Abt Associates Inc.

Cambridge, MA
Lexington, MA
Hadley, MA
Bethesda, MD
Chicago, IL

Evaluation of the Medicare Prescription Drug Card and Transitional Assistance Program: Stakeholder Analysis

Contract No. 500-00-0032, Task Order No. 8

Final Report

September 14, 2005

Prepared for
Noemi Rudolph
Centers for Medicare & Medicaid Services

Prepared by
Marian V. Wrobel
Lynn Barth
Chanza Baytop
Louisa Buatti
Teresa Doksum
A.C. Doyle
Andrea Hassol
Rachel Sayko

Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138

Contents

Executive Summary

Introduction and Methods

The Medicare-approved prescription drug discount card program engages key private sector stakeholders and invites them to deliver a benefit on behalf of the public sector. These stakeholders include card sponsors (typically pharmacy benefit managers, insurers, and health plans), pharmacies, and manufacturers. States and organizations serving beneficiaries also become stakeholders in the program through their engagement with beneficiaries and the potential for coordination between States' Pharmacy Assistance Programs (SPAPs) and the drug card program.

The drug card program embodies many of the concepts that are intended to modernize Medicare. These include private sector provision, competition among plans, voluntary enrollment, and choice on the part of beneficiaries. Starting in 2006, the Part D drug benefit will engage the same key stakeholders and embody the same concepts but on a more significant scale.

This report documents the motivations, experiences, program impacts, and suggestions of key stakeholder groups in the Medicare-approved prescription drug discount card program. Its purpose is to generate background and insight relevant to both the drug card program and the Part D drug benefit.

These findings are based on 137 individual in-depth interviews: 32 with representatives of card sponsors, 12 with independent pharmacists, 10 with chain pharmacists, 17 with executives of chain pharmacies, 16 with prescription drug manufacturers, 22 with State Health Insurance Assistance Programs, 8 with information intermediaries (e.g., non-profit advocacy groups and local Area Agencies on Aging), 10 with representatives of professional associations, and 10 with thought leaders. The research design also featured four site visits to drug card sponsors and an analysis of secondary data sources related to the impact of the drug card program on SPAPs.

This evaluation was part of a larger effort by CMS to collect information from all stakeholders (beneficiary and non-beneficiary) involved in the Medicare Prescription Drug Discount Card and Transitional Assistance Program to determine the impact of the program and to derive some lessons for the implementation, design and operation of the Medicare Prescription Drug Coverage Program. CMS and Abt Associates have been involved in ongoing communications regarding the findings from this evaluation to provide input into the larger effort. Appendix A is a document created by CMS that further describes how lessons learned from operating the Medicare Prescription Drug Discount Card have been applied by CMS toward implementation of the Part D drug benefit.

Stakeholders' Experience

Overall Experience and Assessment of Program Value

Many stakeholders saw the fact that the program was successfully launched in a challenging timeframe as a noteworthy accomplishment. Sponsors were particularly pleased that manufacturers were willing to offer generous rebates. Sponsors and organizations working on behalf of beneficiaries did comment that the rapid implementation timeline posed many difficulties.

Across all stakeholder groups, most respondents considered the drug cards valuable to beneficiaries, especially when combined with Transitional Assistance (T.A.). The open-ended questions in the interview guide did not specifically inquire about the program's value to

beneficiaries, but many stakeholders did comment upon this topic in the course of other discussions. Some respondents mentioned the significant incremental benefit when manufacturers' pharmacy assistance programs wrapped around the Medicare drug discount cards.

As part of the interview, 131 respondents answered a closed-ended question concerning the program's value for beneficiaries who were eligible for the $600 credit. Of these, half said that the program's value for beneficiaries who received transitional assistance was excellent; an additional 40 percent said this value was good. No respondents deemed the value poor or very poor.

Experience with Private Sector Provision and Competition

Private sector stakeholders participated in the drug card program for humanitarian, competitive, and financial reasons and to prepare for the Part D drug benefit. All private sector stakeholders cited a desire for Medicare beneficiaries to have better access to prescription drugs and lower out-of-pocket costs. Stakeholders also had some competitive or financial motivations. Card sponsors sought to maintain or expand their current client bases; their typical financial objective was for their drug card product to have a "break even" financial performance. The retail pharmacy sector sought to boost sales or at least to retain customers in a changing environment. Manufacturers wished to expand access to their drugs. Finally, all sectors saw the drug card program as an opportunity to establish relationships and gain experience that would be useful for when they participate in the Part D drug benefit.

There was not much direct competition among sponsors. Many general card sponsors did not emphasize direct marketing but worked through new or existing partnerships to gain access to beneficiaries. These might be partnerships with health plans, insurers, employers, or unions. The one site of direct marketing and direct competition was CMS's price comparison website. In addition, competition among cards may have been dampened by the lack of noteworthy differences among the drug cards. Most cards offered discounts on all drugs. Most of our interviews suggested that sponsors all received comparable manufacturer rebates. Finally, sponsors' marketing materials tended to be very similar due to the reliance on CMS' model materials.

Respondents from the retail pharmacy sector expressed some dissatisfaction with the drug card program. They described their relationship with sponsors as one-sided and characterized by "take-it-or-leave-it" contracts. Some pharmacists believed that the pharmacies were funding the discounts. Many commented that the program reduced their profit margins.

Relationships between sponsors and manufacturers were generally cordial with some points of stress. Sponsors and manufacturers shared a commitment to the program's philosophy of private sector provision. There was some initial tension regarding inaccuracies in data posted on the web, and there was some ongoing tension over rebates. More than half of the 16 manufacturers interviewed wanted the rebates that were offered to drug card sponsors to be passed through to the customer in full. Several of these mentioned a perception that sponsors' high transactions or administrative fees had cut into the value of the net discount that reached the customer.

The program's financial impacts were negative for sponsors and pharmacies and negligible for manufacturers. For sponsors, the program required a major systems effort and high marketing costs and generated a low financial return. Some pharmacy margins were reduced by use of Medicare-approved drug discount cards by customers who formerly paid full price. Manufacturers reported a negligible financial impact.

Experience with Voluntary Enrollment and Choice

According to the perceptions of stakeholders, the target population was hard-to-reach and confused, especially by the need to choose among a large number of cards.

Stakeholders found it challenging and time-consuming to educate beneficiaries. Organizations serving beneficiaries, including pharmacists, remarked that it was challenging and time-consuming to explain the Medicare drug discount card program to the target audience. The individualized nature of decision-making among the large number of cards added considerably to this challenge. Both stakeholder groups said that one of the program's impacts for them was an increased workload.

The price comparison website was a good concept but not appropriate for the target population. Organizations working on behalf of beneficiaries reported that it was helpful to have a personalized decision-making tool. All stakeholders agreed that, whatever the website's strengths, CMS could not rely on the website as a primary mode for beneficiary communication and decision-making, because of limited computer access and computer literacy in the target population. Many stakeholders also commented that the website was difficult to use.

Many stakeholders were disappointed by the low levels of enrollment in the cards. In addition to beneficiaries' confusion, they cited negative publicity about the program, certain features of the program (sponsors' ability to change prices, beneficiaries' limited ability to change cards), and characteristics of the target population (low literacy, low computer literacy, skepticism regarding government programs, resistance to change) as drivers of low enrollment.

Experience with CMS

Stakeholders applauded CMS's dedication but noted weaknesses in program implementation. Stakeholders agreed that CMS staff worked hard, wanted to help, and had performed well, given the tight timeframe and requirements of the legislation. Stakeholders noted that there was room for improvement in program implementation, stakeholder communications, and communications with beneficiaries. In program implementation, sponsors noted particular challenges related to: changes and lack of clarity in program policies, reporting requirements, and the approval process for marketing materials.

Stakeholders' Suggestions for CMS

Stakeholders had many suggestions for CMS about both the drug card program and the Part D drug benefit. Because suggestions directed at the two programs were very similar, they are presented together.

Program Implementation: Stakeholders, especially sponsors, called for releasing all rules, regulations, and requirements with adequate lead-time and keeping mid-course corrections to a minimum. Exclusive card sponsors asked that CMS devote adequate attention to their unique position and needs.

Stakeholder Communications: Many stakeholders asked that CMS offer more opportunities for stakeholders and CMS to communicate; all groups believed that the Medicare drug benefit programs could be strengthened if CMS invited more input from their sectors especially during the development of policies and requirements. In particular, the retail pharmacy sector felt left out of the drug card communications and wanted to be included in further communications related to Part D.

Beneficiary Communications : In stakeholders' views, CMS should strengthen its campaign to reach out to beneficiaries through a wide range of intermediaries, including pharmacists, manufacturers, physicians, beneficiary organizations, and others. Stakeholders recommended that communications should be simple, carefully keyed to the target audience, and adapted to local conditions and insurance options. CMS should take active steps to combat negative publicity about Medicare drug benefit programs. Exclusive card sponsors reminded CMS that its messages should offer adequate information about managed care options.

Other Suggestions: Some stakeholder suggestions may fall outside CMS' purview. Some stakeholders thought that CMS should simplify the process of choice for beneficiaries either by limiting the number of choices or by standardizing cards/plans. Some members of the retail pharmacy sector asked that CMS limit sponsors' fees, require sponsors to pass all rebates through to the customer, and further deter sponsors from steering customers away from retail pharmacies and into mail-order drug purchase.

Discussion and Conclusion

The Medicare-approved drug discount card program was characterized by robust private sector participation and by levels of beneficiary enrollment that were below expectations. Stakeholders believed that beneficiaries were very confused by the drug card program, especially by the large number of cards. Under the Part D drug benefit, private sector engagement may be quite different. Private drug plans need different capabilities than drug card sponsors, notably the ability to bear risk. Manufacturers may have different motives regarding rebates. It is likely that the retail pharmacy sector will remain a reluctant participant in a program that it views as threatening to its profit margins. Moreover, the longer life of the program and the more significant resources at stake will almost certainly affect market dynamics.

Some features of beneficiaries' experience will probably persist from the drug card into the Part D drug benefit, including the nature of the target population and the potential for confusion. However, it is also likely that some features of beneficiaries' experiences will be different due to the greater potential value of the benefit, the incentives to join the program early, and different competitive dynamics.

There are several opportunities for CMS to continue to support private sector provision, competition, voluntary enrollment, and choice under the Part D drug benefit. CMS could support private sector provision by inviting input from private sector stakeholders and by making implementation processes responsive to their needs. CMS could support competition by allowing diversity in marketing materials and by allowing plans to differ in ways that are meaningful and comprehensible to beneficiaries.[1] CMS could promote enrollment through optimally designed outreach and education, by allowing more active marketing by plans and manufacturers, and by maximizing the value of the benefit, perhaps by facilitating coordination between the private drug plans and other pharmacy assistance programs.

To promote choice, CMS could continue to develop tools that facilitate informed choice, such as the price comparison website, and make them widely accessible. In considering these activities, CMS will have to balance its program development role with its regulation and oversight role and the need to conform to its Congressional mandate.

[1] This supports non-price competition.

1.0 Introduction

1.1 The Medicare Prescription Drug Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created a new voluntary Medicare prescription drug benefit in two distinct phases, the interim phase being the implementation of a prescription drug discount card and transitional assistance program in Spring of 2004, and the mature phase being the Part D drug benefit in 2006. This two-phased program represents a significant expansion of Medicare and an initiative in which private entities will work directly with the Centers for Medicare and Medicaid Services (CMS) to offer a benefit on its behalf.

The transitional assistance program (T.A.) offers $600 of annual federal assistance that may be applied directly to the cost of prescription drugs for beneficiaries whose income does not exceed 135 percent of the federal poverty level and who do not have drug coverage through Medicaid, employer-sponsored insurance, FEHBP, or TRICARE. This benefit is administered via the drug discount cards, greatly enhancing the value of the drug discount cards for beneficiaries who are eligible for the $600 credit.

While the Part D benefit is more substantial than the drug discount card combined with T.A., there are notable similarities between the two programs. Both programs 1) invite the private sector to deliver a public benefit and seek to encourage competition among plans as a way to maximize program value, 2) involve choice on the part of beneficiaries in terms of both whether to enroll and which card/plan to choose, and 3) engage similar organizations (health plans, insurers, pharmacy benefits managers, pharmacies, manufacturers, organizations serving beneficiaries, and the states).

1.2 Evaluation Purpose and Overview

The purpose of the project entitled "Evaluation of the Medicare Prescription Drug Discount Card and Transitional Assistance Program: Stakeholder Analysis" is to support the Medicare prescription drug discount card initiative by documenting and analyzing the motivations, experiences, successes, challenges, perceived impacts, and satisfactions of four stakeholder groups (card sponsors, pharmacies, manufacturers, and states), all of whom will also be key players in the Medicare Part D drug benefit. The evaluation represents an opportunity to extract lessons that can be productively applied both to the Medicare-approved drug discount card program and the Part D drug benefit.

This is a two-phase evaluation. The research design for Phase I included individual in-depth interviews with a broad range of stakeholders, site visits to card sponsors, and analysis of secondary data. Phase I offers a broad overview of stakeholders' perspectives on the drug card program with a focus on the drug card sponsors, who represent the heart of the drug card program. In particular, the primary data collection component of the Phase I evaluation consisted of:

- Individual in-depth interviews with 137 individuals including representatives of card sponsors, independent and chain pharmacists in the retail pharmacy sector, chain pharmacy executives, the manufacturers of prescription drugs, organizations that seek to assist Medicare beneficiaries, and experts.

- Site visits to four drug discount card sponsors.

In addition to analyzing these primary data, the Phase I evaluation also analyzed several secondary data sources including:

- Sponsors' applications to participate in the drug card program.
- Card-level enrollment data from CMS' beneficiary datamart.
- Card-level data from CMS Health Plan Management System (HPMS).
- CMS' website.
- Reports, presentations, and testimony related to the States' experiences with the drug discount card program.

As currently planned, the research design for Phase II calls for repeat interviews with approximately half of the Phase I interview respondents, a cross-stakeholder panel, three community case studies, and four focus groups with pharmacists. Phase II will add to the Phase I findings by capturing changing views of the program as it matures, exploring how the program is operationalized in local communities, and adding an emphasis on pharmacies and pharmacists.

This evaluation was part of a larger effort by CMS to collect information from all stakeholders (beneficiary and non-beneficiary) involved in the Medicare Prescription Drug Discount Card and Transitional Assistance Program to determine the impact of the program and to derive some lessons for the implementation, design and operation of the Medicare Prescription Drug Coverage Program. CMS and Abt Associates have been involved in ongoing communications regarding the findings from this evaluation to provide input into the larger effort. Appendix A is a document created by CMS that further describes how lessons learned from operating the Medicare Prescription Drug Discount Card have been applied by CMS toward implementation of the Part D drug benefit.

1.3 Overview of the Report

The remainder of this report is organized as follows:

- Chapter 2.0 is a brief description of the methods used for Phase I data collection and analysis.
- Chapter 3.0 presents the findings regarding card sponsors. A short initial section draws on CMS secondary data to characterize the universe of participating sponsors. The main part of the chapter describes findings from sponsor interviews and site visits.
- Chapter 4.0 describes findings from pharmacy interviews with chain pharmacy executives, chain pharmacists, and independent pharmacists.
- Chapter 5.0 covers findings from interviews with manufacturers.
- Chapter 6.0 describes findings from service organizations that work on behalf of beneficiaries. The first section of the chapter discusses interviews with State Health Insurance Programs (SHIPs); the second interviews with other information intermediaries; the third analysis of secondary data concerning interaction of State Pharmacy Assistance Programs (SPAPs) with the Medicare-approved drug discount card program.

- Chapter 7.0 reports on interviews with representatives of professional associations, defined as organizations that represent provider groups, and on interviews with thought leaders, defined as individuals who pay very close attention to the drug card program but are not direct participants.

- Chapter 8.0 is a cross-stakeholder chapter that synthesizes all the Phase I results, highlighting major themes and convergences and divergences of perspectives among stakeholders.

- Chapter 9.0 discusses the implications of the results and concludes.

References and six appendices follow the chapters:

- Appendix A is a document created by CMS that further describes how CMS has applied the learned from operating the Medicare Prescription Drug Discount Card toward the implementation of the Part D drug benefit.

- Appendix B presents detailed methods for Phase I.

- Appendix C displays the discussion guide used in interviewing stakeholders.

- Appendix D presents the sources used for the analysis of secondary data related to SPAP program.

- Appendix E names the professional associations and individual thought leaders who participated in interviews[2].

- Appendix F reports in detail on respondents' answers to the closed-ended (Likert scaled) questions included in the interviews.

A revised version of the sponsor summaries based on the secondary data sources listed above was provided to CMS as a separate deliverable from this report.

2.0 Methods

2.1 Individual Interviews

Individual in-depth interviews conducted by telephone formed the core of the Phase I report. These interviews allowed the project team to gather a range of perspectives on topics of interest to the evaluation.

The Phase I Evaluation Report incorporates 109 individual in-depth interviews with members of the four stakeholder groups and an additional 28 in-depth interviews with other individuals with important perspectives on key issues regarding the Medicare drug discount card program. These interviews were distributed as follows:

[2] All other interview respondents were promised anonymity/confidentiality.

Exhibit 1: Distribution of Interviews (Phase I)

Card Sponsors	32
General endorsement	19
Special endorsement	4
Exclusive	9
Manufacturers	16
Pharmacies	39
Executives of chain pharmacies	17
Pharmacists in chain pharmacies	10
Pharmacists in independent pharmacies	12
States and Territories	22
SHIPs program directors	22
Others	28
Info intermediaries and beneficiary advocates	8
Professional associations	10
Thought leaders	10
Grand Total	137

All interviews included in this report were conducted between November 11, 2004 and February 28, 2005.

The interviews document the most salient features of the drug discount card program, from the point of view of each set of stakeholders. In addition, the interviews sought to capture stakeholders' perspectives on certain specific topics deemed to be of interest to CMS. Many of the topics were relevant to all of the stakeholder groups; others pertained to only some of them.

Exhibit 2 shows the major research topics and the associated stakeholder groups who were interviewed about these topics.

Exhibit 2: Major Research Topics and Associated Stakeholder Groups

	Sponsors	Pharmacy Executives	Chain Pharmacists	Independent Pharmacists	Manufacturers	SHIPs	Info Intermediaries
Reasons for Participation and Objectives	X	X		X	X	X	X
Overall Experience	X	X		X	X	X	X
Sponsor/Pharmacy Experience	X	X		X			
Sponsor/Manufacturer Experience	X				X		
Experience with Beneficiary Choice			X	X		X	X
Experience with Enrollment Process and Cards at Point of Sale			X	X		X	X
Experience Working with CMS	X	X		X	X	X	X
Interaction of MDDC with State and Manufacturer PAPs					X	X	X
Impacts on Own Organization	X	X	X	X	X	X	X
Strengths and Weaknesses	X	X	X	X	X	X	X
Lessons for the Part D drug benefit	X	X		X	X	X	X
Overall Rating of Program	X	X	X	X	X	X	X

MDDC: Medicare-approved drug discount card. PAP: pharmacy assistance program.

