Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# TEMPORARY MEDICARE-APPROVED DRUG DISCOUNT CARD: BENEFICIARIES' AWARENESS AND USE OF INFORMATION RESOURCES


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# EXECUTIVE SUMMARY

## OBJECTIVE

To determine the extent of beneficiaries' awareness and use of information resources for the Medicare-approved Drug Discount Card (drug card) program for the purpose of maximizing the effectiveness of outreach and education efforts for the new Medicare drug benefit.

## BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created the temporary drug card program to provide immediate access to discounted drugs. Under the drug card program, some low-income beneficiaries also qualify for a $600 annual credit toward drug purchases. The MMA also added a new outpatient prescription drug benefit to Medicare under Part D that becomes effective in January 2006.

The Centers for Medicare & Medicaid Services (CMS) is required to broadly disseminate information to beneficiaries about the drug card program. CMS offers information through a toll free number (1-800-MEDICARE) and a Web site, both of which allow beneficiaries to compare drug prices and program features across available drug cards. CMS also developed television and radio ads and mailed information about the drug card program to all eligible beneficiaries. In addition, CMS has awarded grants to State Health Insurance Assistance Programs (SHIP) to provide beneficiary education and counseling. Private companies that sponsor drug cards (card sponsors) are also required to make available specific information to promote informed choice.

To measure beneficiary awareness and use of information, we conducted a national survey of a stratified random sample of beneficiaries. We stratified based on drug card enrollment status as of August 1, 2004, and our sample included 550 enrolled beneficiaries (population of about 1.8 million) and 620 nonenrolled beneficiaries (population of about 33.4 million).

This inspection is intended to assist CMS in maximizing the effectiveness of beneficiary information and outreach efforts for the new drug benefit. As such, we are reporting on beneficiaries' awareness and use of drug card resources so that CMS can take these behaviors into account for current and future efforts.

## AWARENESS AND USE OF RESOURCES

**Almost three-quarters of beneficiaries are aware of at least one source they could contact for information about the drug card program.** Seventy-two percent of all beneficiaries are aware of at least one of the following five sources that they could contact for drug card program information: 1-800-MEDICARE, Medicare Web site, drug card sponsors, pharmacies, and SHIPs. Awareness seems highest for 1-800-MEDICARE and lowest for SHIPs. Enrolled beneficiaries are more likely to be aware of information sources than nonenrolled beneficiaries.

**Beneficiaries most commonly used passive sources such as news media and mail for drug card information. Only one-fifth of beneficiaries contacted a source requiring self-initiated action.** Overall, 65 percent of beneficiaries used the news media and 53 percent used information in their mail to make enrollment decisions. We categorized news media and mail as "passively acquired" sources because obtaining information from these sources does not require the self-initiated action by the beneficiary needed to contact any of the "actively acquired" sources. Actively acquired sources are 1-800-MEDICARE, the Medicare Web site, card sponsors, pharmacies, and SHIPs. Twenty-one percent of all beneficiaries have contacted one or more of these sources for information on the drug card program.

Enrolled beneficiaries had a much higher rate of use (77 percent) of any actively acquired sources than nonenrolled beneficiaries (17 percent). Among nonenrolled beneficiaries, those with drug coverage are less likely to contact any actively acquired sources for information than those without drug coverage. Those who used news media or mail are more likely to also use an actively acquired source.

**Just over one-third of enrolled beneficiaries needed help with the enrollment process.** Thirty-seven percent of enrolled beneficiaries needed help with the process of signing up after they decided to enroll. These beneficiaries most frequently needed help completing the enrollment form or applying for the $600 credit. Among the beneficiaries who needed help signing up, the most common sources that provided enrollment help were pharmacies and 1-800-MEDICARE.

## IMPLICATIONS FOR THE NEW DRUG BENEFIT

To maximize the effectiveness of beneficiary education, we suggest that CMS consider the following implications for the new drug benefit.

**For the new drug benefit, CMS should consider expanding the efforts it used to inform beneficiaries about the availability of information resources for the drug card program.** Overall, CMS's efforts to make beneficiaries aware of information resources, including 1-800-MEDICARE, seem effective in reaching most beneficiaries. However, the information did not reach all beneficiaries. Expanding these efforts and extending them to additional sources could help to increase awareness of specific information resources.

**CMS should recognize and consider capitalizing on beneficiaries' propensity to use passively acquired information.** More beneficiaries obtained information through news media and mail than any other sources, so CMS could take advantage of these mechanisms to reach the greatest number of beneficiaries. CMS could use these sources to promote increased use of other sources of information on the new drug benefit, including 1-800-MEDICARE, drug plan sponsors, SHIPs, and community-based organizations.

**CMS should consider collaborating with the sources that beneficiaries contact most frequently, including pharmacies and sponsors.** CMS should consider working to assist pharmacies, the most commonly contacted information source, in responding to beneficiary inquires. CMS could provide fact sheets and materials to pharmacists to give to beneficiaries and referrals to direct beneficiaries to other sources of assistance, such as 1-800-MEDICARE or SHIPs. In its oversight capacity, CMS should work with drug plan sponsors to ensure that they provide beneficiaries with useful information about the new drug benefit. This is particularly important because drug card sponsors were the second most commonly contacted source for the drug card program.

**Anticipating the need for enrollment assistance, CMS could promote available sources of assistance and continue to invest in the capacity of those sources to meet beneficiary needs.** Over one-third of enrolled beneficiaries needed help enrolling in a drug card, and drug plan enrollment will likely be more complicated. CMS should anticipate and continue to prepare to meet beneficiary need for enrollment assistance. We support CMS's plan to develop an online enrollment system and encourage continued efforts to facilitate drug plan enrollment.

## AGENCY COMMENTS

CMS stated that it views the drug card as an important opportunity for "lessons learned" for outreach and education strategies for the drug benefit and agreed with each of the implications for the drug benefit that we suggested. CMS noted that it has substantially more time to plan for the drug benefit, as compared to the drug card program, and thus has been able to develop stronger collaborations and partnerships to achieve these goals. CMS detailed several planned and ongoing outreach and education activities related to our suggestions. The agency described a targeted education effort that incorporates media advertising, simple fact sheets, detailed publications, direct mail, and community-based grassroots outreach with numerous partners (including pharmacies). CMS also highlighted the personalized information available through the Drug Plan Compare web tool and 1-800-MEDICARE. CMS thanked OIG for providing constructive and timely information. The complete text of CMS's comments is included in Appendix F.

## OFFICE OF INSPECTOR GENERAL RESPONSE

OIG appreciates CMS's response to this report and the detailed descriptions of its ongoing and planned beneficiary outreach and education efforts for the drug benefit. This inspection is intended to assist CMS in maximizing the effectiveness of beneficiary information and outreach efforts for the drug benefit. We are pleased that CMS found this information to be constructive and agrees with our suggestions. We recognize that CMS is devoting substantial effort toward beneficiary outreach and education.

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# INTRODUCTION

## OBJECTIVE

To determine the extent of beneficiaries' awareness and use of information resources for the Medicare-approved Drug Discount Card (drug card) program to maximize the effectiveness of outreach and education efforts for the new Medicare drug benefit.

## BACKGROUND

### Medicare Coverage of Prescription Drugs

In 2004, Medicare provided health insurance for approximately 41.8 million Americans; this includes more than 35 million seniors and 6.5 million nonelderly people with disabilities.[1] Medicare Part B covers a limited range of drugs, primarily those administered in a physician's office. In 2003, Medicare spent approximately $4 billion on prescription drugs covered under Part B.[2]

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173, added an outpatient prescription drug benefit to Medicare under Part D. Effective January 2006, all Medicare beneficiaries will be able to enroll in private plans, which will cover a percentage of their drug costs. Assistance with premiums and cost sharing will also be provided to an estimated 11 million low-income beneficiaries.[3] Estimates of the Part D drug benefit cost range from $47 billion to $58.9 billion for fiscal year (FY) 2006.[4]

### Medicare-Approved Drug Discount Card Program

While the full Medicare prescription drug benefit will not be implemented until January 2006, the MMA also created the drug card program to provide immediate access to discounted prescription drugs. All Medicare beneficiaries who are enrolled in Medicare Part A and/or Part B and do not have outpatient prescription drug coverage under Medicaid are eligible. Beneficiaries were able to enroll at any time from May 3, 2004, through December 31, 2005. Discounts became available in June 2004 and end January 2006 with the advent of the full prescription drug benefit. The Centers for Medicare & Medicaid Services (CMS) reported in December 2004 that 5.8 million beneficiaries had enrolled in the drug card program.[5]

In early 2004, CMS approved private companies (sponsors) including health insurance companies, drugstore groups, and managed care firms, to provide a total of 73 Medicare-approved drug discount cards.

Sponsors offer approximately 40 different national drug cards and 33 regional drug cards.

Medicare beneficiaries are only allowed to enroll in one drug card per year. Once beneficiaries are enrolled, they are not allowed to switch to a different drug card until the next open-enrollment period.

