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Beneficiary Information and Decision Supports for the Medicare-Endorsed Prescription Drug Discount Card

Diane Justice, Domestic Social Policy Division

March 24, 2005

Abstract. On December 8, 2003 the President signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173). This legislation establishes a Medicare prescription drug program, effective January 1, 2006. In the interim, the legislation requires the Department of Health and Human Services (HHS) to establish a temporary program of Medicare-endorsed prescription drug discount cards. The program has two objectives. One is to provide access to prescription drug discounts to persons who voluntarily enroll with a private drug card sponsor. The second is to provide low-income beneficiaries with transitional assistance to pay for some of their prescription drug costs until the new Medicare prescription drug benefit becomes available in 2006. Despite concerted efforts by the Centers for Medicare and Medicaid Services (CMS), 25% of low-income persons who qualify for the program's transitional assistance have enrolled.

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Summary

On December 8, 2003 the President signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173). This legislation establishes a Medicare prescription drug benefit, effective January 1, 2006. In the interim, the legislation requires the Department of Health and Human Services (HHS) to establish a temporary program of Medicare-endorsed prescription drug discount cards.

The program has two objectives. One is to provide access to prescription drug discounts to Medicare beneficiaries who voluntarily enroll with a private card sponsor. The second is to provide low-income beneficiaries with transitional assistance to pay for some of their prescription drug costs until 2006, when the new Medicare drug benefit begins. Despite concerted efforts by the Centers for Medicare and Medicaid Services (CMS), 25% of the 7 million low-income beneficiaries who qualify for transitional assistance have enrolled in the card. Low-income Medicare beneficiaries could realize the most tangible benefit from enrolling since they would receive transitional assistance of $600 for both 2004 and 2005. Those who did not enroll in 2004 can do so by March 31, 2005 and receive the full $600 for 2005.

Beneficiaries can select from 38 national discount card programs offering different prices for specific drugs, some variation in covered drugs and distinct pharmacy networks. Thus, beneficiaries have many considerations when selecting a card. To make such a choice, they first need to know the program exists. Next, they need both information to determine whether to enroll in the program and decision supports to help them select the card most suited to their own circumstances.

Many of the same outreach and education methods CMS has used in the past to inform beneficiaries about new Medicare benefits are being employed and intensified for the discount drug card program. In particular, CMS has placed increased emphasis on the Internet as an information vehicle for beneficiary information.

Some observers have commented that the complex decisions beneficiaries must make about program enrollment and card selection have led to confusion and inaction among older people. These factors, coupled with the approximately 70% of Medicare beneficiaries who are unable to use the Internet for any purpose, some suggest, have constrained program enrollment. CMS has improved its outreach and education strategies as it obtained more beneficiary feedback. Many acknowledge that reaching low-income people with information that would encourage their enrollment in new programs is a difficult challenge — one faced by many governmental programs.

The outreach and education experience of the discount card program can offer lessons for implementing the Medicare prescription drug benefit beginning in 2006. Then, decisions beneficiaries must make are likely to be more complex and the stakes higher for not enrolling and/or selecting a prescription drug plan that does not target an individual's needs as well as alternative plans. This report will be updated.

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Beneficiary Information and Decision Supports for the Medicare-Endorsed Prescription Drug Discount Card

On December 8, 2003 the President signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173). This legislation establishes a Medicare prescription drug program,[1] effective January 1, 2006. In the interim, the legislation requires the Department of Health and Human Services (HHS) to establish a temporary program of Medicare-endorsed prescription drug discount cards.[2]

The program has two objectives. One is to provide access to prescription drug discounts to persons who voluntarily enroll with a private drug card sponsor. The second is to provide low-income beneficiaries with transitional assistance to pay for some of their prescription drug costs until the new Medicare prescription drug benefit becomes available in 2006. Despite concerted efforts by the Centers for Medicare and Medicaid Services (CMS), 25% of low-income persons who qualify for the program's transitional assistance have enrolled.

All beneficiaries who currently lack private coverage for prescription drugs might benefit in varying degrees from enrolling in a drug discount card and gaining access to negotiated drug prices. Low-income persons could realize the most tangible benefit from enrolling since they would receive transitional assistance of $600 for each of 2004 and 2005 to be applied to their prescription drug costs. Those who did not enroll in 2004 can do so by March 31, 2005 and receive the full $600 transitional assistance for 2005. A pro-rated amount will be awarded to persons who enroll later in the year. As a practical matter, the transitional assistance is provided as a credit though the drug card and declines as the beneficiary uses it to purchase prescription drugs.

Medicare beneficiaries eligible for the drug card credit have annual incomes equivalent to 135 % of poverty or less. In 2005, that equals $12,919 for an individual and $17,320 for a couple. In determining eligibility, income from most sources is counted, with the exception of Supplemental Security Income (SSI), other public assistance benefits, and certain types of insurance payments. Assets are not

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[1] For additional information on the new drug benefit see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan.

[2] For additional information on the drug discount program, see CRS Report RL32283, *Medicare-Endorsed Prescription Drug Discount Card Program*, by Jennifer O'Sullivan.

considered. Persons who have prescription drug coverage through retiree health plans or federal employee health insurance cannot participate in the program. Low-income Medicare beneficiaries who are also enrolled in Medicaid receive drug coverage through that program and are therefore not eligible for transitional assistance.[3]

Program Enrollment Challenges

When implementing any new public program, federal agencies are faced with the challenge of making the intended participants aware of the new benefits and getting the assistance to people who need it the most. When the target population is low-income older persons, achieving a significant level of program enrollment is particularly difficult. Based upon the experiences of other federal programs targeted to this group, intensive education and outreach efforts are required, and even then, significant proportions of the eligible population may not participate.[4]

Several factors present particular complications in designing information strategies targeted to low-income Medicare beneficiaries. Literacy rates among low-income persons are lower than for the rest of the population.[5] In addition, low-income beneficiaries are less likely to have access to certain communication vehicles frequently used to disseminate program information, particularly the Internet.[6] Finally, some research indicates that there are age-related cognitive declines in the ability to comprehend comparative information and apply it to one's own circumstances.[7]

For the drug discount card program, not only does information about the program need to reach low-income beneficiaries, but information also needs to facilitate their ability to choose which card bests fits their needs. Individuals can choose from 38 cards available through sponsors operating nationally, and depending upon their state of residence, additional options may be offered in their geographic area or provided exclusively by managed care plans for their enrollees.

While low-income persons enrolled in any card can receive transitional assistance credited toward their drug expenditures, the cards have different prices for

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[3] Medicare beneficiaries who are also enrolled in the Medicaid program — the dually eligible — will receive drug coverage under the new Medicare prescription drug benefit beginning in January 2006.

[4] Dahlia K. Remier and Sherry A. Giled, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health*, vol. 93, no. 1, Jan. 2003.

[5] Institute of Medicine, *Health Literacy* (Washington, D.C.: National Academies Press, 2004), p. 64.

[6] Susannah Fox, *Older Americans and the Internet*, Pew Internet and American Life Project, Mar. 25, 2004.

[7] Judith H. Hibbard, Paul Slovic, Ellen Peters and Melissa Finucane, *Older Consumers' Skill in Using Comparative Data to Inform Health Plan Choice: A Preliminary Assessment*, AARP, Sept. 2000. (Hereafter cited as Hibbard, *Older Consumers' Skill.*)

specific drugs, some variation in covered drugs and distinct networks of participating pharmacies. Thus, beneficiaries have a number of distinctly different factors to consider when comparing and selecting a card.

Current Program Enrollment

As of February 2005, nearly 6.2 million beneficiaries were enrolled in a Medicare-endorsed drug discount card. Of these, only 1.7 million persons received the low-income credit,[8] a number significantly below expectations. When the program began, CMS estimated that 7 million persons would quality for the $600 annual credit and 4.7 million would enroll.[9]

Almost half of the 6.2 million card participants were automatically enrolled by entities that had the authority to act on their behalf. Of these, at least 2.4 million persons were enrolled in a card by their Medicare managed care plan, and 350,000 were enrolled by state pharmacy assistance programs established by some states with their own funds to help older people pay for prescription drugs. Thus, about 3.5 million persons enrolled in the card program through their own initiative. Data are not available on the proportion of low-income persons who enrolled through each of these methods.