Professional association respondents were asked manufacturer, sponsor, and pharmacy executive questions, according to the sectors they followed/represented. Thought leaders were asked all questions, with emphases according to their areas of expertise.

Interview procedures were designed to create an objective and accurate documentation of stakeholder perspectives. For each of the major stakeholder groups, the project team identified an objective and representative source of potential respondents and created an initial sample if necessary. (Appendix B offers more detail about the development of the interview samples and other methodological issues.) These initial samples were based on the project team's estimates of the number of interviews that would be necessary to reach the so-called "point of saturation," the point at which additional interviews no longer yield additional information. Recruitment continued until the interviewers reported that new insights were few and discussions were becoming repetitive. At that point, scheduled interviews were concluded.

The project team developed a discussion guide based on the topics in Exhibit 2. The discussion guide primarily used open-ended questions to elicit information from respondents on these topics. Close-ended questions with five response categories (ranging from "very poor" to "excellent") were used to obtain their overall ratings of the various features of the program from the point of view of their organization as well as the point of view of beneficiaries. Sponsors, pharmacists, and manufacturers were asked an additional question about their satisfaction with the relationships between each other. This discussion guide appears in Appendix C.

The majority of potential respondents were mailed an advance recruitment letter cosigned by the CMS Project Officer or other CMS staff and Abt's Project Director. Project staff followed up with a telephone call to answer questions about the study and to schedule an interview. In conjunction with

the recruitment letter and again at the time of the interview, all potential respondents were informed of the purpose of the study, its confidentiality procedures, and the fact that participation was voluntary.[3] All respondents were promised full confidentiality except for professional associations and thought leaders. These two groups were asked for permission to include their name (thought leaders only) and the name of their organization in an appendix. All agreed and these names are shown in Appendix E.

Interviews were conducted by telephone, and were attended by one or two project staff members. Interviewers took notes during the interview and confirmed their understanding of essential points with the respondent during the interview. Immediately after the interview, one of the interviewers created a written summary of the interview using a standard format. These summaries were assembled into an NVivo database.[4]

The project team then analyzed the summaries. Initially, the data were coded according to structural codes that mirrored major sections in the interviewer's protocol and were similar for all interview groups. As part of the analytic process, analysts identified more precisely defined themes for each stakeholder group. Analysts also examined how many times each theme was raised by respondents, in order to add rigor and objectivity to the process of documenting widely held views. In the report, certain major sections of the protocol are discussed together. In particular, the project team found great overlap between respondents' discussion of their own general experiences and their discussion of the program's strengths and weaknesses and between their suggestions for CMS regarding the drug card program and their "lessons learned" for the Part D drug benefit.

2.2 Drug Card Sponsor Site Visits

To add depth and detail to the findings regarding card sponsors, the project team also conducted site visits to four Medicare-approved drug discount card sponsors. During these site visits, we conducted individual and small group conversations with professionals responsible for drug discount card: product management, customer service, information technology, pharmacy contracting, contracting with drug manufacturers, CMS reporting requirements, and financial analysis.

These drug discount card sponsors were selected to represent diversity in terms of types of cards offered (general, exclusive, special endorsement), the character of the sponsoring organization (pharmacy benefits manager or a health plan), and in terms of special features (working closely with an SPAP, close ties to the retail pharmacy industry). All were large sponsors with drug discount card enrollment in excess of 100,000 Medicare beneficiaries. The CMS Project Officer and the project team worked together to select and recruit the card sponsors for the site visits.

During each site visit, two members of the project team spent approximately a day and a half in the offices of each of the four drug discount card sponsors. The site visits expanded on the same major research topics that were discussed in telephone interviews with other card sponsors. Project staff created a more detailed version of the discussion guide used for the telephone interviews, to support the site visits, but, in general, site visit discussions were conversational and wide-ranging. Interviewers launched initial questions then followed up on themes of interest as these arose. Project staff took notes during these conversations and their notes were compared and formally summarized shortly after the visit. In this report, findings from the site visits are not treated separately but are integrated into the discussion of findings from the individual telephone interviews. This was

[3] A letter and accompanying interview script, approved by Abt Associates' Institutional Review Board, was used to explain these procedures and protections.

[4] NVivo is a software product used for qualitative data analysis.

appropriate because the site visits tended to expand on the topics covered more briefly in the telephone interviews.

2.3 Sponsor Summaries

To add further depth and understanding of the drug discount card sponsors in the program, Project staff created sponsor summaries for all card sponsors apparently active at the time of launch.[5] Since sponsors could offer more than one drug discount card, each summary consists of a description of the sponsor and the drug discount cards that the sponsor offered. The summaries were based on secondary data supplied by CMS, including drug card sponsors' initial applications, data from the Health Plan Management Systems (HPMS), card enrollment data from CMS' beneficiary datamart (July 2004 enrollment data), and information from CMS' website. In conjunction with CMS, project staff designed a uniform template then populated the template using data from these various sources. These "sponsor summaries" provide a compact source of information for project staff and CMS. In order to facilitate access to the information, the summaries were organized in binders and on CD-ROM, and sorted by general/special endorsement sponsors, and exclusive sponsors. Project staff used the drug card sponsor summaries to prepare for interviews with card sponsors and in selecting drug card sponsors for site visits.

2.4 Analysis of Secondary Data Regarding State Pharmacy Assistance Programs (SPAPs)

The Centers for Medicare and Medicaid Services (CMS) was particularly interested in learning how the drug discount card program impacted States. At the state level, the key stakeholders are the SPAPs. Medicaid beneficiaries are not eligible for the drug card program, although dual eligibles will enroll in private drug plans beginning in 2006. State insurance commissioners do not have regulatory oversight over Medicare products including Medicare-approved drug discount cards. The project team did not conduct interviews with SPAP officials because other researchers had recently conducted similar research. Instead, we conducted an analysis of secondary information sources examining the implications of the Medicare-approved drug discount card program on SPAPs.

The secondary data analysis attempted to answer the following research questions:

- How has the Medicare-approved drug discount card interacted with State Pharmacy Assistance Programs?
- What lessons have SPAPs learned that can be applied to the Part D drug benefit?

Data sources were identified through a number of methods. First, we obtained recommendations from the CMS project officer and searched for material on the agency's website. Second, we reviewed health policy newsletters for references to new studies about the drug discount card program and the states. Third, we asked experts for sources of information during the interview portion of this project. Finally, using Internet search engines we identified additional materials related to the drug card program and states. From these, we selected the documents that were most relevant to our research objectives: (These documents are listed in Appendix D.) After selecting the documents most relevant to the SPAP programs' experience with the drug card program, we identified and

[5] Some drug cards were not fully implemented by their sponsors, but this was not known at the time of launch when the data for these summaries was assembled.

summarized major findings. When possible, we discussed how these findings compare to information obtained during the interview portion of this study.

3.0 Results: Sponsors

3.1 Analysis of Sponsor Summaries

As discussed in the "Methods" above, project staff created a short profile of each sponsor who participated in the Medicare-approved drug discount card program, at the time of program launch. These sponsor summaries were a separate deliverable for CMS. This section draws on those summaries to offer an overview of the universe of drug card sponsors and the universe of drug cards, based on the information in the sponsor summaries.

According to the data sources used for the sponsor summaries, 87 card sponsors offered a total of 163 separate Medicare-approved drug discount cards. While the number of cards offered by sponsors ranged from 1 to 14, 59 (67.8 percent) only offered one card and 18 (20.7 percent) offered 2 cards; the average (mean) number of cards offered by sponsors was 1.9.

Sponsors could offer general or exclusive cards. General cards consisted of national, regional or special endorsement drug discount cards, with enrollment open to eligible beneficiaries regardless of whether they were a member of a Medicare Advantage plan (those whose M.A. plans sponsored exclusive cards did not have the option of enrolling in a general card but were instead enrolled by their M.A. plan into its sponsored card). Exclusive cards were offered by Medicare Advantage plans only for their existing members, although some of these sponsors decided to open up enrollment to beneficiaries who were not also members of their M.A. plans. Of the 163 cards offered by sponsors, 81 (49.7 percent) were general cards and 82 (50.3 percent) were exclusive cards. Of the 81 general cards, 39 were national, 32 were regional and 10 were special endorsement cards. Of the 87 sponsors, 47 (54 percent) offered only general cards and 40 (46 percent) offered only exclusive cards.

Exclusive cards were offered by the following organization types: Medicare Coordinated Care Plan (CCP), Medicare Managed Care Demonstration (Demo), Medicare Private-Fee-For-Service Plan (PFFS), or Medicare Cost Plan (1876 Cost). Out of the 82 exclusive cards, 65 (79.3 percent) were CCP, 13 (15.9 percent) were Demo, 3 (3.7 percent) were 1876 Cost, and 1 (1.2 percent) was PFFS.

For the general cards, cards were assigned an applicant type: pharmacy benefits manager (PBM), managed care organization (MCO), or 'other.' Of the 81 general cards, 48 (59 percent) were PBMs, 9 (11.1 percent) were MCOs, and 24 (29.6 percent) were 'other'.

Card sponsors had the option of charging an enrollment fee of up to $30.00 per year for their Medicare-approved drug discount card.[6] Overall the majority of exclusive cards were free; when cards were stratified by type, the general cards had an average enrollment fee of $20.19 in contrast to an average enrollment fee of $1.46 for exclusive cards.

Mail order data were drawn from sponsors' applications to CMS and reflected sponsors intentions about mail order features of their programs, at the time the application was submitted. Sixty-three

[6] The Medicare Modernization Act waived the enrollment fee for beneficiaries who were eligible for the $600 Transitional Assistance.

(72.4 percent) of sponsors reported that they would offer mail order, while 14 (16.1 percent) reported that they would not offer this service.[7]

Data from HPMS showed that one hundred thirty-five (83.3 percent) of card sponsors offered an open formulary while 23 (14.2 percent) expected to offer a somewhat limited formulary.[8]

Enrollment data from HPMS indicated that there was a total of 3,849,769 beneficiaries enrolled in the program as of 7/23/2004. Sixty-five percent of these individuals enrolled in exclusive cards (many probably being automatically enrolled by their M.A. plans), while 35 percent enrolled in general cards (some of these being automatically enrolled by SPAP programs).

- Of the exclusive card enrollees, 94 percent were beneficiaries who did not qualify for the T.A, and 6 percent were beneficiaries who did qualify for T.A.

- Of the general card enrollees, 49 percent were beneficiaries who did not qualify for the T.A., and 51 percent were beneficiaries who did qualify for T.A.

3.2 Interviews and Site Visits with Sponsors

3.2.1 Description of Respondents

Types of Organizations

This chapter is based on interviews with respondents from 32 organizations that sponsor general, regional, and exclusive Medicare-approved drug discount cards. These 32 respondents included:

- 16 Pharmacy Benefits Managers (PBMs).

- 2 Pharmacy Benefits Administrators (PBAs).

- 1 claims processor.

- 3 health care administrators or providers.

- 1 administrator of a SPAP which is also now a T.A. card sponsor for their state.

- 9 Medicare Advantage (M.A.) plans offering exclusive cards.

Thirteen general card sponsors and four exclusive card sponsors had offered other discount cards to various populations before the Medicare-approved drug discount card program began.

Roles of Respondents

Among the respondents from general card sponsors, 18 identified themselves as involved in lines of business associated with new business or government programs, and others included pharmacy directors, an executive director, and an operations director. Among the respondents from exclusive

[7] Abt was missing application data for 10 (11.5 percent) of card sponsors, and therefore did not have data regarding mail order for these sponsors.

[8] 4 (2.5 percent) of cards were missing data regarding formulary. Also, while HPMS uses the term "formulary," drug cards offered discount drug lists not actual formularies.

card sponsors, seven described themselves as involved with the Medicare program as compliance officers and product managers, one was a chief operating officer, and the ninth was a medical director. Many interviews had multiple respondents joining the call, representing various functional areas associated with card sponsorship, the most being five on one call.

3.2.2 Reasons for Participation

Expansion or maintenance of their core business and preparation for the Part D drug benefit were the reasons most often given by the 23 general card sponsors for participation in the drug card program. Of the 23 respondents associated with general card sponsors, more than half saw the card program as an opportunity that was closely related to their core businesses and reported that one reason for participating was to support or expand their current client bases (insurance companies, managed care plans, unions and employers, and other like groups) to whom they provide pharmacy benefit services. Many of these respondents noted that sponsoring a card would enable them to co-brand with current customers; their arrangements were to provide the pharmacy benefit administration portion of the program while their co-brand partners handled some portion of promotion, enrollment, or other program activities. More than half of the general card sponsors also reported that one objective of their organization's participation in the drug card program was preparation for the **Part D drug benefit** program. A few remarked that they saw the drug discount card program as an opportunity to become familiar with CMS or to establish credibility with CMS.

More than half of the general card sponsors interviewed mentioned financial objectives for participating in the program. Of these, eight said that their initial goal had been to break-even financially, while two others reported that they realized early on in the project that they would not make a profit and revised their initial expectations downward. Four respondents reported their initial objectives as being making a profit or growing their business.

Among the nine exclusive card sponsors, respondents cited access to the Transitional Assistance program, member retention pressures, and preparation for the Part D drug benefit as reasons for participation in the card program. Most exclusive card sponsors cited the ability to provide their members with Transitional Assistance as a major motivation for participation. Two respondents pointed out that the drug discount card benefits all members as a good supplement to the managed care plan's current pharmacy benefits, providing reduced prices for those members who need more than what is ordinarily available through the managed care plan.

Six of the nine exclusive card sponsors reported that the decision to participate in the card program was also a strategy to retain members in a competitive environment. They anticipated that their competitors would also offer Medicare drug discount cards and so decided to participate as a defensive strategy. And six exclusive card sponsor respondents also cited preparation for or exploration of implications for the Part D drug benefit as a reason for participation.

3.2.3 Overall Experience

Successes and Perceptions of Program Strength

More than half of the card sponsors agreed that the Transitional Assistance benefit was the greatest success of the card program for their enrollees. Eight of the nine respondents from exclusive card sponsors identified the T.A. program as the major strength of the program, and three others noted benefits to members not eligible for T.A. Among the 23 respondents from general sponsors, half specifically mentioned the T.A. program while eight others mentioned the value for all beneficiaries.

Among the 23 respondents from general card sponsors, many also recognized that aspects of program implementation had been a success. Five mentioned the assignment of card managers at CMS as a great help; four mentioned the conference calls as a useful communication tool. Four also mentioned that their experience with the enrollment and eligibility system was positive and two mentioned the success of the payment system interface for T.A. claims and enrollment fees.

Other strengths reported by several general sponsors had to do with the working relationships between the sponsors and CMS. A few respondents cited strengthened relationships and increased communication or involvement of the industry with CMS as positive outcomes of the drug discount card program. A few individuals praised CMS for its success in implementing the program quickly and for transforming its level of knowledge of the industry. The other successes that respondents identified generally related to business expansion successes: increased name recognition among clients, co-branding as a successful strategy, the successful start-up of a call center, increased enrollment via manufacturers' pharmacy assistance programs that they also operate, etc.

Challenges and Perceptions of Program Weakness

Two themes emerged from the 23 general card sponsor respondents' descriptions of the challenges they experienced with the discount drug card program: that the implementation of the card program was more difficult than they had anticipated, and a sense that Medicare beneficiaries are harder to reach and to attract than many sponsors originally expected. Respondents from the nine exclusive card sponsors raised somewhat similar issues regarding implementation but since their organizations have group-enrolled their memberships into the card program, they did not share the general sponsors' difficulty in attracting beneficiaries to the program. The exclusive card sponsors did raise one issue specific to their dual role as both M.A. plans and card sponsors: in the rush to implement the general card program, CMS gave little attention or guidance as to how requirements and challenges would necessarily differ for exclusive card sponsors. When new guidance or requirements were issued by CMS, these card sponsors generally asked, "How does this apply to us?" and often CMS could not immediately answer because they had not considered the somewhat different circumstances of exclusive card sponsors.

Implementation of the Medicare drug discount card program has been more time-consuming and more costly than most card sponsors expected. Many respondents expressed a frustration with various aspects of the implementation process, primarily the information systems interfaces and information sharing with CMS, and the rules, processes, and restrictions on marketing to beneficiaries.

Many respondents recognized that the rushed timeframe played a role in the difficulties encountered in implementation, but it was not possible for respondents to untangle which aspects were within CMS control to plan and manage and which were not. Most respondents described their experience as one where requirements kept changing, making continuous redesign demands on staff and other resources, and where there was little communication among the parties as to the necessity and rationale for changes. Some respondents suggested that industry input during the development of requirements might have avoided some pitfalls, especially related to information processing issues, since management of large scale transactional and financial data is a core competency of the PBM industry. More specific implementation issues are described below.

Many card sponsor respondents reported that the drug discount card program confused beneficiaries. Many found that using traditional methods to market directly to this population were not successful. For many respondents, enrollment in their cards was dramatically lower than originally expected. And when CMS tried to increase enrollment through auto-enrollment of beneficiaries enrolled in the Medicare Savings Plans (MSP), the results were also well below

expectations. According to respondents, the costs associated with their role in the MSP project far exceeded the returns, given the very low enrollment rate.

Nine of the 23 respondents from general card sponsors suggested that the program is too complicated, with four specifically stating that it is too complicated for beneficiaries to understand, and three said that it is difficult for sponsors to understand as well. Three exclusive card sponsor respondents also saw the drug discount card program as too complicated: one commented that it is overly complicated compared to its value, another reported that it took months for his call center staff to learn enough about the program to fully understand the nuances of the questions callers asked.

Many respondents cited beneficiary confusion as a substantial problem, and raised concerns about the adequacy of outreach and education. Some respondents pointed to problems at the initial program launch as essentially setting the tone for what followed. They commented that beneficiaries were given mixed messages from CMS at the start, first to "hurry and sign up" and then "wait and see," which left beneficiaries confused and unsure. The lack of an effective educational/promotional effort was identified as a program weakness by many respondents. Many felt that the price comparison website and CMS website were the wrong information channel for most seniors, especially those who would be eligible for T.A. Many also reported that outreach materials were confusing and overly complicated, and the 1-800-Medicare helpline had long queues.

Many respondents commented on examples of poor program implementation. Four specifically commented on the MSP program, observing that the program was not well thought through and not well run. Other examples of program weaknesses mentioned by card sponsors included: CMS's inability to give good data to sponsors regarding beneficiary drug utilization or CMS' estimates of likely enrollment, limiting sponsors ability to forecast their own costs or design their own product; poor communication to sponsors; and too many sponsors in the program, resulting in beneficiary confusion and inability to leverage market power.

3.2.4 Experience Working with Pharmacies

Overall, most card sponsors reported that the development and maintenance of their pharmacy networks have been smooth processes and not very different from their usual experiences. A few noticed that some pharmacists had difficulty understanding the program at first, but those concerns have not continued. Others mentioned that a few pharmacy chains that had developed their own cards, through sponsorship or co-branding, had decided against participating in other Medicare-approved drug discount cards. A few sponsors raised concerns that pharmacists might be more likely to recommend cards that are in their own (or their company's) interest rather than recommending the best card for each individual beneficiary.