Beneficiaries are expected to consider several program features when deciding which drug card is best for them. These features relate to each card's specific discounts, formulary, enrollment fee, and network of pharmacies that will accept the card. Drug card discounts vary between cards and may vary within each drug card program. Drug card sponsors can offer discounts on all drugs allowed by CMS or may cover only a select list of drugs (i.e., a formulary). A drug card formulary may vary throughout the life of the program. Drug card sponsors may charge an annual enrollment fee of up to $30 or may offer a card without an enrollment fee. Finally, discounts are redeemable only at network pharmacies, which also vary by drug card.

### $600 Transitional Assistance Credit

In addition to the discounts available through the drug cards, a $600 transitional assistance credit ($600 credit) is available for beneficiaries with incomes at or below 135 percent of the Federal Poverty Level and without other drug coverage.[6] Eligible beneficiaries may use the annual $600 credit toward prescription drug purchases in both 2004 and 2005. CMS also will pay any enrollment fees for these beneficiaries. According to CMS, 1.5 million drug card enrollees were receiving the $600 credit as of December 2004.[7]

### Beneficiary Education

*CMS.* The MMA requires CMS to broadly disseminate information to individuals eligible for the drug card program. Required information includes enrollment procedures, a comparison of cards' annual enrollment fees, and information on the variability of discounts and drug prices under an approved drug card. In accordance with this mandate, CMS has emphasized the importance of Medicare beneficiaries' access to "all the information available to make decisions about choosing the card that best fits their needs."[8]

CMS has initiated several efforts to reach out to beneficiaries and to ensure their access to information on the drug card program. CMS mailed program information to all eligible beneficiaries and has spent $60 million for an advertising campaign. In addition, CMS established a Web site (www.Medicare.gov) and a toll free number

(1-800-MEDICARE) where beneficiaries may compare enrollment fees, discounted drug prices, and formularies offered by the drug card programs available in their geographic areas. These sources also provide information on eligibility and how to apply for the $600 credit.

Representatives at 1-800-MEDICARE also refer callers to additional resources, including State Health Insurance Assistance Programs (SHIP), as needed. In April 2004, CMS awarded $21.1 million in grants to States in support of local SHIPs to help Medicare beneficiaries understand and take advantage of new benefits and programs in Medicare.[9] SHIPs provide one-on-one counseling to beneficiaries.

CMS and other stakeholders targeted additional education efforts toward low-income beneficiaries likely to be eligible for the $600 transitional credit. For example, CMS collaborated with the Social Security Administration (SSA). SSA mailed letters to all Social Security recipients who were likely to be eligible for the $600 credit informing them of this benefit. CMS also developed TV and radio advertisements (ads) that focus on the $600 credit and target low-income beneficiaries.

*Approved Card Sponsors*. The MMA requires each card sponsor to make available information on enrollment fees, negotiated price information for covered drugs, and other information deemed necessary by the Secretary of the Department of Health and Human Services to promote informed choice. [10] Each card sponsor must have a mechanism, including a toll free number, for providing specific information to individuals enrolled in the program. The Secretary is required to provide "appropriate oversight to ensure compliance of card program sponsors with the requirements."[11]

CMS describes the required sponsor information in its Information and Outreach Materials Guidelines for sponsors' materials. CMS regulations incorporate these Information and Outreach Materials Guidelines by reference.[12] Examples of required information include:

- information on how to become enrolled in a program,
- eligibility qualifications for the $600 credit,
- toll-free telephone numbers,
- enrollment fees,
- a list of contracted pharmacies and prescription drugs offered for a negotiated price, and
- a notice that drugs and prices may change and a description of how enrollees can obtain information regarding those changes.[13]

Drug card sponsors also are required to obtain CMS approval of all information and outreach materials before distributing them to beneficiaries. According to CMS, the goal of this review of beneficiary materials is to ensure that information and outreach materials promote informed choice.[14] Card sponsors began sending CMS-approved information and materials to beneficiaries in May 2004.

### Enrollment

To participate in the drug card program, Medicare beneficiaries (excluding those automatically enrolled through a Medicare Advantage program or their State's Pharmancy Assistance Program) must directly enroll with the drug card sponsor of their choice. CMS issued a standard enrollment form accepted by all approved drug card sponsors. CMS intends the standard form to make it easier for community-based organizations, health professionals, and consumer groups to assist beneficiaries with the enrollment process.[15] To enroll, beneficiaries must complete either CMS's or their selected drug card sponsor's enrollment form and send it to their selected card sponsor.

### Implications for the New Medicare Drug Benefit Under Part D

This inspection is intended to assist CMS in maximizing the effectiveness of beneficiary information and outreach efforts for the new drug benefit. As such, we are reporting on beneficiaries' awareness and use of drug card resources so that CMS can take these behaviors into account for ongoing and future efforts. CMS plans to spend $300 million in 2005 to educate Medicare beneficiaries about the new drug benefit, including initiatives with SSA, States, and national and community-based organizations.[16] While the drug card program will end with the start of this benefit in 2006, understanding beneficiaries' awareness and use of information resources for the drug card program is instructive for the new drug benefit. It is reasonable to expect that beneficiaries will become aware of and obtain information about the drug benefit through channels similar to those they used for the drug card program.

### Concurrent Office of Inspector General Inspections

The Office of Inspector General (OIG) conducted two additional studies related to the drug card program. One study, Assessment of Sponsors' Materials Under the Medicare-Approved Drug Discount Card Program (OEI-05-04-00190), assessed the extent to which drug card sponsors' materials promote informed choice for beneficiaries. The second study, Analysis of Drug Card Sponsors' Drug Prices (OEI-05-05-00020),

monitored the prescription drug prices posted on the Medicare Web site and determined the extent to which sponsors are changing these prices.

## METHODOLOGY

We conducted a national survey of a stratified random sample of Medicare beneficiaries eligible for the drug card program. The following provides a general overview of our methodology. See Appendix A for more details on our methodology.

### Sampling

Our population is Medicare beneficiaries who are eligible to participate in the drug card program, excluding beneficiaries who were automatically enrolled by their Medicare Advantage plan. All Medicare beneficiaries except for those who receive drug benefits under Medicaid are eligible to enroll in the drug card program.

From this population, we selected a stratified random sample of beneficiaries from four mutually exclusive strata based on two criteria: enrollment status as of August 1, 2004, and eligibility for the $600 credit. For beneficiaries enrolled in the drug card program, we stratified based on whether the beneficiary was also enrolled in the $600 credit. For nonenrolled beneficiaries, we used low-income ZIP codes as a proxy to ensure that our sample would include some nonenrolled beneficiaries eligible for the $600 credit. Table 1 describes our four strata.

**TABLE 1: Population and Sample Size, by Strata**

| Strata Description | Population Size | Sample Size |
|---|---|---|
| 1. Enrolled beneficiaries receiving $600 credit | 817,969 | 300 |
| 2. Enrolled beneficiaries not receiving $600 credit | 928,928 | 250 |
| 3. Nonenrolled beneficiaries residing in low-income ZIP code | 38,524 | 400 |
| 4. Nonenrolled beneficiaries not residing in low-income ZIP code | 33,346,431 | 220 |
| **Totals** | **35,131,852** | **1,170** |

### Survey and Response Rates

We developed two survey instruments, one for enrolled beneficiaries and one for nonenrolled beneficiaries. Most of our key survey questions on awareness and use of resources were identical across the two surveys.

This allows us to combine information across all respondents and project to the total population.

We conducted these surveys primarily by mail. In addition, we hired a contractor to call beneficiaries who did not respond to the mail survey. Surveys were completed between September and December 2004.

Our overall response rate was 65 percent. Enrolled beneficiaries responded at a higher rate than nonenrolled beneficiaries. By strata, our response rates ranged from 50 percent (nonenrolled beneficiaries residing in a low-income ZIP code) to 77 percent (enrolled beneficiaries not receiving the $600 credit). We conducted a nonresponse analysis that found no evidence of nonresponse bias. Details of this analysis are included in the detailed methodology in Appendix A.

### Analysis

We used several methods to analyze the survey data and focused on the key questions related to our objective, i.e., questions about awareness and use of information resources, and the enrollment process. Appendix A provides details of our analysis and Appendix B provides confidence intervals for key statistics at the 95 percent confidence level. We weighted the data based on probability of selection to project to the population. It is important to note that beneficiaries in strata four have a substantially greater weight than the other three strata because this strata (not enrolled, not low-income ZIP code) represents 95 percent of our total sampling population.

In addition to our key questions on awareness, use, and enrollment, we analyzed information pertaining to nonenrolled beneficiaries' enrollment decisions and beneficiaries' knowledge of the drug card program. This information may be found in Appendixes D and E.

This inspection was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency.

## AWARENESS AND USE OF INFORMATION

**Almost three-quarters of beneficiaries are aware of at least one source they could contact for information about the drug card program**

Seventy-two percent of all beneficiaries are aware of at least one of five information resources that they could contact to obtain information about the drug card program. These five sources include: 1-800-MEDICARE, the Medicare Web site, drug card sponsors, pharmacies, and SHIPs.[17] Ninety-one percent of enrolled beneficiaries and 71 percent of nonenrolled beneficiaries are aware that they can get information about the drug card program from at least one of these sources. Of these five sources, enrolled beneficiaries are aware of 2.4 sources on average and nonenrolled beneficiaries are aware of an average of 1.9 sources.

