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ScienceDirect
Research in Social and Administrative Pharmacy 10 (2014) 398–407
RESEARCH IN SOCIAL & ADMINISTRATIVE PHARMACY

Original Research

The role of satisfaction and switching costs in Medicare Part D choices

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Abstract

Background: Most U.S. states had over 50 Medicare Prescription Drug Plans (PDPs) in 2007. Medicare beneficiaries are expected to switch Part D plans based on their health and financial needs; however, the switching rate has been low. Such consumer inertia potentially has negative effects on both beneficiaries and the insurance market, resulting in a critical need to investigate its cause.

Objectives: To 1) describe how Medicare beneficiaries who were satisfied with their current Part D plan differed from those who were not satisfied; 2) examine the effect of switching costs on consideration of switching among Medicare beneficiaries who were dissatisfied with their current Part D plan.

Methods: Data from the 2007 Prescription Drug Study supplement to the Health and Retirement Study (HRS) survey were used in this study. The satisfied and dissatisfied groups were compared in terms of cost variables, switching costs, and perception of Part D complexity. Structural equation modeling was used to examine relationships among switching costs, Part D complexity, cost variables, and consideration of switching for beneficiaries who were dissatisfied with their current Part D coverage.

Results: Out of 467 participants, a total of 255 (54.6%) were satisfied with their current Part D plan. The satisfied group paid lower out-of-pocket costs ($50.63 vs. $114.60) and premiums ($30.88 vs. $40.77) than the dissatisfied group. They also had lower switching costs. Only 11.3% of the dissatisfied beneficiaries switched plans. Among respondents who were dissatisfied with their current plan, those who perceived Part D as complex had high switching costs and were less likely to consider switching plans. Out-of-pocket cost did not have a statistically significant association with consideration of switching.

Conclusions: Medicare beneficiaries who were satisfied with their current Part D plans had lower out-of-pocket costs and premiums as well as higher switching costs. Among beneficiaries who were dissatisfied with their current Part D plan, those who had higher switching costs were less likely to consider switching Part D plans.

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Keywords: Medicare Part D; Plan choice; Plan stickiness; Switching cost; Satisfaction

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http://dx.doi.org/10.1016/j.sapharm.2013.06.010

Synopsis

U.S. Medicare Part D beneficiaries have many plan choices every year. Despite frequent changes in plan attributes and beneficiaries' health needs, Part D beneficiaries often do not switch plans in response to those changes. Consumer inertia refers to this tendency to stay in their initially chosen plan. This study utilized Health and Retirement Study (HRS) survey data to examine why consumer inertia occurs. Descriptive results revealed Part D beneficiaries who were satisfied with their current Part D plans had lower out-of-pocket costs and premiums as well as higher switching costs than those who were dissatisfied. Structural equation modeling analysis identified switching costs as a main factor in consumer inertia among those who were not satisfied with their Part D plan.

Introduction

Medicare is a U.S. government-run insurance program for the elderly and the disabled. Medicare Part D (hereafter, Part D) was newly introduced in 2006 to provide outpatient prescription drug coverage to Medicare beneficiaries. Medicare beneficiaries can obtain Part D through either Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PD). All Part D coverage is through private companies. The MA-PDs combine prescription drug coverage with coverage for other health care services while the PDPs only cover outpatient prescription drugs. In 2012, 63% of Part D beneficiaries were enrolled in PDPs and the rest were enrolled in MA-PDs.[1] Medicare Part D emphasizes individual choice and thus has allowed many insurers to enter the market. Generally Part D has worked well, but over time several issues have occurred. One problem is the large number of options given to beneficiaries. There were around 50 PDPs available in 2007.[2] If these plans were distinct from each other and Part D was an easy product to evaluate, traditional economic theory suggests that giving many choices might benefit Medicare beneficiaries because of price decreases resulting from competition.[3] However, Part D has a complex structure, and insurers are required to offer very similar plans with only slight differences in Part D attributes (e.g., small differences in copayments) to have them be actuarially equivalent to the standard benefit structure designed by the Centers for Medicare and Medicaid Services (CMS). CMS is the government agency that determines rules and procedures for Part D. The complexity of Part D and the many choices with little product differentiation have overwhelmed beneficiaries.

