to which these inefficiencies could be hurting patients, GoodRx Research dug into thousands of Medicare Part D plans to estimate how much money patients could be leaving on the table.

First, we estimated how much out-of-pocket costs vary across Medicare Part D plans, even for the same patient. Then, we calculated the "unrealized savings" each Medicare patient faces on each plan, capturing the difference in annual out-of-pocket costs compared to their cheapest plan.

These unrealized savings demonstrate just how different a patient's cost burden can be depending on the plan they enroll in. Our findings, detailed in the rest of this white paper, underscore how important it is for patients to be able to select the best insurance plan for their needs.

Calculating unrealized savings for every Medicare Part D plan

To estimate unrealized savings for Medicare patients not enrolling in their optimal plan, we first needed to gather an accurate picture of which medications Medicare patients fill in a year. For many, cost is a key factor in determining whether or not to fill a prescription, so we wanted to measure medication needs regardless of each individual plan's costs. We also wanted to capture all prescription drug costs, including medications that are not covered by Medicare and paid for without insurance.

To do so, we used a nationally representative sample from the Medical Expenditure Panel Survey to build person-level profiles of total prescription drug use in a year for Medicare Part D (including both original Medicare and Medicare Advantage) enrollees who took prescription medication. For an apples-to-apples comparison, we focused on people who were only eligible for Medicare and were not dually eligible for Medicaid. We used data for

the most recent year available, 2019, to proxy for present-day medication needs. This yielded us over 2,450 individual drug profiles, representing medication needs for almost 25 million Medicare Part D enrollees.

Next, we simulated the out-of-pocket cost for each drug profile in every Medicare Part D plan available in 2022, taking into account prescription drug premiums, eligibility, plan type (original Medicare or Medicare Advantage), and regional availability. This allowed us to estimate each person's healthcare costs in their "best plan" — the plan with the lowest out-of-pocket cost for their drug profile — regardless of whether or not the person was actually enrolled in it. Likewise, we also simulated each person's healthcare costs in their "worst plan" — the plan with the highest out-of-pocket cost for their drug profile.

To estimate the costs associated with the "average plan," we took the enrollment-weighted average out-of-pocket cost across all available plans for each person's drug profile. To mirror the actual plans a person would likely be choosing from, we restricted the set of possible plans to those that were available in the person's region and were the same type of plan (original Medicare or Medicare Advantage) that the person was actually enrolled in. In total, we simulated out-of-pocket costs for 4,920 Medicare Part D plans.

Finally, to calculate unrealized savings for each person in a given Part D plan, we took the difference in annual out-of-pocket cost for a given plan, relative to the out-of-pocket cost for the same person in their best plan.

Calculating unrealized savings for the average Medicare patient

To summarize our findings across the distribution of Medicare Part D enrollees, we applied nationally representative survey weights. As the figure below shows, we calculated the out-of-pocket cost for the "average enrollee" across different Part D plans.

In other words, if every Medicare Part D patient were enrolled in the best plan for their individual medication needs, the average out-of-pocket cost across all drug profiles would be **$544 per year**. If every Medicare Part D patient were enrolled in the average Part D plan, the average out-of-pocket cost would be **$1,384 per year**. If every Medicare Part D patient were enrolled in

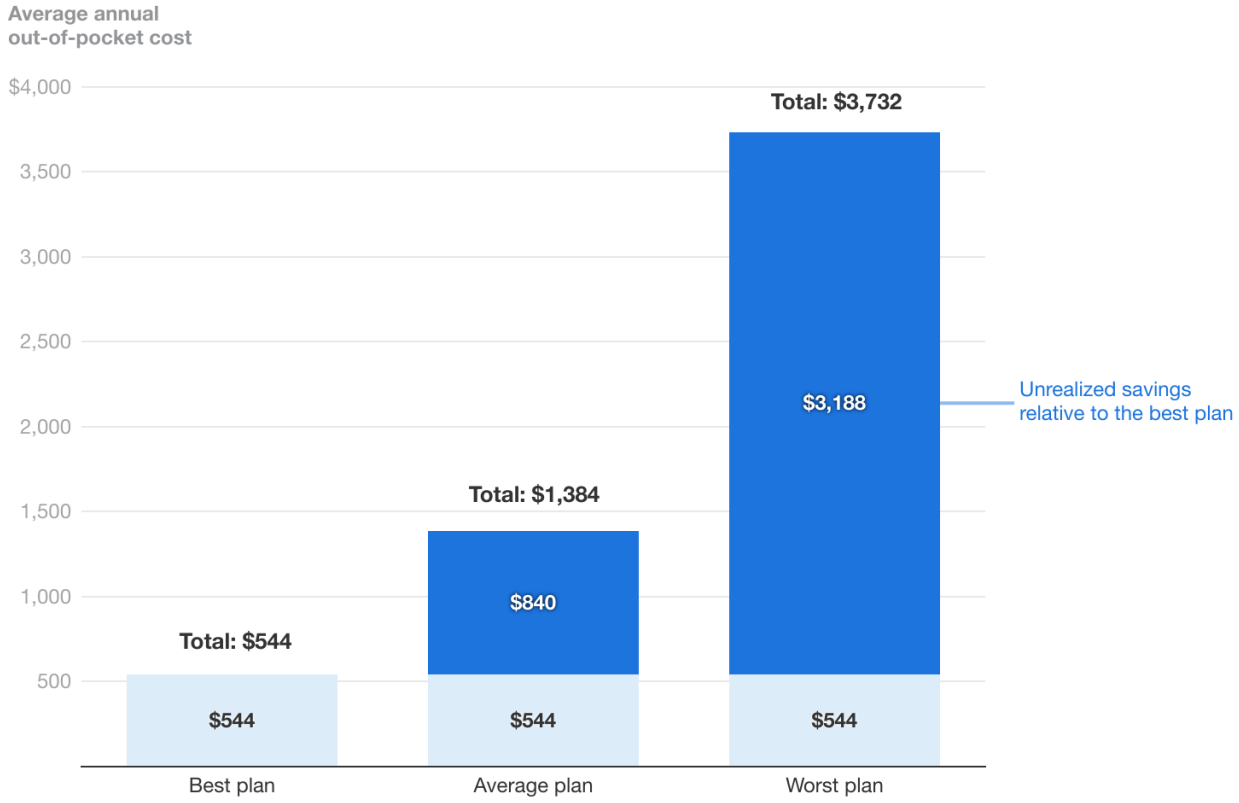
If every Medicare patient were enrolled in the best Part D plan for their medication needs, they would pay an average of **$544 per year** out of pocket.