**Among both enrolled and nonenrolled beneficiaries, most beneficiaries are aware of 1-800-MEDICARE and the fewest are aware of SHIPs**

We ordered the sources by awareness, and we found a similarity in this ordering for enrolled and nonenrolled beneficiaries. For both groups, most beneficiaries are aware of 1-800-MEDICARE and the fewest are aware of SHIPs.[18] As shown in Table 2, 75 percent of enrolled and 56 percent of nonenrolled beneficiaries are aware that they could contact 1-800-MEDICARE for information about the drug card program. Twenty-two percent of enrolled and 21 percent of nonenrolled beneficiaries are aware of SHIPs as a source of information about the drug card program.

**TABLE 2: Beneficiary Awareness of Available Information Sources**

| Information Resource | Enrolled Beneficiaries Aware | Nonenrolled Beneficiaries Aware |
|---|---|---|
| 1-800-Medicare* | 75% | 56% |
| Card sponsors* | 65% | 38% |
| Pharmacy* | 60% | 41% |
| Medicare.gov* | 58% | 47% |
| SHIP | 22% | 21% |

* Statistically significant difference between enrolled and nonenrolled beneficiaries using the chi square test, $p<0.05$.

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

*Profile of those aware of 1-800-MEDICARE.* We explored the characteristics of beneficiaries who are aware of 1-800-MEDICARE to identify any useful lessons for educating beneficiaries about available resources. We found that receiving mail, seeing television ads, and hearing radio ads about the drug card program are significantly related to awareness of 1-800-MEDICARE. Beneficiaries who received no mail about the drug card program are much less likely to be aware of 1-800-MEDICARE. Also, among enrolled beneficiaries, those who have seen television ads or heard radio ads about the drug card program are more likely to be aware of 1-800-MEDICARE than those who have not seen or heard such ads. Demographic characteristics (including income, age, education, and gender) are not related to awareness of 1-800-MEDICARE. Appendix C provides details of this logistic regression analysis.

CMS promoted this information source through the written materials it mailed to beneficiaries and through television and radio ads. It is plausible that beneficiaries learned that they could call this source for drug card information through CMS's mail and ads, suggesting that these education efforts are effective for those whom they reach. However, not all beneficiaries heard ads or received any mail.

*Profile of those aware of SHIPs.* We also analyzed characteristics of beneficiaries who are aware of SHIPs to identify any useful patterns. In April 2004, CMS awarded $21.1 million in grants for SHIPs to help Medicare beneficiaries understand and take advantage of new benefits, including the drug card.[19]

We found three characteristics related to awareness of SHIPs. Two of these are hearing radio ads and receiving mail about the drug card program. Beneficiaries who have heard radio ads about the drug card program are more likely to be aware of SHIPs than those who have not. For example, 42 percent of the beneficiaries who have heard radio ads about the drug card are aware of SHIPs, compared to 12 percent of those who have not heard radio ads. Also, beneficiaries who received no mail about the drug card were less likely to be aware of SHIPs than those who received mail. It is possible that radio ads or mail informed beneficiaries about SHIPs, or they could have indirectly led to SHIP awareness by encouraging the beneficiary to seek out more information.

The third characteristic is eligibility for the $600 credit, which was significant only among enrolled beneficiaries. Twenty-six percent of enrolled beneficiaries eligible for the $600 credit are aware of SHIPs as

a source of information about the drug card, compared to 17 percent of those ineligible for the $600 credit. This difference is small but statistically significant. Other demographic characteristics (including age, education, and gender) are not significantly related to awareness of SHIPs. Appendix C provides details of this logistic regression analysis.

**Beneficiaries most commonly used passive sources such as news media and mail for drug card information. Only one-fifth of beneficiaries contacted a source requiring self-initiated action**

Most beneficiaries obtained information about the drug card program by reading newspaper articles, seeing television news stories, or reading their mail. Overall, 65 percent of beneficiaries used the news media (i.e., newspaper articles or televised news stories) and 53 percent used information in their mail to make enrollment decisions. We categorized news media and mail as "passively acquired" sources because obtaining information from these sources does not require the self-initiated action by the beneficiary needed to contact any of the other "actively acquired" sources.

Overall, 21 percent of beneficiaries have contacted one or more of the following actively acquired sources for information on the drug card program: 1-800-MEDICARE, the Medicare Web site, card sponsors, pharmacies, or SHIPs.[20] A greater proportion of enrolled beneficiaries (77 percent) used any actively acquired sources compared to nonenrolled beneficiaries (17 percent). However, because there are many more nonenrolled than enrolled beneficiaries in the population, the overall rate of use more closely reflects the use among nonenrolled beneficiaries.

#### Nonenrolled beneficiaries tended to use passively acquired sources exclusively, compared to enrolled beneficiaries who also used actively aquired sources

The majority of all beneficiaries used at least one passively acquired source (i.e., news media or mail) for information about the drug card program. Eighty-four percent of enrolled beneficiaries and 76 percent of nonenrolled beneficiaries used at least one passively acquired source. News media and mail were the two most commonly used information sources among both enrolled and nonenrolled beneficiaries.

However, enrolled and nonenrolled beneficiaries differed dramatically in their use of actively acquired sources. Enrolled beneficiaries are significantly more likely to contact those sources. While 77 percent of

enrolled beneficiaries used any actively acquired sources, only 17 percent of nonenrolled beneficiaries contacted any of those sources for information about the drug card program.

Enrolled and nonenrolled beneficiaries also differed significantly in their rate of use of each source, but the order of sources (from highest to lowest use) appears to be similar across these two groups. Table 3 provides the rates of use for enrolled and nonenrolled beneficiaries for each source in our survey. [21]

**TABLE 3: Beneficiary Use of Information Resources**

| Information Resource | Enrolled Beneficiary Use | Nonenrolled Beneficiary Use |
|---|---|---|
| News Media (P) | 69% | 64% |
| Mail (P) * | 68% | 52% |
| Pharmacy (A) * | 42% | 10% |
| Card Sponsors (A) * | 38% | 4% |
| 1-800-MEDICARE (A) * | 27% | 3% |
| Medicare Web site (A) * | 9% | 2% |
| SHIP (A) | 4% | 2% |

(A) denotes actively acquired source, (P) denotes passively acquired source.

*Statistically significant difference between enrolled and nonenrolled beneficiaries using CMH test, $p<0.05$.

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

### For nonenrolled beneficiaries, awareness of actively acquired sources often did not result in use of those sources

Awareness of an information source is necessary but not sufficient to result in a beneficiary using that source. For each actively acquired source, we determined what proportion of nonenrolled beneficiaries aware of the source used it. When we exclude the beneficiaries who are not aware of the information source, the rates of use among aware beneficiaries increase slightly. When we ordered the sources by use, pharmacies showed the highest proportion of users among nonenrolled beneficiaries aware of pharmacies as an information resource. Of all nonenrolled beneficiaries who knew they could get information from their pharmacies, 21 percent contacted their pharmacies about the drug card program. In contrast, 5 percent of nonenrolled beneficiaries aware

of 1-800-MEDICARE called for information about the drug card. Table 4 provides these rates for each source.

**TABLE 4: Nonenrolled Beneficiary Use by Those Aware of Source**

| Information Resource | Awareness | For How Many Beneficiaries Did Awareness Result in Use? |
|---|---|---|
| Pharmacy | 41% | 21% |
| Card Sponsors | 38% | 12% |
| SHIP | 21% | 7% |
| 1-800-MEDICARE | 56% | 5% |
| Medicare Web site | 47% | 5% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

*For nonenrolled beneficiaries, lack of drug coverage and use of passive sources predict use of actively acquired sources.* As awareness does not necessarily lead to use, we explored other characteristics that might explain resource use among nonenrolled beneficiaries. Among nonenrolled beneficiaries aware of any sources, we found two factors that are related to their use of actively acquired sources. Appendix C provides details of this logistic regression analysis.

Having other drug coverage is related to beneficiaries' use (or lack of use) of actively acquired sources. Half of nonenrolled beneficiaries indicated that they have prescription drug coverage through another source such as retiree benefits.[22] Among nonenrolled beneficiaries aware of any sources, those with existing drug coverage are less likely to contact any sources than those without drug coverage. Only 6 percent of nonenrolled beneficiaries with drug coverage contacted any actively acquired sources, compared to 41 percent of those without drug coverage. Drug coverage is not related to whether these beneficiaries used any passively acquired sources (news media or mail). One plausible explanation is that beneficiaries with drug coverage have less incentive to make an effort to contact an information source and instead rely on the information provided to them through the passively acquired sources. Appendix D provides information on existing drug coverage as an explanation for why some nonenrolled beneficiaries have decided not to enroll in a drug card.