At the urging of beneficiary organizations, CMS recently decided to facilitate enrollment in the discount card program for beneficiaries who participate in one of the Medicare Saving Programs (MSP).[10] Because these programs, which cover various Medicare-related out-of-pocket costs, are targeted to low-income beneficiaries, virtually all participants would meet the income criteria for receiving the drug card credit. In October 2004, CMS mailed drug cards to 1.1 million MSP participants. Once these persons called 1-800-MEDICARE or the phone number of the card sponsor to which they had been randomly assigned, enrollment would be activated. As of January 2005, less than 10% of those who were mailed cards had enrolled in the program.

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[8] U.S. Department of Health and Human Services, *HHS Budget in Brief: Fiscal Year 2006*, Feb. 2005, p. 52.

[9] CMS Office of Legislation, *State Drug Card Statistics at a Glance*, May 19, 2004.

[10] Medicare Savings Programs finance certain Medicare cost-sharing expenses for three categories of Medicare beneficiaries. Qualified Medicare Beneficiaries (QMB) have incomes below the federal poverty level (FPL) and assets no greater than $4,000 for an individual and $6,000 for a couple. They are entitled to have their Medicare cost-sharing amounts and their Part B premiums paid jointly by federal and state governments through the Medicaid program. Specified Low-Income Beneficiaries (SLMB) meet QMB criteria except that their income is greater than 100% of the FPL but less than 120%. The Medicaid program pays their Medicare Part B premiums. Qualifying-Individuals (QI-1) meet QMB asset criteria but have incomes between 120% and 135% of the FPL. States receive a capped federal allotment that pays this group's Part B premiums until the annual allotment has been spent. Some states allow individuals to retain additional income or assets and still qualify for each of these three MSP categories.

This report addresses the approaches CMS has been using to inform beneficiaries about Medicare's covered benefits and options. But most specifically, it focuses on education and outreach strategies adopted to both inform beneficiaries about the prescription drug discount card program and assist them in choosing the card that best fits their circumstances. Lessons learned from these current efforts can help Congress oversee the design and implementation of strategies for assisting beneficiaries to understand an even more complicated Medicare prescription drug benefit and make informed decisions in the fall of 2005 about new private drug plans.

Evolution of Beneficiary Outreach and Education Programs

Enactment of Medicare

The challenge of educating older people about new Medicare benefits dates back to the program's enactment in 1965. Then, federal officials needed to locate all 19 million persons age 65 and over to enroll them in the Medicare program.

All older people were initially covered by the hospital insurance program, Medicare Part A. Participants in Social Security were automatically enrolled in Part A by the Social Security Administration (SSA). But about 4.5 million older people did not receive Social Security payments, primarily because they were retired from federal, state, or local governments that had established separate public pension systems for their employees. To participate in Part A, these individuals were required to submit an application to SSA.

All older people also had the choice of enrolling in the voluntary Supplementary Medical Insurance (SMI) program, Medicare Part B. Thus, they needed to learn about this option and determine whether they wanted to participate.

Beneficiary Outreach. In 1965, SSA launched a massive effort to enroll all older people in Part A and Part B of the Medicare program. With the assistance of the Internal Revenue Service, the Federal Civil Service Commission (now the Office of Personnel Management) and state and local governmental retirement systems, practically all older persons who were not eligible for Social Security were identified and eventually enrolled in Part A. Those individuals, along with all Social Security beneficiaries, were mailed applications for Part B enrollment.

About half of the target population responded to the first mailing, most choosing to enroll in Part B. A second mailing, a media campaign and a targeted door-to-door $7.2 million outreach effort, "Operation Medicare Alert," sponsored by the U.S. Office of Economic Opportunity, achieved a Part B enrollment of 88% of the eligible population. Congress enacted legislation to extend the Part B enrollment deadline for two months, after which the participation rate increased to 90%. In addition, about 1 million older persons declined Part B participation, meaning that almost all

eligible individuals proactively responded to the various outreach efforts during the nine-month enrollment period.[11]

Beneficiary Enrollment. Achieving a 90% enrollment rate in the Medicare program at its inception was a truly remarkable accomplishment. Communication methods used today, such as national toll-free telephone lines and the Internet, were not available. Eligible individuals without any prior connection to a federal benefit program had to be located. And many older people who had limited exposure to insurance terms needed to learn about premiums, deductibles, and co-payments in order to make a decision about enrolling in Part B.

On the other hand, compared to the complex decisions individuals must make when enrolling in the drug discount program, enrollment in Part B was a relatively straightforward process. When beneficiaries decided whether to enroll in Medicare Part B, their primary consideration was whether the monthly premium of $3 was worth the program's benefits. Only a small percentage of older people had to compare Part B benefits with their existing insurance plan since so few had private health care coverage for physician services and the other new Part B benefits. In contrast, the decisions beneficiaries face in choosing a drug discount card are complicated due in part to the number of cards available and the variation among them in drug prices, covered drugs, and participating pharmacies.

Also because in 1965 older people had only two choices — to enroll in Part B or not — the SSA was able to mail each person a standard application form that asked for a simple yes-no response to be sent back to SSA. In contrast, when the discount card program began, a low-income person who wanted to enroll in a card and apply for the $600 credit needed to mail an application to a particular card sponsor rather than apply through a common point. In the fall of 2004, CMS began permitting card sponsors to accept beneficiary applications for both the card and the credit through an online link to the sponsor's website posted on [http://www.medicare.gov] or over the phone

Current CMS efforts to educate Medicare beneficiaries about the program's covered services and to facilitate consumer decision-making in choosing a drug discount card are rooted in two prior significant congressional reform initiatives. These are (1) the creation of standardized supplemental insurance plans in 1990, and (2) the establishment in 1997 of new types of managed care plans under the Medicare+Choice program. Both provided new program options to beneficiaries who often needed tailored information and decision supports in order to take maximum advantage of the choices created by these initiatives.

Omnibus Budget Reconciliation Act of 1990: Medigap Plan Choices

With passage of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-518), Congress enacted reforms to restructure Medicare Supplemental Insurance,

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[11] National Academy of Social Insurance, *Implementation Aspects of National Health Care Reform: Reflections on Implementing Medicare*, Mar. 15, 1993.

commonly known as Medigap. In response to both widespread fraudulent sales practices and concerns that Medigap insurance policies were too complicated to understand and difficult to compare, Congress mandated that all policies sold be designed to conform to one of 10 standardized plans.

Section 4360 of the Act also created the Information, Counseling and Assistance program, later renamed the State Health Insurance Assistance Program (SHIP), funded by federal grants to states awarded by the Health Care Financing Administration (HCFA), now CMS. Fifteen states already had similar programs upon which the federal program was modeled. In each state, the Governor designated the state agency to manage the program. In two-thirds of the states, state Offices on Aging have that responsibility, and in the remaining one-third, State Insurance Commissions administer the SHIP.

Initially SHIPs were charged with providing information, counseling and assistance to beneficiaries in making choices about Medigap and long-term care insurance, and more generally helping them understand their Medicare coverage, reconcile erroneous billings and recognize fraudulent insurance practices. Over the past 14 years, their roles have significantly expanded as subsequent legislation created Medicare managed care options and established Medicare-endorsed drug discount cards and a Medicare prescription drug benefit. The one-on-one counseling and decision support provided by SHIPs has evolved to meet beneficiary needs for information and decision support in selecting from among these new types of options.

The resources allocated to the program, however, remained relatively stable. When it was first established, the initial level of support was $10 million for FY1991. Over the next 12 years, annual funding levels fluctuated up and down along a band ranging from $10 million to $16 million. With enactment of the MMA and the new benefit choices it created, CMS increased funding for the SHIP program from $12 million in 2003 to $21 million in 2004 and $31 million in 2005 to provide a higher level of beneficiary decision support.