their worst plan, the average out-of-pocket cost would be **$3,732 per year**.

The difference in average annual out-of-pocket costs for a given plan and the best plan represents the average enrollee's unrealized savings. If the average enrollee is enrolled in the worst plan for their medication needs, they face unrealized savings of **$3,188 each year**. If the average enrollee is enrolled in the average Part D plan, they face unrealized savings of **$840 each year**. These unrealized savings represent wasted money for the patient, who could have filled the exact same prescriptions for less on a different plan.

Out-of-Pocket Costs Under Medicare Part D Vary Widely Across Plans

The average Medicare Part D plan costs $840 more per year than the best plan for the average enrollee. The worst plan costs $3,188 more per year than the best plan.



This figure shows the annual out-of-pocket cost (including prescription premiums) in different Medicare Part D plans for the average Medicare Part D enrollee who takes prescription medication. Unrealized savings represent the difference in annual out-of-pocket cost in a given plan, compared to the out-of-pocket cost for the same person in the best plan for their medication needs. For the average Medicare Part D enrollee, the best plan has the lowest out-of-pocket cost; the average plan reflects the enrollment-weighted average out-of-pocket cost across all plans; and the worst plan has the highest out-of-pocket cost.

Source: GoodRx analysis of data from GoodRx, Medicare Part D, and Medical Expenditure Panel Survey

Our analysis shows that out-of-pocket costs vary widely across Medicare Part D plans. If patients are not choosing the best plan available to them, they could end up overpaying for their medications by hundreds if not thousands of dollars.

Next, we dive deeper into how unrealized savings can hit some patients even harder and discuss the potential ramifications of failing to choose the best plan.

Read more on the data in the methodology at the end of this paper.

$840 per year

THE AMOUNT OF UNREALIZED SAVINGS FOR THE AVERAGE MEDICARE PATIENT IF THEY SWITCHED FROM THE *AVERAGE* PART D PLAN TO THEIR BEST PLAN

$3,188 per year

THE AMOUNT OF UNREALIZED SAVINGS FOR THE AVERAGE MEDICARE PATIENT IF THEY SWITCHED FROM THEIR *WORST* PART D PLAN TO THEIR BEST PLAN

Picking the right Medicare plan is especially important for patients with chronic conditions and high medication costs

Above, we discussed how the average patient could save as much as $840 per year by enrolling in the best Part D plan for their medication needs. But not surprisingly, those who are filling more prescriptions or more expensive prescriptions stand to lose even more per year — up to $6,272, to be exact. This makes sense, as more medications can lead to higher out-of-pocket costs. And it indicates just how important it is for these individuals to shop around for their optimal plan every year.

The chart below shows the range of out-of-pocket costs for different patients in the best Medicare Part D plan, the average plan, and the worst plan. In this scenario:

- The **median patient** represents the medication needs of the majority (50%) of Medicare patients with prescription drug coverage. These patients fill about one to two prescriptions each month on average.
- The **average patient**, as described above, represents the medication needs of the average Medicare patient with prescription drug coverage.
- Finally, the **high-cost patient** represents the medication needs of Medicare patients who spend the most (90th percentile of unrealized savings and above) on medications. These high-cost patients fill around four prescriptions per month on average.

