GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

November 18, 2005

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

Subject: *Medicare: CMS's Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Assistance Program*

Dear Mr. Waxman:

Established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Medicare Prescription Drug Discount Card and Transitional Assistance Program[1] is designed to help participants obtain prescription drugs at reduced prices.[2] All Medicare beneficiaries, except those with drug coverage through Medicaid, are eligible to enroll in the program to obtain drug discount cards, which are offered through private sector sponsors. In addition, enrollees in the program with low incomes who lack other drug coverage are also eligible for up to $600 each year in transitional assistance to help pay for their prescriptions. The drug card program, which began enrolling beneficiaries in May 2004, serves as an interim measure until January 1, 2006, when, in accordance with MMA, a prescription drug benefit becomes available to the nearly 42 million people enrolled in Medicare.

MMA required the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS) to broadly disseminate information on the program to the millions of Medicare beneficiaries—seniors and people under age 65 with permanent disabilities—who are eligible for a drug discount card. In response, CMS began education and outreach efforts designed to publicize the availability and features of the drug discount cards, provide information to facilitate beneficiary choice, and assist beneficiaries with the enrollment process. You asked us to provide information on CMS's efforts because the agency's experience in supporting the drug card program may yield important insights relevant to implementing the new prescription drug benefit that becomes effective in 2006. In this report, we (1) describe CMS's education and outreach efforts in support of the

[1]Throughout this report we refer to the Medicare Prescription Drug Discount Card and Transitional Assistance program as the drug card program.

[2]Pub. L. No. 108-173, sec. 101(a), § 1860D-31, 117 Stat. 2066, 2131–48 (to be codified as 42 U.S.C. § 1395w-141).

drug card program and review assessments of these efforts by public and private health care research organizations and (2) provide data on enrollment in the drug card program and identify factors that may have limited this enrollment.[3]

To do our work, we focused on several key education and outreach efforts that CMS used to provide Medicare beneficiaries with information on the drug card program. We interviewed CMS officials involved in planning and implementing the program's education and outreach efforts and reviewed relevant agency documents. We also reviewed various assessments of CMS's drug card campaign as well as relevant studies of some of CMS's traditional means of disseminating information about Medicare. Specifically, we reviewed assessments by various research organizations, other government entities, and beneficiary advocacy groups as well as our own previous reports. These included assessments conducted by AARP, Abt Associates, the American Enterprise Institute (AEI), the Congressional Research Service (CRS), the Kaiser Family Foundation (KFF), the Medicare Payment Advisory Commission (MedPAC) and the Medicare Rights Center. We provided information on CMS's expenditures on specific efforts in the drug card campaign to the extent such information was available.

We obtained program enrollment data from CMS. To initiate a beneficiary's enrollment for the drug discount card and for transitional assistance, CMS determines the applicant's eligibility using Medicare and Medicaid enrollment data and federal sources of income data. Although we did not independently verify the accuracy of CMS's program enrollment data, we believe they are sufficiently reliable for the purposes of this report. Our work was performed from May 2005 through November 2005 in accordance with generally accepted government auditing standards.

Results in Brief

CMS implemented a variety of education and outreach efforts that included the use of mass media and individualized counseling to inform beneficiaries about the drug card program and to assist in enrollment. Assessments we reviewed showed that CMS was effective in raising awareness of the drug card program, but was less effective in its efforts to inform and assist beneficiaries. In general, studies found that CMS's efforts did not consistently provide information that was clear, accurate, and accessible, and they collectively fell short of conveying program features. At the same time, these assessments acknowledge the actions taken by CMS to address some of these problems. Studies we examined indicated that disseminating information via mass media and direct mail may not have been effective in reaching beneficiaries, particularly those with low incomes. Studies also found that CMS's telephone help line and Web site did not always provide the information beneficiaries needed to choose a card that was best for them. Assessments also showed that CMS-

[3]Other GAO products related to this topic include Medicare: CMS's Implementation and Oversight of the Medicare Prescription Drug Discount Card and Transitional Assistance Program, GAO-06-78R (Washington, D.C.: Oct. 28, 2005), and a review of sponsors' processes related to the drug card program (forthcoming).

funded State Health Insurance Assistance Programs offering one-on-one counseling provided valuable assistance to beneficiaries but were limited in the number of people they could serve. An analysis of CMS partnerships with community-based organizations showed that these organizations could have been utilized more effectively in promoting the drug card program.

As of September 1, 2005, about 6.4 million Medicare beneficiaries were enrolled in the drug card program, including 1.9 million who received transitional assistance. Many more beneficiaries were automatically enrolled than enrolled on their own. A variety of factors may have limited enrollment in the program. CMS attributed the extent of enrollment to confusion and misperceptions about the drug cards among Medicare beneficiaries. In addition, other assessments noted that the drug card program's unfamiliar design, abundance of choices, and uncertain value may have discouraged some beneficiaries from enrolling.

Background

The drug card program is operated through private drug card sponsors, approved by CMS, and provides discounts off the retail price of prescription drugs.[4] On average, beneficiaries have a choice of 37 general drug discount cards—including both national (nationwide) and regional (state specific) cards—and pay an annual enrollment fee of $19.[5] To enroll, beneficiaries may submit standardized information to a drug card sponsor by mail, telephone, or via the Internet. An open enrollment period was established at the end of 2004 for beneficiaries who wished to change their card selection.

Transitional assistance is available for Medicare beneficiaries who are at or below 135 percent of the federal poverty level and not enrolled in any public or private insurance plans that provide drug coverage.[6] Beneficiaries who qualify do not have to pay an enrollment fee, pay 10 percent or less of each prescription's retail price, and

---

[4]Drug card sponsors are required to offer a discount for at least one drug in each of the 209 therapeutic categories identified by CMS on a list of frequently used medications, and are precluded from offering discounts for nine classes of drugs. 42 C.F.R. § 403.806(d)(2) (2004). The formularies, or sets of preferred drugs, that are covered by the discounts, may not include all of a beneficiary's drugs. Beneficiaries who use drugs not included in the formulary will not be able to obtain discounts for those drugs. However, if a beneficiary is approved for transitional assistance, payment may be made for a drug, even if it is not on the formulary.

[5]Among the qualifications to offer drug cards, sponsors—pharmacy benefit managers, heath insurers, and others—had to secure a large network of retail pharmacies. CMS established separate access requirements for urban, suburban, and rural areas. For example, in urban areas, at least 90 percent of a card's enrollees must live within 2 miles of a network pharmacy.

[6]To qualify for transitional assistance, a beneficiary must (1) have an income at or below $12,569 per year for an individual, or $16,862 for a couple in 2004 and (2) not have other prescription drug coverage through Medicaid, employer-sponsored group health insurance programs, an individual health insurance policy, TRICARE (health care program for active duty and retired uniformed services members and their families), or the Federal Employee's Health Benefits Program. MMA 117 Stat. 2133.

receive a $600 annual credit toward their drug purchases.[7] Beneficiaries apply for transitional assistance through card sponsors. CMS then verifies the beneficiary's income and drug coverage status, determines eligibility, and notifies the drug card sponsor, which informs the beneficiary of the decision.[8] Low-income beneficiaries currently enrolled in pharmaceutical manufacturers' card programs—arrangements that offer discounts on particular manufacturers' drugs—may also enroll in a discount card program to take advantage of the $600 transitional assistance.