Overwhelmed beneficiaries may choose to do nothing to save their cognitive efforts. Consumers tend to take the default option when they face complicated tasks,[4] which in the case of Part D is to stay with their current plan. Beneficiaries may not respond to changes in their plan, or to changes in their financial and health needs. Such tendency to stay with their initially chosen plan informally has been called "plan stickiness." In previous Part D studies, the term plan stickiness has been used interchangeably with consumer inertia, a term that has been used to describe non-switching behavior in the marketing literature. Consumer inertia has been defined in various ways such as spurious loyalty, unconscious form of retention, and tendency to stay at status quo.[5–7] These definitions share a common idea of "unintended not-switching" behavior, which captures what happens in Medicare Part D. This study, hereafter, refers to the tendency not to switch plans as consumer inertia because consumer inertia better captures the unintended nature of non-switching behavior being observed in Part D choices.

Consumer inertia matters because it promotes insurers taking a "bargains-then-ripoffs" pricing strategy where firms initially set low prices to attract consumers, and then raise their prices later when consumers became less sensitive to product price.[8] For example, Humana set the lowest premium in the market and achieved the highest enrollment in 2006, but then quadrupled their premium between 2006 and 2009.[9] Beneficiaries who do not respond to such huge premium changes pay more money than they would have paid if they switched to a less expensive plan. Abaluck and Gruber quantified the amount of saving Part D enrollees could have obtained by choosing the lowest cost plan and found it to be around $300.[10]

An important question to consider is why consumer inertia occurs. Why do beneficiaries fail to switch into a less expensive plan even though they can save average of $300, and sometimes much more? They might stay with their current plan despite its higher price because they are satisfied with other aspects of the plan, but there have been no studies examining this link. If they were simply overwhelmed by many options, consumer inertia would be solved by reducing the number of plans. However, a previous study examining 401K retirement plan choice

indicated there are other factors driving beneficiaries' inertia. Although employees have smaller choice sets in 401(K) plan decisions, they still made suboptimal choices and remained in their initial plans.[11]

Marketing studies raise switching costs as a leading explanation for consumer inertia.[5,6] Switching costs are defined as the time and efforts required to switch providers and are classified in various ways by different researchers. This study will adapt the classification of Burnham, who categorized switching costs into procedural, financial, and relational switching costs.[12] The influence of each dimension of switching costs varies across industries; in the context of Part D, procedural switching costs likely are most important because PDPs do not offer any special services or benefits to long-term enrollees and beneficiaries do not develop personal relationships with insurers during the plan purchasing process. Patients might develop a personal relationship with a pharmacist, but the role of patient–pharmacist relationship tends to be limited to medication related matters[13] and the role of this relationship in insurance choice is still unknown. Data were not available in this study to examine the role of the pharmacist in switching, so this study focused on only procedural switching costs that are comprised of learning, set-up, and economic risk costs (Table 1). Burnham suggested that product complexity predicts switching costs which in turn, positively affect intention to stay with incumbent provider.[12] The model of consideration of plan switching was built based on these relationships.

As mentioned above, one potential reason beneficiaries do not switch plans is because they are happy with their current plan. Satisfaction is one of the most influential factors in the repurchasing decision[14] and also has a negative relationship with switching costs.[15] This study incorporated satisfaction by describing how satisfied and dissatisfied Part D beneficiaries differed and examining why dissatisfied beneficiaries did not consider switching Part D plans. The study tested the following hypotheses in order to examine the role of switching costs in consumer inertia: 1) higher product complexity is associated with higher switching costs and 2) higher switching costs are associated with higher consumer inertia (lower consideration of switching).

Methods

Dataset

The Health and Retirement Study (HRS) survey is a longitudinal national survey measuring heath, work and retirement, wealth, and lifestyle. Data from the 2007 Prescription Drug Study (PDS) supplement to the HRS were used in this study. The PDS is a biannual survey designed to capture changes in prescription drug utilization before and after implementation of Medicare Part D. The 2005 PDS was the baseline survey. The PDS 2007 was linked to the tracker file 2011 and HRS core survey in 2004 to obtain participants' demographic and health status information. The tracker file helps link information across waves and years of the HRS.