Most respondents reported that the financial arrangements between sponsors and pharmacies were going smoothly, with some respondents suggesting that their contractual terms were reasonable and welcomed by pharmacists.

Role of Discount Drug Lists

Twenty-four respondents responded to questions about discount drug lists; of these, 19 reported that they were offering discounts on all drugs. Those who commented on beneficiary reaction to this approach saw it as positive because all drugs (with the few universal exclusions determined by CMS) were covered.

3.2.5 Experience Working with Manufacturers

According to card sponsor respondents, arrangements with manufacturers for the Medicare drug discount card program were different from the usual approaches with funded benefits or other discount cards. Ten respondents reported that **manufacturers offered similar rebates to all card sponsors and did not engage in negotiation**. Some sponsors viewed this approach as showing a willingness on the part of the manufacturers to participate. Others felt that there were other reasons for these standard rebate offers. For example, the rushed implementation would have made it enormously difficult to negotiate contracts with more than 70 parties in a timely fashion. Some manufacturers were also perceived as having taken an initial "sit back and wait" position, and then followed the lead of their peers who were offering standard rebates across the board. A few respondents commented that manufacturer prices did change (decline) when the price comparison website was introduced on the CMS website.

3.2.6 Experience with Beneficiary Choice and Marketing to Beneficiaries

Respondents from the 23 general card sponsors described their experiences with beneficiary choice. In general, respondents described a limited number of strategies for marketing the discount card, beyond their participation in the CMS Price Comparison website. About half described one of their marketing strategies as co-branding or collaborating with one or more parties, where the other parties brought marketing access to a specific population of beneficiaries. These co-branding partners included organizations with closed groups of beneficiaries such as insurance companies, Medicare Advantage plans, and labor unions, while other co-branding partners offered access to large customer bases from general retail chains with in-house pharmacies, pharmacy associations or pharmacy retailers. Most sponsors confined their marketing to co-branding and affiliation, or sales to customers in retail outlets. Only a few of the sponsors reported trying other marketing techniques, such as buying mailing lists.[9]

Several general card sponsor respondents noted that they participated in SPAP programs (see the section entitled "Experience Working with the States). Ten of the 23 general card sponsors reported that they participated in the MSP program, in which their roles were to market to beneficiaries in the program who had been assigned to them.

A few respondents remarked that the point-of-sale relationships with the pharmacies were beneficial because of the critical role pharmacists play with beneficiaries, who turn to them for opinions or recommendations about the card. Of these marketing strategies, respondents who co-branded or collaborated met with more success than those who followed other strategies. Examples that involved co-branding or working with pharmacy chains or associations or retail chains with in-house pharmacies were specifically pointed out as successes. The several respondents who had worked with state SPAP programs had mixed experiences, since the states varied in their policies around SPAPs and in the sophistication of their information processing systems.

Almost all the respondents who reported participating in the MSP program were disappointed with the low enrollment levels, noting that the costs to market to the population were extremely high, creating a financial loss. Others noted that the follow-on activities were also costly, including purchase of telephone lists and staffing for telephone outreach, because the CMS lists did not contain telephone numbers for beneficiaries. On the other hand, one respondent from a smaller organization expressed high satisfaction with the program, stating that his company saw the MSP program as a

[9] One sponsor's usual practice was to pay a broker to enroll large groups (e.g. employer groups), but this practice was explicitly forbidden by CMS for the Medicare drug discount program.

way to gain enrollment without having to compete with larger firms that had known brand names and more resources for advertising.

Few respondents attempted marketing to the general Medicare population directly, i.e., outside of the marketing channels described above. Of these, success was limited. A few respondents reported that they had conducted traditional mail campaigns, with little success. One respondent noted that his organization had conducted two campaigns, one to more than one million beneficiaries and another to more than 150,000 in a specific geographic area, with almost no enrollment as the result. Another respondent reported a simple mailing, emphasizing the availability of Transitional Assistance, to more than 75,000 beneficiaries, and enrolled a few hundred from that. Another reported that his company had attempted to market at churches and fairs but got no results, so quickly stopped. Another scrapped a plan for direct marketing the day CMS announced the awards and he saw the number of competitors; he felt their card would have no chance without prior name recognition, because the field was just too crowded. Aside from these early, failed attempts there was little or no direct marketing to the general public taking place, at least according to these respondents.

For beneficiaries not touched by the channels described above**, respondents reported that the Medicare website and its price comparison website was the primary source for obtaining information about individual Medicare -approved drug discount cards**. Ten of the 23 general card sponsors interviewed mentioned the CMS website as a means to inform beneficiaries. Half of these suggested that the website was not appropriate for many seniors because many don't have access and if they do, the website is difficult to navigate. One person commented that CMS staff and card sponsors are probably using the price comparison website more than beneficiaries are. A few others suggested that the price comparison website misleads and confuses users because prices vary depending on bottle size and other variables, such as pharmacy outlet. Another commented that the price comparison website does not incorporate pharmaceutical companies' assistance programs, so low income beneficiaries are not informed of what their full savings could be. In contrast to these views, one respondent noted the establishment of the price comparison website as a positive innovation in terms of the price information it provides to consumers which has never been available before; another noted that he is very satisfied since much of his enrollment is generated from those using the price comparison website.

Printed materials were the primary means general card sponsors used to inform beneficiaries about their products, no matter what marketing channel they used. Almost all respondents commented about their experiences with the rules, reviews, and restrictions around marketing materials (see below), which were viewed as more stringent than necessary and inconsistent.

Many respondents commented about the reactions of beneficiaries to the Medicare drug discount card program. Many expressed the opinion that **a large number of beneficiaries either were unaware of the program or did not understand it.** Several respondents suggested that the use of the CMS website as CMS's primary strategy to inform beneficiaries was a mistake. Others commented that the messages about the card program were not clear enough to attract beneficiaries to find out more. They suggested that the lack of beneficiary response indicated that CMS did not have a good understanding of Medicare beneficiaries, especially the group eligible for Transitional Assistance, especially in terms of how to reach them with information about a new program. Others pointed to the product launch as the key event: had CMS responded to the initial bad press differently, perhaps the image of the entire drug discount card program would have been improved. This was a critical issue for respondents as they look forward to the Part D drug benefit; at the time of the interviews (Winter 2004/2005), they identified beneficiary awareness and education as an important key to success for that program.

3.2.7 Experience with the Enrollment Process

More than half the respondents commented on issues related to the enrollment and eligibility process. The major issues cited were: beneficiaries' difficulty understanding the applications for enrollment and Transitional Assistance; systems coordination between the GHP files and Enrollment and Eligibility Verification System (EEVS) for M.A. plans, and the coordination needed between the sponsors and CMS (and CMS's reconsideration subcontractor) to complete enrollment.

Many respondents commented that some beneficiaries had difficulty completing the enrollment form and Transitional Assistance application. Several noted that beneficiaries found it difficult to understand whether to check yes or no when responding to a statement that was articulated in the negative in the enrollment form: "I do not have outpatient prescription drug benefits under my state Medicaid Program." Several respondents noted that when completing the application for Transitional Assistance, many beneficiaries do not understand how to calculate income. A respondent from a large organization noted that about 30percent of applications sent by individuals have errors, which then requires staff to telephone and mail beneficiaries to obtain accurate information. This organization had anticipated that most enrollment would be completed on the web, and instead has had to assign about three times as many people as originally planned to manage various aspects of paper enrollment.

Several respondents reported that extra demands have been put on customer service operators to assist beneficiaries. While the respondents saw this activity as very appropriate and necessary, it was also seen as somewhat unexpected; that is, the length of individual calls have been longer than originally assumed and some sponsors were not initially prepared for the amount of beneficiary education that would be necessary.

Call centers have played an important role in the MSP program as well, according to some respondents, providing outbound calls to those beneficiaries whose telephone numbers could be obtained, since initial response to the sponsor mailings have been low. However, several respondents also reported that many beneficiaries frequently did not understand that these calls were about a legitimate and valuable program and would hang up.

Many respondents also commented on the systems issues related to coordination between CMS and sponsors around enrollment and eligibility. Respondents noted that the EEVS system was not fully tested before implementation; it was presumed to be working appropriately, but did not. Respondents described problems with transmission of files back and forth, error rates, lost data, unexplained data, lack of clear communication, and confusion, which resulted in extensive time required from IT staff. These problems also carried over into coordination with CMS' reconsideration subcontractor, according to some respondents. They cited instances of lost data, pended applications that were never resolved, and miscommunications. Some respondents noted that the staff at the EEVS helpdesk were a good support in resolving many of the EEVS related problems, however.

Several noted that the enrollment and eligibility system was an example where CMS was accustomed to using a batch-processing model while the pharmacy benefit industry had adopted real-time methods. A few respondents pointed out that the current model makes updating and correcting data very time-consuming, cumbersome, and prone to human error. Sometimes beneficiaries have to be dis-enrolled and re-enrolled in order to resolve a simple problem. Given that updating is frequently necessary, to correct an identifier or some personal information or to register a change related to enrollment, respondents suggested that CMS might explore developing a means to achieve a more efficient solution, such as data-sharing through a secure website or some other mechanism.

Respondents from M.A. plans reported a problem particular to their group: the coordination between the GHP system, which is used for M.A. enrollment, and EEVS. These respondents noted that there is a one-month delay in card enrollment for new M.A. members; while the new member is enrolled in the plan on the 1st of one month, their enrollment in the discount card program is delayed until the 1st of the succeeding month.

3.2.8 Experience Working with CMS

In discussing their experiences working with CMS, respondents tended to focus on five aspects: the overall implementation experience, the development of the systems interfaces with CMS, the processes involved in development of marketing materials, the MSP project as an effort to expand enrollment, and the use of card managers to assist them.

Overall, respondents from the exclusive card sponsors raised fewer concerns about the implementation process than those from organizations that offer general cards. Since many M.A. plans contracted with PBMs to manage various components of their exclusive drug discount card programs, their experiences working with CMS may differ from the experiences of general card sponsors.

As has been discussed in earlier sections, the rushed timeframe affected most, if not all, aspects of the Medicare drug discount card program's development and implementation. In general, the respondents acknowledged that this circumstance was out of CMS's control, and many commented that agency staff had performed well, given the conditions. However, most also reported that the implementation process was far more difficult and more costly than anticipated, whatever the root causes might have been.

The overall experience was made more difficult and costly than sponsors expected because decisions about program design and rules continued to change well after the actual product launch (and still continue to change). Many respondents from general card sponsors described the overall implementation as a chaotic process where requirements were constantly changing and several program functions, such as marketing materials reviews and systems development, appeared unsystematic and arbitrary. Deadlines were described as unrealistic, information was often either lacking or inaccurate, and it was difficult to get reliable direction from CMS on important policy and operational issues that had substantial cost implications. Several respondents commented that CMS staff had no prior experience with this type of program, and lacked project management skills. Several others suggested that CMS staff were unaware of the operational and financial implications of their decisions on sponsors, and especially might not have known of lesser-cost or less labor-intensive alternatives that were available to achieve the same ends.

Some respondents suggested that the implementation process would have been more efficient and smoother if CMS had sought input or feedback from the sponsors, especially during the design phase for the program and its reporting requirements. First, many sponsors identified various implementation issues as indicating that CMS staff had little expertise in the pharmacy benefit area. Input from sponsors might have helped to identify the implications of decisions on sponsors and would have provided CMS with additional information on which decisions could be based, according to many sponsors we interviewed.

Second, many sponsors noted that the pharmacy benefit industry has widely-accepted industry standards regarding information processing and common processes that could have been adapted to the Medicare drug discount card program's use. According to these respondents, many aspects of the discount card program did not adhere to industry standards (National Council for Prescription Drug Programs, Inc., NCPDP), making compliance unnecessarily difficult and expensive, and sometimes

impossible. Organizations in this industry consider themselves experts in the field and generally provide consultation and guidance on project development when working with a new client.

The development and implementation of systems interfaces between the sponsors and CMS were problematic and time-consuming. Most respondents identified systems interfaces as major areas of concern. They described the overall implementation conditions – rushed timeframe and evolving program design – as having significant effects on this function, where the usual approach is a methodical testing and re-testing to assure data accuracy. Some respondents gave estimates on how much time a new systems implementation usually takes in other areas of their businesses, for comparison's purposes. Although estimates varied, in general, implementations easily take 90 – 120 days *after* specifications are finalized, while in the case of the Medicare drug discount card program, much less time was available before the product rollout and specifications continue to be developed and revised, even today. While CMS may not be able to change overall timelines, one respondent suggested that CMS could publish, "release schedules" so sponsor staff don't have to make multiple phone calls to track a file or process.[10]

Many sponsors thought that system interfaces and design revisions was one area where the unanticipated costs of participation were very high. One large sponsor noted that during the most intense development period, more than a hundred technical staff were assigned to the Medicare drug discount card implementation because all changes had to be followed into more than 25 applications. Another respondent noted that his information technology costs were twice what was originally planned. A third commented that the retooling costs to meet CMS's technical standards were at least $1,000,000, and another said that his company expected to be done with development and implementation by July, but is still devoting a full time person to system changes in order to comply with CMS' ongoing updates.

In the area of enrollment systems, some respondents recounted experiences of lost enrollment and eligibility files on CMS' end, inaccurate data on enrollment files, and receipt of multiple versions of the same file, all labeled with the same identifier. One respondent suggested that CMS could establish a secure "real-time" interface where sponsors and CMS can both make necessary changes to enrollment or other data, such as correcting an identification number, without having to send and re-send data.

In the area of payment systems, some respondents mentioned that there was something of a "mismatch" between state-of-the-art pharmacy benefits systems technology and CMS technology. They pointed out that most pharmacy benefit processing is highly automated and conducted real-time. CMS requirements differed from this model, and are based more on uploading files and a batching process, according to these respondents. These respondents noted that they had to re-tool to accommodate some CMS requirements. Several respondents expressed concern about the processing model, as one that increases the potential for error and quality problems.

While respondents complained about some aspects of CMS' implementation process, **they saw card managers as an important support during this process.** Most respondents saw the card manager role as critical to working with CMS, although experiences varied: while some saw their card manager as a reason they were able to succeed, others expressed concern about performance citing poor training and education, constant turn-over of staff, and lack of back-up when the manager isn't

[10] While respondents during the interviews and site visits provided many specific examples of the difficulties encountered in the systems interfaces and implementations, we are also aware that most sponsors participated in the CMS "lessons learned" activities and provided extensive material regarding these issues directly to CMS in that process. We therefore do not go into extensive detail on such suggestions in this report.

available. Despite these concerns, as can be seen in the section on Lessons for Part D below, most respondents recommended that the concept itself is valuable and should be continued.

Several exclusive card sponsors noted that while the concept of a card manager was good, their M.A. plans already had plan managers assigned, and guidance from these two CMS sources was sometimes contradictory. They suggested that the product manager function for both plans and cards be consolidated into a single person.

The RFP Process

Respondents had mixed opinions about their experiences during the RFP process. While about half commented that the application process itself was relatively straightforward, others expressed concerns about various aspects of the process.

Seven respondents commented that the rushed schedule meant that CMS staff was also learning about the card program at the same time that they were guiding and advising the applicants about the program requirements, often leaving sponsors to make guesses about the requirements in order to meet the deadlines. Various respondents mentioned that it was difficult to get answers to questions or clarifications on important issues and to get CMS staff on the phone. One respondent from an exclusive card sponsor raised concern that the CMS Regional Office staff were not informed about the application process and were not in a position to respond to questions. He also commented that there was some confusion during the RFP process about which requirements applied to those offering exclusive rather than general cards. Two respondents noted that there was a long delay after their bids were submitted, during which time they could not get information from CMS, making it impossible to anticipate when they could actually start their programs.

A few (3) respondents were surprised by decisions made during the application process. One noted that his organization had expected to use a particular outreach model (an enrollment model), which during the review process was not approved by CMS. Another respondent noted that his organization had submitted identical applications for several cards, yet one of these was not approved, leaving him with the opinion that the review process was inconsistent. A third commented that if he had known CMS was going to approve essentially all applicants, which he saw as creating confusion in the marketplace, he might not have decided to participate.

One respondent had a more positive experience. He explained that his initial application was rejected, but CMS told him exactly what he needed to do in order to be accepted and he was able to revise and resubmit his proposal, which was then quickly accepted by CMS.

Reporting Requirements

This is an area where the experiences of sponsors of exclusive and general cards differ somewhat. Respondents from the exclusive card sponsors noted that some CMS requirements for general card sponsors were waived for them. And it appears that some exclusive card sponsors rely on PBM partners for their reporting to CMS and therefore do not have personal experience with this facet of their program.

There was substantial agreement among respondents from general sponsors and some from exclusive sponsors that **the process of meeting reporting requirements has been labor-intensive, time-consuming, and costly.** Many respondents described an environment where requirements were constantly changing (with each change labeled as a *final* document), requiring staff time for manual re-programming when each change occurred. One respondent indicated that there had been as many as eight or nine sets of changes over a course of eight weeks, while another said his organization had

stopped responding and wouldn't make any further changes until CMS could assure them that the requirements were actually final. Another noted that CMS errors had affected compliance with several reporting requirements, but that these errors went uncorrected. Several questioned whether CMS staff recognized the costs and administrative burdens associated with each change, especially in relation to the deadlines CMS set for compliance. One respondent noted that he would occasionally get changes marked with required dates that had already passed, clearly indicating to him that CMS did not appreciate the time required to make such changes. One respondent suggested that all updates/upgrades should be issued by CMS quarterly, with a full quarter allowed for compliance and testing, rather than being issued on a rolling basis.

Some respondents from general card sponsors addressed the quality of the reporting requirements themselves. While four described these requirements as fine, six suggested that reporting might have been better-designed and more efficient to carry out if the industry had been consulted. They pointed out that the pharmacy benefit industry information-processing systems have the capacity to do a wide range of reporting and that CMS might have found options that met its needs among them. Echoing a theme related to systems in general, sponsors perceived CMS' reporting requirements as archaic; two respondents were surprised that their staff had to do manual data entry to comply with them.

CMS Communications with Card Sponsors

The primary communication mechanisms discussed by respondents were the regular teleconference calls and CMS' sponsor website. Several sponsors also mentioned e-mail as a communication method.

Overall respondents found the teleconferences and sponsor website useful tools for communication; not one respondent said they should be discontinued or lacked value. Most respondents commented directly that the teleconferences were helpful, although almost all of these followed up with suggestions for improvements as well. Other respondents did not specifically comment on the value of the teleconferences; instead they directed their comments toward suggestions for improvement. Given the rushed timeframe and the fact that the program was still in development as it was being implemented, as discussed in earlier sections, the teleconferences were a critical mechanism for collecting and distributing program information.