In addition, nonenrolled beneficiaries who have used any passively acquired sources are more likely to use any actively acquired sources than those who did not use news media or mail. Of those who used news media or mail, 30 percent also used at least one actively acquired source, compared to less than 1 percent of those who did not use news media or mail. It could be that use of mail or news media spurred beneficiaries to seek more information; alternatively, these beneficiaries may have greater interest in the program and therefore take advantage of multiple information sources.

No other factors are significantly related to nonenrolled beneficiaries' use of actively acquired sources. Factors tested include demographic characteristics (age, education, income, gender, and marital status), seeing television or hearing radio ads about the drug card, and whether a proxy respondent completed the survey for the beneficiary.[23]

**For enrolled beneficiaries, card sponsors and pharmacies seemed to help the greatest proportion of beneficiaries who used them**

When we asked beneficiaries about the information resources they used, we also asked them to specify whether their use of each source helped or did not help them to make their enrollment decision. For each source, we determined the rate of users who were helped. We focused this analysis on enrolled beneficiaries to identify sources that helped beneficiaries decide to enroll, as encouraging enrollment will be a primary goal of outreach and education efforts for the new drug benefit.

Contacting card sponsors and pharmacies seemed to help the greatest proportion of beneficiaries who used them, helping 86 percent and 83 percent of users, respectively. Though the greatest number of beneficiaries used news media, this source helped the lowest proportion (56 percent) of the beneficiaries who used it. Table 5 shows enrolled beneficiaries' use and the proportion of users helped for each source.

**TABLE 5: Proportion of Users Helped by Source, Enrolled Beneficiaries**

| Information Resource | Use | Proportion of Users Helped |
|---|---|---|
| News Media | 61% | 56% |
| Mail | 61% | 65% |
| Pharmacy | 41% | 83% |
| Card Sponsors | 34% | 86% |
| 1-800-MEDICARE | 25% | 68% |
| Medicare Web site | 8% | (64%)* |
| SHIP | 4% | (77%)* |

* Because few beneficiaries used the Medicare Web site or SHIPs, confidence intervals for these estimates are wide.

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

The closed-ended survey questions used to calculate the proportion of users helped measured whether each source helped or not, but they did not rank the sources by their helpfulness. To identify the most helpful sources, we used an open-ended question that asked beneficiaries, "What was the most helpful source to get information about the Medicare approved drug discount card?" Of the enrolled beneficiaries who responded, the most commonly named sources were pharmacy (21 percent); media, including media ads (12 percent); and resources provided by Medicare (10 percent).

## Just over one-third of enrolled beneficiaries needed help with the enrollment process

Thirty-seven percent of enrolled beneficiaries needed help with the process of signing up after they decided to enroll. We asked beneficiaries to specify for which steps in the process they needed assistance. Of these beneficiaries who needed help, 51 percent needed help filling out the enrollment form. Forty-four percent of those requiring assistance needed help applying for the $600 credit, and 36 percent needed help obtaining an enrollment form.[24]

### Among the beneficiaries who needed help signing up, the most common sources that provided enrollment help were the pharmacy and 1-800-MEDICARE

Of the enrolled beneficiaries who needed help signing up for a card, 81 percent identified at least one source that provided them enrollment

help. Pharmacies and 1-800-MEDICARE were the most common sources of enrollment help. Among the beneficiaries who needed assistance, 41 percent received help signing up from a pharmacy. Twenty-one percent obtained enrollment help from 1-800-MEDICARE. Ten percent of these beneficiaries called card sponsors for assistance with enrollment. Few enrolled beneficiaries obtained help with signing up from either the Medicare Web site or SHIPs.

When Medicare's voluntary Part D drug benefit becomes available, beneficiaries will face more complicated enrollment decisions than they have under the drug card program. The potential costs and benefits to the beneficiaries are greater under the new drug benefit, and the program is more complex. Beneficiaries will need information, and perhaps individualized assistance, to decide whether to enroll in this drug benefit and to identify which plan best meets their needs. They may also need assistance completing the enrollment process.

This inspection is intended to assist CMS in maximizing the effectiveness of their beneficiary education and outreach efforts for the new drug benefit. As such, we are reporting on beneficiaries' awareness and use of drug card resources so that CMS can take these behaviors into account in implementing ongoing and future efforts. One might expect that beneficiaries will become aware of and obtain information about the drug benefit through channels similar to those they used for the drug card program. We suggest that CMS consider the following implications for the new drug benefit.

### IMPLICATIONS: BENEFICIARY AWARENESS OF RESOURCES

**For the new drug benefit, CMS should consider expanding the efforts it used to inform beneficiaries about the availability of information resources for the drug card program**

Overall, CMS's efforts to inform beneficiaries about the availability of information resources seem to be effective in reaching most beneficiaries. Almost three-quarters of beneficiaries are aware of at least one source they could contact to obtain information about the drug card program. However, this message about availability of information resources did not reach all beneficiaries. Expanding these efforts and extending them to additional sources could help to increase awareness of some lesser-known sources of information. For example, we found that beneficiaries who received mail about the drug card, saw television ads, or heard radio ads were more likely to be aware of 1-800-MEDICARE. We suggest that CMS continue to broaden its use of these and other methods to inform beneficiaries about the various information resources available for the new drug benefit.

## IMPLICATIONS: BENEFICIARY USE OF RESOURCES

### CMS should recognize and consider capitalizing on beneficiaries' propensity to use passively acquired information

Given that 91 percent of enrolled and 71 percent of nonenrolled beneficiaries used at least one passively acquired source of information (news media and mail), CMS could take advantage of these mechanisms to reach the greatest number of beneficiaries. Additionally, CMS could use these sources of information to promote increased use of actively acquired sources of information for the new drug benefit, including 1-800-MEDICARE, the Medicare Web site, drug plan sponsors, SHIPs, and community-based organizations. Among nonenrolled beneficiaries, those who used passively acquired sources were more likely to contact any actively acquired sources.

While CMS has less influence over the news media than other sources, news media is the most common source of information that beneficiaries used. CMS should consider making a concerted effort to properly educate the media about the new drug benefit. Efforts to reach out to news media outlets could help CMS to educate beneficiaries about the new drug benefit. These efforts could include holding press conferences; offering interviews with top Medicare officials; and disseminating press releases, fact sheets, and media information packets.

Mail is also an important mechanism, commonly used by both enrolled and nonenrolled beneficiaries. We suggest that CMS continue to invest in developing and disseminating useful outreach and education materials by mail. CMS should consider using the mail to reach as many beneficiaries as possible but not rely solely on this method to reach all beneficiaries. Almost half of all beneficiaries indicated that they did not receive any mail about the drug card despite CMS's efforts to mail information to all beneficiaries.

### CMS should consider collaborating with the actively acquired sources that beneficiaries contact most frequently, including pharmacies and sponsors

CMS should consider working collaboratively with pharmacies because pharmacies were the most commonly contacted source of information about the drug card. In addition, among enrolled beneficiaries, pharmacies helped 83 percent of beneficiaries who contacted them. One might expect that beneficiaries will turn to pharmacies for similar assistance with the new drug benefit. Recognizing this, CMS could work with pharmacies to assist them in responding to beneficiary inquires. This assistance could include disseminating fact sheets or

other materials to pharmacists to provide to beneficiaries and informing pharmacists about how to direct beneficiaries to other information sources, such as 1-800-MEDICARE, a local SHIP, or a community-based organization.

Card sponsors were the second most commonly contacted source for drug card information. Also, among enrolled beneficiaries, card sponsors seemed to help the highest rate (86 percent) of beneficiaries who used them. In their oversight capacity, CMS should work with drug plan sponsors to ensure that they also provide beneficiaries with helpful information about the new drug benefit. OIG conducted another inspection, focused specifically on card sponsors' beneficiary education materials, which provides more detailed suggestions to CMS on beneficiary education by drug plan sponsors. Suggestions include requiring sponsors to provide specific information critical to beneficiary understanding of the program, providing model materials for sponsors, and facilitating in-person education of beneficiaries.[25]

## IMPLICATIONS: ENROLLMENT PROCESS

### Anticipating the need for enrollment assistance, CMS could promote available sources of assistance and continue to invest in the capacity of those sources to meet beneficiary needs

While the enrollment process has not been implemented yet, we anticipate that a significant number of beneficiaries may need help enrolling in a drug plan. More than one-third of enrolled beneficiaries needed help with the enrollment process for the drug card program, which is a simpler process than the drug benefit enrollment process will be. Of these beneficiaries, about half needed help filling out the enrollment form.

Promoting available sources of enrollment assistance could help such beneficiaries to identify available information sources. Given the potentially large number of beneficiaries needing assistance, these sources may benefit from continued investment by CMS in the capacity of those sources to meet beneficiaries' needs. For the drug card program, pharmacies and 1-800-MEDICARE were the most common sources where beneficiaries obtained help with enrollment. CMS plans to develop an online enrollment system to facilitate drug plan enrollment by SHIPs, community-based organizations, and other partners. We support this initiative and encourage CMS to continue to develop strategies for simplifying the enrollment process.