Balanced Budget Act of 1997: Choice of Managed Care Plans

The second major Medicare policy change that triggered new consumer education efforts was the creation of Medicare+Choice managed care plans coupled with an intensified emphasis on increasing beneficiary enrollment in managed care. When enacting these changes in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33), Congress specified a set of activities HHS was required to conduct to educate older people about the Medicare program in general and assist them in making choices between traditional Medicare and the new plans authorized in the Act.[12] For a variety of reasons, managed care options did not increase over the next several years; but a broad range of efforts to help older people better understand Medicare and choose among existing options was instituted; these remain today as the core components of what has become known as the National Medicare Education Program (NMEP). As discussed below, the NMEP included the SHIP as well as the activities mandated by BBA 97.

[12] Section 1851(d).

Congress established the building blocks of the NMEP out of two concerns. First, it had heard recurring beneficiary concerns about how difficult the Medicare program is to understand. Second, it wanted to encourage expansion of Medicare managed care options and recognized that many beneficiaries would need extensive information in order to elect a new form of health care delivery that was different from the traditional system to which they had become accustomed.

BBA 97 mandated specific methods to be used by HHS for the provision of beneficiary information to promote informed choice. These include:

- Written materials, sent annually to beneficiaries to coincide with the open enrollment period for Medicare+Choice plans, which provide (1) a detailed description of benefits covered under the original Medicare fee-for-service program; (2) congressionally-specified comparative information about Medicare+Choice plans available in a beneficiary's geographic area; (3) Medigap policy benefits and requirements; and (4) procedural beneficiary rights under traditional Medicare and Medicare+Choice;
- A *toll-free telephone number* to respond to beneficiary inquiries;
- An Internet site providing information on Medicare plan choices and, specifically, on available Medicare+Choice plans; and
- A *nationally coordinated educational and publicity campaign* to inform beneficiaries about Medicare+Choice plans and how to elect them.

These components are now taken for granted as routine ways of providing consumer information about Medicare and are cited in the MMA as core mechanisms for disseminating information about the private drug plans that will become available in 2006. However, when these methods were mandated by Congress in 1997, HCFA (now CMS) had to create entirely new information products and vehicles. Their evolution forms the basis for current beneficiary educational efforts.

Written Materials. *The Medicare and You Handbook* was substantially revised to meet the mandate for provision of comprehensive yet understandable written materials. The new version underwent extensive testing to ensure that information was presented in language understandable to a consumer audience. To provide comparative information on Medicare+Choice Plans available in specific geographic areas, in the fall of 1999, HHS published tailored versions of *Medicare and You*, mailed to beneficiaries living in distinct areas.

Because this endeavor was such a complete overhaul of previous materials provided to beneficiaries, HHS decided to test use of these materials in five pilot states beginning in fall of 1998 before disseminating them nationwide. The pilot states were Arizona, Florida, Ohio, Oregon, and Washington. These states were chosen to provide a mix of places with varying degrees of managed care penetration and a range of beneficiary demographic characteristics. In particular, Arizona and Florida provided an opportunity to test the Spanish version of *Medicare and You.*

Toll-Free Number. Establishing a nationwide 800 help line number presented a different set of challenges, related in part to limitations in the capacity of the

nation's telecommunication infrastructure at the time. Several years previously, SSA had introduced an 800 number that was fraught with implementation problems. SSA underestimated the call volume it would receive; neither the telecommunication network nor the number of service representatives hired to handle the calls could effectively respond, leading to an angry public outcry about service failures. Therefore, HHS was anxious to avoid a similar outcome.

Implementation of the toll-free number was piloted in the same five states that were testing *Medicare and You*. Scripts were written for service representatives to use in answering the most typically asked questions, and protocols were developed to identify more complicated questions that should be referred to other sources, such as Medicare contractors or the appropriate SHIP.

Eventually 1-800-MEDICARE was expanded to achieve nationwide coverage by phasing in regions of the country on a rolling basis while HHS monitored the line's capacity to handle increased call volume. While access to the number was available nationwide following the five state pilot test, nationwide publicity announcing the number was put on hold while state and local publicity about the help line was incrementally rolled out.

Website. In 1998, the Health Care Financing Administration (HCFA) established a new website [http://www.medicare.gov] targeted to a beneficiary audience. Its initial content included general information about the Medicare program, detailed information about benefits and coverage under the traditional fee-for-service program, and comparative data about Medicare+Choice plans organized by zip code. It also included a component that provided information about various programs designed to help older people pay for prescription drugs. These included state pharmacy assistance programs established by some states with their own funds to help older people pay for prescription drugs, and special assistance programs offered by individual pharmaceutical manufacturers.

When the website was launched, beneficiary organizations voiced some of the same concerns as those being raised today. In particular, questions were raised about reliance on the Internet as a major vehicle for providing comparative information about Medicare options because of the relatively low level of Internet usage by older people in general, and particularly among the oldest and the lowest income segments of the beneficiary population. Those concerns were somewhat offset by HCFA's publication of geographically tailored versions of "*Medicare and You,"* which included detailed written information about Medicare+Choice plans available in distinct areas of the country.

Nationally Coordinated Educational and Publicity Campaign. In addition to mandating in BBA 97 the three specific activities described above, Congress laid out a more general requirement that HHS conduct an educational and publicity campaign in the fall of each year concurrent with the Medicare+Choice open enrollment period. This mandate was initially implemented through the production of television and radio public service advertisements and by health fairs sponsored by HCFA regional office staff under the rubric of "Regional Education About Choices in Health" (REACH). In addition, the annually updated *Medicare and You* handbook was mailed to all Medicare beneficiaries in the fall of each year.

Previously, it was only sent to persons when they initially enrolled in the program or upon request.

National Medicare Education Program. From the start, HCFA viewed the SHIPs and all of the components established in the BBA 97 to be part of an overall effort which it termed the National Medicare Education Program. National organizations representing older people and persons with disabilities were solicited by HCFA to become partners in carrying out educational efforts at the state and local levels. Partners were generally organizations that had an existing relationship with beneficiaries and could help educate them about Medicare as the partners carried out their primary roles. And HCFA began describing and budgeting for education and outreach activities under this single umbrella.

After pilot testing written materials and phasing in national operation of the toll-free number, 1-800-MEDICARE, the NMEP was fully implemented in the fall of 1999. Since then, CMS has made incremental changes.

Changes to the operation of 1-800-MEDICARE extended the period during which callers could talk directly to a customer service representative from the initial 8 ½ hours, Monday-Friday, to 24 hours, seven days a week. In 2001, CMS launched a major media campaign that began paying for television ads rather than relying on public service messages, which had limited exposure due to the time slots television stations made available for them. CMS also developed a tool for use on its website, [http://www.medicare.gov], to help beneficiaries more easily compare the features of available Medicare+Choice plans and calculate each plan's probable out-of-pocket costs based on their health status and age.

To solicit stakeholders' input on opportunities for HCFA and HHS to enhance the federal government's effectiveness in implementing a national Medicare education program, HHS in 1999 established the Advisory Panel on Medicare Education. The membership, appointed by the HHS Secretary, includes individuals affiliated with beneficiary organizations, Medicare providers, insurers and experts in consumer health communications.

Medicare Modernization Act of 2003: Prescription Drug Benefit and Discount Card

The most recent set of Medicare reforms was enacted by Congress in 2003. In creating a Medicare prescription drug benefit, as well as an interim drug discount card, Congress recognized the need for outreach and education directed to Medicare beneficiaries to assist them in understanding these program benefits and to make informed choices among available options.

Congress provided detailed expectations in the MMA for education strategies to be adopted in the fall of 2005 and in subsequent years to help beneficiaries choose among new private drug plans. The statute mandates that information activities carried out by CMS be similar and coordinated with the approaches mandated by BBA 97 and specifies the comparative information about drug plans that must be

made available to beneficiaries. In addition the MMA conference agreement emphasizes the importance of targeting outreach efforts to low-income older people.

In mandating education and outreach activities to be conducted for the prescription drug discount card, the MMA takes a slightly different approach from the processes laid out for the prescription drug plans. It requires use of the 1-800-MEDICARE number to respond to inquiries and complaints about the card program, but it does not specify additional vehicles that must be employed for outreach and consumer decision-making support. Instead, HHS is required to "broadly disseminate information to discount eligible individuals" about features of the card program and provide comparative information about the endorsed cards to promote informed choice by beneficiaries. The MMA also specifies that to "the extent practicable, information dissemination is to be coordinated with dissemination of educational information on other Medicare options."[13]

Building on its previous efforts under the NMEP, initially created to implement BBA 97, CMS has been conducting similar activities and starting new ones to assist beneficiaries in accessing the drug card program. The following section lays out the various beneficiary education strategies adopted by CMS and discusses ways their initial implementation has evolved to respond to aspects identified as needing improvement.