For various groups of beneficiaries, enrollment in the Medicare drug card program may be made automatically—with an option for the individual to decline—by virtue of beneficiaries' participation in other Medicare or state programs. Beneficiaries in managed care plans—Medicare Advantage—may be group enrolled in exclusive drug cards sponsored by their health plans.[9] In some states, state pharmacy assistance programs, which provide prescription drugs at low or no cost to needy Medicare beneficiaries and others who do not qualify for Medicaid, may automatically enroll beneficiaries in a drug card program and choose to pay the enrollment fee and coinsurance.[10] In addition, CMS decided to facilitate enrollment in the discount card program for certain low-income beneficiaries.

CMS estimated that beneficiaries enrolling in drug card programs would experience significant savings on their prescription drugs. The discounts would vary depending on the drug card selected, the drugs purchased, and the pharmacy used. According to an October 2004 CMS study, prices for commonly used brand-name drugs under the discount card program ranged from 12 to 21 percent below national average retail pharmacy prices. It stated that savings for generic drugs were larger, with prices ranging from 28 to 75 percent lower than the typical price paid nationally.

---

[7]MMA 117 Stat. 2140-42. Qualified individuals were entitled to receive the full $600 credit amount in 2004 regardless of when they enrolled. If they enrolled in 2005, the credit was prorated based on the quarter in which they enrolled. Any 2004 credit balance was rolled over into 2005; and any 2005 credit balance will be rolled over into 2006 until the individual enrolls in a Medicare prescription drug plan or the initial part D enrollment period closes on May 15, 2006, whichever comes first.

[8]Once an applicant is determined eligible to receive transitional assistance, CMS transfers funds from the Medicare part B Trust Fund directly to the approved discount card sponsor with which the eligible beneficiary has enrolled. The discount card sponsor is responsible for applying each eligible enrollee's $600 subsidy to the beneficiary's cost of prescription drugs covered under the program.

[9]Although many Medicare managed care plans already offer drug coverage, not all do so and most offer limited coverage. The discount card would be used in situations of no coverage or limited coverage under the plans. If the Medicare managed care plan offers a drug card, its members may only get that drug card. If a Medicare managed care plan does not offer a drug card, its members may sign up for any card available in their area.

[10]Because people enrolled in state pharmacy assistance programs receive comprehensive help with their drug expenditures, their coverage may not change under a drug card program. However, with such enrollment, federal dollars substitute for state dollars, thus reducing the cost of those state pharmacy assistance programs.

In implementing its education and outreach efforts, CMS focused on enrolling those beneficiaries most likely to benefit from the drug discount card and transitional assistance program. Not all beneficiaries eligible to enroll in the drug card program were expected to do so because many have coverage through other sources. CMS assumed that those who could benefit from the card and subsidy were low-income beneficiaries eligible for transitional assistance and beneficiaries who were not low income but either had no or limited drug coverage.[11] Therefore, in developing and disseminating messages and materials promoting the drug card program, the agency placed special emphasis on low-income beneficiaries.

CMS had a limited amount of time to plan and launch the drug card program. Although agency officials started planning for the discount card shortly before enactment of MMA, they did not begin developing a strategy for communicating with beneficiaries until regulations detailing the requirements of the new program were issued on December 15, 2003. MMA required that the Medicare discount card program begin operating within 6 months of enactment. The education campaign began in January 2004; enrollment for the drug card began May 3, 2004; and the card was effective June 1, 2004.

To evaluate its 2004 education and outreach efforts, CMS initiated a lessons learned process whereby information was collected from various entities involved in the drug card program. They included CMS central office staff, regional office staff, and contractors hired to provide marketing reviews and CMS customer service. In total, 212 individuals participated in discussions to obtain information on the effectiveness of various elements of the agency's communications strategy and how best to implement Medicare's prescription drug benefit program. The results of this process were reported in February 2005.[12]

CMS Used Multiple Education and Outreach Efforts; Assessments of These Efforts Identified Weaknesses

CMS relied on multiple education and outreach efforts—some that used mass communication and others that provided individualized attention—to support the drug card program. Specifically, these efforts included media advertising, direct mail, Medicare's Web site and toll-free help line, one-on-one counseling, and partnerships with community organizations. Assessments we reviewed showed that CMS was effective in raising awareness of the drug card program, but its efforts were limited in their ability to inform and assist beneficiaries. Studies indicated that CMS's

[11]In 2002, 18 percent of noninstitutionalized Medicare beneficiaries lacked drug coverage for the full year. Others obtained drug coverage from a variety of sources, including employer-sponsored plans (34 percent), Medicaid (14 percent), Medicare managed care plans (12 percent), Medigap policies (12 percent), and other public programs (10 percent).

[12]Centers for Medicare & Medicaid Services, *Medicare-Approved Drug Discount Card and $600 Credit Program: CMS and Drug Card Sponsor Lessons Learned, Final Results and Analysis* (Baltimore, Md.: February 2005).

education and outreach activities did not consistently provide information that was clear, accurate, and accessible. Reports also indicated that, in some cases, CMS made improvements when problems were identified.

Media Advertising and Direct Mail

As part of its education and outreach efforts, CMS initiated a multimedia advertising campaign—the National Publicity Campaign—in 2004 to generate awareness about changes to the Medicare program, including the 2006 prescription drug benefit and the interim drug card program, as well as sources of additional information. By February 2004, CMS began using television and print media to introduce beneficiaries to the changes in Medicare established by MMA. In spring 2004, CMS launched another series of advertisements specifically to educate Medicare beneficiaries on the availability of drug discount cards and their key features. A third set of advertisements in late summer and early fall 2004 sought to encourage enrollment by highlighting the savings offered through the drug discount cards. According to CMS, in fiscal year 2004, funding for the National Publicity Campaign was approximately $65 million.

Another component of the National Publicity Campaign relied on several direct mailings to promote the drug card program. According to CMS officials, the agency's discount card materials were consumer-tested to ensure they were understandable by various population groups, including beneficiaries with low literacy, poor English proficiency, or low income. In its first mailing, in February 2004, CMS sent a letter and a flyer to all Medicare beneficiaries alerting them to the drug discount cards as well as to the upcoming 2006 prescription drug benefit. In April 2004, CMS issued a second direct mailing, this time a three-page description of the drug card program. Another more targeted letter was sent that month to persons with Social Security payments below the income eligibility threshold established to qualify for transitional assistance. This communication focused on the benefits available to low-income persons and the process for obtaining a card and applying for the $600 credit. According to CMS officials, the agency spent at least $18 million of its publicity campaign funds on these mailings.

Assessments of the National Publicity Campaign found that the impact of the campaign was mixed. On the one hand, it helped generate awareness that the drug card program existed. In a June/July 2004 survey developed by KFF and the Harvard School of Public Health, fewer than one-third of respondents 65 years of age or older said they were aware of the drug card program.[13] A November/December 2004 follow-up survey showed that 86 percent of respondents over the age of 65 were aware of the discount card program, and 67 percent said they were aware of the $600 subsidy.[14]

---

[13]Kaiser Family Foundation/Harvard School of Public Health, *Views of the New Medicare Drug Law: A Survey of People on Medicare*, publication no. 7144 (Washington D.C.: August 2004).