The weaknesses respondents saw in the teleconferences fall into four categories: completeness and accuracy of information, decision-making, management of the teleconference process, and written documentation of guidance offered verbally during the teleconference. Regarding staff participation, several respondents pointed out that the lack of overlap in CMS staffing of the 'policy' calls and the 'operations' calls sometimes hampered accuracy or completeness of information and delayed the decision process. Others noted that even within the policy calls alone, sometimes the appropriate CMS staff, i.e., those who were in the position to make a decision, were not available. A few also reported that decisions that were made or announced during teleconference calls were sometimes changed later, causing confusion, while others cited instances when CMS staff had to put the teleconference call on hold as they arrived at a decision. This latter experience suggested to participants in the calls that CMS staff had not anticipated important issues in their planning and were 'winging it' during the conference calls. A few respondents also addressed the quality of presentations during the conferences, where presenters might skim over vital information, assuming that the audience was already as familiar with the material as the presenter was.

Many respondents also expressed concerns about the management of the teleconference process, indicating that inadequate preparation and documentation hinder the effectiveness of the calls. They

noted that agendas are distributed so late, sometimes just minutes before the call is to begin, that sponsors can't always get their appropriate staff to attend. They also suggested that the lack of minutes or other means to document meeting discussions and decisions hampers information distribution to all who need it. A few sponsors noted that if they missed a conference call, they were not always able to find out what they had missed. Apparently some material from the conference calls does appear on the sponsor website, but the more fine-grained operational details often do not.

One respondent noted that while she does get notified when changes have been made to the sponsor website, there is no indication of what changes have been made. In order to find the "new" information, she has to compare the previous version with the new version.

In addition, a few respondents from exclusive card sponsors pointed out that the teleconference agendas and discussion do not address the concerns of exclusive card sponsors.

When asked how CMS might improve its communications, card sponsor respondents offered the following suggestions:

- Ensure that CMS staff who represent both policy and operations attend both sets of teleconferences.
- Plan and distribute agendas far enough in advance that appropriate CMS as well as sponsor staff can attend the calls to participate in specific discussions and decision-making.
- Ensure that decisions made or announced at the teleconferences should be final and not subject to change and should be documented in detailed minutes following each teleconference.
- Follow-up with written answers/responses from questions that are deferred or not answered during a call, and post the information.
- Make better use of the sponsor website for information distribution: Post new rules and new decisions as soon as possible.
- Improve the sponsor website by establishing a "what's new" section, or an "update" section, so users can easily and quickly identify what has been updated and what the updates are.
- Update the "question and answer" section to attain version control and reduce confusion.
- Keep sponsors informed about information processing schedules and activities, so they don't have to make multiple phone calls to track progress.
- Group all updates/upgrades/revisions and announce them quarterly, to bring some predictability into the process.

Respondents recognized, however, that many of the problems sponsors experienced could have been avoided if the program design and specifications had been resolved before implementation, something that was not possible given CMS' legislative mandate.

CMS Oversight of Sponsors' Marketing Materials

This was another area, similar to information technology, where respondents associated with general sponsors raised many concerns. According to respondents, CMS introduced the model materials relatively late in the development process, after many sponsors had spent significant time developing their own. Most sponsors adopted the model materials because of the rushed project timeframe and the need to get their materials into the marketplace. Several respondents raised concerns about the usefulness of the materials for individuals with low educational levels or cognitive impairment.

All respondents who commented on the materials review process found it to be inconsistent and more time-consuming than necessary, especially when the timeframe was so rushed. The majority of sponsors were dissatisfied with the review process. They described the process as slow, cumbersome, erratic, and subjective. They cited examples where identical sets of materials would be sent for review, and one would be approved and the other not. A respondent described a situation in which he wanted to add a single sentence to materials that had already been fully reviewed and approved. The entire package was re-reviewed completely and disapproved, not because of the new sentence but because the previously accepted materials were not considered acceptable in this second review. One respondent commented that the concept of "file and use" might have improved the review process, i.e., once language is cleared, the user can use it repeatedly without re-review. Many respondents also expressed concern about the time required for review (generally 30 days) in a situation where it was important to communicate with beneficiaries.

The effects of the review process, according to many respondents, were delays in reaching beneficiaries, and final materials that were not conveying the messages that sponsors wanted the market to hear.

Some respondents observed that the marketing guidelines and review process hampered individualized communications with beneficiaries. These respondents were surprised at the extent to which printed materials (and call center scripts) were regulated in the Medicare drug discount card program. The result of the oversight process was a homogenization of materials, according to these observers. One respondent noted that if a beneficiary asked for materials from several different sponsors, he would receive packages that all looked very much the same. Several respondents questioned the required use of "disclaimers" in their materials, noting that implicit message is that sponsors are not trustworthy. Others suggested that the communications guidelines were not always appropriate for the target population. They believed shorter and simpler messages were needed.

Some respondents raised questions about the usefulness of sending so much written material to beneficiaries. According to respondents, sponsors were required to send pre- and post-enrollment materials, which were often identical except for the cover page. Another area of concern was a requirement that a list of the "100 most used drugs" be included in the mailed materials. Several respondents reported that beneficiaries were confused by the list, thinking perhaps that if their medication was not on the list, it was not covered by the card.

The 1-800-Medicare Helpline

Very few respondents commented directly on the helpline. The few who did, had negative opinions, but it is not clear if these stemmed from their own experiences.

CMS' Price Comparison Website

As mentioned earlier, about half the respondents from general card sponsors commented on the CMS website and price comparison website. A few other respondents commented on other aspects of the

CMS website, its role in the product launch, and its role as the only mechanism in the Medicare drug discount card program where consumers could measure one product against another.

Two respondents looked back at the launch of the drug discount card program as a critical point in terms of public perception, and observed that the early malfunctions and inaccuracies in the price comparison website contributed to the press's negative coverage and damaged the program's reputation even as it began. Another respondent observed that the use and perception of the price comparison website could have influenced manufacturers' pricing strategies. He suggested that this website was the only avenue for display of price differentiation; if manufacturers thought the web was highly used, they might modify their prices to compete, and if they thought it wasn't used, they would have no reason to lower prices. In fact, a few respondents noted that some manufacturers did lower their prices early on, possibly based on the exposure their prices received in the price comparison website. Finally, one respondent commented on the website's limitations regarding display of innovative product features. According to this respondent, the website design encompassed limited parameters, and any product features outside those parameters (prices, pharmacies) were ignored.

3.2.9 Experience Working with the States

Some respondents from general card sponsors commented in the interviews on working with State Pharmacy Assistance Programs (SPAPs). They spoke from their experiences participating with states that identified several card options for beneficiaries of state programs. Respondents reported that enrollment was lower than anticipated, a few dropped out of the programs due to low enrollment, and others noted that the coordination between the states and the sponsors went well. One respondent from a M.A. plan in a state where auto-enrollment into a single card sponsor took place noted that the process went smoothly.

3.2.10 Interaction of Drug Card Program and Other Pharmacy Assistance Programs

Some card sponsors were able to comment on the coordination between manufacturer pharmacy assistance programs and the Medicare drug discount card, particularly the T.A. component. These respondents agreed that the combined programs add value for beneficiaries, but that beneficiaries don't seem to be aware of this added value or to understand how these programs coordinate. And there are additional costs involved in this coordination, to implement the coordination that each manufacturer imposes between their assistance programs and the Medicare drug card's T.A.

3.2.11 Business Impacts

Across both the exclusive and general sponsors, **most respondents reported that the financial impacts on their organization from participation in the card program have been negative.** Of the 15 respondents from general card sponsors who described the financial impact of participation in profit or loss terms, 14 reported expenditures exceeding revenues. This group and others as well cited far higher expenditures on information technology and marketing efforts than originally planned, and disappointing enrollment levels. While respondents from exclusive card sponsors did not discuss financial results, they also pointed to high information technology costs, increased staff requirements to conduct the implementation, increased calls to their call centers, and high expenditures for mailing required materials.

Respondents reported that high information technology expenditures were the result of the constant changes made to requirements. One respondent commented that it cost his company over $1,000,000 to retool the technology to interface with CMS's older systems. Another noted that his organization is now doing some work manually, because it wasn't possible to retool their technology to interface

with CMS. Another cited reprogramming to accommodate manufacturers' wraparound programs as very costly.

Marketing was another area that respondents saw as costly. Seven respondents cited the MSP project specifically as a loss because of the costs of mailed pre-enrollment materials and increased call center staff needed to reach out to the MSP participants. The resulting poor enrollment gained from these efforts did not compensate for the financial outlays, according to these individuals. A large managed care organization reported spending millions to mail not only required materials, but also corrections when CMS materials turned out to have errors, to its members.

Some respondents reported positive impacts. One respondent from a general sponsor reported that his organization had gained visibility with its clients; another noted that his organization expected to break-even by reaching out aggressively to the MSP population. Several respondents pointed out that they have learned a great deal from the card program that will be applied to the Part D drug benefit.

3.2.12 Suggestions for CMS

When asked about the upcoming Part D drug benefit, card sponsors offered five clusters of suggestions for CMS:

- Adapt a sense of urgency regarding the timeframe for program development.
- Improve implementation management.
- Incorporate industry involvement in implementation.
- Recognize the importance of beneficiary education and understanding.
- Address specific issues that add to sponsors' sense of uncertainty about the program.

Nine sponsors mentioned concerns about the timeframe for development of the Part D drug benefit. These respondents expressed concern that the problems encountered in development of the drug discount card program would again be encountered with the Part D drug benefit if there is another rushed schedule. A few noted that critical information about risk adjustment and regional boundaries were not yet distributed (at the time of our interviews) and saw this as an indication that CMS would be late with the other program design decisions. Respondents reported that development of the Part D drug benefit will take more time than the drug discount card program did, and this should be considered in developing the schedule. Given the risks of the Part D program, several sponsors commented that if the timeframe was not adequate for a smooth development, then CMS should consider delaying the launch.

Almost all of the respondents from exclusive card sponsors and two-thirds of those from general card sponsors recommended improvements in the implementation process for the Part D drug benefit. Many sponsors stated that the program design for the Part D drug benefit, including specifications for systems and reporting, should be finalized before the beginning of implementation, in order to avoid the missteps of the drug discount card program. One respondent emphasized that clarity is critical, since the implementation costs for The drug benefit will be ten times the costs for the card program. Others were less stringent, but their recommendations were in the same general direction: that changes to information systems must be managed better with more time for system testing, and that the materials review process must be more timely and predictable. Others commented on CMS staff readiness and suggested that CMS might increase staff to meet the demand for information during implementation, train technical and card manager staff more completely and avoid staff re-assignments once in place. Comments about communication methods were similar to what was reported above: ensure that appropriate CMS staff participate in the teleconferences,

distribute agendas early enough to be useful, document decisions, don't change decisions once made, and post information clearly and quickly on the sponsor website.

More than half of the respondents (18) stressed the importance of improving beneficiary education and raising beneficiary awareness of the program. Many respondents felt some urgency about this, commenting that beneficiary outreach and education needs to be conducted *before* the program's launch. Some suggestions card sponsors offered included bringing all who are involved with beneficiaries into the program and ensuring that a consistent message is delivered. Others commented that CMS needs to work much harder to reach the low-income population, possibly by streamlining its approach to those eligible for MSP. Some exclusive card respondents commented that CMS should be even-handed in its description of the drug benefit for seniors, so that beneficiaries understand that they can enroll in the drug benefit through a stand-alone plan or through a managed care plan.

Seven card sponsor respondents pointed to an increased awareness of the uncertainties associated with the Part D drug benefit. Several remarked that the CMS data were unreliable for predicting enrollment and stressed the need for better data for the Part D drug benefit. A few noted that utilization data gained by many sponsors from card sponsorship will not be adequate for predicting utilization under the Part D drug benefit which is so different, and that sponsors will need to attain data from other sources to make projections. A few expressed concerns that the implementation for the Part D drug benefit might be as difficult as it was for the discount card. Others questioned the real level of interest among beneficiaries, given the enrollment results for the drug discount card program**.**

Some sponsors that are PBMs or PBAs and have not previously offered risk-bearing products, are uncertain about whether they will participate as Part D plan sponsors, or simply fill their traditional PBM role for other sponsors. Their concerns about continuing as sponsors included lack of state authorization to offer risk-bearing products, lack of utilization data for pricing, inexperience in risk underwriting, and the absence of a large membership from other insurance products for direct marketing of Part D plans. Part D plan sponsors who are also insurers are better positioned in all these regards, in the opinion of some PBM card sponsors, making competition difficult.

4.0 Results: Retail Pharmacy Sector

4.1 Interviews with Pharmacy Chain Executives

This section discusses the results of interviews with executives in 17 pharmacy chains.

4.1.1 Description of Respondents

Types of Organizations

The project team contacted 19 pharmacy chains, including the largest national chains, and a sample of regional and state chains. All but two agreed to be interviewed.

A majority of the organizations were pharmacy-specific companies, but several grocery store and mass merchandise chains with pharmacy counters were included, as well as one warehouse discount club.

The number of outlets ranged from 51 to 5,300, with an average of 1,435, and a median of 1,009. National chains usually had one to several thousand stores, while regional chains had a few hundred outlets and single state chains had well under 100 outlets.

Roles of Respondents

Most of the respondents were either Vice President or Director of Pharmacy Operations. A few were dedicated to government relationships. At the single-state level, the respondents may have been called "manager" or "co-coordinator", but they had the same role with regard to pharmacy operations as the VPs and Directors in larger chains.

4.1.2 Reasons for Participation

Chain pharmacy executives cited these reasons for their firms' participation in the program:

- **Service Existing Clientele:** All but one respondent said they participated in the Medicare-approved drug discount card program to serve the needs of their existing clientele. It was essentially a defensive strategy in the minds of many chain pharmacies – they were unwilling to lose customers in such a competitive marketplace.

- **Provide More Affordable Drugs*:*** Five respondents expressed concern at the high cost of prescription drugs, particularly for seniors who often fill many prescriptions at the same time. These pharmacy chains felt that it was important to provide whatever discounts were available, in order to lessen the financial burden on their most regular customers.

- **Boost Sales*:*** Three chains felt that the program might increase their volume of sales. We will see below that this expectation was unmet, but it was part of their original consideration.

- **Prepare For the Part D drug benefit*:*** Two respondents felt that the program would provide training and education, both for their pharmacists and their clientele, in advance of the Part D drug benefit in 2006.

- **Support The Government/Program*:*** Two respondents thought participation was a sign of good faith in support of the government's agenda.

4.1.3 Overall Experience

Successes and Perceptions of Program Strength

Chain pharmacy executives noted four broad strengths of the drug card program:

- **Indication of Public and Industry Commitment:** Nearly half felt that the program, while imperfect, sent a signal that both government and industry are concerned with the high cost of prescription drugs, and realize that something had to be done.

- **Solid Discounts for Beneficiaries*:*** Nearly all agreed that the program provided a discount to some customers, ranging from "okay" to "good".

- **Low Levels of Enrollment*:*** Four sponsors were pleased that program enrollment was low because the use of drug cards reduced pharmacy margins.

- **Learning for the Part D Drug Benefit*:*** Several executives felt the program was a valuable learning process for the Part D drug benefit.

Challenges and Perceptions of Program Weakness

When asked to discuss the Medicare drug card program, executives in chain pharmacies communicated discontent. They felt that they had not been included in the process of program design and implementation and they felt that they had born the financial burden of the drug card discounts due to a one-sided relationship with card sponsors, especially PBMs. These two points are discussed under "Experience Working with CMS" and "Experience Working with Sponsors."

In addition, retail pharmacy executives cited the following challenges:

- **Rapid Implementation:** Several respondents felt the program was implemented too quickly, particularly when the rules were not yet fully designed.

- **Pharmacists in Awkward Position Of Ignorance:** One third of executives observed that the program undermined the relationship between seniors and their pharmacists. Seniors expect a pharmacist to be knowledgeable about their prescription needs, and CMS provided insufficient educational materials for pharmacists to understand the program or the enrollment process. This put the pharmacists in the unfamiliar position of being unable to serve their customers and act as experts.

- **Administrative Burdens Imposed by the Numbers of Cards:** Five chains felt that there were simply too many cards. Four respondents felt that the number of cards put an excessive burden on systems and contracting. This burden was most acutely felt among the smaller chains.

- **Coordination of Benefits:** In some cases, the co-ordination of benefits between state pharmacy assistance programs and the transitional assistance credit led to questions and challenges. Many respondents felt that they bore the burden of resolving these issues and that this was not appropriate or fair.

- **Beneficiary Confusion:** Most of the pharmacy executives believed the program and enrollment process was far too complex for the average senior to comprehend. As

corollaries to this sense of confusion, these other program shortcomings were frequently mentioned:

- The website was an inappropriate vehicle for the target audience.
- There were too many cards to choose from.
- CMS communications, including the Price Comparison website, were weak and featured conflicting messages.
- It was difficult to understand the level of discounts.
- The enrollment process was daunting.

- **Low Levels of Enrollment:** Several respondents were disappointed by the low uptake of the Medicare-approved cards. A few of these had expected the program to boost their sales volume, and were disappointed that it did not end up doing so.

- **Insufficient Discounts:** Six respondents felt that the discounts were not particularly good, especially for those ineligible to receive the $600 transitional assistance allowance. A few of these chains claimed that their existing senior discounts were superior to the ones provided by the Medicare-approved discount cards. Others mentioned state programs or pension plans as offering access to better discounts.

- **Overly Politicized:** Four respondents felt that the program became a pawn in election-year politics, which undermined its credibility. Two felt that CMS did not manage the negative press coverage well. These factors together tarnished the program's image and led more seniors to seek drugs from Canada.

4.1.4 Experience Working With Sponsors

Pharmacy Discount Process

PBMs and other sponsors approached the pharmacies with proposals. Most were along standard RFP lines. The vast majority of contracts were signed with PBMs who already maintained relationships with the pharmacies, usually as addenda to existing contracts. New contracts were drawn up for cards offered by sponsors with whom they had no prior relationship.

Most of the pharmacies offered no endorsements. Those who did usually chose one of the larger consortiums, among whom the Pharmacy Care Alliance (PCA) was most frequently mentioned. Several pharmacies mentioned their extreme displeasure with PBMs trying to shift customers to mail order, essentially "stealing" them from the pharmacies. Accordingly, two pharmacies endorsed the McKesson card, since it was not offered by a PBM.

Eleven chains accepted some of the sponsor offers, and rejected those whose prices were too low (occasionally below cost). Five chains accepted every drug discount card offered.

Two mentioned that rules governing the level of compensation from sponsors were unclear, which was disconcerting to both their financial staff as well as line pharmacists. The manufacturer rebate levels were never known to retail, and there was no way to tell how much of the rebate was lost in PBM fees.

Two others mentioned that some sponsors offered good marketing and educational materials, which they put out on their counters.

Successes

- **Contract Administration:** Two thirds of the chains reported that contract administration and claims adjudication were easy and straightforward.

- **Educational Materials:** Five chains said that some sponsors provided good counter-top educational materials for seniors.

- **Positive Relationship with Preferred Sponsor:** While many of the chains reported dissatisfaction with card sponsors as a whole (especially with PBMs), several reported positive relationships with the card sponsor preferred or endorsed by their chain. Four of the five cited Pharmacy Care Alliance as being the sponsor of choice and complimented their performance.