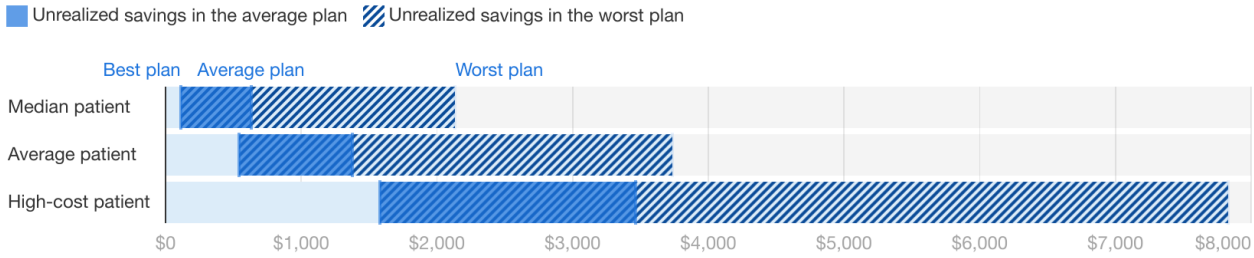
It's clear that the spread in unrealized savings differs drastically based on the number of prescription drugs that someone is taking. The majority of patients (represented by the median patient) can face unrealized savings of up to **$450 per year** if they're enrolled in the average Part D plan. Under the worst plan, this same subset of patients could save up to **$1,890 per year** if they switched to their optimal plan. And as discussed earlier, the average patient could give up nearly two times as much in unrealized savings as the median patient if they're not enrolled in the best plan for their needs — paying **$840 more each year** if they're enrolled in the average plan or **$3,188 more each year** if enrolled in their worst plan.

These unrealized savings grow exponentially for patients with costlier medication needs. High-cost patients — those who are in the 90th percentile of unrealized savings and fill

around four prescriptions per month on average — stand to lose **$6,272 every year** if they enroll in the worst Part D plan for their medication needs. Even in the average Part D plan, high-cost patients would overspend by **$1,653 per year** compared to being enrolled in the cheapest plan for their needs.

Medicare Patients With Higher Prescription Drug Costs Could Save Even More By Enrolling in the Best Plan for Their Needs

High-cost Medicare patients face unrealized savings of $1,653 per year in the average plan and $6,272 per year in the worst plan, compared to the best plan for their needs.



This figure shows the range of annual out-of-pocket cost (including prescription premiums) for the best (cheapest), average, and worst (most expensive) Medicare Part D plans for different Medicare Part D enrollees who take prescription medication. The median patient reflects the 50th percentile of Medicare Part D patient expenses in a given plan; the average patient reflects the national average patient expense in a given plan; and the high-cost patient reflects the 90th percentile of unrealized savings in a given plan. Unrealized savings represent the difference in annual out-of-pocket cost in a given plan for a given patient, compared to the out-of-pocket cost for the same patient in the best plan for their medication needs. For a given patient, the best plan has the lowest out-of-pocket cost; the average Medicare Part D plan reflects the enrollment-weighted average out-of-pocket cost across all plans; and the worst plan has the highest out-of-pocket cost.

Source: GoodRx analysis of data from GoodRx, Medicare Part D, and Medical Expenditure Panel Survey

$450 per year

THE AMOUNT OF UNREALIZED SAVINGS FOR THE *MEDIAN* MEDICARE PATIENT IF THEY SWITCHED FROM THE AVERAGE PART D PLAN TO THEIR BEST PLAN

$1,653 per year

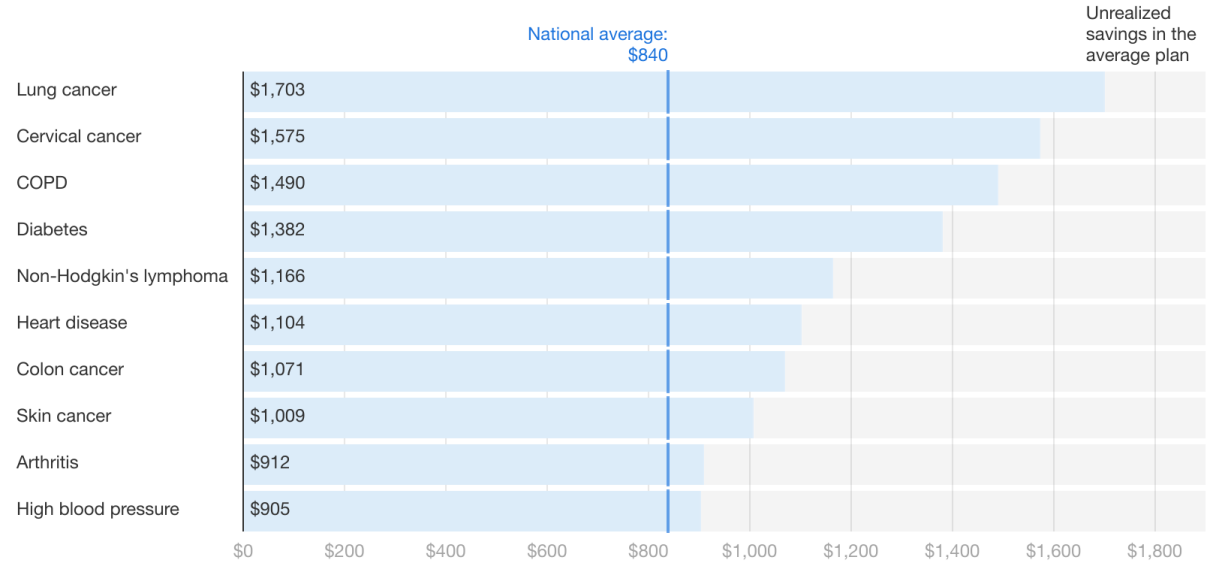
THE AMOUNT OF UNREALIZED SAVINGS FOR A *HIGH-COST* MEDICARE PATIENT IF THEY SWITCHED FROM THE AVERAGE PART D PLAN TO THEIR BEST PLAN

Unrealized savings and chronic conditions

High-cost patients tend to be those diagnosed with a chronic condition. And patients who take regular medications to treat and manage chronic conditions stand to lose the most if they don't enroll in the best Medicare Part D plan for their needs.