## AGENCY COMMENTS

CMS stated that it views the drug card as an important opportunity for "lessons learned" for outreach and education strategies for the drug benefit and agreed with each of the implications for the drug benefit that we suggested. CMS noted that it has substantially more time to plan for the drug benefit, as compared to the drug card program, and thus has been able to develop stronger collaborations and partnerships to achieve these goals. CMS detailed several planned and ongoing outreach and education activities related to our suggestions. The agency described a targeted education effort that incorporates media advertising, simple fact sheets, detailed publications, direct mail, and community-based grassroots outreach with numerous partners (including pharmacies). CMS also highlighted the personalized information available through the Drug Plan Compare web tool and 1-800-MEDICARE. CMS thanked OIG for providing constructive and timely information. The complete text of CMS's comments is included in Appendix F.

## OFFICE OF INSPECTOR GENERAL RESPONSE

OIG appreciates CMS's response to this report and the detailed descriptions of its ongoing and planned beneficiary outreach and education efforts for the drug benefit. These descriptions highlight substantial efforts by CMS toward beneficiary outreach and education. This inspection is intended to assist CMS in maximizing the effectiveness of beneficiary information and outreach efforts for the drug benefit. We are pleased that CMS found this information to be constructive and agrees with our suggestions. We recognize that CMS is devoting substantial effort toward beneficiary outreach and education.

# ENDNOTES

[1] Centers for Medicare & Medicaid Services, "2004 CMS Statistics," Table 1, October 2004.

[2] Part B summary data, CMS National Claims History file, calendar year 2003.

[3] Centers for Medicare & Medicaid Services, "Medicare Fact Sheet: Final Rules Implementing the New Medicare Law: A New Prescription Drug Benefit for All Medicare Beneficiaries, Improvements to Medicare Health Plans and Establishing Options for Retirees," p. 3, January 21, 2005.

[4] Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2006 to 2015," p. 55. January 2005. Also, Centers for Medicare & Medicaid Services, "Releasing the HHS proposed budget for FY2006," February 7, 2005.

[5] Centers for Medicare & Medicaid Services, "Fact Sheet: Medicare Modernization Benefits in the First Year," December 8, 2004.

[6] Low-income beneficiaries who receive Medicaid, TRICARE (military health insurance), the Federal Employees Health Benefit Program, or an employer's health plan are not eligible to enroll in the Transitional Assistance program.

[7] Centers for Medicare & Medicaid Services, "Fact Sheet: Medicare Modernization Benefits in the First Year," December 8, 2004.

[8] HHS Press Release, March 25, 2004.

[9] Centers for Medicare & Medicaid Services, Press Release: "CMS Begins to Award $21 Million in Grants to SHIPs," April 6, 2004. Available online at http://www.cms.hhs.gov/media/press/release.asp?Counter=1004.

[10] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, § 101, subpart 4, codified in § 1860D-31 (d)(2)(A) of the Social Security Act.

[11] P.L. 108-173.

[12] 42 CFR § 403.806(g)(5)(i) requires sponsors to ". . . comply with the Information and Outreach Materials Guidelines published by CMS." CMS initially published the "Medicare Prescription Drug Discount Card and Transitional Assistance Program, Information & Outreach Materials Guidelines" on January 22, 2004, and subsequently revised these guidelines in August 2004.

[13] 68 Fed. Reg. 69867-8 (December 15, 2003).

[14] 68 Fed. Reg. 69869 (December 15, 2003).

[15] Medicare News Release, Saturday, April 17, 2004.

[16] Centers for Medicare & Medicaid Services, "Ensuring the Success of the New Medicare Drug Benefit," Issue Paper #24, January 19, 2005. Available online at http://www.cms.hhs.gov/medicarereform/pdbma/aiandocs/issue_paper_24__ensuring_success-aian.pdf.

[17] In our survey instrument, we used the proper name and abbreviation of the State Health Insurance Assistance Program in the beneficiary's State. For example, for respondents in New York, we referred to the New York State Health Insurance Information, Counseling, & Assistance Program (HICAP) in all relevant questions.

[18] We were not able to test for statistically significant differences in awareness across each source as beneficiaries could indicate awareness of multiple sources.

[19] Centers for Medicare & Medicaid Services, Press Release: "CMS Begins to Award $21 Million in Grants to SHIPs," April 6, 2004. Available online at http://www.cms.hhs.gov/media/press/release.asp?Counter=1004.

[20] The rate of "any use" across these five sources may overestimate use based on the way we calculated it. Our survey included a question on use for each source, and a respondent only had to tell us they used one of these sources to be counted as a "yes" for "any use." However, a

respondent would have to answer all five questions to be counted as a "no" for "any use." If a beneficiary said "I did not use" to four sources and left the fifth source blank, that beneficiary is excluded from this calculation, making the denominator ("no use") smaller.

[21] All rates of use are based on beneficiaries who definitively indicated that they used or did not use a specific source. "Don't know" or missing values are excluded.

[22] We did not ask a general question about whether beneficiaries had any source of drug coverage. These 51% of nonenrolled beneficiaries indicated having drug coverage either by checking "I have other prescription drug insurance" in the list of reasons why the beneficiary was not going to sign up or was undecided about signing up for a drug card, or by checking the specific coverage types about which we asked—Employee/Retiree health plan," "TRICARE for Life," or "Federal Employees Health Benefit Program (FEHBP)."

[23] We asked that if someone other than the beneficiary makes health care decisions on behalf of the beneficiary, then that person complete the survey. Approximately 20 percent of surveys were completed by someone else on behalf of the beneficiary, i.e., a "proxy respondent."

[24] Totals exceed 100 percent because some beneficiaries needed help with more than one step in the enrollment process.

[25] "Assessment of Sponsors' Materials under the Medicare-Approved Drug Discount Card Program" (OEI-05-04-00190).

## DETAILED METHODOLOGY

### Sampling

Our population is Medicare beneficiaries who are eligible to participate in the drug card program, which includes all Medicare beneficiaries except for those who receive drug benefits under Medicaid. We also excluded beneficiaries who were automatically enrolled in a particular drug card by their Medicare Advantage plan.

From this population, we selected a stratified random sample of beneficiaries from four mutually exclusive strata based on two criteria: enrollment status and eligibility for the $600 credit. To achieve our first stratification, we distinguished beneficiaries who had enrolled in the drug card program as of August 1, 2004 (enrolled beneficiaries), from those who had not enrolled by that date (nonenrolled beneficiaries). From the enrolled beneficiaries, we further stratified based on whether the beneficiary was enrolled in the $600 credit. For the nonenrolled beneficiary population, we stratified based on whether the beneficiary resided in a low-income ZIP code. We used low-income ZIP codes as a proxy to ensure that our sample would include some nonenrolled beneficiaries who would be eligible for the $600 credit. Table 6 provides the description, population size, and sample size for each of our four strata.

**TABLE 6: Population and Sample Size, by Strata**

| Strata Description | Population Size | Sample Size |
|---|---|---|
| 1. Enrolled beneficiaries receiving $600 credit | 817,969 | 300 |
| 2. Enrolled beneficiaries not receiving $600 credit | 928,928 | 250 |
| 3. Nonenrolled beneficiaries residing in low-income ZIP code | 38,524 | 400 |
| 4. Nonenrolled beneficiaries not residing in low-income ZIP code | 33,346,431 | 220 |
| **Totals** | **35,131,852** | **1,170** |

We obtained our populations of enrolled and nonenrolled beneficiaries (as of August 1, 2004) from CMS. For enrolled beneficiaries, the CMS data included an indicator for whether the beneficiary was also enrolled in the $600 credit. We used this indicator to distinguish strata 1 from strata 2, and then randomly selected our samples from each strata.

To stratify the nonenrolled beneficiaries, we used data from the year 2000 Bureau of the Census to identify low-income ZIP codes. We defined low-income ZIP codes as residential ZIP codes where the median income was at or below 135 percent of the Federal poverty level in 2000. We used 135 percent of poverty because this is the income threshold for eligibility for the $600 credit.

### Survey and Response Rates

We developed two survey instruments, one for enrolled beneficiaries and one for nonenrolled beneficiaries. Most of our key survey questions on awareness and use of resources were identical across the two surveys. This allows us to combine information across all respondents and project to the total population. However, our questions regarding enrollment differed. For example, we asked enrolled beneficiaries about whether they needed and received help with the enrollment process. We asked nonenrolled beneficiaries whether they plan to enroll in a card and why they had not enrolled.

We allowed proxy respondents. We asked that if someone other than the beneficiary makes health care decisions on behalf of the beneficiary, then that person complete the survey. Approximately 20 percent of surveys were completed by someone else on behalf of the beneficiary.

We conducted these surveys primarily by mail. In addition, we hired a contractor to call beneficiaries who did not respond to the mail survey. For beneficiaries with valid phone numbers, we made three attempts by mail and eight attempts by phone to obtain their responses. For beneficiaries without valid phone numbers, we made five mail attempts. These surveys were conducted between September and December 2004.

Our overall response rate was 65 percent. Enrolled beneficiaries responded at a higher rate (75 percent) than nonenrolled beneficiaries (56 percent). Table 7 provides the response rates by strata and in total.