- **Relationships Strengthened:** Three respondents viewed their relationships with several PBMs as having been solidified and improved due to their mutual work over the course of the program

Challenges

- **Rebates Not Passed Through:** A majority of respondents believed that the PBMs did not pass along the rebates to the consumer as they had promised to do. Many respondents were passionate in this belief, although it was not clear what evidence lay behind it. They also felt that the PBMs were deliberately unclear about their rebate policy in contracting and adjudication.

- **Excessive Fees:** As a corollary to the concerns about rebates, almost half of the respondents criticized the PBMs for excessive enrollment and/or transaction fees. The transaction fees were often over $3, and sometimes as high as $4 per prescription. Similar fees in third party contracts are $0.10 to less than $1. The retail pharmacy was expected to fund these fees from their margin.

- **One-Sided Negotiation:** Seven respondents felt that certain PBMs, particularly the large ones or card consortiums, were extremely aggressive and unpleasant in their negotiating tactics, and often demanded a chain "take it or leave it" with prices that were sometimes below cost.

- **Steering Customers Toward Mail Order:** Six chains resented the PBMs encouraging seniors to switch to mail order, which they viewed as stealing customers. A few mentioned that they had raised this issue with PBMs, but that PBMs had not altered their practices. A few respondents made the important observation that mail order can be a threat to the health of seniors, because prescriptions are provided without cognitive services or any monitoring of compliance.

- **Inconsistency/Lack of Experience:** Six respondents felt that there was far too much inconsistency in the way sponsors contracted and administered the program, with many of the newer sponsors lacking the experience to administer the program in a smooth and competent manner, or provide data on a timely basis.

- **New Cards Indistinguishable from Existing Ones:** One respondent said that among certain sponsors and states, the Medicare-approved drug discount cards were issued under

the exact same format as their older discount cards, making it difficult for the pharmacist to know which system to process them under.

- **No Challenges:** Two larger chains said that the program was problem-free, by and large.

Level of Pharmacy Compensation

Nearly every respondent reported a comparable level of compensation between the Medicare-approved discount cards and the level in funded plans. Some mentioned that it was lower than cash customers – this was largely a concern for mass merchandisers. One mentioned that it was lower for generic drugs than the level offered by funded products. A few claimed their own discounts were superior. But as a rule, the level of compensation for the Medicare-approved drug discount cards was either 1) roughly midway between higher-paying cash customers and lower-paying large employer plans or 2) comparable to the employer (funded) plans.

One chain refused to answer.

4.1.5 Experience Working With CMS

CMS Communications With the Pharmacy Sector

Executives in chain pharmacies raised a number of themes when asked to discuss their experiences working with CMS:

- **Insufficient Contact with CMS:** A strong majority of respondents claimed that CMS made no contact with them whatsoever, and hence had no direct working experience to report on.

- **Sense That Other Sectors Were More Closely Consulted:** Of those 11 who had no contact, 8 specifically complained that CMS had engaged large manufacturers and PBMs, but not the retail pharmacy sector, and this decision had a negative impact on the program. One chain, which had been consulted by CMS, appreciated the opportunity, but went out of their way to mention that they were the only one, while most of their competitors were ignored.

- **Difficulties Obtaining Answers to Questions:** A significant majority of the respondents complained that technical assistance was either unavailable or very poor. CMS typically was unable to answer questions. Two respondents said the website similarly failed to answer their questions. Three chains called 1-800-MEDICARE, but were all frustrated by the inability of CMS staff to provide answers.

- **Adequate but Limited Written Materials:** Slightly over half felt that the communications materials were "adequate", but "limited"

- **Resulting Reliance on Trade Organizations:** Four respondents, three of whom had no contact with CMS, said that their only source of good information was their national lobbying body, the National Association of Chain Drug Stores. Four respondents mentioned their own PBM subsidiary or the sponsor Pharmacy Care Alliance as their only source of useful information.

- **Marketing Restrictions:** Two respondents cited CMS's restrictions on marketing and educational efforts on the part of retail as being detrimental to their ability to communicate the program clearly to their customers.

- **Good Experience*:*** One respondent said his firm's relationship with CMS was fine.

Communications with Beneficiaries

Four respondents felt that CMS should have focused on better communications directly to consumers.

CMS' Price Comparison Website

Most respondents felt it was a poor vehicle for communicating with the target population, who, in their view, are likely to either mistrust the Internet or have no access to it.[11] Three respondents cited inaccurate pricing on the price comparison website. Two respondents mentioned that the posting of retail prices on the website was an unpleasantly aggressive tactic. Six respondents criticized the website as unhelpful and/or inaccurate. One respondent was concerned that the prices on the website were based on the highest price offered by any retail outlet in their chain, which penalizes chains with service in remote regions, such as Alaska, where distribution costs naturally spawn a higher retail price – he felt the prices should be their average retail price.

4.1.6 Working with States

Most chains reported virtually no direct involvement with states in terms of consulting or facilitating auto-enrollment from SPAPs. Six of these said that their endorsed or subsidiary PBMs did work with the states, but at the retail level all they did was accept the new customers.

Four chains reported close cooperation and consultation with states in which they had large numbers of outlets. Two one-state chains said that their own state's discounts were superior to the Medicare-approved discount cards, and hence witnessed virtually no enrollment in Medicare-approved drug discount cards.

Four respondents felt that the state programs were shuffling patients among programs in order to reduce State expenditures.

4.1.7 Business Impacts

Financial

Most chains reported very low participation rates. One third of those expected the low turnout, so the result was no surprise. Half of the chains reporting low enrollment were pleased because of the negative impact of the drug cards on their bottom line, as high-margin cash customers shift to low-margin discount card customers.

[11] While many interview respondents suggested that the program's target population were not computer literate, CMS' own research suggests that seniors are one of the fastest growing segments of Internet users and that health is one of the most common search topics when seniors seek information on the Internet. In addition to Medicare beneficiaries themselves, CMS' price comparison website serves CMS' customer service representatives, professional advocates and information intermediaries, and others assisting beneficiaries. These groups are very likely to have Internet access and strong computer skills.

Five chains reported a negative impact on their business. Of those five, two reported a small increase in customer volume, but insufficient to make up for the lower margins, while the other three reported a measurable decline in margins due to card use.

Marketing and Image

Nearly half of the chains felt that the program reduced pharmacists' stature in the eyes of customers. Because CMS provided the retail pharmacy sector with insufficient education, information, and technical support, their line pharmacists were unable to answer many of the important questions posed to them by seniors.

Seven chains also felt that the program's confusing nature, bad press, and limited level of discounts were a black eye for the pharmaceutical market as a whole, and led many seniors to consider Canadian drugs.

Five chains thought that while the program may have hurt the pharmaceutical industry's image, the image of their own firm was improved because they did a better job than their competitors of explaining the program and administering its discounts for their customers. Four chains reported no change in their marketing or image.

Operations/Systems Impacts

Ten chains reported a significant commitment of resources to contracting and systems work related to the Medicare-approved drug discount card. Several of these mentioned "chaos at the counter", difficulties with coordination of benefits, difficulties with brand versus generic processing, and HIPAA problems with some sponsors and states. The smaller chains believed that it was an unfair burden on them, while chains of varying sizes felt it was a burden disproportionate to the level of enrollment. Five chains reported only a minor incremental effort, primarily in contract negotiation and preparing systems. Two chains reported no impact at all.

Changes in Customers or Sales

Eleven chains reported no changes in customer sales, though few of them had actually analyzed it rigorously. Four chains reported a small increase in customers, but typically insufficient to make up for the financial impact of the decrease in margins. Two respondents refused to answer.

4.1.8 Suggestions for CMS

Executives' suggestions for CMS follow:

- **Communicate program details early.** Many chains felt they were given insufficient time to properly launch and manage the Medicare-approved drug discount card program

- **Involve retail pharmacies in planning, design, implementation, outreach, and marketing.** The retail counter is where the prescription drug dispensing, advice, consultation, education, cautions, ***and discounting***, actually get performed. To ignore the most critical point of the chain for distribution and use of medications is unwise.

- **Regulate sponsors.** Pharmacy executives suggested that CMS require full pass-through of rebates, regulate transaction and enrollment fees, and restrain sponsors' tendency to steer customers toward mail order, possibly by not allowing entities with ties to mail order to sponsor cards. While most retail pharmacy chains called for regulation of the

card sponsors; some called for eliminating the PBMs from the drug card program altogether.

- **Simplify the process of choosing a card and enrolling.** Make everything easier for seniors, as well as for the pharmacists serving them.

- **Improve outreach to beneficiaries.** Increase effort in this area, distribute the materials sooner, orient materials to the Medicare population, and seek guidance from the pharmacy sector in the development of message.

- **Endorse fewer drug cards and fewer private drug plans.** Over half thought there were too many cards permitted in the drug card program, and that CMS should have limited the number of sponsors. Many respondents felt that the number of cards and PDPs should be sharply curtailed under Part D.

- **Monitor and manage coordination of benefits.** In executives' view, the coordination of benefits is an issue between the states, the sponsors, and CMS, and it is inappropriate for the retail pharmacy sector to bear the responsibility of resolving problems. These respondents expect the problem to worsen *significantly* under the Part D drug benefit.

4.2 Interviews with Independent and Chain Pharmacists

4.2.1 Description of Respondents

This section discusses the results of interviews with 22 pharmacists: 12 independent pharmacists and 10 chain pharmacists in the U.S. All independent pharmacists worked for independent/community pharmacies and over two-thirds were also the managers and/or store owners. All chain pharmacists worked for retail pharmacies and were the pharmacy managers. The 10 chain pharmacists represented 7 chains.[12]

All but two pharmacists (one chain and one independent) had the experience of customers using a Medicare-approved drug discount card at his pharmacy; one from California and one from Illinois. Both pharmacists had spoken to customers about the program but never had a customer use one of the drug discount cards to purchase a prescription, and therefore had no experience dealing with the drug discount cards at the point of sale. These two pharmacist's opinions on some topics are included below, but many questions were outside of their experience and were not discussed.

4.2.2 Reasons for Participation and Objectives

The main reason most independent pharmacists participated in the Medicare-approved drug discount card program was that they wanted to meet the needs of their elderly customers[13]. They thought that:

- The elderly have carried the burden of higher drug prices in the U.S.
- Seniors and disabled people could benefit from the discounts.
- Those who qualified for the $600 T.A. would benefit from the savings.

[12] Three chain pharmacy executives did not grant Abt permission to contact their chain pharmacists who were selected in our sample for an interview.

[13] Chain pharmacists were not asked about reasons for participating in the program, rather chain pharmacy executives responded to this question.

Several independent pharmacists participated in the program in order to retain their customers. They believed that if they decided not to accept some, or all, of the Medicare-approved drug discount cards, their customers might take their business to another pharmacy in order to use the drug discount cards to fill prescriptions.

4.2.3 Overall Experience

Successes and Perceptions of Program Strength

The majority of independent and chain pharmacists thought that once customers selected and received a drug discount card, the process of running the cards through their automated systems at the point of sale went relatively smoothly.

The majority of pharmacists thought that the Medicare-approved drug discount card program's strength was that it saved beneficiaries money on their prescription drugs. Specifically, a few thought the $600 T.A. for qualifying individuals was a strength of the program.

Two pharmacists noticed that some customers who enrolled in a Medicare-approved drug discount card were increasingly compliant with certain medications, such as insulin. Two pharmacists thought the enrollment forms and process was straightforward.

Only two independent pharmacists worked with the states on the Medicare-approved drug discount card and both had favorable experiences [Pharmaceutical Assistance Contract for the Elderly (PACE) and Elderly Pharmaceutical Insurance Coverage Program (Epic)].

One pharmacist noted that the program helped to prepare all the stakeholders for the Part D drug benefit.

Challenges and Perceptions of Program Weakness

Several independent and chain pharmacists thought that the Medicare-approved drug discount card program was very confusing for their elderly customers. These pharmacists felt that beneficiaries were confused about the program in general, especially the number of choices, and they did not feel certain that they could help beneficiaries select the best drug discount card to meet individual circumstances.

Pharmacists highlighted the following challenges:

- Discounts not significant enough to help seniors in need.
- Too many cards to choose from.
- T.A. income eligibility level is too low; many needy beneficiaries do not qualify for Transitional Assistance.
- Problems during program implementation with information on the price comparison website and problems getting through when calling 1-800-Medicare.
- Little interest in the program among beneficiaries, including those who would qualify for the $600 credit.
- Additional time needed for pharmacists to help beneficiaries choose a card.

- Financial burden of the discounts falling disproportionately on pharmacies and decreased profit margin for pharmacies.

- Pricing decisions made by drug manufacturers and sponsors, rather than the federal government.

- Beneficiaries are not allowed to switch drug discount cards at any time, even though sponsors are allowed to adjust prices of drugs.

- Enrollment fees create a barrier for enrollment.

Pharmacists had suggestions regarding how CMS could improve the Medicare-approved drug discount card program, and ideas about what CMS could have done differently with the program. They suggested that CMS could have:

- Increased communication with pharmacists during program implementation.

- Been more involved with price negotiation.

- Increased education about the program for beneficiaries and pharmacists.

- Decreased the financial burden of the program on pharmacies.

- Translated program materials into Spanish.

- Limited the number of card sponsors.

- Allowed beneficiaries to switch cards at any time.

4.2.4 Experience Working with Sponsors

Independent pharmacists have had little direct interaction with card sponsors in relation to the Medicare-approved drug discount card program[14]. Pharmacists often received contracts for various discount drug cards by mail from sponsors, and some respondents felt that their relationships with sponsors of the Medicare-approved drug discount cards were no different from existing relationships they have with sponsors of other non-Medicare drug cards. A couple of pharmacists received suggestions from Independent Pharmacy Associations about which cards to promote to their customers. Several pharmacists thought that they should have been consulted during the design phase of the program and given an opportunity to offer suggestions and share their perspectives.

Many pharmacists reported that the card sponsors and PBMs set the drug prices and reimbursement rates that pharmacies would receive for the discount drug cards. They pointed out that there was no negotiation with sponsors regarding pharmacies' profit margins and that the contracts for the discount drug cards were 'take it or leave it' contracts. Even with the risk of losing some customers, **several pharmacists decided not to accept the most deeply discounted cards** based on the low reimbursement rates for the pharmacy. One pharmacist was displeased that some sponsors automatically enrolled his pharmacy into their Medicare discount drug card when he did not return the contract (the sponsor assumed acceptance).

[14] Chain pharmacists were not asked about their relationship with sponsors, rather chain pharmacy executives were asked about their relationship with sponsors.

The Medicare-approved drug discount card program, like all discount programs, has reduced the number of full-pay patients for pharmacies; patients who traditionally provided the highest profit margin. Many pharmacists were displeased with the smaller profit margin that pharmacies were getting through the discount drug cards and thought that **pharmacies faced an increased financial burden due to the program.** A few pharmacists thought that the lower profit margins for pharmacies did not take into account the costs of filling prescriptions and time spent counseling beneficiaries for the program. And a few pharmacists pointed out that they could not sustain their business if many customers were using the most deeply discounted cards.

Several pharmacists were pleased with some of the Medicare-approved drug discount cards, which offered fair pharmacy profit margins, such as the Community Care Rx card. They were also in favor of the few cards that were not pushing beneficiaries to use mail order, thus allowing patients to continue to fill prescriptions at the pharmacy without penalty.

4.2.5 Experience with Beneficiary Choice

The majority of independent and chain pharmacists felt that **they did not have the time to properly educate beneficiaries about the program and to help them decide which card to select.** Some pharmacists felt that those beneficiaries who really understood the program and enrolled in a card were finding it beneficial and appreciated the discounts. One pharmacist felt satisfied in helping his elderly customers understand the program and enroll. Another pharmacist was pleased that clearer information about the program was available as the program progressed. One chain pharmacist said that several customers were thankful when he recommended a preferred card that his pharmacy was endorsing because it helped beneficiaries make a decision about selecting a card, even though the card might not be best suited for the customers specific needs. In addition, one chain pharmacist noticed that seniors who were able to enroll in a drug discount card over the phone thought the process went much smoother.

Some independent pharmacists who attempted to help beneficiaries with the program spent up to 30 minutes educating and assisting customers with enrolling in a drug discount card, while a few others chose not to recommend any specific card. Most chain pharmacists referred their customers to the 1-800-Medicare number for assistance in selecting a card, or suggested that they enroll in the card that their chain was sponsoring or endorsing.

Pharmacists noted the following challenges for beneficiaries in understanding the program and enrolling in a card:

- Some beneficiaries were reluctant to sign up for a card because they were unsure if it was going to help them save money.
- The elderly generally are not computer literate and therefore could not utilize the price comparison website.
- The number of choices of drug discount cards was confusing.
- Some beneficiaries were uncertain if they qualified for the $600 T.A.

Most pharmacists thought that the most important factor for beneficiaries when they selected one of the drug discount cards was the purchase price of their drugs and how much money they would be saving by using their card.

4.2.6 Experience at the Point-of-Sale

The majority of pharmacists thought that the **Medicare-approved drug discount cards were processed relatively smoothly when customers were filling prescriptions.** Several mentioned that once the discount drug cards were set up correctly in their automated systems, there were no problems. A few mentioned that the software necessary to process the drug discount cards was already set up for existing health plans and discount programs, so they did not need to install new software in order to run the program. Two pharmacists were especially pleased with the timely reimbursement from CMS when they processed T.A. claims. Many pharmacists were pleased that their customers were satisfied with the discounts they received from the drug discount card.

Almost half of our respondents reported that they have never had to check the balance of the T.A. credit for a customer. Several pharmacists who had checked the balance of a beneficiary's $600 credit, thought the process went smoothly. One pharmacist thought that it was difficult for beneficiaries to know what their T.A. balance was before filling a prescription. And a couple had to spend time calling the card sponsor in order to get the customer's T.A. balance.

While most pharmacists were pleased with the automated processing of the drug discount cards, a few mentioned the following challenges:

- Setting up the drug discount cards in the system required additional time.
- Explaining to customers the specific discount that a drug discount card provided and what drugs were discounted was sometimes challenging.
- Pharmacists were supposed to be able to process multiple claims at the same time in order to save on additional transaction fees, but sometimes this did not work.
- If there was a price conflict the pharmacist had to spend time on the phone to figure it out.
- Only certain cards provided the T.A. balance.

A few pharmacists noted coordination of benefits challenges such as:

- Confusion about which card would give the best price when a customer had a Medicare-approved drug discount card and a manufacturer pharmacy discount card.
- Confusion about whether elderly beneficiaries on Medicaid are eligible for a Medicare-approved drug discount card.
- Confusion regarding billing when customers had a Medicare-approved drug discount card and were involved in an SPAP.
- Confusion for beneficiaries who were previously enrolled in a manufacturer pharmacy discount card that was phased out into a new Medicare-approved drug discount card.

4.2.7 Experience Working with CMS

Most independent and chain pharmacists reported that they had no direct communication with CMS. Some used CMS's price comparison website to find information, and a few received mailings. Several pharmacists were satisfied with the communications from CMS. One pharmacist was very

pleased with an informational session he attended, put on by CMS, where card sponsors answered questions for pharmacists about the program. A few respondents said that the information they received came from card sponsors rather than CMS. In addition, a few chain pharmacists only received information about the program from their corporate headquarters.