National Publicity Campaign

Initially the Medicare drug card education campaign got off to a rocky start. Soon after enactment of the MMA, CMS developed television advertisements that were aired on the major networks, highlighting the new law. Print ads placed in newspapers across the country carried the same message as the television ads: Medicare is the same program as before with more benefits; people can keep their same coverage; and beneficiaries will save on their drug expenses. Immediately the ads generated controversy.

GAO Legal Opinions Requested. Some Members of Congress objected to the advertisements, saying they were misleading and promotional, and did not provide information that would help beneficiaries understand Medicare's new benefits. They formally requested a legal opinion from the Government Accountability Office (GAO) to determine whether the ads were permissible under the Consolidated Appropriations Resolution of 2003 (P.L. 108-7) which prohibits federal agencies from using public funds for propaganda.[14] Due to this controversy, the national television network, CBS, suspended airing the ads until a decision about their legality could be issued. Within several days, CBS reversed its decision and put the advertisements back on the air.

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[13] Section 1860-31(a)(1).

[14] Letter from Sens. Lautenberg, Kennedy, Kerry, Corzine, Reps. Schakowsky, Pallone, Stark, Rangel and Jim Davis to David Walker, Comptroller General of the United States, Feb. 5, 2004, at [http://lautenberg.senate.gov/medicare.html].

The Administration responded that the ads were necessary because many beneficiaries were unaware of the new benefits and the "MMA not only authorizes, but in fact requires that we inform beneficiaries of the new benefits provided in the MMA."[15]

GAO's legal opinion, issued on March 10, 2004, found that the ads had notable omissions and weaknesses. On the central point, however, GAO concluded that the expenditure of funds for the advertisements did not violate the publicity or propaganda prohibitions of P.L. 108-7. GAO stated that the ads' content "does not constitute a purely partisan message."[16]

A similar controversy arose over a set of video news releases issued by CMS and distributed to television stations across the country. Developed in a format resembling broadcast news stories, staff of an HHS contractor served as a reporter, interviewing HHS officials and older people about their perspectives on the new Medicare prescription drug benefits. These releases were distributed to television stations for their broadcast on local news programs, at the discretion of each station.

GAO conducted another review to assess the legality of a federal agency spending public funds for this form of communication. In response to concerns raised by GAO and some Members of Congress, CMS released examples of ways the previous administration had used this same communication method and contended that video news releases are a "well-established and well-understood use of a common news and public affairs practice."[17]

GAO's legal opinion, issued on May 19, 2004, stated that the key difference between the news videos released by the previous administration and the videos addressing the new prescription drug benefit was that the ones produced in 2004 did not inform viewers that the story was produced by the Administration. It concluded that the prescription drug video news releases were "covert propaganda" because they were government-produced or commissioned media that were "misleading as to their origin." Thus, GAO concluded that use of appropriated funds for the production and distribution of the story packages violated the publicity or propaganda prohibitions of P.L. 108-7.[18] This is the same law considered in the previous GAO ruling but in this instance, the primary issue was the manner in which the messages were conveyed, not their content.

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[15] Letter from Dennis G. Smith, Acting Administrator, Centers for Medicare and Medicaid Services, to Gary L. Kepplingter, Deputy General Counsel, Government Accountability Office, Feb. 25, 2004.

[16] U.S. General Accounting Office, *Medicare Prescription Drug, Improvement and Modernization Act of 2003 — Use of Appropriated Funds for Flyer and Printing and Televison Advertisements*, B-302504 (Mar. 10, 2004), decision available at [http://www.gao.gov/decisions/appro/302504.pdf]. See CRS Report RS21811, *Medicare Advertising: Current Controversies*, by Kevin R. Kosar.

[17] U.S. General Accounting Office, *Department of Health and Human Services, Centers for Medicare and Medicaid Services — Video News Releases*, B-302710 (May 19, 2004), decision available at [http://www.gao.gov/decisions/appro/302710.pdf].

[18] Ibid.

Publicity About the Prescription Drug Discount Card. Following these two initial communication initiatives that addressed the MMA in general, in late April 2004 CMS began running paid television, radio and print ads focusing specifically on the Medicare drug discount card program, which would become operational June 1, 2004. The ads urged beneficiaries to call Medicare's toll-free telephone line or access its web page to learn more about the cards' benefits and how to enroll in the card of their choice.

Given the detailed amount of information beneficiaries need to choose a card and enroll, coupled with the time limitations of 30 and 60 second ads, CMS conveyed a consistent message in these and subsequent ads. For further information, the ads directed people to CMS's two major information portals, [http://www.medicare.gov], its consumer website, and its toll-free telephone line, 1-800-MEDICARE.

A second set of television and radio ads was launched in late summer and early fall of 2004 using a similar message, with an added emphasis on savings beneficiaries could achieve by enrolling in a Medicare drug discount card. A third series of ads, with the same message was released in October 2004, coinciding with the annual coordinated election period during which beneficiaries could change their enrollment from the drug discount card they initially chose to a different one for 2005. The ability of beneficiaries to make that change, however, was not part of the publicity campaign's message. Given the relatively low beneficiary participation rate in the card program, the message focused on encouraging more people to enroll.

Medicare Internet Website

Making beneficiaries aware of the Medicare drug discount card is just the first challenge in facilitating their access to program benefits. The next is providing comparative information about specific drug cards to enable older people to decide which card to choose. Since individuals enroll in a specific card rather than in the program generally, the $600 yearly credit toward the purchase of prescription drugs by low-income older people only becomes available after selecting a card.

One of the primary vehicles CMS uses to inform beneficiaries about the various Medicare-endorsed drug discount cards is its website targeted to beneficiaries, [http://www.medicare.gov]. In the very short time frame between CMS' selection of drug card sponsors and the date established in the MMA when program enrollment must begin, CMS posted on its Medicare.gov website details about each endorsed card.

Prescription Drug Assistance Program. A tool called the Prescription Drug Assistance Program (PDAP) was developed to present information about each card sponsor, the pharmacies included in its network, the drugs each sponsor covers in its formulary and their prices. Thus a wide range of information has been made available to beneficiaries to use in deciding whether to enroll in the card program and in selecting the card that best suits their needs.

To use the PDAP, beneficiaries enter their zip codes and respond to a series of questions that establish their eligibility to enroll in a card and to qualify for its credit. Next they enter the drugs they use on a regular basis, their dosage and the monthly

quantity of each drug taken. The search engine produces a list of card sponsors that cover all of their drugs along with their prices. Since some beneficiaries want to ensure the pharmacy they typically use is included in a card sponsor's network, the tool enables individuals to search for a list of cards a particular pharmacy accepts.

When the PDAP was inaugurated in May 2004, it received a great deal of attention in the press and among stakeholder organizations. Some hailed the comprehensive scope of the data available to help consumers make informed decisions. Others pointed to what they perceived as its limitations, such as the level of computer skills required of users to enter the required information and to navigate the tool's search functions for making comparisons among cards.

The speed with which CMS was able to post such detailed data on each card sponsor's offering had a downside. In some cases the pharmacies listed as part of a sponsor's network had moved or gone out of business. Having a more serious effect on public confidence, some drug sponsors publically stated that some of their posted prices were too high. CMS responded that some sponsors provided to CMS a range of prices for specific drugs and without more precise information, it posted the maximum price cited by sponsors in their applications to become selected as a Medicare-endorsed card sponsor. Other sponsors were not able to submit all of their pricing information before the PDAP was launched.

As a result, initial calculations of potential savings individuals might achieve by enrolling in a card program were lower than expected. This led CMS to advise beneficiaries to wait a few weeks before enrolling because it expected drug costs to drop due to both competition among sponsors and more accurate postings of the sponsors' prices. Within several weeks the website did reflect lower costs.