**TABLE 7: Response Rates by Strata**

| Strata Description | Sample Size | Response Rate |
|---|---|---|
| 1. Enrolled beneficiaries receiving $600 credit | 300 | 74% |
| 2. Enrolled beneficiaries not receiving $600 credit | 250 | 77% |
| 3. Nonenrolled beneficiaries residing in low income ZIP code | 400 | 50% |
| 4. Nonenrolled beneficiaries residing in non-low income ZIP code | 220 | 67% |
| **Total** | **1,170** | **65%** |

### Nonresponse Analysis

Nonresponse can bias survey estimates if nonrespondents would have answered questions differently than respondents did, so we analyzed how nonresponse to our survey may have affected our survey estimates. We examined potential nonresponse bias effects on key survey questions related to awareness and use of each information source in our survey. Variables we had available for both respondent and nonrespondent beneficiaries were age, sex, race, and strata. We also categorized our respondents as either "early" or "late" responders depending on how many attempts it took to obtain their response.

Our analysis provides no evidence that our survey results are biased due to nonresponse. Our general approach for each key variable was to impute missing data values, calculate a point estimate that included these imputed values, and compare this point estimate to our survey estimate from only respondent data. We imputed missing values using a two-stage method. First, we conducted multiple logistic regression analysis using the age, sex, race, and strata variables to predict response propensity to each key question. Second, we used information on how "late responders" answered key questions to impute specific values for nonrespondents. We assumed our imputed estimate was unbiased, and if it fell within the 95-percent confidence interval of the respondent-only estimate, then we judged our survey estimate unbiased. All point estimates using both respondent and nonrespondent-imputed data fell within the confidence intervals of our respondent-only estimates, indicating no evidence of bias.

### Survey Analysis

We used several methods to analyze the survey data and focused on the key questions related to our objective, i.e., questions about awareness

and use of information resources and the enrollment process. We first calculated basic frequencies, weighted proportions, and confidence intervals using the statistical package SUDAAN. Appendix B provides confidence intervals for key variables at the 95 percent confidence level. We weighted the data based on probability of selection. It is important to note that beneficiaries in strata 4 have a substantially greater weight than the other three strata because the strata (not enrolled, not low-income ZIP code) represents 95 percent of the total sampling population.

Next, we ran Cochran-Mantel Haenszel chi-square (CMH) tests (a chi-square test designed for stratified samples) to identify significant difference between enrolled and nonenrolled beneficiaries. We also tested for significant associations among our key awareness and use variables. We considered associations to be statistically significant if the p-value was less than 0.05. Finally, we used SUDAAN to conduct logistic regression analysis to identify significant predictors of key variables, including awareness and use of specific sources. Appendix C provides additonal details on our logitic regression analysis.

In addition to our key questions on awareness, use, and enrollment, we analyzed information pertaining to beneficiaries' knowledge of the drug card program and nonenrolled beneficiaries' enrollment decisions. This information is presented in Appendixes D and E.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

## CONFIDENCE INTERVALS FOR KEY STATISTICS

Table 8 provides confidence intervals for key statistics presented in the report for the overall population of beneficiaries (enrolled and nonenrolled). Tables 9 and 10 present confidence intervals for the enrolled beneficiary population for key statistics on awareness and use of information resources. Tables 11 and 12 provide information on the same statistics for the nonenrolled beneficiary population. Table 13 presents confidence intervals for statistics on enrollment assistance.

**TABLE 8: Key Statistics, All Beneficiaries**

| Percent of Beneficiaries: | n | Point Estimate | 95 Percent Confidence Interval |
|---|---|---|---|
| Aware of any of the following information resources: 1-800-MEDICARE, Medicare Web site, card sponsor, SHIP, or pharmacy | 741 | 72% | 64-79% |
| Used any of the following actively acquired sources: 1-800-MEDICARE, Medicare Web site, card sponsor, SHIP, or pharmacy | 586 | 21% | 15-29% |
| Used any of the following passively acquired sources: news media or mail | 664 | 76% | 68-82% |
| Used news media | 662 | 65% | 56-72% |
| Used mail | 660 | 53% | 45-61% |
| Saw television ads about the drug card | 706 | 71% | 63-77% |
| Heard radio ads about the drug card | 698 | 26% | 19-33% |
| Received no mail about the drug card program | 721 | 48% | 40-56% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

**TABLE 9: Awareness Statistics, Enrolled Beneficiaries**

| Percent of enrolled beneficiaries who are aware they can get drug card information from: | n | Point Estimate | 95 Percent Confidence Interval |
|---|---|---|---|
| Any of the following information resources: 1-800-MEDICARE, Medicare Web site, card sponsor, SHIP, or pharmacy | 408 | 91% | 87-93% |
| 1-800-MEDICARE | 406 | 75% | 70-79% |
| Card sponsors | 407 | 65% | 60-70% |
| Pharmacy | 409 | 60% | 55-65% |
| Medicare Web site | 405 | 58% | 53-63% |
| State Health Insurance Assistance Program | 410 | 22% | 18-26% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

**TABLE 10: Use Statistics, Enrolled Beneficiaries**

| Percent of enrolled beneficiaries who used the following sources for information about the drug card: | n | Point Estimate | 95 Percent Confidence Interval |
|---|---|---|---|
| Any actively acquired sources (i.e., 1-800-MEDICARE, Medicare Web site, card sponsor, SHIP, or pharmacy) | 341 | 77% | 72-81% |
| Any passively acquired sources (i.e., news media or mail) | 372 | 84% | 80-87% |
| News media | 365 | 69% | 64-73% |
| Mail | 370 | 68% | 63-73% |
| Pharmacy | 389 | 42% | 38-47% |
| Card sponsors | 336 | 38% | 33-44% |
| 1-800-MEDICARE | 360 | 27% | 23-32% |
| Medicare Web site | 351 | 8% | 6-12% |
| State Health Insurance Assistance Program | 330 | 4% | 2-6% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

**TABLE 11: Awareness Statistics, Nonenrolled Beneficiaries**

| Percent of nonenrolled beneficiaries who are aware they can get drug card information from: | n | Point Estimate | 95 Percent Confidence Interval |
|---|---|---|---|
| Any of the following information resources: 1-800-MEDICARE, Medicare Web site, card sponsor, SHIP, or pharmacy | 333 | 71% | 63-78% |
| 1-800-MEDICARE | 336 | 56% | 47-64% |
| Medicare Web site | 333 | 47% | 39-55% |
| Pharmacy | 334 | 41% | 33-49% |
| Card sponsors | 330 | 38% | 30-46% |
| State Health Insurance Assistance Program | 332 | 21% | 15-29% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

**TABLE 12: Use Statistics, Nonenrolled Beneficiaries**

| Percent of nonenrolled beneficiaries who used the following sources for information about the drug card: | n | Point Estimate | 95 Percent Confidence Interval |
|---|---|---|---|
| Any actively acquired sources (i.e., 1-800-MEDICARE, Medicare Web site, card sponsor, SHIP, or pharmacy) | 245 | 17% | 11-26% |
| Any passively acquired sources (i.e., news media or mail) | 292 | 76% | 67-83% |
| News media | 297 | 64% | 56-72% |
| Mail | 290 | 52% | 39-57% |
| Pharmacy | 314 | 10% | 6-16% |
| Card sponsors | 326 | 4% | 2-9% |
| 1-800-MEDICARE | 333 | 3% | 1-8% |
| Medicare Web site | 326 | 2% | 1-7% |
| State Health Insurance Assistance Program | 253 | 2% | 0-7% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

**TABLE 13: Enrollment Assistance, Enrolled Beneficiaries**

| Percent of Enrolled Beneficiaries: | n | Point Estimate | 95 Percent Confidence Interval |
|---|---|---|---|
| Needed help signing up for a drug card | 416 | 37% | 32-41% |
| **Of those beneficiaries who needed help enrolling, percent:** | | | |
| Needed help filling out the enrollment form | 155 | 51% | 43-59% |
| Needed help applying for the $600 credit | 155 | 44% | 36-52% |
| Needed help obtaining the enrollment form | 155 | 36% | 29-44% |
| Obtained enrollment assistant from any source | 155 | 81% | 74-86% |
| Obtained enrollment assistance from a pharmacy | 155 | 41% | 33-49% |
| Obtained enrollment assistance from 1-800-MEDICARE | 155 | 21% | 15-28% |
| Obtained enrollment assistance by calling a card sponsor | 155 | 10% | 6-16% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

## LOGISTIC REGRESSION MODELS

We used logistic regression to identify predictors of several key variables. We first ran CMH tests (a chi-square test designed for stratified samples) to identify variables that were significantly related (p value <0.05) to our variable of interest. Then, we included these significant variables in a logistic regression model predicting the dependent variable of interest.

The following tables display the odds ratios for each of the significant predictors (at p< 0.05 level) in each of those logistic regressions. The nonsignificant variables are also listed below each table. In logistic regression, an odds ratio of one is considered neutral, an odds ratio greater than one is considered a positive relationship, and anything less than one indicates a negative relationship. For example, as shown in Model 1 below, beneficiaries who have seen television ads about the drug card are 2.80 times more likely to be aware of 1-800-MEDICARE than beneficiaries who have not seen such ads.