Pharmacists suggested that CMS could improve its communications plan and information materials for pharmacies by doing the following:

- Emailing pharmacists with updates and increasing online communication.
- Soliciting feedback from pharmacists during program implementation.
- Communicating more with pharmacists rather than leaving communication about the program up to card sponsors.
- Providing pharmacists with materials detailing the discounts that each sponsor provides, the program's goals, and expectations of pharmacists.
- Distributing mailings listing pharmacist's frequently asked questions.

4.2.8 Business Impacts

The majority of pharmacists did not see a change in the number of customers, or in product sales, as a result of the program; one did see an increase in new customers, which he attributed to the program. But as discussed above, half of the independent pharmacists interviewed and a few chain pharmacists saw a **decrease in their profit margin when customers used the Medicare-approved drug discount cards.** Several others thought the impacts were minimal thus far, because they had not had many customers using the drug discount cards at their pharmacies. One pharmacist noticed that a few customers were more likely to purchase generic drugs since using a Medicare-approved drug discount card.

Three pharmacists noticed that some customers who enrolled in a Medicare-approved drug discount card were **increasingly compliant** (refilling prescriptions on time) with certain medications, such as insulin, which also increased the number of prescriptions the pharmacy filled.

Most independent and chain pharmacists reported spending an increased amount of time helping beneficiaries to understand the program and enroll in a card.

The program did not affect most independent pharmacies' marketing or operational systems.[15] A couple of pharmacists thought their pharmacy's image was positively affected since customers were pleased that they were accepting the drug discount cards at their store.

4.2.9 Suggestions for CMS

Several pharmacists, mostly independent pharmacists, thought that the financial burden of the Part D drug benefit should not fall predominately on the pharmacies and that CMS should ensure that pharmacies receive a fair profit margin. A few pharmacists suggested that CMS should

[15] Chain pharmacists were not asked to speak about impacts on marketing or operational systems; rather chain pharmacy executives spoke about this issue.

acknowledge the time pharmacists spend with beneficiaries to explain new benefits and that there should be some incentive for pharmacists to be willing partners in the Part D drug benefit.

Pharmacists offered the following suggestions related to the Part D drug benefit:

- CMS should distribute clear and concise information materials for beneficiaries and pharmacists before program launch.
- CMS should work more closely with pharmacists during program launch to learn from their front-line experience with beneficiaries.
- CMS should not allow drug plans to persuade beneficiaries to use mail order.
- The federal government should take an active role in drug pricing.
- CMS should standardize the card format of the drug plans and allow pharmacists to swipe the cards through a magnetic reader.

5.0 Results: Interviews with Manufacturers

5.1 Description of Respondents

Types of Organizations

This chapter reports on sixteen interviews completed with pharmaceutical manufacturers, one of which (the only generic manufacturer who agreed to an interview) is not participating in the Medicare-approved discount drug card program. In the sections below, 'respondents' refers to the fifteen non-generic manufacturers interviewed who are participating in the drug discount card program, except where otherwise noted.

Roles of Respondents

The respondents were typically directors or vice-presidents, from either managed care contracting, national accounts, or government relations areas of their respective firms. In most instances, only one individual was interviewed.

5.2 Reasons for Participation

Manufacturers viewed the drug discount card program as an opportunity to help the needy get better access to prescription drugs. Nearly every respondent said that improving access for the needy was one of his major reasons for participating. It was occasionally unclear whether they meant access to their own company's drugs, or access in a more general sense. Five of these respondents additionally said it was "the right thing to do", from a societal perspective.

Manufacturers also wanted to show support for the Medicare Modernization Act (MMA) and private sector provision. Nine respondents spoke of political support for the MMA, a belief in competition, and a corporate preference for toward free-market solutions, as among their reasons for participating. In a few instances, the firms were visible enough in their lobbying efforts on behalf of such solutions that they felt it would be hypocritical not to participate.

Manufacturers wanted to learn about the process in advance of the Part D drug benefit. Six respondents said that the learning curve required to implement the Medicare-approved discount drug card program would help them in the implementation of the Part D prescription drug benefit when it begins in 2006. Others did not mention the drug benefit as a specific motivation for participating, but later in the interview said that the systems, processes, and relationships established for the current program would be invaluable in the transition to the Part D drug benefit.

The Medicare-approved drug discount card program is consistent with some manufacturers' pre-existing discount drug cards. Three respondents cited their existing commitment to providing discount drug cards to the needy, and ability to integrate these programs and relationships with the Medicare-approved discount drug card program, as motivating factors for participation.

5.3 Overall Experience

Overall Impressions

Manufacturers believe strongly in both the Medicare-approved discount drug card program and the Part D benefit to come in 2006. They are committed to free-market solutions, competition-based, and representing a collaboration between the public and private sectors. They do not believe that these programs will necessarily generate profits for them in the short run, although they are eager to ensure that their own drugs are offered and accessible. They believe it is the right thing to do, and many view it as an extension of their existing commitments to assisting the needy in gaining access to life-saving and health-improving medications.

Most were disappointed in the first year's enrollment. They attribute the low enrollment to excessive complexity in the sign-up process. There are too many cards, and evaluating them all is too difficult. Additionally, the price comparison website is not an effective vehicle for reaching indigent populations, and difficult to use for those who do access it. Finally, they believe that the failure of promotional and outreach efforts may be rectified by partnering with the manufacturers themselves, who have many decades of experience in reaching these populations.

Manufacturers expressed a need for more time to prepare for the Part D drug benefit, and urged CMS to develop the rules and formulary as quickly as possible and to release them well in advance of program implementation. They also encouraged CMS to develop a website, call center, and user conferences that are better prepared to answer the most likely questions. They hoped the the Part D drug benefit rules discourage sponsors from artificially inflating administrative/transaction fees as a means of passing through less than the entire rebate to consumers (see below).

Manufacturers believed that the lessons learned, the systems and processes developed, and the relationships formed over the course of the Medicare-approved discount drug card program, should pave the way for a successful roll-out of the Part D drug benefit, and they commended the CMS staff on their very diligent efforts and collegiality.

Successes and Perceptions of Program Strength

Successful Implementation: Six respondents expressed pleasant surprise that the Medicare-approved discount drug card program had been successfully implemented, given the tight timeline, proliferation of cards, and technical confusion over pricing and discount drug lists. That the program could be administered in a straightforward fashion after the early tribulations was reassuring to them, especially given what some saw as an unreasonably tight timeline.

Access to Prescription Drugs: A majority of respondents were pleased that needy patients were enjoying improved access to the drugs they need. The program is allowing the necessary medications to get to target populations that had formerly been under-served. Nearly all agreed that the program is getting drugs out to the neediest populations.

Relationships: More than half of the respondents said that the relationships with CMS, with the sponsors, or both had been collegial and collaborative.

Preparation for the Part D drug benefit: Seven respondents explicitly mentioned the learning process as being beneficial for the transition to the drug benefit, and several others mentioned this either earlier or later in the interview. Respondents felt that the drug discount card program was a valuable learning process for the Part D drug benefit, for manufacturers, sponsors, seniors, and for CMS. It also required a variety of systems upgrades and new contractual relationships that will probably remain in place for the Part D drug benefit.

Value*:* Half of the respondents said that the discounts provided by the program, were "okay", or "decent", or "good". Later, in closed-ended questions, nearly every respondent said the discounts were "good" for beneficiaries who did not receive the $600 allowance and "excellent" for those who did.

Ease of Contract Administration*:* Three respondents mentioned the ease of contract administration as being a success. Most others mentioned it later in the interview, with regard to sponsor relationships: after initial troubles with a large number of contract negotiations, the actual adjudication process became quite straightforward.

Industry-Government Collaboration*:* Three respondents believed that the program demonstrated that the public and private sectors can work together, and can do so successfully.

Private-Sector Orientation*:* Several respondents cited the program's private sector and competition-based philosophy as being a good sign from the government that it will let industry steer future programs.

Quick Fix: One respondent complemented the speed with which CMS fixed pricing errors on the website that affected their primary product.

None: One respondent at a major pharmaceutical company that was participating in the program said that nothing had gone well, and that the program was an unmitigated disaster which had given the industry a black eye and sent more seniors in search of Canadian drugs.

Challenges and Perceptions of Program Weakness

The following issues were mentioned by manufacturers as being challenges during the first year of the drug discount card program.

Sponsors' Initial Approaches to Rebates and Fees (discussed below).

Rapid Implementation*:* Most of the respondents cited the short timeline of program implementation as a challenge. The program was designed and implemented too quickly, sacrificing quality for speed. At the same time, some noted that the very fact that the program got up and running was impressive, given how little ramp-up time was allotted.

Poor Promotion, Outreach and Education on CMS' Part: Five respondents mentioned this specifically as a challenge and all of the respondents mentioned it at some point during the interview.

Several explicitly linked this concern with frustration that CMS did not permit manufacturers to participate in outreach and education, at which they are far more expert than CMS or the sponsors. And manufacturers were concerned that the poor public perception of the program encourages seniors to continue looking to Canada for prescriptions savings.

Consumer Confusion*:* Most respondents cited consumer confusion as a challenge. Enrollment and choosing a card were seen as especially confusing. Seniors don't deal well with complexity, in the opinion of manufacturers, and both the price comparison website and other means for choosing cards and enrolling were needlessly complex and discouraging to the target populations.

Price Comparison Website: The majority of respondents cited the website as a challenge. Some said it was confusing, some said it was too long, two manufacturers said the initial pricing information was wrong, and one said their dosage information was wrong. Several noted that it was **an inappropriate vehicle to reach the target audience**, since those elderly who were PC-savvy probably had supplemental drug coverage or insurance, while those the program was trying to reach either mistrusted or had no access to the Internet.[16]

Uncertainty about the Rules and Technical Components*:* Four respondents felt challenged by the evolution of programmatic details during the implementation and contracting process. Several others mentioned that they hoped all of the nuts and bolts for the Part D drug benefit are agreed upon and well-publicized long before the Part D drug benefit begins, to avoid the ongoing refinement of program rules.

Too Many Cards*:* Four respondents said that CMS allowed too many cards. The proliferation of cards was confusing to seniors and pharmacists, and also led to a massive amount of contracting between manufacturers and sponsors, since nearly every card required a separate RFP, contracting, and adjudication process. Other respondents did not cite this as a specific challenge, but implied it when they suggested CMS limit the number of private drug plans available in 2006. Manufacturers felt that seniors and pharmacists were confused, and contractual negotiations and early administration was burdensome for everyone, due to the multitude of cards.

Low Enrollment: Four manufacturers mentioned low enrollment specifically as a challenge, while nearly all commented upon it. Some noted, however, that the poor sign-up in the early months has gradually been alleviated by better results near the end of 2004. Many linked low enrollment to both poor promotion and consumer confusion.

Increased Workload: Five respondents said that the staff resources required to negotiate and administer the contracts was burdensome, and two noted that this is particularly onerous for smaller manufacturers. These five respondents linked the high workload to the excessive number of cards, and the lack of contractual standards for sponsors.

Mixed Messages to Manufacturers*:* Respondents reported that CMS treated manufacturers as both allies and enemies. The policy side of CMS and the operations side would often give conflicting instructions. Manufacturers were invited in as partners and then told they weren't allowed to market. Manufacturers were asked for advice, which was then ignored.

Uncertain Value: Outside of the T.A. population, the discounts were not sufficient to encourage much participation.

[16] As noted earlier, seniors' use of computers is growing and Medicare beneficiaries are not the only clients of the price comparison website.

5.4 Experience Working With Sponsors

Manufacturer Rebate Process

Most of the manufacturers offered only one rebate deal to card sponsors , and did not discriminate among the sponsors who sought to do business with them. Several mentioned being pressured by certain sponsors or sponsor-consortiums into increasing the rebate, but all but one manufacturer held firm and made a single offer that applied to all sponsors, across their entire product line. These respondents were primarily brand-name manufacturers, and only included branded products in their rebate offers. Not all sponsors contracted with the manufacturers, and not all replied to manufacturer solicitations.

A few very large manufacturers already had a majority of the sponsors as clients, and found the RFP, negotiation, and contracting process extremely easy and straightforward, while others were disappointed by some sponsors' rebate expectations and slow contracting processes among sponsors.

One manufacturer lamented that a large PBM "coerced" them into signing a contract before the CMS regulations were finalized, and it turned out to be a very poor deal for them. They negotiated all other contracts on a uniform basis once the rule was released in its final version.

Approximately two-thirds of manufacturers expressed dissatisfaction with certain sponsors' initial approaches to rebates and fees. Three manufacturers explicitly stated that they wished for their rebates to be passed through to beneficiaries at the point of sale but that some sponsors tried to arrange contracts that would pemit them to effectively retain rebates by manipulating their fees. (It is unclear whether these attempts were successful in any particular case, and it is clear that they were unsuccessful in several cases.) An additional five manufacturers stated that they wished for their rebates to be passed through in full and were dissatisfied with sponsors' initial response to this request. The remaining three expressed dissatisfaction with rebates or fees in some other way.

Manufacturers also communicated that while they were dissatisfied with certain sponsors, other sponsors were quite willing to pass the entire rebate to beneficiaries with little or no transaction/administrative fee.

Nearly all respondents said that the contract and rebate administration went smoothly once the various contracts were up and running. Three complained that some sponsors did a poor job of administering wrap-around programs. Some larger manufacturers, on the other hand, reported that the administration of wrap-around programs and the integration of benefits went seamlessly. One respondent said that while most PBM sponsors were reasonably knowledgeable, a few other sponsors were very unfamiliar with the process and confused by the demands of contract administration.

More than half of the 16 manufacturers interviewed wanted the rebates that were offered to drug card sponsors to be passed through to the customer in full. Several of these mentioned a perception that sponsors' high transactions or administrative fees had cut into the value of the net discount that reached the customer.

Several respondents refused to discuss their rebates. Some large sponsors and sponsor-consortiums pressured manufacturers to provide larger rebates, but only two respondents did so. Several respondents offered a two-tier rebate to sponsors – for example, 15 percent for those beneficiaries not eligible for the $600 allowance and 30 percent for those who were eligible – but most offered the same rebate levels across their entire product line.

Two respondents offered different rebates for chronic versus acute drugs.

One manufacturer claimed that the public reporting of prices on the Price comparison website caused them to refrain from offering their best price, and suspected that many other manufacturers responded in a similar fashion.

Successes in Working with Card Sponsors

Smooth Contract Administration: The overwhelming sentiment among manufacturers was that contract administration was smooth after the initial negotiations and set-up were complete. The adjudication and rebate process for the Medicare-approved discount drug cards was essentially the same as for any program they already had in place.

Positive, Collaborative Relationships: Over half of the respondents were pleased with how collegial and collaborative the sponsors were, particularly after the early disagreements over rebate levels. They found that the sponsors were willing, even eager, to make the program work.

Acceptance of Rebate Pass-Throughs: A handful of manufacturers were pleased that once the sponsors realized that the manufacturer was firm in its resolve to pass along the entire rebate to the consumer, they stopped imposing administrative fees and fulfilled the altruistic nature of the program.

Existing Client Relationship Strengthened: Two large manufacturers believed that the Medicare-approved discount drug card program actually enhanced and cemented existing client relationships with pharmacy benefit managers (PBMs), the most common type of sponsor.

Preparation for the Part D drug benefit: Two manufacturers believed that it was important that the sponsors also learn about the required processes in advance of the Part D drug benefit, and that their willingness to climb the learning curve hand-in-hand with the manufacturers suggests that contract negotiations and administration might be easier for the drug benefit.

Challenges in Working with Sponsors

The challenges cited by manufacturers varied widely, and none were cited by a large number or majority of respondents. The following challenges were mentioned by some respondents:

- An increase in staff workload at the outset, primarily due to the number of cards/contracts.
- Unreasonable sponsor expectations for rebates and haphazard contracting processes.
- Never being approached at all by some sponsors.
- Sponsors returning data on rebates and utilization too slowly, or not at all.
- Some sponsors' inability to administer wrap-around products.
- Poor marketing/outreach.
- Sponsor demands for early payment (rebates), creating a de facto escrow account.

One participating manufacturer claimed to have had no troubles at all.

5.5 Experience Working With CMS

Overall Impressions

In addition to many issues already mentioned above, manufacturers described the following impressions about working with CMS - a new experience for several of them.

Dedication and Commitment of CMS Staff: Most respondents went out of their way to compliment CMS staff. They cited the diligence, hard work, good temperament, and perseverance of CMS staff, under a very aggressive timeline. A few found it astonishing that CMS produced a workable program at all. Several asked specifically that the project team report back to CMS their pleasure and compliments on "doing the best with the bad hand they were dealt".

Implementation Too Quick: Six respondents said that CMS designed and implemented the program too quickly. Nearly every respondent mentioned the overly aggressive timeline at some point during the interview.

Poor Technical Support/Inability to Answer Questions: Five respondents cited their frustration with CMS's inability to answer their questions. Some mentioned the bidders' conference, others the website, others the call center (each of which were mentioned by many respondents at during the interview), but there was concern that the most common CMS answer to their questions was "we don't know".

Little or No Communication: Seven respondents were upset that CMS did not communicate with them directly at all, or only in an extremely limited fashion. A number felt that the larger manufacturers were the only ones with whom CMS had a serious direct dialogue.

Program Implementation Before Rules Confirmed: Two respondents were frustrated because the program was implemented before the final rules were in place. This is obviously a subset of the "implementation too quick" concern, but it was particularly upsetting to those manufacturers whose drugs were not properly represented at the outset.

Communications with CMS, and from CMS to Beneficiaries

The very largest manufacturers thought the communications with CMS were good. The smaller manufacturers typically replied "what communications?" Several respondents again mentioned the website, call center, and bidders' conference as frustrating due to the lack of answers to most questions.

Many respondents felt that the **manufacturers should be allowed to engage in more aggressive and direct marketing and outreach to consumers.** They also wanted more communication between CMS and manufacturers with regular newsletters and more frequent forums. A few suggested that the operations staff and policy staff at CMS should collaborate and integrate their approaches, since coordination seemed to be inadequate during the program's implementation. There was wide support for earlier publicizing of rules.

The 1-800-Medicare Helpline

All manufacturers but one criticized the helpline . It was not useful to them nor did they believe it was useful to seniors. The manufacturer who spoke well of the helpline had only one covered product and noted that their reliance on the helpline was thus minimal.

The Price Comparison Website

Nearly all respondents found the website too complex and long (too many screens). Several complained of inaccurate data on prices and dosages at the beginning of the program. A number of manufacturers felt that it had improved over the course of the program, and was now a reasonable tool.

Several respondents noted that a website is not an appropriate vehicle for reaching the indigent. They either have no Internet access or do not trust the Internet in terms of privacy and government intrusiveness.

5.6 Interaction of Drug Card Program and Manufacturer Pharmacy Assistance Programs

All but one respondent were operating one or more Pharmacy Assistance Programs (PAPs). Several larger manufacturers also participated in the Together Rx consortium. Several had free product programs, several had arrangements with state Medicaid programs, and most had some sort of co-pay program targeting patients between 135 percent and 200 percent of the federal poverty income level (FPL).