Sample

The PDS 2007 sample includes all the non-deceased participants from the 2005 PDS. The PDS 2005 sample was drawn from HRS 2004 respondents, who were born in 1942 (who became 65 years old in 2007) or earlier or already covered by Medicare or Medicaid between 2002 and 2004. Among 4779 eligible cases, 3536 responded to the PDS 2007 either via mail or telephone interview (a response rate of 74%).[16] For the current study, those who had Medicare Part D as a primary source of prescription drug payment were included and those who paid premiums to an HMO, Medicare Advantage, or Medigap plan were excluded. The participants with these types of plans were excluded because they cover not only prescription drugs but also other types of medical services and this coverage makes it

Table 1
Typology of switching costs by Burnham et al[12]

Procedural switching costs	Financial switching costs	Relational switching costs
Economic risk costs	Benefit loss costs	Personal relationship loss costs
Evaluation costs	Monetary loss costs	Brand relationship loss costs
Set-up costs		
Learning costs		

difficult to separate choices about prescription drug coverage from decisions about other coverage.

Measures

Satisfaction

Satisfaction was measured using the question "in the last year, have you thought about switching to a different provider or a different plan of the same provider?" since a direct measure of satisfaction was not available in the data, and the response categories for this item captured satisfaction. The "satisfied group" was defined as those who stated "No, I have not thought about switching. I am happy with my plan" and the "dissatisfied group" as the rest. The rest answered "No, I have not thought about switching. I wanted to avoid the trouble of going through the whole plan comparison and choice process again" or "Yes, I have briefly considered switching to a different plan or provider" or "Yes, I have thoroughly considered switching to a different plan or provider and compared plan details." This dichotomous variable was used in the descriptive analysis.

Consumer inertia

Consumer inertia was operationalized as not considering switching despite feeling dissatisfied. The consumer inertia analysis included only the dissatisfied group defined above. Consideration of switching was defined based on responses to the question about consideration of switching and measured as an ordinal variable with three response categories of not considered, briefly considered, and thoroughly considered as described in the previous paragraph. The measurements of satisfaction and consumer inertia are summarized in Table 2.

Procedural switching costs

A measure of procedural switching costs was constructed by combining items for economic risk cost, learning cost, and set-up cost. The economic risk cost represents psychological uncertainty of risk from using unfamiliar providers while learning cost is defined as the time and effort to evaluate choice sets.[12] The economic risk cost construct was measured using 2 items, "I am more likely to make a wrong choice if I have lots of different options to choose from" and "whenever I make a choice about Medicare, I worry it will be the wrong one." Learning cost was measured using two items, "I often feel overwhelmed because there is too much information about each plan to take in" and "I am confused about the changes in Medicare." The items for both economic risk cost and learning cost used 5-level Likert scales (agree strongly, agree somewhat, neither agree nor disagree, disagree somewhat, disagree strongly). Set-up cost was defined as "the time and effort associated with the process of initiating a relationship with a new provider"[12] and measured by two items, "the enrollment process was very complicated" and "the enrollment process was clear and straightforward." Both set-up cost items used 4-level Likert scales (strongly agree, agree, disagree, strongly disagree). All the switching cost items were coded so that higher scores signified higher costs.

Product complexity

Since previous research suggests many choices and complex structure of Part D overwhelm beneficiaries,[17] this study measured the perception of complexity of Part D. Product complexity is defined as "the extent to which the consumer perceives a product to be difficult to understand or use."[12] It was measured using three items, two of which used 4-level Likert scales: "I had difficulty understanding how Medicare Part D works

Table 2
Measures of satisfaction and consumer inertia

In the last year, have you thought about switching to a different provider or a different plan of the same provider?		Satisfaction	Consideration of switching
A	No, I have not thought about switching. I am happy with my plan.	Satisfied group	
B	No, I have not thought about switching. I wanted to avoid the trouble of going through the whole plan comparison and choice process again.	Dissatisfied group	Low
C	Yes, I have briefly considered switching to a different plan or provider.		Medium
D	Yes, I have thoroughly considered switching to a different plan or provider and compared plan details.		High

and what savings it would provide" and "it was difficult to determine whether specific medications are covered by the plans that are offered." The other item used a 5-level, Likert-type scale: "I have difficulty understanding the information about Medicare coverage options." All three items were summed to create a Part D complexity scale where higher scores signified higher complexity.