[14]Kaiser Family Foundation, *November/December 2004 Health Poll Report Survey*, publication no.7247 (Washington, D.C.: January 2005).

On the other hand, CMS was less successful in conveying essential features about the discount cards. Based on focus groups conducted in fall 2004 and winter 2005, Abt Associates reported that one-quarter to one-half of beneficiaries were unaware that there was more than one drug card to choose from.[15] In addition, in its February 2005 self-evaluation, CMS reported that the campaign was not effective in educating beneficiaries on the details and complexities of the program, especially on how to obtain transitional assistance. The agency noted that weaknesses in the communications strategy it developed prior to the launch of the drug card program may have led to these shortcomings. It cited, for example, the volume and content of CMS and drug card sponsor outreach material as contributing factors. In a legal analysis issued in March 2004, we found that CMS's initial print advertisements contained a number of significant omissions. For example, while all of the materials we reviewed mentioned the new drug discount cards, none indicated that the cards may not be free and that savings may vary among drugs.[16]

The assessments we reviewed also found limitations in the use of direct mail to help increase enrollment in health care initiatives. In particular, studies have shown that direct mailings may not be an effective outreach tool for Medicare beneficiaries with low incomes. In its report, MedPAC found that low literacy rates, poor English proficiency, and unfamiliarity with health care programs limit low-income beneficiaries' ability to comprehend and act on direct mail instructions.[17] Similarly, in 2004 we reported that a 2002 direct mailing to low-income Medicare beneficiaries by the Social Security Administration (SSA) had a low response rate. SSA conducted a direct mailing campaign to encourage low-income beneficiaries to enroll in a program that provided assistance with premiums and other out-of-pocket costs associated with Medicare. Of the 16.4 million low-income beneficiaries that SSA targeted with the mailing, we found that 74,000 additional eligible beneficiaries—about 0.5 percent of all letter recipients—enrolled in Medicare savings programs than would have likely enrolled without the letter.[18]

Among low-income elderly, a lack of knowledge regarding the drug discount card and transitional assistance persisted into the summer. In a June/July 2004 survey, KFF and Harvard School of Public Health found that 70 percent of beneficiaries with incomes below $15,000 did not know enough to say if the drug discount cards were

---

[15]Abt Associates, *Evaluation of the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance Program: Interim Evaluation Report, Final Report* (Cambridge, Mass.: October 11, 2005).

[16]GAO, *Medicare Prescription Drug, Improvement, and Modernization Act of 2003--Use of Appropriated Funds for Flyer and Print and Television Advertisements*, B-302504 (Washington, D.C.: March 10, 2004).

[17]Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (Washington, D.C.: June 2005).

[18]GAO, *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries*, GAO-04-363 (Washington, D.C.: March 26, 2004).

part of the new Medicare drug law, and only 13 percent of those surveyed were aware that low-income beneficiaries can receive a $600 credit.[19]

Medicare Web Site

In addition to the National Publicity Campaign, CMS used its Medicare Web site—www.medicare.gov—to educate beneficiaries about the drug card program and the choices they have when selecting a card. In particular, users of the Web site could access a tool called the Prescription Drug Assistance Program (PDAP), which was developed to help beneficiaries determine whether they were eligible to enroll in the drug card program, decide whether to enroll, and select the discount card that best suited their needs. Launched in April 2004, PDAP allowed users to compare drug cards by displaying information on the pharmacies that accept each card, the drugs each sponsor covers in its formulary, and the prices beneficiaries should expect to pay for these drugs.[20] CMS also included a price comparison feature on PDAP so that users could compare drug prices offered through the various discount cards based on dosage and quantity.

To use PDAP, beneficiaries entered their zip codes and responded to a series of questions that were used to determine eligibility for the drug card program. Next, beneficiaries selected the drugs they use regularly along with dosage and monthly quantity. PDAP then generated a list of available drug card sponsors and the prices available through their cards. Because a beneficiary may prefer a specific pharmacy, PDAP could search for a list of drug cards that a particular pharmacy accepts.

Several assessments that reported on PDAP found that the Web-based tool was an important resource for Medicare beneficiaries and those who assist them in selecting drug discount cards. In general, these assessments indicated that PDAP could perform the complex calculations required to determine the comparative value of numerous discount cards available to eligible beneficiaries. For example, both CRS and MedPAC observed that the comparative information provided by PDAP was valuable for family members and others who help beneficiaries select a drug card.[21]

Although PDAP was viewed as an important resource, several studies found that when the tool was first introduced, it did not always provide accurate information. Assessments indicated that the Web-based tool listed inaccurate drug prices and pharmacies that were not participating in the drug card program. According to CRS,

---

[19]Kaiser Family Foundation/Harvard School of Public Health, *Views of the New Medicare Drug Law: A Survey of People on Medicare, Additional Findings by Income Group*, publication no. 7169 (Washington, D.C.: September 2004).

[20]According to the CMS Administrator, PDAP includes information on approximately 60,000 drug products and 75,000 pharmacies. The component of the Web site with information about drug prices was deactivated on September 30, 2005.

[21]For example, see Congressional Research Services, *Beneficiary Information and Decision Supports for the Medicare-Endorsed Prescription Drug Discount Card*, RL32828 (Washington, D.C.: Mar. 24, 2005).

because CMS posted the maximum price cited by drug card sponsors, some prices displayed on PDAP were too high. In addition, we found that some pharmacies reported being incorrectly listed as participating in the program, but most of the inaccurate listings were attributed to pharmacies being unaware that they had contracted to participate in a card sponsor's network, according to CMS.[22] In response to these problems, CMS officials told us that they updated and verified drug pricing and corrected the pharmacy participation information.

Another issue reported by CRS was that some users may have had difficulty navigating the Web site, and MedPAC reported that beneficiaries were overwhelmed by the number of drug cards from which they could choose.[23] According to KFF, most beneficiaries do not use the Internet, and even those who assist them often found the Web-based information more perplexing than helpful. An April 2004 KFF survey showed that use of the Internet by seniors is growing but overall remains low, with about 70 percent of those age 65 or over reporting that they never use the Internet. Of those who do go online, 2 percent reported having visited Medicare's Web site. Furthermore, according to KFF, the use of the Internet among beneficiaries also varied significantly by income. For those with incomes below $20,000—nearly two-thirds of seniors in 2002—only 15 percent have ever used the Internet. For beneficiaries with incomes above $50,000—about 1 in 12 seniors in 2002—65 percent reported having ever used the Internet.[24]

By July 2004, CMS officials took steps to make PDAP more user friendly. For example, CMS created an option to sort and view the top five drug cards with the lowest cost for the beneficiary and provided information on the annual savings offered by various drug cards. While CMS addressed certain problems associated with PDAP, these changes did not eliminate the challenge for CMS in using the Internet as an information resource for Medicare beneficiaries.[25]

Medicare Telephone Help Line

One of the goals of the National Publicity Campaign was to make the public aware of CMS's telephone help line—1-800-MEDICARE—as a primary source of information on the Medicare program, including information on the drug card program. The toll-free telephone help line is a vehicle for Medicare beneficiaries, their families, and other members of the public to obtain answers to their questions about the drug card program features and enrollment. During the 6 months following the enactment of MMA, the help line handled over 9 million calls—many of which involved questions

[22]GAO-06-78R.