Few of the respondents attempted to integrate their free product or PAP programs with the Medicare-approved discount drug cards, although a couple of very large manufacturers did. The Together Rx program was not integrated or 'wrapped around' the drug discount card. One small manufacturer complained that the expectation of programmatic integration is excessively burdensome on smaller firms. Among the handful of larger manufacturers who did integrate their programs, two said it worked well, and one said it had been a big problem for sponsors to administer.

Every respondent but one said they intend to wait until the issuance of the the Part D drug benefit rule before making any further decisions about changing their assistance programs. The one manufacturer who did not intend to wait on the rule said that they would not integrate their PAP programs with the drug benefit.

5.7 Business Impacts

Those manufacturers who believed the early projections of six to eight million enrollees were disappointed with actual enrollment and with the financial results. Those who used their own internal projections, typically much more pessimistic, were neither surprised nor disappointed. **None made money on the program, and none expected to.**

Most felt the program had made no difference to their image, or their approach to marketing. A few were concerned that the public perception of the program as a failure would drive more seniors to seek re-imported Canadian drugs. Two firms felt their public recognition by the Department of Health and Human Services had a salutary impact on an already existing image of generosity.

Other impacts

A few respondents noted again that the staff resources required for systems upgrades and contract implementation were quite burdensome. A small manufacturer said that they feel even more isolated now in terms of government relations.

5.8 Suggestions for CMS

The major lessons that manufacturers thought were most important for CMS can be summarized as follows (most are discussed above):

- **Allow more time for implementation:** Publish the rules early, do not change them, and develop the discount drug lists or formulary guidelines before implementation.

- **Work with manufacturers:** Allow them to participate more fully in marketing and outreach, and treat them as partners rather than adversaries. Pay more attention to non-Top-10 manufacturers.

- **Improve outreach and promotion:** Use community groups, churches, state and local agencies, etc., to achieve better outreach to the indigent and to publicize the good discounts and transitional assistance available. Let the public know that the benefits are actually pretty good, and that the program is working – all the public heard was about the early troubles.

- **Simplify enrollment:** Recognize that the elderly do not want to go through screen after screen on a website or review 40 different brochures at their pharmacy counter. Standardize the discounts and rebates across cards, permit fewer cards, and make enrollment short and easy. Focus on the consumer, not the industry.

- **Target communications at beneficiaries:** Make promotional and educational materials consumer-friendly, and concentrate on simple communications with seniors rather than material oriented toward PBMs.

Some noteworthy suggestions/comments were made by just one manufacturer each:

- Make sure all regular senior prescriptions are in the formulary for the Part D drug benefit.

- Give pharmacists more time to prepare and provide them with better education/information.

- Don't force physicians to re-issue competing prescriptions based on price or formulary (i.e. physicians having to write a second prescription for an on-formulary drug that was not the first drug-of-choice for the patient).

- Develop a better strategy for beneficiaries residing in long-term care facilities.

- If CMS targets only low-income/high-utilizers, the program economics will fail.

- Do not require too much public reporting: Manufacturers will "dig deeper" for better rebates if their best prices are not divulged to the public and competitors.

- Determine approach to large employer retiree plans: Manufacturers suspect that large employers will shift the burden from their own pension plans onto Part D private drug plans.

- Expand focus beyond lipids and acids: There are many therapeutic classes pertinent to the elderly population that are not incorporated into the formulary. This discriminates

against niche manufacturers as well as those seniors suffering from less common conditions.

- Make standardized rules for MAP contracting.

- **Establish qualification rules for PDPs and eliminate those who are unable to understand and process the rebates and pricing.**

Most respondents felt that it is too late for CMS to provide them with much assistance for the remainder of the Medicare-approved discount drug card program, and that CMS should instead concentrate on the Part D drug benefit. Those who did comment were nearly unanimous in suggesting that CMS keep enrolling seniors right up until the start of the drug benefit, and to concentrate particularly on those who are not auto-enrolled from state programs.

6.0 Results: Organizations Serving Beneficiaries

6.1 Interviews with State Health Insurance Assistance Programs (SHIPs)

6.1.1 Description of Respondents

This section discusses the results of interviews with 22 of the 51 program directors of State Health Insurance Assistance Programs (SHIPs) from the 50 states and Washington D.C. SHIP directors represented all of the 10 CMS regions in the United States.

Types of Organizations

Either the state health insurance agency or the state department of aging administers the SHIPs. Respondents described their programs as being designed to provide information and assistance regarding health insurance and benefits to state Medicare beneficiaries and their partners, families, and caregivers. SHIPs provide this information and counseling through in-person and telephone consultation, as well as outreach services (e.g., presentations, health fairs, etc.). Most SHIPs provide counseling to beneficiaries through volunteer staff. Some of these volunteer staff were formally affiliated with local Area Agencies on Aging (AAA). Exhibit 3 shows characteristics of the SHIPs interviewed.

Exhibit 3: Characteristics of SHIPS Interviewed (N=22)

	Number	Percent
Organization affiliation		
State Aging or Elder Services	14	64%
State Insurance Dept.	8	36%
CMS Regions		
I	2	9%
II	2	9%
III	3	14%
IV	5	23%
V	2	9%
VI	2	9%
VII	1	5%
VIII	2	9%
IX	2	9%
X	1	5%

Roles of the Respondents

The primary role of SHIP directors is general oversight of the SHIP program in terms of its outreach, budgeting and finance, reporting requirements, and monitoring regional coordinators and their programs. Directors also oversee the training of volunteers and development of training materials. While some directors provide the training to the counselors, other directors subcontract with another entity to provide the training or have a paid staff member conduct the training. Most SHIP directors reported that they provide technical assistance to their staff and volunteers by keeping them up to date with information. Some directors do participate in direct counseling to beneficiaries, although for most directors this activity is a relatively small percentage of their workload. Some directors also conduct public speaking engagements (for outreach and educational purposes) to beneficiaries.

Organization's Role in the Drug Card Program and Partnering Arrangements

We asked SHIP directors what role their organization played in the Medicare-approved drug discount card program. Most see their role as educating beneficiaries about the program, helping them to examine their options, and assisting them in completing the application. Some SHIP directors specifically target their efforts to low-income beneficiaries eligible for the $600 credit. Some directors commented that their role also includes legal advocacy for beneficiaries regarding their benefits related to the Medicare-approved drug discount card.

We then asked SHIP directors whether their SHIP had any partnerships with organizations related to the Medicare-approved drug discount card and whether these partnerships were developed specifically for the Medicare-approved drug discount card or had previously existed. All of the respondents reported having partnered with at least three agencies or organizations and most of these relationships existed prior to the Medicare-approved drug discount card. Almost all of the respondents mentioned partnering with the Area Agencies on Aging. Other typical partners for most

SHIPs included the State Medicaid agency and other local and state government agencies, AARP, large civic groups like the Kiwanis, and other private associations that represent the interest of beneficiaries. Some SHIPs also partnered with provider or professional associations, pharmaceutical companies, chain pharmacies, and universities. Very few respondents had partnerships that were formed specifically for the drug discount card program; although many reported that existing partnerships were strengthened as organizations worked together on the new program.

Most SHIP directors described the role of the SHIP in these partnerships as providing training so that the partner organization could appropriately refer beneficiaries to the SHIPs. Other SHIP roles in these partnerships included sharing information on issues related to the Medicare-approved drug discount card, especially when there was integration of the Medicare-approved drug discount card with other assistance programs, such as manufacturers' assistance programs, Medicaid, or SPAPs.

Most SHIP directors described their partners' roles as providing venues to educate beneficiaries. For example, partners would help to sponsor and/or publicize an educational event for beneficiaries, or simply organize the logistics for an event. Other partners acted as a referral source by helping to identify potentially eligible beneficiaries for the Medicare-approved drug discount card program and T.A. In fact, a few SHIP directors explained that partners trusted by seniors were a valuable resource for gathering seniors for educational events and counseling, in areas where beneficiaries were hard to reach.

6.1.2 Overall Experience

Despite the challenges of limited time and changing information, most SHIP directors expressed confidence and success in their efforts to explain the program to beneficiaries, so that they can make informed choices.

Successes and Perceptions of Program Strength

Four SHIP directors reported that the implementation of the Medicare-approved drug discount card program provided an opportunity to educate various stakeholders in preparation for the Part D drug benefit. For example, one SHIP director explained how the program promoted an open dialogue with Medicare beneficiaries about drug pricing and safety, and the future of Medicare in general.

A few SHIP directors used creative outreach strategies to educate beneficiaries. For example, one SHIP director said that their counselors used a song to provide information to beneficiaries in a memorable way. At one community event, beneficiaries were given pre-programmed cellular telephones to sign up for cards by calling 1-800 Medicare. This event had fax machines available on site so that the Medicare office could fax information back to beneficiaries. A third example was a "Brown Bag event" where beneficiaries were told to bring all their medications in a paper bag so that on-site pharmacists could go through their medications to help them choose a card.

Some SHIP directors reported that their partnerships have been a great resource and have been strengthened as a result of the Medicare -approved drug discount card. SHIP directors explained that some of their partners gave them access to the hard-to-reach, low-income beneficiaries who were typically mistrusting of government programs. These partners were well respected and trusted by beneficiaries. One SHIP director reported that the partner agencies also came to better appreciate the value of SHIPs in assisting beneficiaries.

While most SHIP directors expressed initial frustration with the CMS price comparison web website, due to its early inaccuracies, most SHIP directors highlighted its improvement. Some mentioned that their counselors used the price comparison website for counseling beneficiaries about their choices;

counseling is speeded up by giving clients the cost compare template to fill out and submit to a counselor, prior to a counseling session.

Nearly all SHIP directors cited the savings on prescription drugs as the strength of the Medicare-approved drug discount card program. Almost half of the SHIP directors specifically cited the $600 credit as the program's strength.

Challenges and Perceptions of Program Weakness

The short time frame and the constant flow of new and changing information were described as major challenges for the SHIPs. Many SHIP directors described their experience with the Medicare-approved drug discount card as trying "to play catch up" with the changing information and meeting the community's demand for information within a short period of time. SHIP directors explained that the constant flow of new information and changing regulations related to the Medicare Modernization Act necessitated training and retraining of SHIP counselors in a short span of time. This often made it difficult for SHIPs to keep their volunteers abreast of important information. In fact, at times information was provided to beneficiaries before it reached SHIPs. Two SHIP directors described how this made it difficult for volunteers to earn the trust and confidence of beneficiaries, since at times the volunteers either provided inaccurate information (through no fault of their own), or could not answer questions because necessary information had not yet reached the SHIPs. In addition, three SHIPs directors pointed out that their organizations required time and resources to analyze the drug card program in light of local pharmacy assistance options (notably SPAP programs) and to adapt training materials and presentations accordingly.

A few SHIP directors raised the point that having **too many card choices** was also a weakness of the program, caused great confusion among beneficiaries, and did nothing to redeem the negative public image of the program. Two SHIP directors said the fact that **card sponsors could change prices at any time** was also a weakness of the program and may have contributed to some public disregard for the program. Changing prices and the number of card options were discouraging to beneficiaries and made it difficult to make choices about which card would best suit their needs over time.

Some SHIP directors suggested that while the discounts varied by card, in general the discounts were fairly minimal and inadequate for beneficiaries who were not eligible for the $600 credit. Two SHIP directors said that real savings seemed even more unattainable for beneficiaries with many prescription drugs.

Some SHIP directors cited the temporary nature of the drug card program as a program weakness. The program was described as a short-term, temporary solution to a complicated problem. SHIP directors suggested that by the time the program was learned and understood, it would be eliminated by the introduction of the Part D drug benefit.

6.1.3 Experience with Beneficiary Choice

Nearly all SHIP directors reported difficulty in helping beneficiaries understand the design and implementation of the Medicare-approved drug discount card and its potential benefits, and had to overcome negative publicity, low literacy, missing or inconsistent information, overwhelming volume of information, and a general mistrust of the government.

Many SHIP directors explained that **beneficiaries reported being inundated by marketing materials from various card sponsors** and were confused by information that was sometimes inconsistent. SHIPs counselors were especially challenged in working to simplify the volume of information received by elderly people with low literacy. Several SHIP directors explained that some

beneficiaries ignored mailings because of the sheer volume and often threw out pertinent information or even a card that they may have been enrolled in automatically.

Almost all SHIP directors said that there were too many card choices, which made the decision-making process overwhelming, and the counseling challenging. One SHIP director noted that the individual nature of the decision process placed more burden on SHIPs. The process was time consuming and at times required extensive research to identify the most appropriate card. With drug cards differing in their discount drug lists, prices and participating pharmacies, it was often difficult to help beneficiaries decide. Many SHIP directors expressed their commitment to being an objective resource for beneficiaries, even though many beneficiaries just wanted someone to make the decision for them.

Many SHIP directors explained that initially the CMS price comparison website and the 1-800-Medicare helpline added to the challenge for SHIP counselors. Despite their computer savvy, SHIP counselors often had difficulty accessing the website due to technical difficulties within the website and the complexity of the system. It was particularly frustrating when the website gave inaccurate information about drug card discounts at pharmacy locations.

Some SHIP directors explained that the beneficiary's perceived lack of value of the card also added to the challenge of assisting them in making choices about the card. A few SHIP directors noted that many of the hard-to-reach beneficiaries were skeptical about government programs. Other beneficiaries were discouraged about the uncertainty of the long-term benefit of the card in the face of changing prices and discount drug lists. Negative publicity from the media and word of mouth also made it difficult to overcome negative perceptions of the drug card and thus lack of interest. One SHIP director described how it was difficult to convince beneficiaries that they may realize savings with the card, when friends shared the experience of not realizing any savings using the card. A few SHIP directors explained that many elderly were simply used to the way things were and had little interest in change.

Despite the difficult decision process and the apparent challenges, a few SHIP directors reported that counseling had gone well and counselors had been able to simplify information to help beneficiaries make decisions. Some SHIP directors noted that once CMS made improvements to the price comparison website, it became a helpful tool in explaining beneficiary options. A few SHIP directors stressed the importance of in-person consultation rather than phone counseling. With in-person consultation, counselors could literally show beneficiaries the card to help explain how it works. Also beneficiaries would be asked to bring in all their prescription drugs so counselors could better assist them with identifying options for them. The counselor and beneficiary could then walk through the card price comparisons together, using the website.

A few SHIP directors described the counseling process as a good opportunity to educate beneficiaries about other prescription drug assistance programs that sometimes offered deeper and/or more comprehensive discounts. For example, a few respondents mentioned that their SPAPs offered deeper discounts than the cards, while others said that there were pharmaceutical companies' PAPs that offered some drugs at greatly reduced prices (or even for free). Two SHIP directors were successful in using the $600 credit as a "carrot" to market the value of the card and pique interest in learning more about the program.

Once beneficiaries understand the program, almost all SHIP directors reported that the **key choice parameter is the level of savings**. The second most important factor in choice was pharmacy location.

6.1.4 Experience with the Enrollment Process and Cards at Point-of-Sale

Only about half of the SHIP directors could comment on what they have heard from beneficiaries about their experience with the enrollment process and with using the card at point of sale. Of those SHIP directors that did comment, **most reported that beneficiaries were frustrated and discouraged by the long processing time for the card, and the delayed or lack of confirmation from card sponsors regarding the status of the application.** They described beneficiaries who said they never received their cards, and others who waited 4 to 6 weeks to receive a card, without communication from the card sponsors during that time. A few SHIP directors described how some beneficiaries forgot which card they enrolled in while they were waiting to receive it. Complicating matters further, beneficiaries were so inundated with marketing materials that some might have accidentally thrown out the card when it arrived in the mail. SHIP directors said that beneficiaries expressed frustration with trying to contact either the card sponsors or 1-800-Medicare to inquire about the status of their card application.

A few SHIP directors explained that often beneficiaries were enrolled in a card without knowing it. For example, one SHIP director described how beneficiaries went to informational meetings where they completed a generic application without realizing they had signed up for a card. Some filled out applications from other sources not realizing that they were getting a card.

Two SHIP directors expressed concern regarding the potential for conflict of interest when pharmacists assist beneficiaries in card selection. These SHIP directors explained that pharmacists would recommend cards to their clients based on their reimbursement rates, even when these cards did not necessarily fit with a client's needs. Since beneficiaries trust their pharmacists and were not knowledgeable about their options, they would enroll in the card that the pharmacist recommended, whether or not it was best suited to their individual situation.

A couple SHIP directors said that the enrollment/choice process seemed less challenging to younger and new beneficiaries perhaps because they were less apt to have health problems, and hence required fewer medications, and/or because they were much more comfortable with computers.

Two SHIP directors said that most beneficiaries with the $600 credit expressed great satisfaction with the savings realized from their card at the point of sale.

6.1.5 Experience Working with CMS

Nearly all of the SHIP directors reported a generally favorable experience in working with CMS on the Medicare -approved drug discount card program. Eleven SHIP directors reported that CMS provided relevant information to SHIPs in a timely manner. Most SHIP directors spoke highly of the materials and trainings provided. A few SHIP directors reported that they appreciated consistent contact with CMS through regularly scheduled conference calls. SHIP directors also recognized the pressures that CMS was under from the MMA, and that the legislation required quick changes and created an atmosphere where SHIPs and other partners were constantly playing "catch-up."

Most SHIP directors were satisfied with CMS's responsiveness to program inquiries. While most directors described CMS as being readily accessible and appropriately responsive to questions, other SHIP directors reported that CMS was unreliable and inconsistent with the accuracy and timing of information. These respondents described how the flow of information and technical assistance was particularly slow at the start of the program implementation. Seven SHIP directors expressed frustration with unanswered questions or a delay in response to inquiries, especially at the start of the program implementation. They explained that questions were often answered sporadically, if

answered at all, and that it was nearly impossible for counselors to answer beneficiaries' repeated questions because they were not getting answers from CMS. There was often so much information given in a short period of time, and so many changes, that it was daunting for SHIPs to keep up and keep their counselors trained and current. Some SHIP directors recognized that time constraints and legislative demands have limited CMS' ability to send out all important information and answer questions in a timely manner.

Some SHIP directors reported a lack of event coordination between the regional CMS office and the SHIPs and other local agencies. This lack of coordination presented a challenge to SHIPs, especially when a CMS event was particularly relevant to the SHIPs. For example, one SHIP director described having found out about a CMS event too late to attend and felt strongly that their attendance could have been beneficial to their partnership building. Another SHIP director suggested that coordination might be improved with more creative communication strategies beyond the deluge of daily emails from CMS. This SHIP director suggested that CMS utilize a centralized Internet bulletin board to post events daily so that SHIP directors and other local providers could access it as often as needed.

About a third of the SHIP directors suggested that CMS could be more proactive in their communications with the SHIPs. This would mean CMS providing information to the SHIPS sooner than was typically available to them during this program implementation. In particular, it would include informing SHIPS about policy changes as they are decided, rather than after they are implemented. As one SHIP director described, the speed with which information is transferred between CMS and the SHIPs is critical to the success of SHIPs in effectively assisting beneficiaries.