PDAP Changes. Over the following several months, CMS made changes to the PDAP to make it easier to use. After hearing consumers' comments on the difficulty of reviewing PDAP search results that produced detailed information on 38 national cards and often some regional ones, CMS created an option called "Price Compare." When selecting this option, the search results displayed are limited to the five cards offering the lowest price for the combination of drugs used by the beneficiary. CMS also made it easier for consumers to enter their drug information and improved the way drug prices are displayed so users can compare prices between comparable generic and brand name drugs.

CMS also added information about other programs that help older people reduce their out-of-pocket drug costs, such as state pharmaceutical assistance programs. Usually such programs are targeted to low and moderate-income persons and may consider assets when determining an applicant's eligibility. To help people determine if they might qualify for a state-specific program, the PDAP can provide them with an immediate preliminary assessment of their eligibility by collecting both income and asset data.

Information about two types of assistance programs offered by specific pharmaceutical manufacturers was also included. Some of these are available to all lower income beneficiaries through a separate application, regardless of whether they enroll in a card. Others are available through arrangements with specific card

sponsors and provide additional benefits that "wrap around" a card's negotiated discounts. Often these wrap-around programs provide some of the manufacturer's drugs free or at a minimal cost for low income enrollees who have used their entire $600 credit. Since individual drug manufacturers make such arrangements with specific card sponsors, beneficiaries need to consider whether the card they choose provides these extra benefits for the drugs they regularly use.

Finally, a recent addition to the PDAP makes several requests of beneficiaries to enter the amount they pay for each of their prescription drugs so the tool can calculate the total savings they will achieve by enrolling in a card program. Asking beneficiaries to provide this information could make the enrollment process seem more burdensome, although the first request for current price data clearly adds that entering it is optional. The Medicare website also asks card enrollees to share with CMS their success stories about the savings they have achieved. Through a link on the PDAP, beneficiaries can indicate they would like to be contacted by a Medicare representative to share their experiences.

Toll-free Telephone Help Line

As in previous beneficiary education campaigns, all CMS written materials and media communications direct beneficiaries to its website or to its toll-free number, 1-800-MEDICARE, to obtain information about the drug discount card. Since many older persons do not use the Internet, the Medicare help line is an alternative source of assistance. Through eight call centers located in several states, Customer Service Representatives (CSRs) respond to inquiries about the Medicare program, often using written scripts that provide standardized answers to a wide range of anticipated questions. These responses are available to CSRs on their computer desktops.

Call Volume. Besides giving general program information, help line operators can use the same PDAP tool located on the Medicare website to provide beneficiaries with comparative information about drug discount card options. Callers are asked to give operators their zip codes, income information that indicates their potential eligibility for the card's credit, and dosage and quantity of each of the drugs they regularly use. When this information is entered into the PDAP, it generates a list of drug cards available in the caller's zip code, the local pharmacies that accept each card and prices for the caller's regularly used drugs. These search results can be mailed to the caller. For more intensive support in deciding which card to choose, a caller might be referred to the appropriate SHIP, as discussed below.

When CMS began its major publicity campaign about the drug card program in late April 2004, it conducted intensive outreach to the press. The tide of resulting newspaper articles and televison stories about the drug discount card program, along with CMS's paid advertisements, generated a flood of phone calls to 1-800-MEDICARE. In May 2004, the toll-free line received approximately 3.8 million calls, exceeding 50% of the call volume CMS anticipated for all of 2004.[19] The result was long waiting times for people to connect with a CSR and frequent

[19] U.S. Government Accountability Office, *Accuracy of Responses from the 1-800-MEDICARE Help Line Should be Improved*, GAO-05-130, Dec. 8, 2004, p. 46.

disconnections. These initial experiences, widely reported in the press, likely contributed to public perceptions that gaining access to the Medicare drug discount card program was difficult to achieve.

CMS significantly increased the number of operators to absorb this higher call volume. In mid-July, a total of 3,000 customer service representatives were on board, double the number available in May. Following the spike reached in May, call volume declined considerably through the summer and early fall; but call volume typically follows a cyclical pattern and the number of calls received during that time by 1-800-MEDICARE were considerably higher than comparable monthly numbers for 2003.[20]

GAO Evaluation. Ensuring an adequate supply of CSRs to respond to public inquiries is one indicator of the utility of 1-800-MEDICARE. The other is whether once connected to a CSR, callers receive reliable information. GAO recently evaluated the accuracy of responses provided by 1-800-MEDICARE and concluded that CMS needed to take steps to improve the operation of its toll-free number.[21]

GAO placed 420 calls to 1-800-MEDICARE, each time asking one of six predetermined questions. Three were about the prescription drug discount card; three addressed other coverage or eligibility issues. Overall, GAO concluded that 61% of the responses were accurate, 29% were inaccurate, and in 10% of the calls, no answer was provided, primarily because the caller was transferred to a claims processing contractor that was not open for business when the referral was made.

Accuracy rates for responses to each of the six questions varied considerably. Most significant for the drug discount card program, responses to a question about a hypothetical beneficiary's eligibility for the $600 credit were inaccurate 79% of the time. GAO callers represented the individual as having three specified sources and amounts of income. The CSRs incorrectly told callers that the individual's total income exceeded the amount permitted to qualify for the card's credit. Most replies failed to consider that some sources of income are not counted when calculating eligibility. To answer this question correctly, CSRs needed to consult a second script listing exempted sources of income.

Another question about the prescription drug card program asked which card would be accepted by a specific pharmacy while covering all of a beneficiary's drugs at the lowest cost. Help line responses were inaccurate 14% of the time, with an additional 10% of inquiries unanswered due to technical problems. The third drug card question asked whether a relative could receive a card if she has a Medigap policy, which was answered incorrectly 16% of the time.

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[20] Ernest Muldrow and Timothy P. Walsh, *Website and 1-800-MEDICARE Update*, CMS, presented at the National Medicare Education Program Partnership Alliance Meeting, Jan. 24, 2005.

[21] GAO, *Accuracy of Responses from the 1-800-MEDICARE Help Line Should be Improved*, p. 6.

GAO recommended that CMS revise its procedures so calls are not transferred to contractors that are closed at the time of the call; assess current scripts and pretest new and revised ones to ensure they are understandable; conduct more testing of the CSRs' ability to correctly answer questions; and monitor the accuracy rate of each frequently asked question to identify scripts requiring modifications or additional CSR training.

In its comments to GAO, CMS concurred with these recommendations while providing background information on the special circumstances faced by the help line in 2004 and a description of the steps it had already taken to correct some of the problems GAO identified. These include changing call routing plans to ensure that callers are sent to a general CSR when a contractor's office is closed and revising training protocols to better measure the operators' ability to accurately answer questions.

Written Beneficiary Materials

To explain the drug discount card to a variety of audiences, CMS published multiple types of written materials. Some, such as training materials, are targeted to those who assist older people understand the Medicare program; most, however, are designed for beneficiaries to use themselves. In February 2004, HHS Secretary Thompson sent beneficiaries a letter and a brochure describing the new Medicare benefits adopted by the MMA. Another more targeted letter was sent in April 2004 by SSA Administrator Joanne Barnhart to persons with Social Security payments below the income eligibility threshold established to qualify for the drug discount card's credit. This communication focused on the benefits available to low-income persons and the process for enrolling in a card and applying for the credit.

Other new CMS publications include a guide to choosing a Medicare-endorsed drug discount card, enrollment forms, and various brief fact sheets designed to help people enroll in the program. All of these can be downloaded from the cms.gov and medicare.gov websites. The 2005 edition of *Medicare and You*, mailed to all beneficiaries, begins with a section on Medicare-endorsed drug discount cards, the credit available to low-income persons, and the enrollment process.

State Health Insurance Assistance Program

State Health Insurance Assistance programs (SHIPs), funded by CMS since 1991 through grants to states, provide tailored assistance on a wide range of issues to individual beneficiaries who need more guidance than can be provided by informational vehicles aimed at the Medicare population at large. Given the complexity of both the Medicare-Endorsed Prescription Drug Card program and the Medicare Prescription Drug Plans slated to begin in 2006, the type of one-on-one beneficiary counseling and decisions support provided by SHIPs has been seen as an essential complement to the information provided more generally through [http://www.Medicare.gov] and 1-800-MEDICARE.