[23]Medicare Payment Advisory Commission, *Public Meeting: State Lessons on the Drug Card* (Washington, D.C.: Sept. 10, 2004).

[24]Kaiser Family Foundation, *E--Health and the Elderly: How Seniors Use the Internet for Health Information* (January 2005).

[25]According to MedPAC, beneficiaries who are computer literate and have Internet connections in their homes are unlikely to have the high-speed connections necessary to use PDAP.

about prescription drug coverage—more than triple the number handled in the previous 6 months.

As the volume of calls directed to the help line about the drug card program increased, there were concerns about the accuracy and completeness of the information provided by the help line's customer service representatives (CSR). In December 2004, we reported that CSRs had substantial inaccuracy rates when answering questions about the drug discount card and transitional assistance.[26] For example, one question we posed to CSRs about income eligibility for the $600 credit was answered inaccurately in 55 out of 70 calls, generally because the CSRs did not seek the needed information on the sources of beneficiaries' incomes to correctly answer the question. On another question, CSRs responded with inaccurate answers in 10 out of 70 calls when asked to identify the lowest cost card available at a particular pharmacy, given an individual's specific pharmaceutical needs.

Other research organizations have also raised concerns about how information on the drug card program is communicated via 1-800-MEDICARE. MedPAC reported that CSRs provided too much information, rather than helping beneficiaries narrow their options, and that operators conveyed inaccurate information. In addition, KFF and CRS have commented on the long wait times associated with the help line,[27] and the Medicare Rights Center reported frequent disconnections following the influx of calls due to the National Publicity Campaign.[28] In response to the increased call volume, CMS had added over 800 CSRs by October 2004, more than doubling the number of staff previously available.

One-on-one Counseling

For Medicare beneficiaries and their families seeking individual assistance with the drug card program, CMS supports one-on-one counseling through State Health Insurance Assistance Programs (SHIP). Operated by states and funded through CMS grants, SHIPs use over 12,000 trained counselors—mostly volunteers—to provide information and assistance on a wide range of Medicare and Medicaid issues. In 2003, CMS reported that SHIP programs nationwide served over 2 million Medicare beneficiaries, with about 1.2 million of those receiving assistance through one-on-one counseling sessions—in person and over the telephone—and approximately 800,000 receiving assistance through presentations and public education outreach. For the drug card program, these counselors helped beneficiaries and their families make selection decisions using PDAP and assist those applying for transitional assistance. In 2004, SHIPs resources—$21 million—were primarily devoted to informing

[26]GAO, *Medicare: Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved*, GAO-05-130 (Washington, D.C.: Dec. 8, 2004).

[27]See, for example, Kaiser Family Foundation, *Medicare Drug Discount Cards: A Work in Progress*, prepared by Health Policy Alternatives, Inc. (Washington, D.C.: July 2004).

[28]Medicare Rights Center, *Medicare-Approved Drug Discount Cards: A Prescription for Improvement* (New York, N.Y.: May 2004).

beneficiaries and their families about the drug card program. In fiscal year 2005, CMS increased funding for SHIPs by about 50 percent, to roughly $31 million, to expand these efforts.

CRS has noted that one-on-one counseling and assistance to beneficiaries provided by SHIPs have been essential complements to the information disseminated more generally through CMS's other education efforts, such as 1-800-MEDICARE and the Medicare Web site. For its June 2005 report, MedPAC examined the challenges that state officials and beneficiary advocates face in educating beneficiaries about the discount card program. MedPAC suggested that CMS adequately fund SHIP outreach activities and direct beneficiaries to SHIPs for personalized assistance with the program. At the same time, MedPAC acknowledged that SHIPs alone are not able to counsel all Medicare beneficiaries who may need one-on-one counseling.

Partnerships with Local Organizations

As the SHIPs demonstrate, CMS relies on local outreach to help disseminate information and assist beneficiaries. Consistent with this strategy, the agency has developed an outreach effort known as the Regional Education About Choices in Health (REACH) program to increase awareness about changes in Medicare for beneficiaries not generally reached by national efforts due to barriers of language, literacy, location, income, or culture. REACH relies on local community-based organizations to use established networks for distributing health care information to serve beneficiaries in familiar, community settings. In 2004, CMS sponsored training sessions and distributed targeted materials to REACH partners to help them inform beneficiaries and facilitate enrollment for the drug card program and transitional assistance.

In addition, CMS has partnered with the Access to Benefits Coalition (ABC), a group of national nonprofit organizations—including AARP, the Salvation Army, and the American Hospital Association—and 56 local coalitions that help low-income Medicare beneficiaries use private and public resources to save money on prescription drugs. To complement CMS's efforts, ABC awarded $2 million to its network of grassroots groups to educate and enroll lower income beneficiaries in the drug card program. It set a short-term goal to ensure that at least 5.5 million low-income beneficiaries would receive the $600 annual transitional assistance credit by the end of 2005. ABC also developed a Web-based tool for counselors and others to use to determine the individualized combination of programs—the drug card program, state pharmacy assistance programs, manufacturer's discount card programs, and drug company patient assistance programs—that maximize beneficiary savings.

Similarly, in 2004, CMS, in cooperation with HHS's Administration on Aging, contracted with Ogilvy Public Relations Worldwide and spent $6.1 million to select, support, and evaluate community-based organizations to provide outreach related to the drug card. More than 100 organizations, including area agencies on aging, social service providers, health care agencies, and faith-based organizations, were selected to target low-income, hard-to-reach beneficiaries, including those in medically

underserved communities. Most were funded to complete their work from September 2004 through February 2005. Under the terms of their subcontracts with Ogilvy, the community-based organizations agreed to meet measurable performance standards regarding the specific number of beneficiaries they educated, assisted, and enrolled. Local organizations that fell short of achieving their agreed-upon performance standard for the number of beneficiaries whom they assisted with enrollment faced a reduction in their final payment.

Assessments of CMS's efforts to support the drug card program through partnerships with local organizations are limited. We identified an evaluation by Ogilvy that was submitted to CMS in May 2005. That report stated that community-based organizations funded by the partnership assisted nearly 900,000 beneficiaries in the enrollment process, but raised questions about whether these organizations were adequately prepared for the task.[29] Among the shortcomings cited by community-based groups, as reported in the Ogilvy report, were (1) organization leaders received training and orientation, but the training provided to staff and volunteers was insufficient to prepare them to answer the often complicated questions from beneficiaries; (2) the organizations experienced initial frustration and difficulties accessing and using CMS materials, including the Medicare Web site; and (3) outreach to nonelderly disabled beneficiaries was limited, largely because many community-based organizations did not feel qualified or equipped to serve this specific population.

About 6 Million Beneficiaries Obtained a Drug Discount Card; Several Factors May Have Limited Enrollment

Approximately 6 million beneficiaries are enrolled in the drug card program and nearly one-third of these participants received transitional assistance with their drug card. Many more beneficiaries were automatically enrolled than enrolled on their own. The number of beneficiaries in this latter group fell below an enrollment projection set by CMS but exceeded one set by the Congressional Budget Office (CBO). A variety of factors—beneficiary confusion as well as features in the program's design—may have limited enrollment in the drug card program.