Chronic conditions like lung cancer, cervical cancer, COPD, diabetes, and non-Hodgkin's lymphoma not only result in greater medication needs for patients but also wider variation in out-of-pocket costs across Medicare prescription drug plans. As the chart below shows, patients diagnosed with these conditions face higher unrealized savings than the average Medicare enrollee. These patients could save hundreds if not thousands of dollars if they enrolled in the cheapest plan for their medication needs.

Medicare Patients With Certain Chronic Conditions Face Higher Unrealized Savings When They Enroll in the Average Part D Plan



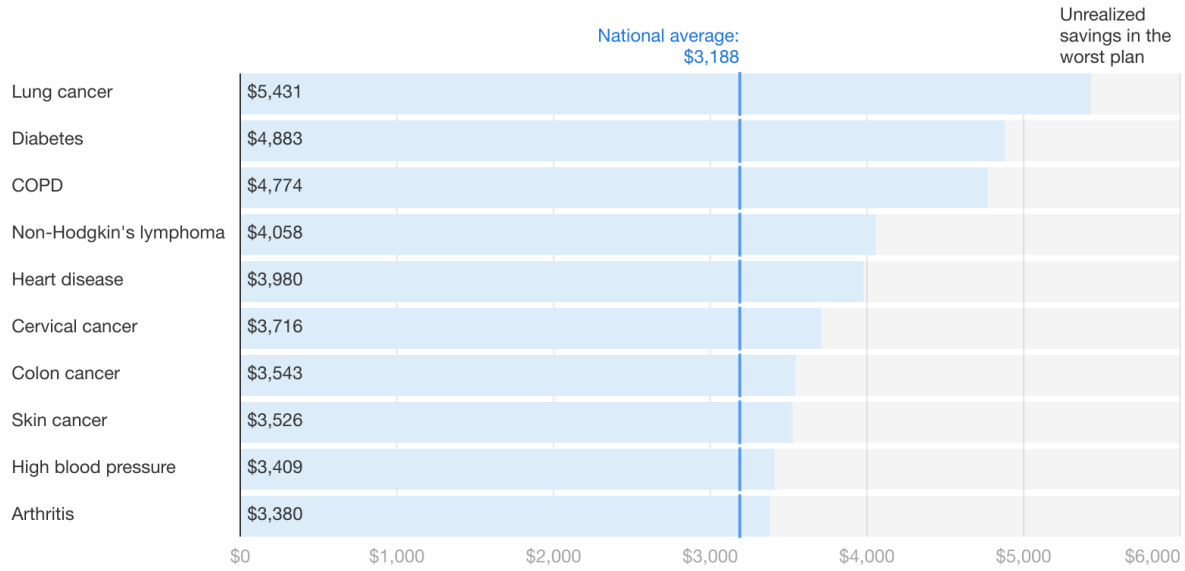
This figure shows unrealized savings in the average plan for the average Medicare Part D patient diagnosed with a given medical condition. Unrealized savings represent the difference in annual out-of-pocket cost (including prescription premiums) in the average Medicare Part D plan, compared to the out-of-pocket cost for the same person in the best plan with the lowest out-of-pocket cost for their medication needs. The average Medicare Part D plan reflects the enrollment-weighted average out-of-pocket cost across all plans. Heart disease includes coronary heart disease, angina, heart attack, and other forms of heart disease. Skin cancer includes melanoma, non-melanoma, and unknown type skin cancer. COPD includes chronic bronchitis and emphysema.

Source: GoodRx analysis of data from GoodRx, Medicare Part D, and Medical Expenditure Panel Survey

$905 to $1,703 per year

THE AMOUNT OF UNREALIZED SAVINGS FOR THE AVERAGE MEDICARE PATIENT WITH A *CHRONIC CONDITION* IF THEY SWITCHED FROM THE AVERAGE PART D PLAN TO THEIR BEST PLAN *(conditions like high blood pressure, cancer, and diabetes)*

Medicare Patients With Certain Chronic Conditions Face Higher Unrealized Savings When They Enroll in Their Worst Part D Plan



This figure shows unrealized savings in the worst plan for the average Medicare Part D patient diagnosed with a given medical condition. Unrealized savings represent the difference in annual out-of-pocket cost (including prescription premiums) in the worst Medicare Part D plan, compared to the out-of-pocket cost for the same person in the best plan with the lowest out-of-pocket cost for their medication needs. The worst Medicare Part D plan reflects the plan with the highest out-of-pocket cost. Heart disease includes coronary heart disease, angina, heart attack, and other forms of heart disease. Skin cancer includes melanoma, non-melanoma, and unknown type skin cancer. COPD includes chronic bronchitis and emphysema.

Source: GoodRx analysis of data from GoodRx, Medicare Part D, and Medical Expenditure Panel Survey

As you can see, patients treating complex conditions like lung cancer, cervical cancer, diabetes, and COPD stand to save the most. Those with diabetes, for instance, could save an average of **$4,883 every year** if they switched from the worst to the best Part D plan for their needs.