Covariates

The 2007 Part D plan premium, out-of-pocket costs, number of regularly taken prescription drugs, self-reported health status, age, and gender were controlled in the analysis. Out-of-pocket costs were measured by typical spending for a one-month supply of regular drugs and highest spending for a one-month supply of regular drugs. Self-reported health status was measured by a 5-level, Likert-type scale ranging from excellent to poor.

Data analysis

The PDS 2007 and demographics and physical health section of HRS core 2004 were linked by household identifier and person number. The 2011 tracker file was also linked to the PDS 2007 in order to track respondent information across different waves of HRS. Descriptive analyses were performed to obtain sample characteristics and compare Medicare beneficiaries who were satisfied with their Part D plan with those who were dissatisfied. Means and frequencies were obtained for continuous and categorical variables, respectively. Also, *t*-tests and chi-square tests were performed to see if there were statistically significant differences between the two groups' characteristics.

Structural equation modeling using AMOS 7.0 with maximum likelihood estimation was performed to examine the role of switching costs in consideration of switching plans.

The dependent variable, consideration of switching, was an ordinal variable with the categories low, medium and high (Table 2). The main independent variables were procedural switching costs and product complexity; their structural relationships with consideration of switching were hypothesized based on Burnham's study.[12] Burnham and colleagues found that higher product complexity is related to higher procedural switching costs and lower intention to switch.[12] The measurement model is summarized in Fig. 1. To examine whether our model adequately explains the variation in consideration of switching, the investigators checked model statistics including the ratio of chi-square test statistic to degree of freedom, comparative fit index (CFI), goodness-of-fit index (GFI), normed fit index, Tucker–Lewis index (TLI), root mean square error of approximation (RMSEA). Structural equation modeling was chosen for the analysis because it allowed us to simultaneously examine relationships among multiple independent variables.

Results

Satisfaction

A total of 474 respondents met the inclusion criteria and a total of 467 observations were used for analysis after removing missing values. Characteristics of respondents are summarized in Table 3 and a comparison of satisfied and dissatisfied respondents is provided in Table 4. Slightly more than half of respondents answered they were happy with their current plan and were categorized as "satisfied" (255, 54.6%). The rest were categorized as "dissatisfied" (212, 45.4%). Both groups had similar percentages of female respondents (satisfied: 37.7% vs. dissatisfied: 37.3%; $P = 0.93$) but the satisfied group had slightly older respondents (satisfied: 71.0 vs. dissatisfied: 69.6; $P = 0.04$). As for the health related variables, there were no statistically significant differences between the two groups in terms of number of regularly taken prescription drugs (satisfied: 4.7 vs. dissatisfied: 4.9; $P = 0.31$) and self-rated health status (satisfied: 2.9 vs. dissatisfied: 2.8; $P = 0.60$). However, there were substantial differences between satisfied and dissatisfied groups for the cost variables (Table 4). The monthly premium, regular out-of-pocket (OOP) cost per month, and maximum OOP cost per month all were significantly different between the two groups ($P < 0.01$). Both the regular and the maximum OOP costs for the dissatisfied group were over twofold higher than for the satisfied group.

There also were significant differences between satisfied and dissatisfied groups in their perceptions of Part D complexity and switching costs (Table 4). Overall, respondents who were dissatisfied with their current plan perceived Part D to be a more complex product to understand or to utilize (satisfied: 8.0 vs. dissatisfied: 9.2; $P < 0.0001$), had higher economic risk cost (satisfied: 6.8 vs. dissatisfied: 7.5; $P = 0.0002$), learning cost (satisfied: 6.9 vs. dissatisfied: 7.7; $P < 0.0001$), and set-up cost (satisfied: 4.5 vs. dissatisfied: 5.2; $P < 0.0001$). The set-up cost scores for both groups were relatively low compared