**Logistic Regression Model 1: Awareness of 1-800-MEDICARE**

The model in Table 14 predicts whether an enrolled beneficiary is aware that he/she can obtain information about the drug card by calling 1-800-MEDICARE.

**TABLE 14: TV and Radio Ads and Receiving Mail Predicting Awareness of 1-800-MEDICARE, Enrolled Beneficiaries**

| Independent Variable | Odds Ratio | P-value |
|---|---|---|
| Receiving no mail | 0.33 | 0.000 |
| Seeing television ads about the drug card | 3.91 | 0.024 |
| Hearing radio ads about the drug card | 2.80 | 0.000 |
| **Variables that were not significantly related:** income, age, education, gender | | |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

We also tested relationships for all beneficiaries. Among all beneficiaries, not receiving any mail about the drug card strongly predicted that the beneficiary is not aware that he/she can get drug card information from 1-800-MEDICARE. In fact, the odds ratio for this variable approached zero. An odds ratio of zero would mean that a beneficiary who receives no mail has zero odds of being aware of

1-800-MEDICARE, i.e., awareness is impossible. For all beneficiaries, seeing television ads and hearing radio ads were each significantly related to awareness of 1-800-MEDICARE among all beneficiaries in CMH significance tests, but they were no longer significant when included in the regression model along with receiving no mail.

**Logistic Regression Model 2: Awareness of SHIP**

The model in Table 15 predicts whether a beneficiary will be aware that he/she can obtain information about the drug card by contact a SHIP.

**TABLE 15: Radio Ads and Receiving Mail Predicting Awareness of SHIP, All Beneficiaries**

| Independent Variable | Odds Ratio | P-value |
|---|---|---|
| Hearing radio ads about the drug card | 3.88 | 0.005 |
| Receiving no mail about the drug card | 0.32 | 0.028 |
| **Variables that were not significantly related:** income, age, education, gender | | |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

In contrast to the variables that were not related to awareness (such as gender), seeing television ads about the drug card was significantly related to SHIP awareness in a CMH significance test. However, seeing television ads was no longer significant in the regression model above once the other variables were included. Also, being eligible for the $600 credit was significantly related to SHIP awareness only among enrolled beneficiaries.

**Logistic Regression Model 3: Nonenrolled Beneficiaries' Use of Any Actively Acquired Sources**

The model in Table 16 predicts whether a nonenrolled beneficiary, who is aware of any actively acquired source (1-800-MEDICARE, Medicare Web site, card sponsor, SHIP, pharmacy) will contact at least one of those sources.

**TABLE 16: Predicting Use of Any Actively Acquired Sources, Nonenrolled Beneficiaries**

| Independent Variable | Odds Ratio | P-value |
|---|---|---|
| Having other drug coverage | 0.13 | 0.014 |
| Using any passively acquired sources (news media or mail) | 510.44 | 0.000 |
| **Variables that were not significantly related :** income, age, education, gender, marital status, proxy respondent, seeing television ads, hearing radio ads, receiving no mail | | |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

## ENROLLMENT DECISIONS AND EXPLANATIONS

While our inspection report focused on beneficiaries' awareness and use of information resources, we have additional information from our survey that falls outside this scope. The information here addresses the enrollment decisions of nonenrolled beneficiaries and the reasons they provided for those decisions.

### Enrollment Decisions of Nonenrolled Beneficiaries

We asked nonenrolled beneficiaries about their enrollment decision. In response to this closed-ended question, 47 percent of nonenrolled beneficiaries indicated that they will not sign up for a card, and 40 percent indicated that they are undecided. Five percent indicated that they have signed up for a drug card. See Table 17. As noted in the methodology, we pulled our sample of nonenrolled beneficiaries in August 2004, and surveys were completed between September and December 2004.

**TABLE 17: Enrollment Decisions of Nonenrolled Beneficiaries**

| Decision | |
|---|---|
| I am not going to sign up for a Medicare drug card. | 47% |
| I have not yet decided whether to sign up for a Medicare drug card. | 40% |
| I am going to sign up for a Medicare drug card but have not applied. | 8% |
| I signed up for a Medicare drug card. | 5% |

Source: Office of Inspector General analysis of national survey of Medicare beneficiaries, 2005.

### Explanations for Enrollment Decisions

*Reasons for not signing up.* Many beneficiaries who say they are not going to sign up for the drug card may have decided against enrollment because they do not need the drug card or it would not benefit them. Eighty percent of the 47 percent of beneficiaries who decided not to sign up indicated it is because they have other drug coverage. Enrolling in the drug card may not be worthwhile for beneficiaries who already have insurance coverage. Additional reasons for not signing up include: "The Medicare card will not save me money" (23 percent), "I am not eligible or cannot tell if I am eligible" (17 percent), and "I do not have the

information I need" (13 percent). Some beneficiaries provided more than one reason for not signing up.

*Reasons for being undecided about signing up.* In general, nonenrolled beneficiaries who are undecided about signing up seem to need more information about the drug card. The most common reasons these beneficiaries gave for being undecided are lack of information and confusion about eligibility. Forty-nine percent of those who are undecided about signing up indicated "I do not have the information I need," and 49 percent said they could not determine if they would save money with the card.

We considered whether beneficiaries who said they did not have the information they needed shared any characteristics that would help to explain their answer. We did not find any significant relationships. Lack of information was not related to awareness of any information resources. Nor was it related to the number of sources the beneficiary is aware of, number of sources used, or use of actively or passively acquired sources.

Additonal reasons beneficiaries gave for being undecided about signing up include: "I am not eligible or cannot tell if I am eligble" (29 percent), "I have other presrcription drug coverage" (25 percent), and "I am waiting to see if prices go down" (20 percent).

## BENEFICIARY KNOWLEDGE OF DRUG CARD PROGRAM

While our inspection report focused on beneficiaries' awareness and use of information resources, we have additional information from our survey that falls outside this scope. The information here addresses beneficiary knowledge of the drug card program.

### General Card Program

Nearly all beneficiaries are aware of the drug card program, but many nonenrolled beneficiaries are confused about eligibility for a drug card. One hundred percent of enrolled beneficiaries and 95 percent of nonenrolled beneficiaries are aware of the drug card program. Only about half of nonenrolled beneficiaries know that they are eligible to sign up for a drug card. It is plausible that some of these beneficiaries confuse eligibility criteria for the $600 credit with eligibility for the card program. When asked why they are not eligible for a drug card, the most common reasons beneficiaries offered relate to having too much income or having other insurance coverage.

### $600 Credit

Most beneficiaries are aware of the $600 credit, although significantly more enrolled than nonenrolled beneficiaries know of this benefit. We asked all beneficiaries whether they have ever heard that some low-income beneficiaries can get a $600 credit on their Medicare drug cards. Ninety-one percent of enrolled beneficiaries are aware of the $600 credit compared to 76 percent of nonenrolled beneficiaries. Higher awareness among enrolled beneficiaries is not surprising when we consider that in our survey population almost half of the beneficiaries enrolled in the drug card program are also enrolled in the $600 credit.

In addition, we determined beneficiaries' actual eligibility for the $600 credit based on their reported income, marital status, and insurance coverage. We then compared actual eligibility to whether the beneficiaries think they are eligible for the $600 credit. We found that, overall, only 30 percent of the beneficiaries who are actually eligible for the $600 credit realize they are eligible. Comparing enrolled to nonenrolled beneficiaries, only 21 percent of nonenrolled beneficiaries who are eligible for the $600 realized they are eligible for the $600 credit. Seventy-two percent of enrolled beneficiaries who are eligible for the credit are aware of their eligibility.

Most nonenrolled beneficiaries who think they are not eligible for the $600 credit cited income or assets as a reason for their ineligibility. It is

possible that some of these beneficiaries mistakenly think that, despite their low income, their financial assets disqualify them from receiving the $600 credit. Alternatively, some might understand that income is a qualifying factor for the $600 credit, but do not know what level of income qualifies them.

### Choice of Cards

Virtually no beneficiaries recognize the breadth of drug cards available from which to choose, and over one-quarter of beneficiaries do not realize they have a choice of cards at all. When asked a closed-ended question about how many cards are available to choose from, less than one percent correctly identified that there are "16 or more" drug cards available. Nineteen percent of beneficiaries recognize that they have some choice by indicating "2 to 15" cards are available. However, 27 percent of beneficiaries do not think they have any choice of cards. The remaining 54 percent of beneficiaries responded "don't know."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

SEP - 6 2005



**TO:** Daniel R. Levinson
Inspector General
Office of Inspector General

**FROM:** Mark B. McClellan, M.D., Ph.D.
Administrator MM

**SUBJECT:** OIG Draft Report: "Medicare-approved Drug Discount Card: Beneficiaries' Awareness and use of information Resources," (OEI-05-04-00200)

Thank you for your efforts assessing beneficiary awareness efforts and use of information resources relating to the Medicare-approved drug discount cards. We are pleased that the study found beneficiary awareness regarding where to get information about the drug card was relatively high. Almost three-quarters of beneficiaries surveyed by the Office of the Inspector General were aware of at least one source they could contact for information about the drug card program. In addition, an independent evaluation has found a high level of satisfaction with the enrollment process for the drug cards (68 percent) and with the discounts obtained on the cards themselves (63 percent) for those who responded to these survey questions. These are important achievements given the extremely short time frame for implementation of the Medicare drug discount card program. Altogether, over 6.5 million beneficiaries with no or limited drug coverage have saved billions of dollars on their prescription drugs using the drug card, which is in line with initial expectations about the Medicare drug discount card program.