Why? These conditions are often treated using brand drugs with no generic version, or a cocktail of multiple costly drugs. First-line diabetes treatments like Trulicity and Januvia are brand drugs that aren't always covered by insurance. If a patient happens to enroll in a plan that doesn't cover these drugs, they could find themselves paying completely out of pocket every month for these medications.

Even chronic conditions with more generic treatment options can incur a wide range of out-of-pocket costs under Medicare. Those working to treat high blood pressure, which affects nearly 17 million individuals represented in our analysis, still face unrealized savings of **$905 per year** in the average plan and **$3,409 per year** in the worst plan.

Unrealized savings and brand drugs

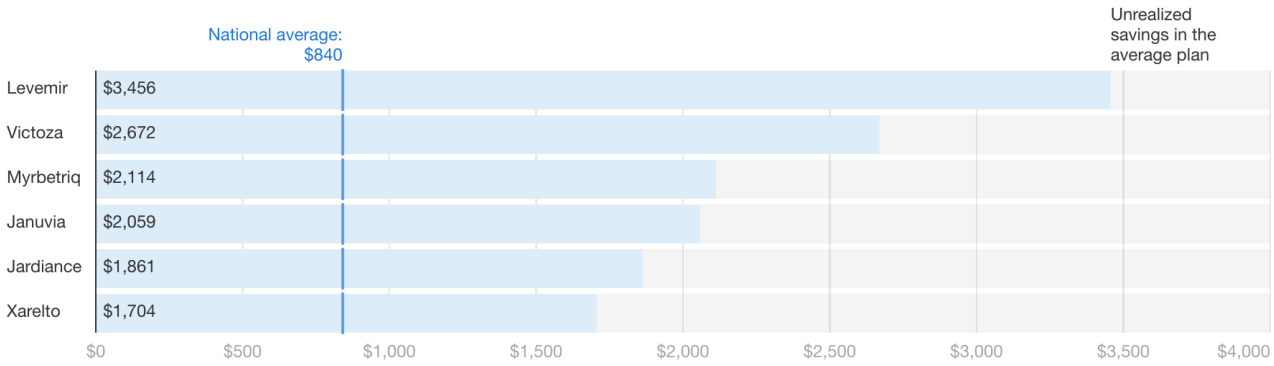
As discussed above, out-of-pocket costs for patients who take brand-name drugs will depend greatly on the plan they enroll in. More specifically, the more expensive the medication, the more likely they are to face variations in insurance coverage.

To compare the impact of unrealized savings to other proposed solutions for lowering drug prices, we highlighted a few brand drugs that have been identified as potential candidates for Medicare price negotiation. Under this policy, the government could demand that Medicare pay lower prices for these medications, saving patients and the government money.

Patients who take Xarelto, Jardiance, Januvia, Myrbetriq, Victoza, or Levemir could save anywhere from **$1,700 to nearly $3,500 per year** if they switched from the average Part D plan to their optimal plan. Unrealized savings are even higher if those same patients are enrolled in the worst plan and range from **$5,000 to over $13,000 per year**.

Medicare Patients Who Take High-Cost Medications Face Higher Unrealized Savings When They Enroll in the Average Part D Plan

Selected drugs have been identified as potential candidates for Medicare price negotiation under the Inflation Reduction Act.

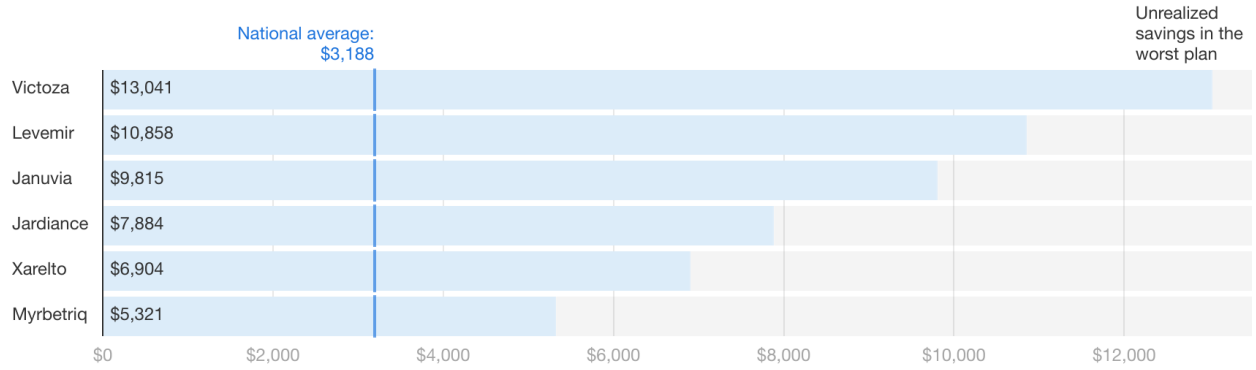


This figure shows unrealized savings in the average Medicare Part D plan for Medicare Part D patients who have filled at least one prescription for these drugs. Unrealized savings represent the difference in annual out-of-pocket cost (including prescription premiums) in the average Medicare Part D plan, compared to the out-of-pocket cost for the same person in the best plan with the lowest out-of-pocket cost for their medication needs. The average Medicare Part D plan reflects the enrollment-weighted average out-of-pocket cost across all plans. The selected drugs have been identified by Bloomberg as potential drugs up for Medicare price negotiation under the Inflation Reduction Act.