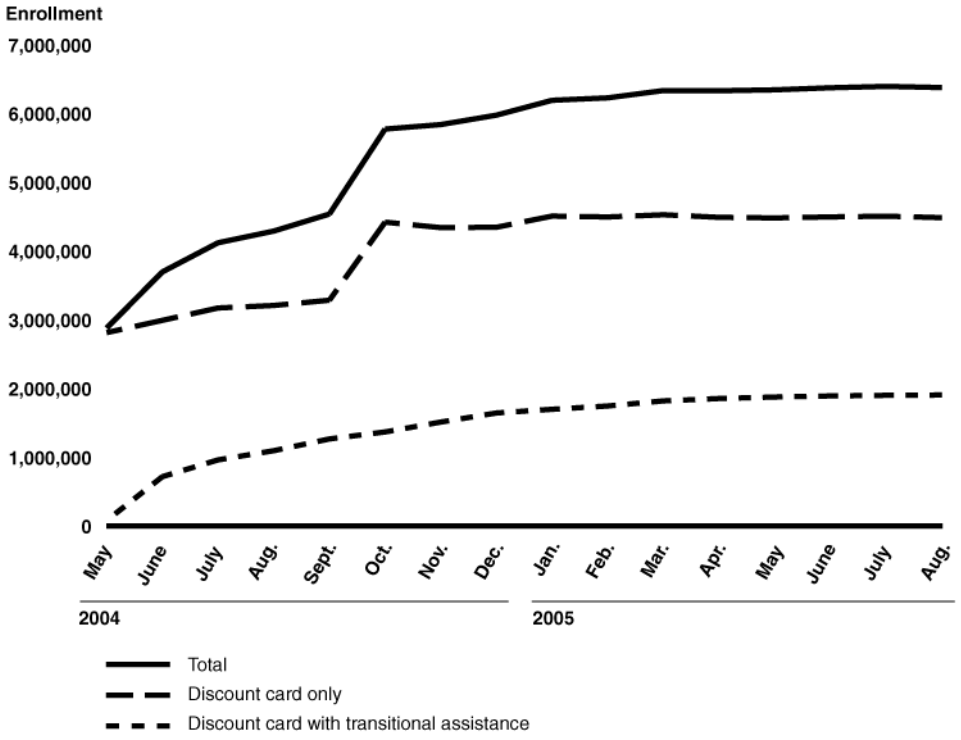
Of the 6 Million Enrollees, Nearly Two-Thirds Were Automatically Enrolled

As of September 1, 2005, approximately 6.4 million Medicare beneficiaries had obtained discount cards through the drug card program. This number included 4.5 million beneficiaries who had obtained only the discount cards and another 1.9 million who obtained both discount cards and transitional assistance. Roughly two-thirds of participants enrolled early in the program—May through July 2004. (See fig. 1.) To enhance enrollment, CMS randomly assigned drug cards to beneficiaries in Medicare Saving Programs (MSP), which cover various Medicare-

[29]Ogilvy Public Relations, *Development of Community-Based Coalitions to Support Drug Card Awareness*, Final report on CMS Contract Number 500-01-0003, Task Order 0011 (May 31, 2005).

related out-of-pocket costs for certain low-income beneficiaries.[30] Drug card sponsors mailed drug cards to about 1.1 million of the beneficiaries in MSPs in October 2004 and to about 120,000 of these beneficiaries in February 2005.[31] Approximately 12 percent of those who received these cards from the agency applied for and obtained transitional assistance.

Figure 1: Enrollment in the Drug Card Program May 2004 through August 2005



Source: CMS.

Note: In May 2004, the first month of the program, 66,910 beneficiaries enrolled in a drug discount card and received transitional assistance. Data are as of the last Thursday or Friday of the month.

CMS data also demonstrated that slightly more than a third of the Medicare beneficiaries who enrolled in the drug card program did so on their own. As shown in table 1, of the 6.4 million total discount card program participants, we estimate that 2.3 million enrolled on their own initiative, and 4.1 million were automatically enrolled by virtue of their participation in other Medicare or state assistance programs.

[30]There are four MSPs, each with differing income eligibility requirements and levels of benefits—the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualifying Individual, and Qualified Disabled and Working Individual programs. To enroll, eligible beneficiaries must have incomes and assets within the specific program's federal ceilings and enroll through their state Medicaid program.

[31]Some of the original 1.1 million MSP beneficiaries that CMS autoenrolled in a general card in fall 2004 subsequently enrolled in a different drug discount card, canceled their assigned card, or died. As of September 1, 2005, this MSP group had declined to about 874,000 enrollees.

Table 1: Estimated Autoenrollment and Self-Enrollment in the Drug Discount Card and Transitional Assistance Program, September 2005

	Discount card only	Discount card with transitional assistance	Total
Autoenrolled	**3,221,147**	**833,075**	**4,054,222**
• Beneficiaries in Medicare Advantage [a]	2,370,463	245,850	**2,616,313**
• Beneficiaries in Medicare Savings Program [b]	850,684	144,225	**994,909**
• Beneficiaries in state pharmacy assistance programs [c]	0	443,000	**443,000**
Self-enrolled	**1,274,725**	**1,065,292**	**2,340,017**
Total	**4,495,872**	**1,898,367**	**6,394,239**

Source: GAO analysis of CMS data.

Note: Enrollments effective as of September 1, 2005.
[a]Medicare Advantage refers to Medicare's managed care plan options.
[b]Medicare Savings Programs assist low income beneficiaries by paying for some or all Medicare premiums and deductibles.
[c]State Pharmacy Assistance Programs provide low income and other beneficiaries with financial assistance for prescription drugs.

Despite efforts to facilitate enrollment, the number of beneficiaries who obtained discount cards with transitional assistance—1.9 million—fell significantly below CMS's projection. CMS anticipated that its drug card program, in general, would have the highest participation rate among those beneficiaries who would also qualify for transitional assistance. Specifically, the agency estimated that 4.7 million of the beneficiaries eligible for transitional assistance in 2004 would enroll in the drug card program and receive transitional assistance.[32] CMS based this estimate on a variety of factors, including enrollment rates in similar programs and the nature and duration of the drug card program. In contrast, the 1.9 million beneficiaries who obtained discount cards with transitional assistance exceeded a CBO estimate. In a July 2004 paper, CBO estimated that about 20 percent of those eligible for transitional assistance, or 1 million beneficiaries, would enroll in the drug card program and receive the $600 credit. CBO estimated that relatively few beneficiaries would participate in the interim program because of the program's relatively short duration before the 2006 prescription drug benefit takes effect and the perception that the interim program is of limited value.[33]

[32]CMS, *Medicare Program:* Medicare Prescription Drug Discount Card; Interim Rule and Notice, 42 C.F.R. Parts 403 and 408, Federal Register/Vol. 68, No. 240/Monday, December 15, 2003.

[33]Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (Washington D.C.: July 2004).

Beneficiary Confusion and Program Design Issues May Have Limited Enrollment

Assessments indicate that the level of enrollment in the drug card program—especially among those receiving transitional assistance—may be explained by a variety of factors. In particular, studies we reviewed found that beneficiary confusion about the drug card program as well as weaknesses in the program's design may have deterred some beneficiaries from enrolling.