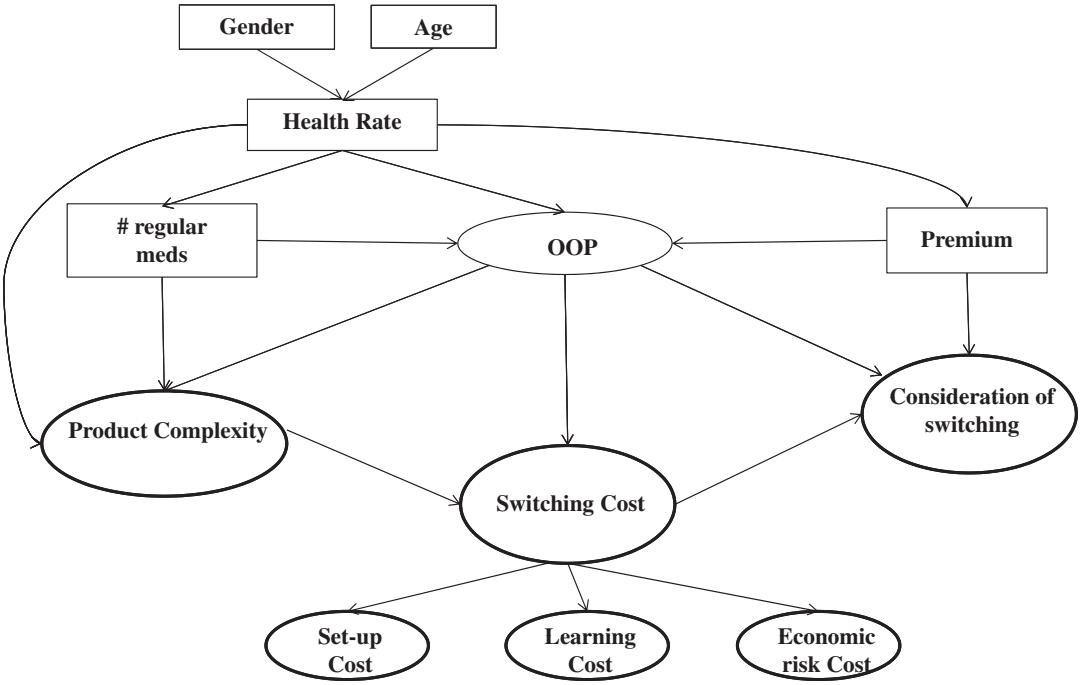

Fig. 1. Measurement model of consideration of switching Part D plan. Square indicates observed variables and circle indicates latent variables; OOP indicates out-of-pocket costs.

to product complexity and the other switching costs, suggesting beneficiaries generally have more difficulty understanding information and finding an optimal plan than they do with the enrollment process.

Even though they had different levels of costs and psychological barriers, both the satisfied and dissatisfied groups had relatively low rates of plan switching; however, the dissatisfied group had a switching rate over 1.5 times higher than the satisfied group (11.3% vs. 7.1%). The somewhat higher switching rate of the dissatisfied group indicates there were some beneficiaries who responded to their dissatisfaction, but there still were almost 90% of beneficiaries who remained in their plan even though they were not happy with it. This finding raises the question of why dissatisfied beneficiaries stay with their current plan. The next section will try to answer this question by focusing on behavior of the dissatisfied.

Consumer inertia

As mentioned previously, it is logical that those who were satisfied with their current plan did not consider switching into other plans; however, it is important to better understand why those who were dissatisfied did not consider switching. The results of structural equation modeling showed dissatisfied beneficiaries who had higher perceived procedural switching costs were less likely to consider switching Part D plans (coefficient $= -0.15$; $P = 0.035$). On the other hand, both out-of-pocket costs and premium did not affect the level of switching consideration (OOP: coefficient $= 0.096$; $P = 0.181$, premium: coefficient $= 0.062$; $P = 0.369$), in contrast to their influence on satisfaction. As for the antecedent of switching costs, product complexity was found to have a very high positive association with procedural switching costs (coefficient $= 0.99$; $P < 0.0001$). Beneficiaries who rated their health as poor were more likely to perceive Part D as a complex product (coefficient $= 0.389$; $P < 0.0001$) but those who took more prescription drugs regularly perceived Part D as less complex (coefficient $= -0.206$; $P = 0.027$) suggesting a self-learning effect. As expected, those who reported poor health used more prescription drugs (coefficient $= 0.335$; $P < 0.0001$), which subsequently was associated with higher out-of-pocket costs (coefficient $= 0.512$; $P < 0.0001$). Higher premium was associated with higher out-of-pocket costs (coefficient $= 0.195$; $P = 0.002$), and age and gender did not have statistically significant effects on any variables in the model.