Source: GoodRx analysis of data from GoodRx, Medicare Part D, and Medical Expenditure Panel Survey

Medicare Patients Who Take High-Cost Medications Face Higher Unrealized Savings When They Enroll in Their Worst Part D Plan

Selected drugs have been identified as potential candidates for Medicare price negotiation under the Inflation Reduction Act.



This figure shows unrealized savings in the worst Medicare Part D plan for Medicare Part D patients who have filled at least one prescription for these drugs. Unrealized savings represent the difference in annual out-of-pocket cost (including prescription premiums) in the worst Medicare Part D plan, compared to the out-of-pocket cost for the same person in the best plan with the lowest out-of-pocket cost for their medication needs. The worst Medicare Part D plan reflects the plan with the highest out-of-pocket cost. The selected drugs have been identified by Bloomberg as potential drugs up for Medicare price negotiation under the Inflation Reduction Act.

Source: GoodRx analysis of data from GoodRx, Medicare Part D, and Medical Expenditure Panel Survey

The wide variation in out-of-pocket costs for patients who take these medications underscores just how much coverage — or lack thereof — can make the difference between paying one to three times as much for the exact same prescription. Even without policies that specifically target drug prices, patients can save thousands by making sure their Medicare plan covers their medications.

While we have to wait until 2026 for Medicare price negotiation to begin, patients who take these drugs can save now by comparing plans and making sure to enroll in the plan with the best coverage.

$5,321 to $13,041 per year

THE AMOUNT OF UNREALIZED SAVINGS FOR THE AVERAGE MEDICARE PATIENT TAKING A *BRAND-NAME DRUG* IF THEY SWITCHED FROM THEIR WORST PART D PLAN TO THEIR BEST PLAN *(drugs like Victoza, Levemir, Januvia, Jardiance, Xarelto, and Myrbetriq)*

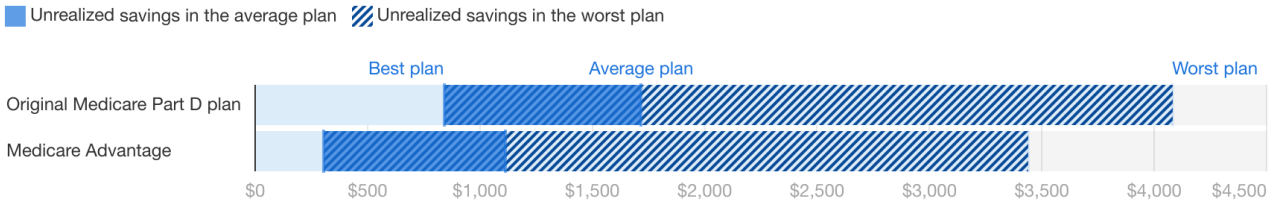
Unrealized savings and Medicare Advantage

Enrollment in Medicare Advantage plans has grown rapidly over the last decade, and the program has been touted as a potential cost-saving alternative to original Medicare. However, as the chart below shows, out-of-pocket costs for prescription drugs still vary widely across Part D plans for both original Medicare and Medicare Advantage.

Under Medicare Advantage, patients can get prescription drug coverage by enrolling in a managed care plan that includes prescription drug coverage.

Out-of-Pocket Costs Vary Across Both Medicare Advantage and Original Medicare Part D Plans

Original Medicare enrollees face unrealized savings of $878 per year in the average standalone Part D plan, compared to the best standalone Part D plan for their needs. Medicare Advantage enrollees face unrealized savings of $808 per year in the average Medicare Advantage plan, compared to the best Medicare Advantage plan for their needs.



This figure shows the range of annual out-of-pocket cost (including prescription premiums) for the best (cheapest), average, and worst (most expensive) plans for the average enrollee, by Medicare Part D plan type (original Medicare with a standalone Part D plan or Medicare Advantage with Part D coverage). Unrealized savings represent the difference in annual out-of-pocket cost in a given plan for a given patient, compared to the out-of-pocket cost for the same patient in the best plan for their medication needs. For original Medicare enrollees, the best plan is a standalone plan with the lowest out-of-pocket cost; the average plan reflects the enrollment-weighted average out-of-pocket cost across all standalone plans; and the worst plan is the standalone plan with the highest out-of-pocket cost. For Medicare Advantage enrollees, the best plan is a Medicare Advantage plan with the lowest out-of-pocket cost; the average plan reflects the enrollment-weighted average out-of-pocket cost across all Medicare Advantage plans; and the worst plan is the Medicare Advantage plan with the highest out-of-pocket cost.

Source: GoodRx analysis of data from GoodRx, Medicare Part D, and Medical Expenditure Panel Survey

Not enrolling in the cheapest prescription drug plan available can cost original Medicare enrollees **$878 per year** and Medicare Advantage enrollees **$808 per year**, on average. Compared to the best standalone Medicare Part D plan, the worst standalone Part D plan costs the average original Medicare Part D enrollee **$3,245 more per year**. Compared to the best Medicare Advantage plan, the worst Medicare Advantage plan costs the average Medicare Advantage enrollee **$3,140 more per year**.

The bottom line? Regardless of the plan type, it pays to shop around.