Beneficiary Confusion

One factor that may have limited enrollment is some beneficiaries' reduced ability to access information and make effective choices about different health care options. The Medicare population has significant vulnerabilities in terms of health and cognitive status: 71 percent of beneficiaries have two or more chronic conditions, 29 percent are in fair or poor health, and 23 percent have cognitive impairments.[34] Efforts to inform beneficiaries are particularly challenging with older members of minority, low-income, limited English-speaking, and other underserved populations. Research has shown that beneficiaries lack a basic understanding of the Medicare program, and even those who know the fundamentals have significant information gaps.

In the case of the drug card program, CMS has acknowledged that confusion or misperceptions about the drug cards among Medicare beneficiaries may have affected enrollment. In its February 2005 self-assessment, CMS found that despite the agency's education and outreach efforts, beneficiaries confused the drug card with the 2006 prescription drug benefit, and some beneficiaries did not enroll because they were under the impression that Medicare would be sending them a card. Furthermore, the concept of a private drug card sponsor was difficult for many beneficiaries to understand. In addition, CMS found that some beneficiaries may not have enrolled because they believed they were ineligible for the discount cards. Specifically, many beneficiaries incorrectly thought that the drug card was only for low-income people, and those who likely qualified for the $600 in transitional assistance did not believe they qualified for it, even after having the income criteria explained to them. CMS also asserted that there was a misconception that acceptance of the $600 transitional assistance would negatively impact a beneficiary's eligibility for other assistance programs, such as housing and food stamps.

Design Features

Several features of the drug card program's design may also have limited enrollment. First, because it was designed as a voluntary opt-in program for most eligible beneficiaries, it represents a significant change in individual responsibility. KFF noted that requiring an active decision and effort may seem unfamiliar to, or be difficult for, some beneficiaries. Unlike more customary expansions in coverage

[34]Kaiser Family Foundation, *Medicare at a Glance*, publication no. 1066-08 (Washington, D.C.: April 2005).

under fee-for-service Medicare—where a new benefit is automatically available to beneficiaries—the drug card program asked beneficiaries to decide to enroll; choose a card; submit enrollment information; and in some instances, apply for transitional assistance. KFF also reported that some Medicare beneficiaries lack familiarity with the concept of drug discount cards and with the tools—for instance using Medicare's PDAP to compare drug prices—that could be used to help make a decision to obtain a drug card. Because of the increased individual responsibility, automatic enrollment proved more effective than voluntary enrollment in increasing participation in the program.

Another factor in the program's design that may have limited enrollment was the number of card options beneficiaries could consider in making their choice. As noted by CRS, studies have shown that the responsibility of choosing from a broad array of options can lead to inaction. In the case of the drug card program, the availability of 37 cards, on average, has made it difficult and time-consuming for beneficiaries to compare their drug card options. KFF and MedPAC reports noted that the amount of information on available cards and participating pharmacies, and the complexity of drug pricing, may have been overwhelming for many beneficiaries and others assisting them. CRS concluded that the large number of cards from which to choose may have deterred beneficiaries from choosing to enroll.

Finally, studies we reviewed suggested that enrollment in the program depended, in part, on beneficiaries' assessment of the value of the drug cards. The greater the perceived value of the discounts offered by the card, the more likely beneficiaries were to make the effort to obtain a card. However, MedPAC found that beneficiaries were uncertain about the value of drug cards, or perceived that they offered relatively small savings, and therefore saw no need to enroll in the program. AEI suggested that since most Medicare beneficiaries already have some type of prescription drug coverage, they may have assumed that a discount card program would be of little value to them.[35] Abt focus group participants reported that they found other ways to reduce costs below what the cards offer, such as getting free samples from their provider(s), using discount cards from other groups, and getting drugs from Canada or Mexico. As noted earlier, according to CBO, the temporary nature of the drug card program—the program was designed to operate for no more than 18 months—may have contributed to low participation.

Agency Comments

We provided a draft of this report for comment to the Administrator of CMS, and we received written comments. (See enc.)

---

[35]Beneficiaries without drug coverage may have discount cards offered by retailers or associations. For example, as reported by AEI, for a $20 annual enrollment fee, AARP's MembeRx Choice provides average discounts of nearly 20 percent off retail prices. Beneficiaries in such programs may have assumed that they do not need a Medicare-endorsed drug card because they already have a private card under a similar corporate name. See: American Enterprise Institute, *Private Discounts, Public Subsidies: How the Medicare Prescription Drug Discount Card Really Works* (Washington, D.C.: June 2004).

CMS commented that the draft report did not provide a complete account of all its education and outreach activities in support of the drug card program. However, we examined several key education and outreach efforts that CMS used to provide Medicare beneficiaries with information on the drug card program. We focused on these key efforts because they were identified as elements in CMS's own communication plan for the drug card program and were highlighted by CMS officials. Furthermore, these key efforts accounted for a substantial portion of CMS's budget for beneficiary education.

CMS provided examples of additional partnerships that we did not include in our report. It highlighted grants to the Department of Agriculture, Indian Health Service, Administration on Aging, and the National Governors' Association. In our review of activities with partner organizations, we focused on those entities that received substantial resources—over $1 million—to provide education and assistance largely to low income beneficiaries.

CMS commented that the draft report presents particularly negative assessments of CMS's efforts, rather than the studies that CMS itself conducted as part of its overall oversight activities. In our draft, we did include discussions of several education and outreach efforts that assessments found to be useful to beneficiaries. Specifically, we noted studies that reported the price comparison information on the Medicare Web site was an important resource for beneficiaries as well as for those who assist them in selecting a drug card. We also reported that one-on-one counseling provided by SHIPs was an essential complement to CMS's other education efforts.

CMS expressed concern about a reference to our December 2004 report in which we found that CSRs had substantial inaccuracy rates when answering questions about the drug discount card and transitional assistance. Specifically, we reported that CSRs inaccurately answered 55 of 70 calls on eligibility for transitional assistance. While CMS questioned the accuracy rate we reported at the time, we continue to believe that this finding was correct, based on the income information we supplied to the CSRs.

CMS commented that we omitted a factor that may have contributed to limited enrollment in the drug card program. Specifically, CMS observed that we did not mention that beneficiaries who take few or no prescription drugs have limited incentive to enroll. However, we did not find this factor identified in the assessments we reviewed. Furthermore, 2003 data show that 89 percent of seniors report taking prescription drugs, and of those nearly half report using 5 or more different drugs.[36]

CMS also provided clarifying information and technical comments, which we incorporated as appropriate.

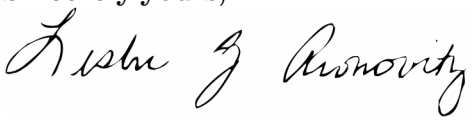
- - - - -

[36]Health Affairs Web Exclusive, *Prescription Drug Coverage and Seniors: Findings From A 2003 National Survey* (April 19, 2005).

As agreed with your office, we plan no further distribution of this report until 30 days after its date. At that time, we will send copies of this report to the Administrator of CMS, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions, please contact me at (312) 220-7600 or at aronovitzl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Other contributors to this report include Rosamond Katz, Assistant Director; Krister P. Friday; and Shirin Hormozi.