Table 3
Sample characteristics

Variables	Characteristics
N	474
Mean age, years (SD)	70.5 (7.5)
Female, %	62.87
Married, %	63.29
Mean number of regularly taken medications (SD)	4.76 (3.1)
Mean Part D premium, $ (SD)	35.7 (37.6)
Mean number of years in school, years (SD)	12.3 (3.1)
≤High school, %	61.81
College, %	26.79
Graduate school, %	11.39
Mean out of pocket cost for prescription drugs, $ (SD)	76.43 (95)
Mean maximum expense per month for prescription drugs, $ (SD)	136.46 (244.9)
Mean score of self-rated health, points (SD)	2.83 (1.1)
Excellent, %	13.08
Very good, %	27.22
Good, %	31.43
Fair, %	19.41
Poor, %	8.86
Satisfied with current Part D plan, %	55.27
Considered switching Part D plans last year, %	24.26
Actually switched Part D plan last year, %	8.86

The scale ranges were 1–5 for self-rated health.

Regarding fit statistics, the model had a 1.702 ratio of chi-square test statistic to degree of freedom ($\chi^2 = 182.17$, df = 107, $P < 0.000$), a comparative fit index (CFI) of 0.94, a goodness-of-fit index (GFI) of 0.91, a normed fit index (NFI) of 0.86, a Tucker–Lewis index (TLI) of 0.92, and a root mean square error of approximation (RMSEA) of 0.058. The CFI, GFI, and TLI higher than 0.9 indicated that the model explained the data well. Also, the NFI higher than 0.85 and the RMSEA lower than 0.06 indicated a good model fit.[18] The results of structural equation modeling as well as model fit statistics are summarized in Fig. 2.

Discussion

This study found Medicare beneficiaries who appeared satisfied with their current Part D plan were different from those who were not satisfied in terms of premium and OOP cost, perception of Part D complexity, and switching costs. Those who were dissatisfied with their current plans paid over two times higher out-of-pocket costs and 1.3 times higher premiums. Such big differences suggest that costs might be a major driver of satisfaction with Part D plans and be a factor that beneficiaries consider very important.

Interestingly, the difference between satisfied and unsatisfied Part D beneficiaries was bigger for OOP cost than for premium. The OOP cost depends on what kinds of drugs beneficiaries take whereas premium does not. Thus, premium is known a priori and is a fixed expenditure for beneficiaries but OOP costs are not fully known at the time of the plan enrollment decision. Beneficiaries may experience higher than anticipated OOP costs, leading them to be dissatisfied with the plan. The cognitive dissonance theory states that individuals defend their prior decisions, that is, once they make a choice, they choose to like it.[19] Therefore, individuals may express satisfaction with their choices even though they are not truly satisfied, unless something occurs that overcomes their predisposition to defend their decision.

This study finding suggests that OOP cost might be such a factor. The premium as a fixed cost would not affect satisfaction level, but when beneficiaries face unexpected OOP costs, they may reevaluate defending their choice. This finding, along with Abaluck and Gruber's finding that beneficiaries overweight premiums compared to OOP cost,[10] may demonstrate why beneficiaries do not consider switching even though they are not satisfied. The unexpected OOP costs lead beneficiaries to be dissatisfied with their current plans, but they undervalue OOP cost over fixed premium when it comes to the point of choosing a plan, resulting in them staying with their current plan. In addition to the tendency to undervalue OOP, the complexity of evaluating OOP cost across plans in contrast to the more visible and easier to compare premium information may explain why beneficiaries who are dissatisfied do not switch plans.