$808 per year

THE AMOUNT OF UNREALIZED SAVINGS FOR THE AVERAGE *MEDICARE ADVANTAGE* PATIENT IF THEY SWITCHED FROM THE AVERAGE PART D PLAN TO THEIR BEST PLAN

Helping patients enroll in their optimal Medicare plan can improve health outcomes and reduce spending

In the end, patients are the ones hurt by inefficiencies in the healthcare system. By not enrolling in their optimal plan, many people could face unnecessarily high healthcare prices that they may not be able to afford.

As a result, some people may struggle to pay for other essential expenses like food and shelter, while others may skip taking their prescribed medications altogether. This could lead to avoidable hospitalizations, disease progression, and even premature death, which all increase costs for both other patients and the healthcare system.

Higher medical cost burdens may also increase patient distrust in providers, feeding into a negative cycle of patients not getting the care they need and experiencing worse, more expensive health outcomes.

On the flip side, if patients were always able to enroll in their best insurance plan, they could recapture hundreds if not thousands of dollars in unrealized savings — money that they could spend on their prescribed medication or otherwise taking care of themselves.

> **Closing the unrealized savings gap could have a substantial impact on not only medication adherence, but also on health outcomes and healthcare spending.**

Take diabetes medications, for example. As discussed above, diabetes patients stand to save an average of **$1,382 a year** if they enroll in their optimal plan, and patients who take Jardiance could save an average of **$1,861 a year**. Adherence to oral diabetes medications has been shown to reduce the odds of emergency room visits and hospitalizations by **13%**, while a clinical trial shows that taking Jardiance reduces the risk of hospitalization for heart failure by **35%** and the risk of death by **32%**.

With over 5.8 million Medicare Part D beneficiaries with diabetes and over 170,000 filling a prescription for Jardiance, selecting the best Part D plan could meaningfully improve

adherence to diabetes medications and reduce the number of adverse health events experienced by patients with diabetes.

These health improvements have also been shown to reduce total healthcare spending. With average emergency department visits costing the healthcare system **over $1,000** and hospitalizations **over $11,500 per episode**, closing the unrealized savings gap has the potential to substantially reduce Medicare costs for the government. In the case of diabetes, research estimates every dollar spent on diabetes medications reduces total healthcare costs by roughly **$7.10**.

Summing it all up

Given the importance of cost in medication adherence, health outcomes, and healthcare spending, it is critical to help patients compare Medicare plans and select the right plan for their needs.

For example, if a patient knows what medications they need to fill every year, they can compare out-of-pocket costs on different plans using Medicare's Plan Finder tool. Licensed Medicare agents or brokers who help patients select their Medicare plan should compare *all* available plans to find the best option.

Policies should also address the sources of inertia in healthcare plans that contribute to **unrealized savings**. They could aim to reduce the burden of processing complex plan information, improve medical finance literacy, and tackle structural barriers like lack of internet access.

Ultimately, helping patients choose the right Medicare plan can be a relatively low-cost, high-impact solution to unaffordable healthcare costs.

Methodology

Medicare drug profiles

To estimate prescription drug use for Medicare Part D enrollees, we used the 2019 Medical Expenditure Panel Survey (MEPS), a nationally representative sample that provides detailed information on total healthcare use and has been previously validated against Medicare data. We limited the population to Medicare Part D enrollees (including both original Medicare and Medicare Advantage plans with Part D) who filled at least one prescription and were not dually enrolled in Medicaid.

For each Medicare Part D enrollee, we created individual drug profiles that linked every person to a basket of prescriptions filled in a year. We used the GoodRx drug database to standardize the prescription drug data reported by MEPS against the Medicare formulary data. To format the drug profiles so they could be simulated through the Medicare copay cost structure, we transformed the reported days supplied and quantity into increments of 30, 60, or 90 days supplied. Due to coverage under Medicare Part B, we excluded prescription fills for the flu vaccine and diabetes medical equipment such as meters, lancets, and test strips.

Simulated out-of-pocket costs

To estimate patient out-of-pocket costs under Medicare Part D, we used 2022 (Q1) data on Medicare prescription drug formularies from the Centers for Medicare & Medicaid Services (CMS). We excluded Medicare-Medicaid Plan and Dual Eligible Special Needs Plans from our analysis. For each patient, we identified the relevant Part D plans they could potentially enroll in based on geographic region and plan type such as standalone Part D (original Medicare) or Medicare Advantage. For the scope of this analysis, we did not simulate costs in standalone Part D plans for Medicare Advantage enrollees, and vice versa, since Medicare Advantage enrollees may have selected a managed care plan for distinct reasons (such as minimizing total healthcare costs).

The data on each Medicare Part D plan's cost structure contains information on whether or not a drug is covered, the copay or coinsurance amount in the different phases, and other details such as the plan's deductible and prescription drug premium. We identified covered and excluded drugs from the formulary data and flagged each drug as either brand or generic using the GoodRx drug database. If a drug was not covered by a plan, we imputed the out-of-pocket cost with the retail price. We calculated the retail price of

each drug using the unit price and median pharmacy dispensing fee. For excluded drugs, for which CMS does not report unit price, we used the average retail price from a nationally representative sample of U.S. retail prescription drug claims. If we did not have enough data to calculate the average retail price, we used the average wholesale price.