Sincerely yours,



Leslie G. Aronovitz
Director, Health Care

Enclosure

Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV - 9 2005

TO: Leslie G. Aronovitz
Director, Health Care
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Government Accountability Office's (GAO) Draft Report: *MEDICARE: CMS's Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Assistance Program* (GAO-06-139R)

We appreciate having the opportunity to review and comment on the GAO draft correspondence entitled, *MEDICARE: CMS's Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Assistance Program* (GAO-06-139R). Since the start of the Drug Card Program, CMS has put into practice a wide range of beneficiary education and outreach activities. These program elements were implemented according to a very short time frame required by statute. Such an undertaking is unprecedented for a program of limited duration. Moreover, all of our activities were initiated in the first year of the program, a remarkable accomplishment. As a result, almost 7 million beneficiaries who did not have complete drug coverage are saving billions of dollars on their drug costs.

While the correspondence points out some shortcomings that we have worked to address in implementing CMS's many education and outreach efforts, it did not create the full picture of the depth and breadth of the actual activities undertaken. In fact, much of the analysis offered in the correspondence was based on our own extensive "lessons learned" activities. These are lessons that we applied early on to adjust our education and outreach efforts for the Drug Discount Card and that we have clearly been applying with the Drug Benefit.

From a public service perspective, the most important question about the Drug Discount Card is whether the program provided discounts and access to prescription drugs for any beneficiary who wanted help. The answer is yes, immediately. People with Medicare began using their discount cards on June 1, 2004, and millions of prescriptions have been filled, with only a tiny fraction of complaints or compliance issues. Another significant and successful undertaking was providing to every beneficiary free access to the cost of their drug comparatively across all of our contracted sponsors—beneficiaries could find out and compare prices for every single covered drug, in every dosage available, located at any contracted brick and mortar or mail order pharmacy. This state-of-the-art approach put choice in the hands of people with Medicare, and will be carried through for the Drug Benefit.

Independent surveys in the fall of 2004 found high levels of satisfaction with the card enrollment process and with discounts received with the card. The CMS was able to meet the challenge of

implementing effectively this program in a short timeframe and we continue to improve the program based on our experience as we plan for the Drug Benefit in 2006. Despite the short startup timeframe for the Drug Card and Transitional Assistance program, CMS developed and implemented an extensive education and outreach program targeting the diverse Medicare beneficiary population. These efforts were complicated by misinformed criticism of the program that unfairly conveyed that the Drug Card did not provide significant assistance, even though study after independent study show real and significant discounts below not only list prices but prices people actually paid for drugs, including those with third party discounts. For the Drug Benefit, it is important that the media and others convey accurate information to ensure that Medicare beneficiaries engage in education and outreach activities.

The GAO correspondence primarily focuses on particular negative results, rather than the process of studies that CMS itself conducted as part of its overall oversight activities rather than the process. Therefore, the letter does not present the context of the larger beneficiary education and outreach effort on the part of CMS, and thus presents an incomplete picture. We suggest that GAO include a comprehensive listing of our overall education and outreach activities, including the many positive findings that came about as part of this effort.

We appreciate your willingness to incorporate information about CMS beneficiary education and outreach efforts into your final correspondence, thereby giving readers and users of the report a more complete picture and understanding of CMS implementation in these areas.

Our specific and technical comments to the draft report are attached.

Attachment

Centers for Medicare & Medicaid Services' Comments to the Government Accountability Office's (GAO) Draft Correspondence Entitled: MEDICARE: *CMS's Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Assistance Program (GAO-06-139R)*

CMS specific comments related to GAO's draft report on *MEDICARE: CMS's Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Assistance Program* are as follows:

RESULTS IN BRIEF

The negative tone of the Results in Brief section is not supported by the content of the body of the document which does point out the success of educating the majority of beneficiaries about the temporary drug card program in a relatively short timeframe, as well as some successes of the multifaceted outreach campaign.

BACKGROUND

The fact that CMS conducted assessments of its own program so soon after implementation (e.g., February 2005) is a positive. CMS made changes to its outreach campaign based on early self-assessments. We believe that this should be highlighted in the correspondence.

CMS USED MULTIPLE EDUCATION AND OUTREACH EFFORTS: ASSESSMENTS OF THESE EFFORTS IDENTIFIED WEAKNESSES

Media Advertising and Direct Mail

GAO Findings

"In a legal analysis issued in March 2004, we found that CMS's print advertisements contained a number of significant omissions. For example, while all of the materials we reviewed mentioned the new drug discount cards, none indicated that the cards may not be free and that savings may vary among drugs."

CMS Response

The focus of the print ads before March 2004 was to introduce the overall benefits of the Medicare Prescription Improvement and Modernization Act of 2003 (MMA), including preventive benefits, the drug discount cards, and new drug coverage. These ads were intended to help people understand that Medicare was not changing but that it was adding new benefits. They were not designed to provide specific details on any of the benefits highlighted in the print ad. However, our print ads designed to introduce the drug discount cards in spring 2004 did, in fact, include details such as "savings may vary" and "enrollment fee, deductibles and co-pay may apply."

3

GAO Findings
"The assessments we reviewed also found limitations in the use of direct mail to help increase enrollment in health care initiatives. In particular, studies have shown that direct mailings may not be an effective outreach tool for Medicare beneficiaries with low incomes. In its report, MedPAC found that low literacy rates, poor English proficiency, and unfamiliarity with health care programs limit low-income beneficiaries' ability to comprehend and act on direct mail instructions."

CMS Response
The CMS believed that using the direct mail approach was a good way to ensure this population received the information it needed. Other outreach channels (www.medicare.gov and 1-800-MEDICARE) would have required a person to take an action to obtain the necessary information.

All of our Medicare-approved drug discount card materials were consumer-tested with samples of the Medicare population to make sure the materials were as understandable as possible. Some of the sub-populations included in testing were beneficiaries with low literacy, beneficiaries with poor English proficiency, and low-income beneficiaries. The Medicare-approved drug discount card materials were also available in Spanish on www.medicare.gov and by calling 1-800-MEDICARE.

Medicare Web Site

While GAO points out that few beneficiaries are internet-proficient and, therefore, the Web site tool was of limited benefit to them, it should be mentioned that the same information was available through 1-800-MEDICARE, which received a record number of calls during early months of the drug card outreach. During the education and outreach effort, many updates to the Web site were made to incorporate comments and make improvements to the Web site. It should also be noted that the Web site was a primary tool used by many of the community organizations and other outreach partners to provide beneficiaries with consistent and accurate information. This had a significant impact on the quality of information used by beneficiaries to make decisions and enroll in the Drug Card Program.

GAO Findings
"According to CRS, because CMS posted the maximum price cited by organizations in their applications to become selected as drug card sponsors, some priced displayed on Prescription Drug Assistance Programs (PDAP) were too high."

CMS Response
Sponsors did not submit pricing information with their applications. The sponsors began submitting the pricing data for PDAP to CMS after they were awarded contracts to become approved card sponsors. The pricing data was updated weekly with the updated data files submitted by the sponsors.

The CMS chose to default to the highest price on the site with the logic that we had no means to know what package type would be used when the pharmacy dispensed the prescription. The highest price displayed on PDAP was valid for the highest priced drug/dose/package submitted by each sponsor; thus the beneficiary would not pay a price higher than what was posted on the Web site (in many instances, they would pay less).

Medicare Telephone Help Line

GAO Finding
"In December 2004, we reported that CSRs had substantial inaccuracy rates when answering questions about the drug discount card and transitional assistance".