Also, the dissatisfied group was more likely to think Part D was complex to use or understand and had higher psychological barriers to switching Part D plans than the satisfied group. We do not know whether their perceptions of cost and complexity led them to be dissatisfied, or whether their dissatisfaction with their plan led them to think Part D is complicated and switching plans is bothersome. However, this study suggests there is at least some association between satisfaction and beneficiaries' perceptions of the complexity of Part D.

Table 4
Comparison between satisfied and dissatisfied groups

Variables	Satisfied	Dissatisfied	*P* value
N (%)	255 (54.6)	212 (45.4)	
Mean age, years	71.01	69.59	0.041**
Female, %	37.65	37.26	0.932
Number of regularly taking medications	4.65	4.94	0.311
Score of self-rated health, points	2.86	2.81	0.597
Product complexity, points	8.04	9.22	<0.0001***
Switching costs			
Lost performance cost, points	6.84	7.53	0.0002***
Learning cost, points	6.87	7.69	<0.0001***
Set-up cost, points	4.47	5.19	<0.0001***
Costs			
Premium, $	30.88	40.77	0.004***
Out-of-pocket cost, $	50.63	114.60	<0.0001***
Maximum expense per month, $	100.70	181.30	0.0004***

The scale ranges were 1–5 for self-rated health. The scale ranges were 3–13 for product complexity, 2–10 for economic risk and learning costs, and 2–8 for set-up costs. Higher scores signify higher level of product complexity or switching costs. ** indicates $P < 0.05$ and *** indicates $P < 0.001$.

Another interesting point from the descriptive results is that set-up cost was relatively low compared to other types of switching costs, regardless of satisfaction. Beneficiaries seemed to have more difficulty evaluating, comparing, and making decisions about plans than they did with the plan enrollment process. Paperwork, travel to the insurance agency, or connecting to the internet are certainly burdensome but can be done. However, beneficiaries were less confident with the outcome and process of their decision-making. A previous Part D study suggested that transaction costs might play a role in enrollment decision but the authors did not specify what kinds of

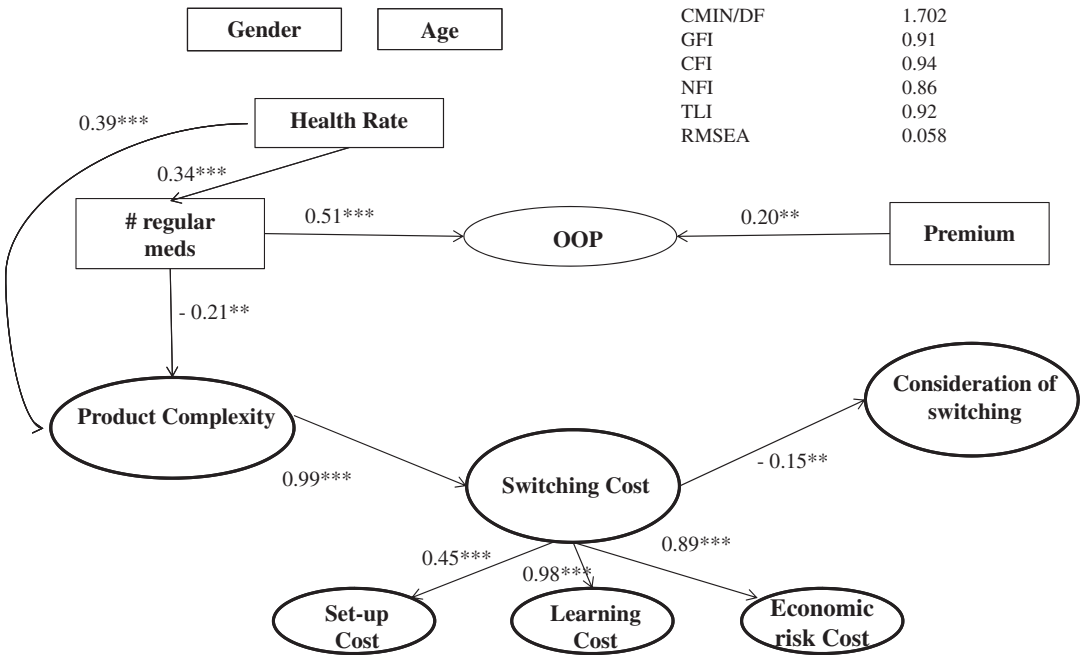

Fig. 2. Final model of consideration of switching Part D plan. Square indicates observed variables and circle indicates latent variables; OOP indicates out-of-pocket costs; ** indicates *P* value <0.05 and *** indicates *P*-value <0.001.