In February 2004, Senator Grassley and Senator Baucus wrote to HHS Secretary Thompson urging him to ensure that when implementing the MMA, adequate

resources are provided to support beneficiary education initiatives. "We expect that substantial additional funding be provided to State Health Insurance Assistance programs, which offer cost-effective beneficiary education, counseling and outreach services throughout the nation."[22] The Senators asked CMS to increase funds allocated to SHIPs from the $12.5 million awarded in 2003 to at least $41 million in each of 2004 and 2005, or approximately $1.00 per beneficiary per year.

Several other Senators sent a separate letter to Secretary Thompson requesting an identical level of support.[23] Since the primary source of federal funding to states for SHIPs is the CMS program management account (and in 2004 and 2005 its MMA implementation account), CMS has latitude in determining the level of support it will provide, within the parameters of Congress' total appropriation for CMS program management.

CMS announced in March 2004 that it would increase funding for the program to a total of $21 million for 2004 and $31.7 million in 2005. **Appendix A** lists the funds awarded to each state in 2004. Despite these increases, a former CMS administrator recently commented that SHIPs are still "tremendously under resourced."[24]

While SHIPs are directed and managed by states, much of their program activity is focused in communities and carried out by volunteers. As discussed previously, SHIPs are charged with assisting beneficiaries with problems and questions related to Medicare generally, Medicare Advantage plans,[25] Medicare supplemental policies, long term care insurance, Medicaid and beginning last year, the Medicare-endorsed prescription drug card program. During the past year, the programs' resources have been primarily devoted to helping beneficiaries navigate the prescription drug discount program.

The SHIPs' central role is providing beneficiaries with one-on-one assistance in resolving their questions or problems. In its printed materials such as *Medicare and You*, CMS promotes SHIPs as the place for beneficiaries to turn when they need more individually tailored counseling than can be provided by the national information sources. With respect to the prescription drug discount card, SHIPs provide decision support to beneficiaries as they consider enrollment in a card program. Specifically, SHIP volunteers use CMS' web tool, the PDAP, to enter beneficiaries' prescription drug profiles and help them identify their best card options.

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[22] Letter from Sens. Grassley and Baucus to HHS Secretary Thompson, Jan. 28, 2004, at [http://finance.senate.gov/press/Gpress/2004/prg012804.pdf].

[23] Letter from Sens. Bingaman, B. Graham, Daschle, Pryor, Lautenberg, Kohl, Corzine, Clinton, Edwards, and Schumer to HHS Secretary Thompson, Apr. 6, 2004.

[24] Comments by Nancy-Ann DeParle during the Sept. 10, 2004 meeting of the Medicare Payment Advisory Commission. Transcript available at [http://www.medpac.gov.]

[25] Medicare Advantage plans, created in the MMA, replace the Medicare+Choice managed care plans established in BBA 97.

Beneficiaries learn about SHIP services through a variety of other avenues — programs conduct aggressive outreach efforts, sponsor community seminars on the drug discount cards, and train other local agencies to handle the more basic types of program inquires. Another way beneficiaries connect with SHIPs is through referrals from 1-800-MEDICARE. If a beneficiary appears to need more guidance than the help line can provide, operators might refer them to their SHIP. According to several SHIP program directors, these referrals have increased, particularly when a beneficiary needs extensive assistance in comparing drug cards and/or enrolling in the program.

Additional Community Outreach

With the advent of the Medicare Prescription Drug Discount Card, both policy makers and beneficiary advocacy organizations recognized that intensified community outreach efforts would be needed to educate beneficiaries about the complex details of this new program and the Medicare Prescription Drug Plan that will follow. In September 2004, CMS and the Administration on Aging (AOA), both agencies of HHS, jointly awarded a total of $3.95 million to 107 community organizations for conducting outreach, education and drug card enrollment assistance to Medicare beneficiaries over the following five months. Priority was given to applicant organizations located in 30 targeted urban areas where almost 70% of all beneficiaries eligible for the discount card credit reside.[26]

AOA funded another concerted effort to encourage low-income beneficiaries to enroll before December 31, 2004, the deadline for eligible individuals to receive the $600 card credit for 2004. Funds were awarded to the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (n4a) to support focused media efforts in 10 targeted media markets to raise awareness about the December deadline. State and area agencies on aging in these locations organized a series of community outreach events during November and December 2004.

Privately funded outreach efforts were also undertaken during 2004 by national organizations of beneficiaries and providers. AARP conducted the most extensive non-governmental efforts. Among these were television and newspaper advertisements designed to create public awareness about the drug card; various written materials on the MMA generally, the drug card specifically, and the financial assistance available to low income persons; and town hall sessions sponsored by local AARP chapters. In addition, it provided funding to nine national organizations representing low-income and minority beneficiaries in order to intensify targeted outreach to specific populations.

The National Council on Aging (NCOA) established the Access to Benefits Coalition (ABC), consisting of more than 90 non-profit national organizations that have set enrollment goals for achieving the participation of low-income beneficiaries in both the prescription drug discount card and in Medicare Prescription Drug Plans.

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[26] CMS and AOA through Ogilvy Public Relations Worldwide, *Medicare-Approved Drug Discount Card Outreach Campaign: Request for Proposals*, July 9, 2004.

With the support of private organizations, especially pharmaceutical-related companies and foundations, the Coalition has awarded $2 million to 53 local coalitions, giving priority to those located in areas where a high number of lower income Medicare beneficiaries reside. These local coalitions have been conducting educational and outreach activities designed to enroll low-income beneficiaries in both public and private prescription savings programs.

Also targeting low-income Medicare beneficiaries, the American Society on Aging recruited and trained volunteers who are assisting older people to better understand the drug discount card program and select a card that best fits their circumstances, supported by funds from Pfizer.

A beneficiary education campaign with a longer time horizon was launched in November 2004 by a coalition called Medicare Today, consisting of health care provider organizations, employers, health plans, pharmaceutical manufacturers and aging advocacy groups. Its goal is to provide Medicare beneficiaries with information on the new prescription drug plan and other new Medicare benefits established by the MMA. The Healthcare Leadership Council, representing health industry leaders, is spending $5 million to finance the initiative.

National Medicare Education Program Budget

In FY2005, CMS has budgeted $340.45 million for its activities to educate beneficiaries about Medicare's benefits and health plan choices.[27] By way of comparison, the beneficiary education budget for FY2003, the most recent "normal year," was $149.6 million.[28] While education and outreach efforts conducted for the discount drug card have required special strategies and intensified use of existing methods, beneficiary information needs about other aspects of the Medicare program continue. For example, a routine, ongoing information activity is the annual publication and mailing of the *Medicare and You* handbook to all beneficiaries.

The FY2005 beneficiary information activities are supported by four sources:

CMS Program Management Account	$ 120.4 M
MMA implementation funds ($1 billion total) authorized by the MMA for 2004 and 2005	$ 191.8 M
Medicare Advantage Plan user fees authorized by MMA to support beneficiary information activities	$ 13.0 M
Quality Improvement Organizations (QIOs) budget for the Consumer Assessment of Health Plans Surveys (survey of consumer health plan experience)	$ 15.25M

[27] U.S. Department of Health and Human Services, *CMS Justification of Estimates for Appropriations Committees, Fiscal Year 2006.*

[28] U.S. Department of Health and Human Services, *CMS Justification of Estimates for Appropriations Committees, Fiscal Year 2004.*

The FY2005 program budget provides the following levels of support for each major component of the National Medicare Education Program:

Table 1. National Medicare Education Program FY2005 Budget

Program Support Services: — Ad campaign — Formative research, evaluation and consumer testing of NMEP products — Consumer Assessment of Health Plans Survey	$39.45 M
Internet Websites: — Maintenance, updates, enhancements to databases and websites — Software licenses	$22.7 M
1-800-MEDICARE: — Call center, customer service representatives — Print fulfillment services	$181.6 M
Beneficiary Materials: — *Medicare and You* handbook: printing and mailing — Targeted materials on specific subjects	$47.9 M
Community-based Outreach: — SHIP grants — REACH (CMS regional office outreach activities) — Horizons (targeted outreach to minority communities) — Grassroots coalitions	$48.8 M
Total	**$340.45M**

Source: HHS, *CMS Justification of Estimates for Appropriations Committees, FY2006*.