We used the Medicare Part D cost structure data and the MEPS drug profiles described above to simulate each drug profile through all relevant Medicare plans. We simulated out-of-pocket costs one prescription fill at a time, accumulating the total out-of-pocket cost with each fill. Fill order was randomly shuffled within each drug profile before simulation. We calculated all fees and costs assuming prescriptions were filled at in-area retail pharmacies and preferred pharmacies where applicable. Cost data was imputed linearly for missing days supplied. For the scope of this analysis, we also assumed that any restrictions such as prior authorizations and step therapy were satisfied.

We accounted for brand or generic status, total retail cost, and true out-of-pocket (TrOOP) in our simulation in order to correctly determine the Medicare phase(s) for each fill and therefore the appropriate cost structure. A prescription fill could occur within one phase or straddle multiple phases, including the deductible phase, the initial coverage phase, the donut hole, and the catastrophic phase. When a fill straddled multiple phases, we distributed the total retail cost of the drug into each phase based on the coverage rules for each phase. We also accounted for Medicare's lesser-of logic in the simulation, capping the out-of-pocket cost in a specific phase at the retail cost in that phase.

Finally, we included monthly prescription drug premiums (if applicable) in our calculation of total out-of-pocket cost, in order to account for more generous plans potentially charging higher premiums.

We note that our simulated out-of-pocket costs may differ from realized out-of-pocket costs for a number of reasons, such as the use of prescription discounts or rebates, pharmacy selection, mail-order pharmacy use, nonadherence under different prices and restrictions, and switching to over-the-counter drugs.

Statistical analysis

To estimate unrealized savings, we first calculated total annual out-of-pocket costs on three plans: the best (cheapest) plan, the worst (most expensive) plan, and the average plan. To estimate the costs associated with the average plan, we took the enrollment-weighted average out-of-pocket cost across all available plans for each person's drug profile. Medicare enrollment in each plan was measured as of March 2022.

Unrealized savings were calculated for the average plan and the worst plan as the difference in total annual out-of-pocket costs relative to the best plan.
To summarize across Medicare Part D enrollees, we calculated the weighted average, median, and 90th percentile of each outcome using MEPS nationally representative survey weights. We also stratified the analysis by the following person-level characteristics identified using MEPS data: medical condition, brand drugs filled, and plan type.

References

Agency for Healthcare Research and Quality. (2019). Medical Expenditure Panel Survey.

Campbell, P. J., et al. (2021). Hypertension, cholesterol and diabetes medication adherence, health care utilization and expenditure in a Medicare Supplemental sample. *Medicine*.

Centers for Medicare & Medicaid Services. (2022). Medicare Advantage/Part D contract and enrollment data.

Centers for Medicare & Medicaid Services. (2022). Prescription drug plan formulary, pharmacy network, and pricing information files for download.

Centers for Medicare & Medicaid Services. (2022). The Inflation Reduction Act lowers health care costs for millions of Americans.

Chandra, A., et al. (2021). The health costs of cost-sharing. *National Bureau of Economic Research*.

Cubanski, J., et al. (2021). Medicare Part D: A first look at Medicare prescription drug plans in 2022. Kaiser Family Foundation.

Cunningham, P. J. (2009). High medical cost burdens, patient trust, and perceived quality of care. *Journal of General Internal Medicine*.

Drake, C., et al. (2021). Sources of inertia in health plan choice in the individual health insurance market. *SSRN*.

Fuglesten Biniek, J., et al. (2022). Medicare beneficiaries rarely change their coverage during open enrollment. Kaiser Family Foundation.

Handel, B. R., et al. (2015). Health insurance for" humans": information frictions, plan choice, and consumer welfare. *American Economic Review*.

Hill, S. C., et al. (2011). Implications of the accuracy of MEPS prescription drug data for health services research. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*.

IPUMS. (2022). Use of samplings weights with IPUMS MEPS.

Jha, A. K., et al. (2012). Greater adherence to diabetes drugs is linked to less hospital use and could save nearly $5 billion annually. *Health Affairs*.

Marsh, T., et al. (2021). The Big Pinch: New findings on changing insurance coverage of prescription drugs. GoodRx Health.

Medicare. (2022). Costs for Medicare drug coverage.

Medicare. (2022). Explore your Medicare coverage options.

Medicare. (2022). Joining a health or drug plan.

Ochieng, N., et al. (2022). A relatively small share of Medicare beneficiaries compared plans during a recent open enrollment period. Kaiser Family Foundation.

Riaz, A., et al. (2021). How agents influence Medicare beneficiaries' plan choices. The Commonwealth Fund.

Roebuck, M. C., et al. (2011). Medication adherence leads to lower health care use and costs despite increased drug spending. *Health Affairs*.

Ruoff, A., et al. (2022). J&J, Amgen, Regeneron drugs likely to face Medicare negotiation. *Bloomberg Law*.

Sokol, M. C., et al. (2005). Impact of medication adherence on hospitalization risk and healthcare cost. *Medical Care*.

Stuart, B., et al. (2011). Does medication adherence lower Medicare spending among beneficiaries with diabetes? *Health Services Research*.

Zinman, B., et al. (2015). Empagliflozin, cardiovascular outcomes, and mortality in type 2 diabetes. *New England Journal of Medicine*.