CMS Response
We have already addressed the GAO findings regarding the inaccurate answers 14 percent and the issues regarding $600.00 credit:

- CMS conducts 1,000 customer satisfaction surveys each month at 1-800-MEDICARE. Consistently, more than 90 percent of the callers report they are satisfied with the services and information they receive. Since satisfaction is just one measure for evaluating the service at 1-800-MEDICARE, CMS also requires its contractors to thoroughly assess the accuracy and responsiveness of the information provided by Customer Service Representatives CSRs. The scores CSRs receive are consistently high, with accuracy rates of around 90 percent.

- GAO listed 55 of the 70 calls as inaccurate. We believe that all of the findings associated with question 2 need to be disregarded and removed from the study. There are several problems with the GAO findings associated with question 2.

- First, GAO determined that a correct answer would be that the caller's mother would qualify for the $600 credit. GAO gave 3 sources of income -- $765 social security, $250 rental income, and $70 monthly payout from husband's life insurance policy. GAO indicated that the CSRs should have disregarded the $70 life insurance income, thus qualifying the mother for the $600 credit. However, GAO neglected to consider that $66.60 monthly Medicare Part B premium needed to be added back into the Social Security income, thus putting the mother over the $1,048 monthly income limit for $600 without considering the $70 life insurance income. GAO considered the responses inaccurate even when their own notes indicated that the CSR was adding back in the Medicare Part B premium.

- Second, at the GAO exit conference with CMS, the GAO auditors clearly stated that they used 3 sources of income in their calls – social security, rental, and annuity policy income. Per CMS policy, all 3 of these income sources would be counted towards eligibility for the $600 credit. Later, the GAO indicated that the information provided at the exit conference was incorrect and that the auditors did not refer to the 3rd income source as "annuity income" in the actual calls. We had hoped that some of the calls may have been captured by our quality assurance software so that we could verify whether GAO auditors perhaps inadvertently switched between referring to the income source as

"life insurance" and "annuity". However, GAO did not provide sufficient information on these calls that would have enabled us to trace them.

- We continue to have issues about question 2 that related to income used to determine eligibility for the $600 credit. We believe that this clearly illustrates the complexity of the income calculations used to determine eligibility for low income assistance programs. In recognition of the complexity involved in making accurate income determinations, the1-800-MEDICARE CSRs will not be making the income eligibility determinations for the drug benefit subsidy. Instead, the 1-800-MEDICARE CSRs will ask the resource screening question and refer callers who meet the resource standard to Social Security Claims Representatives for the actual income eligibility determination. (Note that Social Security will not use their 1-800 Teleservice Representatives to respond to these calls but rather the more highly trained Claims Representatives.) The Social Security Administration has the responsibility for the drug benefit subsidy and the Social Security Claims Representatives have considerable expertise in making these types of income determinations.

GAO Finding

"Also, according to KFF, CSRs can answer inquiries in both Spanish and English but there is limited or no capability to communicate with beneficiaries in other languages."

CMS Response

The 1-800-MEDICARE helpline is staffed with English and Spanish speaking CSRs. In addition, we are also able to communicate with TTY users. The 1-800-MEDICARE helpline can support a variety of different languages through the use of a translation line. The use of translation lines is standard in the call center industry. A very small percent of the overall 1-800-MEDICARE call volume requires support for a language other than English or Spanish. English calls typically represent well over 96 percent of the call volume while Spanish calls represent 3 percent. The remainder of the calls are TTY calls, followed by other language calls.

In addition, CMS has continued to expand partnerships with local organizations to reach beneficiaries through trusted community groups that speak their language. In this way, we intend to increase our capacity to conduct culturally-appropriate outreach and education activities in multiple languages.

Partnerships with Local Organizations

An unprecedented public-private outreach effort was coordinated with CMS and Administration on Aging (AoA) to organize, train, and fund community-based organizations (CBOs) through national, State and local coalitions in order to ensure that the maximum number of low-income Medicare beneficiaries learned about Medicare-approved discount drug cards and how to enroll in the program. In addition to the private groups cited in this document (AARP, Access to Benefits Coalition, and the Medicare Today Coalition):

- A $300,000 interagency agreement was arranged with the United States Department of Agriculture to reach rural underserved audiences about MMA and the drug discount card through USDA county extension service educators.

- A $200,000 interagency agreement were signed with the Indian Health Service to extend education and awareness about the drug discount card benefit to tribal staff and members.

- $250,000 in grants was awarded to minority organizations through the AoA. These grant awards extended previous working arrangements AoA has with groups representing the African American, Hispanic American, and Asian American/Pacific Islander communities.

- A cooperative agreement for $125,000 was signed with the National Governor's Association, Center for Best Practices, to support their study of "Making the Medicare Modernization Act Work in States." Results from this study will be shared through a $125,000 amendment to this cooperative agreement that includes outreach activity that will be accomplished in concert with the Council of State Governments.

Despite shortened timeframes to select community-based organizations through a competitive contractual process, provide training on the drug discount card and transitional assistance programs, and gain the attention on this issue, CMS was successful in reaching the majority of those beneficiaries who would benefit the most. This assistance in paying for prescription drugs was particularly beneficial to the 4.5 million low-income Medicare beneficiaries who would qualify for discounts on their drug purchases and $1,200 in transitional help in paying for those medications. The contractual arrangement through Ogilvy PR Worldwide focused a national effort to promote awareness and enrollment in these programs with the hardest-to-reach of the low-income audience – those Medicare beneficiaries who are barred from the mainstream media by factors such as culture, language, literacy, location, and income. The charge was to coordinate with the AoA in organizing and funding CBOs through national, State, and local coalitions to ensure that the maximum number of low-income Medicare beneficiaries learned about the drug discount card and transitional assistance and how to enroll in the programs.

The crunch of time necessitated that much of this support be provided concurrent with the CBOs initiating their community outreach activities. Upfront training was provided to organizational leaders, with a dependency on the train-the-trainer approach to extend this training to all staff and volunteers. This was part of the contractual arrangement. CBOs varied in their ability to extend this initial training to all members of their organization, but were supported in their effort with the availability of additional online training and resources to answer difficult questions via postings on the www.medicare.gov Web site and queries to 1-800-MEDICARE CSRs.

The CMS materials were pushed to community-based organizations as part of an expedited start-up of outreach efforts, with drop shipments of selected publications made to all CBOs upon initiation of a contractual relationship. Ongoing communication and education support was provided to CBOs via regular e-mails, telephone access to regional coordinators, and a monthly newsletter. CMS staffers at the Regional Offices also were available for troubleshooting.

Outreach to disabled beneficiaries was limited by the ability of the individual CBOs, but was compensated for through support of partners engaged through the Access to Benefits Coalition, Medicare Today, and other national advocacy forums.

7

BENEFICIARY CONFUSION AND PROGRAM DESIGN ISSUES MAY HAVE LIMITED ENROLLMENT

Many design features were not CMS choice but were statutory. There is no discussion in the correspondence of beneficiaries not enrolling because they were low users, that is, regularly took few or no prescription drugs. Given that the card is a discount program, not an insurance program, low users had limited incentives to enroll. Therefore, lack of enrollment on their part constitutes lack of need, not low participation.

8

(290459)

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548