Of course, much more important than this short-term, temporary program that provided discounts for beneficiaries with no or less than adequate drug coverage is the new Medicare prescription drug benefit, which is available to help all beneficiaries with drug costs. In contrast to the short-term, temporary drug card program, which had to be fully implemented in less than six months after the enactment of the Medicare Modernization Act, the drug benefit is a permanent insurance program that provides medically necessary drugs for all seniors and people with a disability served by Medicare. As we take the biggest step ever to bring Medicare's coverage up-to-date and to turn Medicare into a much more prevention-oriented program, your analysis of beneficiary awareness in the drug card program is especially timely. While the drug card program is different in many

aspects, we view it as an important opportunity for "lessons learned" that can assist with the implementation of the drug benefit. In particular, the Centers for Medicare & Medicaid Services (CMS) has launched a very extensive education and outreach efforts, involving our own agency as well as many other government and private-sector partners, so that Medicare beneficiaries can get all the information needed to make a confident decision about their drug coverage. The lessons learned from our outreach experiences with the Medicare drug discount card program have informed our outreach and education strategy with the drug benefit so that we can support beneficiaries to the fullest when they make their decisions about the drug benefit.

We agree with your recommendations that CMS expand our efforts to inform beneficiaries about available information resources on the new drug coverage; use media and mail to convey information to beneficiaries; collaborate with sources that beneficiaries contact most frequently, such as pharmacies; and promote available sources for enrollment assistance and continue to invest in the capacity of these sources. However in contrast to the drug card, we have substantially more time to plan and we have been able to develop much stronger collaborations and partnerships to achieve these goals.

To ensure that every person with Medicare is aware of the new prescription drug coverage, CMS is implementing a data-driven education effort that incorporates media advertising, simple language fact sheets, detailed publications (including the annual "*Medicare & You*" handbook), direct mail, and focused community-based grassroots outreach into a multi-pronged National campaign that targets specific populations with custom-tailored messages. Towards this end, CMS has segmented the beneficiary population into personalized groups that need to know different things to take advantage of the new drug benefit, and we have targeted messages and delivery channels designed to meet the specific needs unique to each population. These distinct populations include people who are eligible for both Medicare and Medicaid (the full-dual eligibles); people who may be eligible for the low-income subsidy; people who already have employment-related coverage; people who are in Medicare Advantage or other Medicare health plans; and people who are in Original Medicare.

With extensive input from outside organizations and experts, we have developed publications, print materials, and other resources that provide tested, standardized information on specific topics targeted to these and other specific kinds of beneficiaries. Materials will include a direct mailer, targeted and tailored fact sheets and tip sheets, a larger consumer booklet, and the *Medicare & You Handbook*.

In addition, this fall we will provide even more personalized support to help people find a drug plan that is a good fit for their needs and preferences. The Drug Plan Compare web tool on the www.medicare.gov web site will be a comprehensive resource for

beneficiaries and those who will help them. By combining some information on preferences for pharmacies, coverage, and other features at the beneficiary's discretion, this web tool will provide personalized, relevant information about Medicare drug plans that provide the most savings for each beneficiary and that best reflect their preferences. Users of the web tool can compare benefits and pricing of locally available plans, and enroll in a plan that best meets their needs. Furthermore, they can obtain other information about how Medicare can help with their drug costs, for example, information on Medicare Advantage plans and on the availability of generic and other lower-cost drug treatments.

However, beneficiaries and their family members and caregivers need not go online to get this kind of personalized information. The 1-800-MEDICARE helpline will provide 24 hour-a-day, 7-day-a-week reference and assistance. Customer service representatives will answer questions about the benefits and costs of locally-available drug plans, take orders for consumer publications, mail out LIS applications, let beneficiaries know their LIS-eligibility status, and take advantage of all the tools on www.medicare.gov on behalf of the beneficiary.

Finally, Medicare has developed much more extensive, stronger partnerships with a broad range of local organizations, so that beneficiaries who prefer it can get face-to-face, personal assistance as well. These local partners are also an essential and major part of our national grassroots education effort.

Over the past year, CMS has devoted substantial effort to strengthen our connections with the local information networks where beneficiaries get most of their information, and to reach every person with Medicare where they live, work, play, and pray. We have been working to identify and establish partnerships with a number of traditional and non-traditional groups to ensure that we are targeting every channel possible to disseminate our messages to each of our various populations, including pharmacies, providers, long-term care facilities, disease organizations, disability organizations, mental health facilities, HIV/AIDS advocates, state and local officials, HHS operating divisions, and other Federal agencies that have contact with beneficiaries (HUD, USDA, DOL, etc.). We've also been partnering with organizations representing various ethnic groups, including Asian Americans, American Indians/Alaska natives, Hispanics, and African-Americans.

To help support this increased local grassroots effort, CMS has implemented a regional campaign structure that mirrors the National education campaign and is designed to help coordinate outreach and awareness activities and support enrollment at the local level. National campaign teams tied to each population are working closely with their regional counterparts to develop materials, target messages, and identify and prioritize partners for maximum leverages. CMS has done extensive demographic research to help all of our partners determine the best ways to reach beneficiaries locally, and we are soliciting our partners for any information they may have on our target audiences as well.

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The CMS has also enhanced its partnership with the State Health Insurance Assistance Programs (SHIPs). CMS has already increased SHIP funding in 2004 and will provide $31.7 million to SHIPs in 2005, reflecting the increased emphasis on personalized, one-on-one counseling for Medicare beneficiaries. The SHIPs will use the additional funds to equip their local organizations with the tools needed to answer beneficiaries' questions. CMS is also working closely with providers in nursing homes, pharmacies, and other health facilities to let them know how they can further assist the beneficiaries with whom they interact. We are developing a variety of training and training support materials in a number of different formats including "Medlearn Matters" national articles, to help these providers and other potential counselors talk about Medicare prescription drug coverage.

Through an intra-agency agreement with the Administration on Aging, CMS will identify, engage, and support key National and community-level organizations within the Aging Network in order to provide enrollment assistance to beneficiaries. The location of these organizations will be determined on the basis of gaps in our extensive partner network identified by Regional Office campaigns.

Your recommendations are consistent with comprehensive strategy, and we intend to work hard to implement them. We have briefly summarized below some of our planned education and outreach efforts that relate to your recommendations:

- CMS will work closely with health care information intermediaries, providers, partner organizations, Federal/state agencies, and health care stakeholders to ensure they have a clear understanding of Medicare prescription drug coverage and their role in educating people with Medicare. CMS will also work with other community-based organizations to disseminate information through informal community grassroots networks such as grocery stores, banks, churches, etc., to raise awareness and support for Medicare prescription drug coverage, and encourage these groups to highlight important Medicare messages in their interactions with people with Medicare and caregivers.

- CMS will conduct ongoing training focused on plans and partners. National Web casts will focus on plan sponsor education, and Web-based training targeted at partners will be made available on www.cms.hhs.gov. A comprehensive Train-the-Trainer Toolkit will be developed for use by those who train others about Medicare prescription drug plans. A listserv and teleconferencing will help distribute training information and materials to partners.

Direct mail as well as other publications and print materials will communicate specific messages at specific times to specific audiences. Both CMS and Social Security Administration (SSA) are sending send direct mail letters to people with Medicare. SSA has also mailed low-income subsidy (LIS) applications to potentially eligible people. We

have already discussed other targeted fact sheets, consumer materials, and the *Medicare & You* handbook that will be part of this effort.

- A National multi-media campaign will raise awareness of Medicare prescription drug coverage, highlight important messages, direct people to information resources, and encourage informed enrollment in Medicare prescription drug plans. Paid media options under consideration include: targeted advertising placements in physician and clinic waiting areas in addition to television, radio, newspaper, and Internet at the National and/or local level.

Given the short time frame for implementing the Medicare drug discount card program, and the fact that it was intended for only a fraction of the Medicare beneficiary population, none of these types of activities were feasible. We are pleased that millions of beneficiaries got the information they needed to save billions of dollars using the Medicare drug discount cards, and that they were generally satisfied with the process of obtaining and using the cards as well. But we are particularly pleased about the extensive collaboration that has gone into developing a much more extensive and comprehensive, targeted outreach and awareness strategy for the Medicare drug benefit—a strategy that is paying off with increasing beneficiary awareness about the new drug benefit. I want to thank you again for your constructive comments as we work to make sure all beneficiaries get the information they need to save money and increase their financial security through their decisions about the most important new Medicare benefit in forty years.

# ACKNOWLEDGMENTS

This report was prepared under the direction of William C. Moran, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Ann Maxwell, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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