transaction costs mattered.[20] Our study finding suggests that Part D beneficiaries are more affected by psychological barriers than by tangible barriers throughout the enrollment process. This result is aligned with focus group results showing reasons for not switching including uncertainty about choosing a better plan than the current one and a belief that switching plans would cause problems.[21,22]

Intuitively, dissatisfied consumers should switch into better plans or at least have an intention to do so. Structural equation modeling was used to examine this question. The results show that those who had higher switching costs were less likely to consider switching even though they were not happy with their current plan. This result is aligned with Ranaweera and Prabhu's findings that switching barriers moderate the impact of satisfaction on customer retention.[23] Interestingly, cost variables did not affect the level of switching consideration among dissatisfied beneficiaries. It is interesting that the dissatisfied and satisfied groups showed significant differences in cost variables from the descriptive results but that difference did not affect switching consideration. This implies that switching costs outweigh needs in this context. According to motivation, ability, and opportunity (MOA) model, needs serve as a predictor of motivation to process information, which determines the attitude toward brand.[24] Beneficiaries were not happy with their current plan, for example because of high costs, and felt the need to have a better plan, which should lead beneficiaries to process plan information. However, if that need was not large enough to overcome switching costs, beneficiaries may not be sufficiently motivated to process plan information and consider switching.

One important implication of this finding is that switching costs need to be reduced in order for Part D beneficiaries to consider switching plans. Professional assistance would be one of the most effective tools to help beneficiaries overcome switching barriers. Given that the pharmacy is the place where patients realize what they pay for prescription drugs, pharmacists could be a good source of professional assistance. One intervention study where pharmacists provided counseling about plan selection showed that plan switching was dramatically increased and expected OOP costs were reduced by 68%.[25] The current study's findings provide theoretical explanation for this success. Pharmacists' intervention using their professional knowledge likely reduced beneficiaries' switching barriers and this led to increased plan switching rate and cost savings.

The study has several limitations. The conclusion of a causal relationship between switching costs and switching consideration should be cautiously made because the study used cross-sectional data. For example, previous Part D plan experiences may have contributed to the beneficiaries' satisfaction or dissatisfaction so the measured satisfaction level may not have solely reflected satisfaction with their current situation. Beneficiaries who stated that they were happy with their current plan were less worried about ending up with a wrong plan, evaluating options and learning new information. It may be that since they had not attempted switching, they were unaware of the challenges associated with the process and thus held a positive attitude toward the decision making process. In contrast, those who were not happy with their current plan might have experienced the switching process in the past and learned it was a difficult task. Survey responses also may be prone to recall bias. The survey questionnaires included questions about different time points such as a year ago or current time; therefore, respondents may not have recalled information accurately.

Conclusion

This study confirms previous findings that Part D beneficiaries generally tend not to switch plans and also suggests that satisfaction may be one factor affecting switching decisions. Medicare beneficiaries who were dissatisfied with their current Part D plan were more likely to switch plans and paid higher costs than those who were satisfied. Although more dissatisfied beneficiaries than satisfied beneficiaries switched plans, approximately 90% of them still did not consider switching plans. Psychological switching barriers were found to explain this behavior. Dissatisfied beneficiaries who had higher procedural switching costs were less likely to consider switching Part D plans. These findings collectively suggest that beneficiaries may become more proactive in switching plans to find an optimal plan if they could overcome switching barriers.

Acknowledgments

This research was supported by an Agency for Healthcare Research and Quality Centers for Education and Research on Therapeutics cooperative agreement (5 U18 HSO16094).

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