Factors Influencing Beneficiaries' Response to Outreach Efforts

CMS has implemented a wide range of education and outreach activities with the goals of informing beneficiaries about the Medicare-Endorsed Prescription Drug Card program, motivating them to enroll, and helping them choose among available card options. Many public and private entities have contributed time and resources to achieving this goal. Despite these efforts, 10 months after program enrollment began, only 6.2 million beneficiaries are participating. Close to half of these were automatically enrolled by either their Medicare Advantage plan or a state pharmaceutical assistance program.

Low-income participants who meet the eligibility criteria for the card's credit comprise 1.7 million of the program's enrollees as of February 2005. Using data from the Current Population Survey and Medicare administrative files, CMS estimated that 7 million beneficiaries would meet the eligibility criteria for receiving the credit, more than four times the number of low-income persons currently enrolled in the program. Of the estimated number of eligible persons, CMS projected at the start of the program that 4.7 million would enroll. These estimates do not include low-income Medicare beneficiaries also enrolled in Medicaid since they are precluded from receiving a discount drug card due to their existing drug coverage.

The challenge of reaching persons with low incomes and motivating them to participate in the drug card program is more complex than outreach efforts conducted by other income-targeted programs. No previous education and outreach experience, by itself, provides a complete roadmap since efforts for this program are needed to both make low-income persons aware of its benefits and to support them in deciding among various program options.

Identifying low-income persons who might be eligible for various income-targeted programs such as food stamps, SSI and the Medicare Savings Programs (MSP) has been a continuing struggle. The substantial outreach efforts targeted toward persons potentially eligible for MSP, for example, have resulted in the enrollment of less than two-thirds of those who could qualify. And while the programs themselves can be somewhat complicated, individuals' choices are to enroll or not. No further decisions are required.

The National Medicare Education Program's previous experience with facilitating choice focused on helping beneficiaries decide whether to participate in the traditional fee-for-service Medicare program or select a managed care plan. In this situation, beneficiaries are already enrolled in a health care program. And while the task of choosing a specific managed care plan can be more complicated than selecting a drug discount card, the implication of making no proactive decision about health plan options is much different — the beneficiary continues to have traditional Medicare coverage. Failing to choose a discount drug card means that a low-income beneficiary forgoes $1,200 in financial assistance (two annual credits of $600 each) that would have been available to meet prescription drug expenses.

After 10 months of implementation experience, some consensus is emerging among researchers and beneficiary organizations about aspects of both the drug card program's design and the mix of methods employed for beneficiary communication that may have influenced the lower than expected level of beneficiary participation. Some research on individual decision-making processes illustrates the type of communication and decision-making support that may be helpful to older people.

Research on Communications and Decision-Making

Making choices among available options requires a variety of skills, such as being able to understand comparative information, apply it to one's own circumstances, and disregard information not relevant to the choice at hand. Research on literacy, health literacy, decision-making and consumer preferences for

communication vehicles highlights key factors that shape the extent to which people can use and process information.

Health Literacy. Being able to interpret unambiguous data correctly is the lowest level of skill involved in using information for decision-making.[29] Several factors influence that ability, including a person's literacy level, cognitive functioning, comprehension skills, and pre-existing knowledge of the subject matter. The most recent available national data on literacy levels is from the National Adult Literacy Survey administered in 1992 to a representative sample of 13,600 adults age 16 and older.[30] The results indicate that one-third of persons age 65 and over have only rudimentary skills at the lowest level measured, and thus by definition have substantial difficulty with reading, writing, communicating, comprehension, and solving problems.

In the context of health care systems, low literacy results in low health literacy, defined as the ability to "obtain, process and understand basic health information and services needed to make appropriate health decisions."[31] One of the most frequently cited studies that measured health literacy among persons aged 65 and over was conducted of 3,250 enrollees in Medicare managed care plans located in four states. Overall, 33.9% of English-speaking respondents and 53.9% of Spanish-speaking respondents had inadequate or marginal functional health literacy. Persons aged 85 and over had even higher rates of impaired health literacy.[32]

The study concluded that even after adjusting for years of school completed and cognitive impairment, reading ability declines dramatically with age. To compensate for this decline, the authors recommend that health care organizations use multiple forms of health communication, particularly audiotapes, videotape recorders and visual cues rather than relying exclusively on written instructions.

Another study conducted under an agreement with AARP and CMS reached a similar conclusion: that age-related declines in information processing, cognitive ability (for non-demented elderly) and comprehension limit the capacity of older people to accurately interpret and use comparative information.[33] In this study, 56% of beneficiaries had trouble with basic comprehension of Medicare information, the precursor skill required to apply comparative information to one's own circumstances for decision-making. Further, those with low comprehension skills view having more information and options to choose from to be a burden. This group generally expressed an interest in having someone help them make choices, but are no more likely than others to seek decision-making assistance.

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[29] Hibbard, *Older Consumers' Skill*.

[30] The survey was administered again in 2003, but results are not yet available.

[31] U.S. Department of Health and Human Services, *Healthy People 2010*, Nov. 2000, vol. 1, pp. 11-20.

[32] Julie A. Gazmararian et al., "Health Literacy Among Medicare Enrollees in a Managed Care Organization," *JAMA,* vol. 281, no. 6 (Feb. 10, 1999), pp. 545-551.

[33] Hibbard, *Older Consumers' Skill.*

The field of psychological economics has researched decision-making within the context of consumer marketing. The conclusions of some studies are strikingly applicable to the drug discount card experience, suggesting that information overload can be dysfunctional and can frequently lead to making no decision at all. Or it can lead to making decisions toward the mean, where the inability to sort relevant information leads to discarding the outliers — even the best choices.[34]

The common theme of all of this research is to simplify available options so people will be able to make better decisions. Hibbard, in particular, has applied decision-making theory to the behavior of Medicare beneficiaries and suggests that if beneficiaries have difficulty understanding program information and/or are overwhelmed their choices, several outcomes are likely. Some beneficiaries will simply not make a choice. Others will make a choice, but take short cuts in decision-making that fail to address all of the important aspects. And many will make decisions in response to emotion laden advertising messages.[35]

To assist beneficiaries in their decision-making, she proposes strategies such as breaking down the process into smaller steps, formatting and highlighting key information to draw attention to important factors, narrowing options, and identifying those who have marginal or inadequate literacy who need one-on-one help. From a long range policy prospective, she suggests that the best solutions would be simplifying options by standardizing benefit designs and offering a reasonable default option.

Communication Vehicles Preferred by Older People. Research on ways beneficiaries prefer to receive information about Medicare consistently concludes that most prefer one-on-one assistance. The Medicare Current Beneficiary Survey in 2000 asked closed ended questions to learn their preferred vehicles for keeping up with Medicare program changes. The results for white non-Hispanic beneficiaries were that:[36]

- 37% prefer to talk face-to-face with someone;
- 25% want to read a brochure or a pamphlet;
- 15% prefer to talk on the phone;
- 9% prefer mass media (televison, radio, newspapers, magazines);
- 1% prefer the Internet; and
- 9% do not want or need information.

Results for black and Hispanic respondents were similar, except that a higher proportion (54%) of black beneficiaries preferred to receive Medicare information

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[34] George Loewenstein, "Is Choice Always Better?," presented at the 11th Annual Conference of the National Academy of Social Insurance, Jan. 27-28, 1999.

[35] Judith Hibbard, "Beneficiary Decision-Making and the New Prescription Drug Benefit," presented at the 17th Annual Conference of the National Academy of Social Insurance, Jan. 28, 2005.

[36] Data from the 2000 Medicare Current Beneficiary Survey reported in *Program Information on Medicare, Medicaid, SCHIP and other Programs of the Centers for Medicare and Medicaid Services*, June 2002, CMS, Section III, B. 7, p. 7.

by talking face-to-face with someone and a smaller proportion (15%) preferred to read a pamphlet.

A recent poll conducted by the Kaiser Family Foundation asked a slightly different closed ended question about consumers' preferred vehicles for receiving program information. The percentage of respondents that preferred each option are listed below.[37]

- 37% mailings
- 25% in-person contact
- 18% telephone hotlines
- 8% the Internet
- 13% don't know

In reviewing implementation of the drug discount program, several researchers have suggested that due to the complex information beneficiaries must process in deciding whether to enroll in a drug card program and then selecting one, additional counseling supports should be made available. In this context, increased funding for the SHIP is frequently mentioned.[38] [39]

On the other end of the preference scale, numerous studies indicate that for the current older population, the Internet may not be the best vehicle for communicating program information. One study on Internet usage by older people show that only 22% of people age 65 have ever gone online to seek information or to communicate by e-mail.[40] Another study of Medicare beneficiaries of all ages found that 31% had ever used the Internet.[41]

That same study asked beneficiaries whether they had heard of medicare.gov. Thirteen percent said they had and 3% of respondents had visited the site. Use and awareness of 1-800-MEDICARE fared somewhat better, with 42% being aware of the number, but only 13% having actually used the help line.[42]

Influence of Discount Card Design Features on Enrollment

Educating beneficiaries about the Medicare Prescription Drug Discount Card program was a major challenge for CMS. Besides the difficulties generally faced by

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[37] Henry K. Kaiser Family Foundation, *Kaiser Family Foundation Health Poll Report Survey: Selected Findings on the Medicare Drug Law*, Jan. 2005.

[38] Health Policy Alternatives, Inc., *Medicare Drug Discount Cards: A Work in Progress*, July 2004.

[39] Jack Hoadly, *State Lessons on the Drug Card*, presentation to the Medicare Payment Advisory Commission, Sept. 10, 2004. Transcript available at [http://www.medpac.gov]

[40] Susannah Fox, *Older Americans and the Internet*, Pew Internet and American Life Project, Mar. 25, 2004.

[41] Henry K. Kaiser Family Foundation.

[42] Ibid.

agencies implementing a new program, some design features of the program itself influenced beneficiary participation.

First, the large number of cards from which beneficiaries could choose and the variation among them in drug prices and participating pharmacies meant that no one simple message could satisfy all of the information needed by beneficiaries to assess their own situation. Many researchers and constituency representatives have commented that the large number of cards from which to choose meant that many beneficiaries made no decision.

Second, the initial release of information about the program was confusing, with inaccurate information posted on the web and long waits to talk to an operator on the 1-800-MEDICARE line. Extensively covered by the press, these initial glitches led to the public perception that accessing the drug card program was problematic. CMS made major strides in overcoming these initial difficulties, but the negative impressions lingered.

Third, some questions initially arose about the card's financial value, fueled in part by the early inaccurate web postings of prescription drug prices available through the cards. Within several weeks of the initial postings, the prices listed for many of the cards were lowered, in part due to more precise information provided to CMS by the card sponsors. Subsequent studies have documented that the cards have provided savings on drug costs for many beneficiaries. According to several studies of beneficiaries' opinions about the drug card program, uncertainty about the cards' potential benefits was a major factor in dampening program enrollment.[43] [44]

Fourth, drug card enrollment procedures for most of 2004 were cumbersome and may have discouraged some beneficiaries who began the process from completing it. Persons seeking to both enroll in a card and apply for transitional assistance needed to mail a signed application to the address of their selected card sponsor. And while CMS did post standardized enrollment and application forms on medicare.gov, some have reported that initially the forms were posted in a location that was hard for beneficiaries to find. As a result, they had to call the sponsor's 800 telephone number to obtain applications. So enrolling in a card required beneficiaries to initiate several actions, all points at which beneficiaries could fall out of the process.

Based on input from beneficiary organizations, CMS has taken several steps to streamline the application process. First, it placed the application materials in a more prominent location on its website. Second, it allowed people to enroll in a card and apply for transitional assistance both over the phone and online through a link from medicare.gov to a card sponsor's website. Thus, in one step people can research their options and immediately enroll instead of making two separate contacts. And third, in December 2004 CMS began permitting family members and unrelated helpers to file drug card applications online or over the phone on behalf a beneficiary.

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[43] Ibid.

[44] AARP, *Filling the Rx: An Analysis of the Perceptions and Attitudes of Medicare Rx Discount Card Holders*, Dec. 2004.

According to beneficiary organizations, this latter change resulted in a surge of completed applications that were previously half finished.

Conclusion

Looking toward the future, beneficiaries will face even more complicated choices. Making a decision about whether to enroll in a Medicare prescription drug plan carries much higher stakes than did enrollment in the card program.

For low-income beneficiaries, the drug plan benefit is larger and the penalty for inaction can be greater. If they delay making an enrollment decision, beneficiaries could be levied a penalty. And choosing a drug plan best suited to their needs will be more important than selecting the best drug card. With the drug card, low-income persons could receive $600 of assistance with drug costs for each of two years regardless of whether they chose the card offering the best discounts for the drugs they regularly use. For the new prescription drug benefit, it will be essential that the plan chosen covers the prescriptions a beneficiary needs because the benefit will be payment for drugs included in a plan's formulary — not general assistance toward the purchase of all drugs.

CMS has contracted with Abt Associates to evaluate the beneficiary impact of the prescription drug discount card. Data have been collected through a survey of card program enrollees and focus groups of enrollees and non-enrollees. Topics addressed by the evaluation include beneficiary information and decision-making, satisfaction with the cards, understanding of the program, transitional assistance, and prescription purchases and savings. The final report is due in April 2005 and is to be one of the sources CMS will use to further inform its outreach and education efforts for the new prescription drug benefit.

Also, CMS routinely conducts formative research to develop communication strategies and messages, as well as evaluations of its information and education efforts. These research results are being used to shape approaches to outreach for the prescription drug benefit. For example, based on its assessment of the drug card experience, CMS has said its information strategy for the new benefit will make less use of television advertisements since it found such ads are generally not successful in raising program awareness among beneficiaries. Additional emphasis will be placed on grassroots outreach by community organizations trusted by beneficiaries.

While CMS' formative and evaluative research is conducted on a continuous basis, few results have been publicly released following the initial evaluations of activities conducted to implement the BBA 97. At a recent meeting of the Advisory Panel on Medicare Education, CMS said it would soon make available the results of its internal research. This information will add to Congress' knowledge of how CMS evaluates its efforts and makes modifications based on its findings.

The experience of the discount drug card program coupled with research on consumer decision-making indicates that CMS' current approach of using multiple communication channels is needed to respond to differing characteristics of the

beneficiary population. This experience also seems to indicate that for the upcoming prescription drug benefit, a greater emphasis may be needed on providing beneficiaries with tailored information and consultation that will enable them to act upon what will certainly be a more complex set of choices.

Appendix A. FY2004 Total SHIP Grant Awards

(through July 2004)

State	Award	State	Award
Alabama	$370,692	**Nebraska**	$253,062
Alaska	$116,823	**New Hampshire**	$148,557
Arizona	$316,372	**New Jersey**	$498,015
Arkansas	$392,423	**New Mexico**	$200,651
California	$1,396,364	**New York**	$1,055,084
Colorado	$245,397	**North Carolina**	$556,597
Connecticut	$272,594	**North Dakota**	$172,168
Delaware	$128,505	**Ohio**	$693,039
District of Columbia	$116,811	**Oklahoma**	$334,182
Florida	$1,316,875	**Oregon**	$263,705
Georgia	$461,036	**Pennsylvania**	$957,268
Hawaii	$144,306	**Rhode Island**	$159,983
Idaho	$215,084	**South Carolina**	$306,266
Illinois	$615,840	**South Dakota**	$193,220
Indiana	$381,132	**Tennessee**	$434,384
Iowa	$426,233	**Texas**	$892,620
Kansas	$288,280	**Utah**	$158,157
Kentucky	$488,377	**Vermont**	$173,096
Louisiana	$300,084	**Virginia**	$395,465
Maine	$212,703	**Washington**	$337,147
Maryland	$313,348	**West Virginia**	$347,803
Massachusetts	$442,956	**Wisconsin**	$379,569
Michigan	$559,964	**Wyoming**	$143,376
Minnesota	$344,697	**Puerto Rico**	$257,984
Mississippi	$441,203	**Virgin Islands**	$33,083
Missouri	$402,907	**Guam**	$32,423
Montana	$200,206		
		Total	$20,462,501

Source: Centers for Medicare and Medicaid Services.