While **most SHIP directors praised the educational materials that CMS provided for trainings**, there were a few directors who thought the materials could be better matched to the target audience. For example, one SHIP director recommended that the PowerPoint presentations should be simplified and that the amount of information should be minimized. As mentioned above, much of the challenge was due to the low literacy among the low-income elderly and particularly those who were eligible for the $600 credit. (Even some counselors found the materials complicated.)

Three SHIP directors also commented that it would have been helpful to involve SHIPs in decisions about how to disseminate information at the local level. One SHIP director said that his CMS regional office got ideas from the SHIP outreach strategies. Another SHIP director suggested that CMS would benefit if the SHIPS were "kept in the loop".

6.1.6 Organizational Impact

Almost all of the SHIP Directors stated that the Medicare-approved drug discount card has had a major impact on their organization. Most SHIPs increased staffing and outreach to meet the demand for information about the Medicare-approved drug discount card. SHIP directors reported an increase in outreach activities as the SHIPs' visibility increased and subsequently in the number of phone inquiries from beneficiaries. A few SHIP directors described the increase in the volume of calls as being anywhere from 30 percent to almost double the call volume before the Medicare-approved drug discount card implementation.

Almost all SHIP directors also reported that the complexity of the decision-making process, particularly due to the number of card choices, has increased the length of time it takes to counsel beneficiaries about their options. **Most SHIP directors report an increase in counseling time from 10 minutes to up to an hour.** Use of the price comparison website, while necessary, also increased the counseling time. Some SHIPS expressed frustration with changing policies and feel that this has

overburdened their volunteers. To meet these increased needs, a few SHIP directors reported increased training efforts and recruitment and training of new volunteers.

6.1.7 Suggestions for CMS

SHIP directors offered the following suggestions for CMS:

- **Facilitate beneficiary choice, potentially by limiting the number of card choices or by standardizing some aspects of the benefit.** Nearly all SHIP directors believed that there are too many card choices and some SHIP directors specifically stated that the number of card choices should be limited (e.g. to ten). Others suggested that premiums should be standardized so that beneficiaries feel more confident in making decisions. A few SHIP directors expressed concern about the flexible discount drug lists and changing prices, and consumer notification of these changes, suggesting that the needs of consumers should be a higher priority than that of manufacturers.

- **Lengthen the enrollment period for the Part D drug benefit.** CMS can't expect beneficiaries to understand the program and choose a plan within 6 months. SHIPs are just now hitting their stride with Medicare-approved drug discount card enrollment after six months. The Part D drug benefit requires rapid enrollment, to avoid penalties, and this is unrealistic. SHIPS directors fear that those who are in greatest need are more likely to be penalized through late enrollment in the Part D drug benefit because information will be delayed in reaching them, as was true of the Transitional Assistance program.[17]

- **Invest in clear and timely communications.** Half of the SHIP directors stressed that point. CMS should strive to anticipate questions and prepare answers that are clear and concise. CMS should also focus on distributing information and training materials to SHIPs as soon as possible and much earlier than they were distributed for the Medicare-approved drug discount card. SHIPs need more time to train volunteer counselors to be competent on the complexities of the program. A few SHIP directors also stressed the importance of providing this information to SHIPs prior to releasing it to the public so that SHIPs are seen as a credible source for accurate and up-to-date information and can avoid the pressure of having to play catch up with the information.

- **Simplify informational materials.** Most SHIP directors described the Medicare-approved discount card program as very complicated and confusing for beneficiaries. Many suggested that the information from CMS regarding the program should be condensed and simplified. One suggested using focus groups to test all informational materials, including letters to beneficiaries and other communications, prior to mass distribution. Another recommendation was for CMS to seek input from the SHIPs in preparing the educational and training materials. One SHIP director explained that beneficiaries are looking for the bottom line – what the program will do for them – and they need help with the decisions they will need to make. The information about the Part D drug benefit has to be packaged to meet that demand for knowing the bottom line.

- **Although the price comparison website is very useful to those who are comfortable with computers, CMS should bear in mind that some beneficiaries may not have direct access to this tool.** Many SHIP directors stated the drug card program's reliance

[17] The Final Rule, released in January, allows for extended special enrollment periods for beneficiaries dually eligible for both Medicare and Medicaid.

on the Internet for disseminating information and assisting beneficiaries in making decisions was unrealistic and inappropriate for the target population. In their view, lack of computer access may be greatest among hard-to-reach and low-income populations who are key clients of the new Medicare drug benefit. At the same time, the website was an effective tool for SHIPs counselors and for some more computer-literate beneficiaries. In the view of SHIPs directors, one of the many opportunities for their organizations was to reach out to those individuals most in need of assistance and least able to access that assistance alone.

- **Provide timely technical assistance to the SHIPs.** For the Part D drug benefit to succeed, CMS should provide technical support regarding the implications and complexities of the drug benefit, and address the wrap-around issues and other complex issues regarding state and federal payments. The relevant information should be made available as soon as possible; timing is critical.

- **Market and promote the SHIPs as a reliable source of information and assistance.**

The first two of these suggestions, while useful, may actually pertain to issues that are outside of CMS' control.

6.2 Interviews with Information Intermediaries

6.2.1 Description of Respondents

Respondents from eight community-based organizations were interviewed; these organizations provide Medicare information directly to beneficiaries. The organizations whose representatives were interviewed are located in eight states in various parts of the country, including the West Coast, Midwest, Mid-Atlantic, and Northeast. Two organizations serve distinctly rural populations, one is urban, and the others serve a mix of suburban/urban/rural areas.

Types of Organizations

Three organizations were described as local Area Agencies on Aging; four were non-profit advocacy and service groups and all but one of these four focus specifically on seniors; the eighth is a statewide association of health facilities. Almost all of these organizations have significant contact routinely with seniors through outreach and education, face-to-face and telephone health benefits counseling, and information and assistance lines. Several respondents reported that their agencies are connected to their state's SHIP system and provide volunteer SHIP counselors to local seniors; two also provide statewide information and assistance telephone services for the state SHIP program. Some organizations were described as offering specific prescription assistance programs, helping seniors and others to identify and access prescription assistance, while two others identified prescription assistance as part of their focus. Most respondents also noted that their organization are involved in the Access to Benefits Coalition (ABC) in some way, either as leader of a local coalition or as participant in a local ABC group.[18]

[18] Four organizations' membership in the Access to Benefits Coalition project was known prior to our interviews, as described in the Methods section.

Roles of Respondents

Most respondents described themselves as directors and coordinators of various health care programs offered by their agencies and the others as executive directors of the agencies themselves. Those who are not executive directors manage one or more functions of the agency having to do with health care, such as outreach, education and training, information and referral hotlines, health benefits counseling, and prescription assistance programs.

6.2.2 Overall Experience

All respondents stated that their agencies provide counseling and education as well as specific assistance with decision-making and enrollment related to the Medicare discount card program to beneficiaries. All respondents said that their agencies have provided outreach services related to the Medicare drug discount card program for varying periods of time, primarily by providing presentations and counseling to local beneficiaries in their service areas.

Overall Impressions

The extent of outreach activities described by most respondents is significant in terms of agency resources expended on the program. For example, one respondent noted that his agency has had about 10,000 contacts with beneficiaries about the program; another that he personally had conducted about 120 presentations since the beginning of 2004; another that five people in the agency had been involved in presentations during the period when the card program was introduced. Other agencies began outreach activities later in the year, after the ABC effort had begun. A few respondents were less involved in outreach activities, because of a focus on coalition building or because of their professional role, e.g., management of call centers and volunteer counselors.

Given the large Medicare populations in these different geographic locations, the outreach efforts described in this report clearly would not reach a large proportion of local beneficiaries. It should also be recognized that these respondents spoke from the experiences they had with those beneficiaries with whom they were in contact, but this small portion of beneficiaries these organizations reach are not necessarily representative of the population as a whole or of specific segments.

Overall, information intermediaries reported encountering more challenges than successes regarding the Medicare discount card program. All respondents reported that one of the major challenges relates to the card program itself; they describe the program as complicated, confusing, and hard to understand for the Medicare beneficiaries they assist. These information intermediaries were challenged in terms of being able to communicate the program and its use to beneficiaries in a way that beneficiaries can understand, and in a way that motivates beneficiaries to become engaged.

The challenge was increased because many of the beneficiaries who might benefit most from the card program are among those who were often described as "hard to reach;" people who do not seek out or follow up on information about programs or services. Further, some respondents mentioned that some beneficiaries are hesitant to enroll in cards and are either taking a "wait and see" attitude or see the cards as risky (even with very low or free enrollment fees). Finally, some respondents noted that the efforts made by CMS to inform beneficiaries about the program have not raised awareness, hence information intermediaries need to raise basic awareness, educate about choices and provide assistance for enrollment.

The intensity of beneficiary interest in the drug card varied from agency to agency. One agency reported that fewer than 20 of the 1000 calls received per month (less than 2 percent) pertained to the

drug card. Another stated that it received 17 calls per day about the drug card program; this represented 70 percent of the calls about health benefits. At a third agency, one member of the call center staff devoted all of his time to assisting beneficiaries with drug card information and decision.

Successes and Perceptions of Program Strength

Almost all respondents thought that a strength of the program was that beneficiaries be nefited from a reduction in out-of-pocket expenses from the drug discount card. In addition, most respondents thought that the $600 T.A. credit was the primary benefit of the drug discount card program. One respondent noted that some beneficiaries saved from $40 to $300 per month by using the cards. The addition of the "wraparound" programs, organized by the pharmaceutical companies to combine their pharmaceutical assistance services with the Medicare-approved drug discount card program, have increased the card program's value to beneficiaries, according to two respondents.

A few respondents commented that increased collaboration among community agencies serving Medicare beneficiaries is a success attributable to this experience. One respondent praised the ABC program as a "huge help" in bringing organizations together and providing support tools such as the RX Check Up program. Two others noted that the outreach and education efforts among agencies strengthened relationships, which will be useful in future coordinated initiatives.

Individuals recounted various other positive experiences. One saw the auto-enrollment of the Medicare Savings Plan (MSP) members as positive, even though there were problems with coordination along the way. Another noted that in his state the coordination between the discount card program and the state's pharmacy assistance program went well. Two reported that the card program's existence had raised awareness among beneficiaries of the prescription drug issue and encouraged beneficiaries to think about the cost of prescription drugs.

Two respondents commented that the federal government's recognition of the problem of affordability of prescriptions for beneficiaries as the motivation for the card programis strength in itself. Various respondents also noted that the involvement of the private sector and the availability of choices among cards are strengths.

Challenges and Perceptions of Program Weakness

The Medicare-approved drug discount card program is complicated and therefore difficult for information intermediaries to explain and for beneficiaries to understand. It is especially hard for beneficiaries to understand how a discount card would work for them. This perception of the program being "complicated" includes not only basic features but also the decision-making process needed to select a card. One respondent reported that it takes 20 minutes to explain the program to an individual so that the individual really understands it. This group also measured the time it takes to assist a beneficiary through the shopping/selection process. Many respondents specifically mentioned the number of choices as an aspect that makes the program complicated. They described beneficiaries as overwhelmed with the number of choices, usually 40 or more, and one added that contemplating choice became even more complicated when factoring in which pharmacies will accept each card. Another respondent described beneficiaries' reactions to his explanations of the intricacies of all 41 choices in his area as resulting in frustration and a desire to avoid getting involved. Two other respondents noted that lack of understanding of the program leads beneficiaries to react with fear because they don't understand how this program fits in with other assistance programs. Both mentioned instances in which beneficiaries became fearful of the loss of state pharmacy assistance benefits if they made use of a discount card.

The value of the drug cards for many beneficiaries, even for some of those eligible for the $600 T.A., was frequently perceived as low compared to alternate options. Some respondents cited perceptions that the Medicare-approved drug discount cards offered discounts levels that were similar to what was already available through other retail sources in their areas. One respondents had done a pricing study at his agency that found the prices of some commonly used drugs similar whether purchased using a discount card or from a local warehouse-type retail store. Many respondents commented that the state, other federal, or other publicly-sponsored pharmacy assistance programs offered better benefits and prices and also had higher income thresholds for eligibility. They explained that when beneficiaries believed they had lower our-of-pocket costs through other options, they found it hard to see any benefit of enrolling in the card.

Two respondents suggested that the costs associated with delivering the program might be higher than the actual benefits delivered. Many also noted that the administrative aspects of the program, such as the MSP auto-enrollment process and the decision-making process in general, are confusing, and one suggested that the program is perhaps overly complicated given the benefit.

The "lock-in" provision of the card program also affected how beneficiaries compared the value of the Medicare-approved cards to other options, according to respondents. Many respondents commented that beneficiaries saw the fact that discount drug lists and prices can change regularly while beneficiaries are "locked in" to their choice for a year, as a negative feature to the card program and a reason for hesitance about enrollment. Two individuals noted that in some instances when the Medicare-approved card seemed to them to be a reasonable option, some beneficiaries were not interested because they wanted an alternative that was less confusing or less complicated, or more portable and "stable."

Some respondents believed that beneficiaries haven't received adequate information about the program from CMS. They reported that CMS information channels were not effective with the beneficiary population these organizations serve. Five respondents commented that many beneficiaries do not have access to the web and that the use of the website as a primary source of information does not meet the target population's needs. Three also noted that the 1-800-Medicare line was problematic because of long waiting times and/or provision of inadequate information. Three also commented that the printed materials sent to beneficiaries were not helpful in explaining how to actually use the card program to their advantage.

Many respondents reported various issues related to the education of beneficiaries as weaknesses of the program. CMS information channels (the internet, 1-800-Medicare, and printed materials) were not adequate to prepare beneficiaries for the program. CMS should have been aware of some beneficiaries' reliance on others (community agencies, caregivers) for assistance and should have anticipated the need for outreach and face-to-face counseling; community organizations were not informed of program events and policies and thus were unable to help reduce confusion.

Three respondents felt that CMS should have tried to avoid the "evolving" nature of the implementation of the card program, which led to problems and confusion for everyone.

One respondent suggested that CMS should have extended the time to enroll in T.A. through 2005.

6.2.3 Experience with Beneficiary Choice

As discussed in the previous section, all of the of information intermediaries we interviewed reported that beneficiaries find the card program, either some aspect of it or all of it, to be complicated and hard to understand. **Most respondents described the decision-making process as difficult, tedious, and cumbersome.** A few respondents stated that, in their judgment, beneficiaries couldn't

sift through the options and go through the choice process without personal assistance. One respondent commented that his organization was concerned about liability issues because its counseling, by necessity, had become so directed.

Related to this, several respondents mentioned their efforts to measure the time it takes to assist beneficiaries with making a choice. One reported that his organization had measured the time it takes for a counselor to assist a beneficiary to "shop" for the card, using the websites and so forth, and found it to be 45 minutes. Other organizations found that counseling beneficiaries around choice took from one to two hours per client. Another noted that while his organization finds face-to-face counseling the most effective, they do some counseling over the telephone, and completing the decision process might take several calls over as long as a two-month period.

Respondents pointed to many aspects of the choice process that they see as cumbersome and difficult. Beneficiaries require access to the web in order to use the price comparison website and they need a detailed inventory of his/her current medications and dosages. The result of the web program yields a number of options, which then must be individually researched and compared. The website's pricing results are bundled and it is cumbersome to calculate the individual price advantages for different drugs among different cards. One respondent noted that beneficiaries need so much information to pursue an application that the people who take this initiative must be relatively high functioning to begin with, suggesting that less capable individuals are be less likely to take on the task in the first place (even though they may be the most in need of prescription drug assistance).

Three respondents mentioned that their agencies had found it necessary to develop new tools to assist beneficiaries in their decision-making process. One put together a "golden book" of instructions so seniors could understand the web screens they would encounter while using the price comparison website. This organization distributed these booklets to local places like senior centers and libraries, where beneficiaries might make use of computer equipment on their own to identify the right card for them. Another organization designed forms and lists to prevent beneficiaries from being overwhelmed, but many still found it to be so confusing and exhausting that they didn't complete the process.

6.2.4 Experience with the Enrollment Process and Point of Sale

In general, respondents did not believe enrollment to be problematic. However, one respondent reported that the language of the enrollment form is confusing, ("Yes, I am not….) and three reported that the application for Transitional Assistance caused some problems, because of ambiguity about income calculations and how T.A. might affect other benefits such as food stamps or subsidized housing. Three respondents also reported that some beneficiaries who enrolled either never received cards, or receipt was delayed, and this caused major problems for those to whom it happened.

MSP auto-enrollment was identified by three respondents as a particular concern, as was correcting enrollment errors/problems. One noted that many beneficiaries called because they were confused by the mail they received; because the agency was not informed about the MSP program its staff were not in a position to immediately help the callers. The lack of coordination with SPAPs was cited as a problem when beneficiaries who were also SPAP enrollees were auto-enrolled into drug discount cards. Another example was those individuals who had enrolled into cards before the MSP auto-enrollment and were then denied in the auto-enrollment step; in these cases denials had to be 'undone' which was complicated and time consuming. Another respondent commented that in his state beneficiaries who were living in nursing homes had been auto-enrolled into cards that did not serve that population; again, correcting the problem was difficult. And another pointed out that card sponsors have tried to verify income during phone calls with beneficiaries – but his agency and others

have long cautioned the elderly not to provide such information over the phone because of concerns about fraud. Two respondents commented that the MSP enrollment was a good idea, even though the process was somewhat rocky.

6.2.5 Experience Working with CMS

Not all respondents in this group work with CMS regularly. Many respondents reported working relationships with CMS Regional Office staff and of these, three commented on the excellence of their working relationships, while one noted that his RO staff contact person left just as the card program began, and another noted that the working relationship was very distant. Two respondents who did have contact with CMS Central Office observed that during the initial launch period CMS staff had seemed to want to work alone on the card program, rather than involve community organizations. One also noted that the ABC program, which was viewed by respondents as an important activity, got started in September, months after the program launch. One respondent who has little contact with CMS noted he received ample materials about the drug card program from CMS.

The few respondents who had used the call center to get information had mixed reviews. One found it inconsistent and unclear, with service representatives confined to reading from scripts while two others reported it was useful.

CMS' Communications with Information Intermediaries

Only three respondents commented on printed materials that were offered to information intermediaries. Two reported receiving materials and one of these was disappointed with the materials he received; he thought that the materials had a "public relations" tone.

CMS' Communications with Beneficiaries

Just two respondents commented directly about the printed materials CMS directed toward beneficiaries and both stated that the information materials need significant improvement regarding how beneficiaries should approach "shopping" for an appropriate card. One respondent had analyzed the outreach materials and had comments regarding areas for improvement, many of which were related to the need for beneficiaries to receive information that is as comprehensive and tailored to their specific situation as possible, with lists of sponsors and what steps to take to select a card. A third respondent suggested that CMS create a simple brochure that can be understood by people with limited education.

The 1-800-Medicare Helpline

Five respondents commented on 1-800-Medicare. All but one referenced extensive delays and waiting times at least during the start-up period, and provision of inaccurate information by service representatives. The remaining respondent reported good personal experiences, despite what she had heard from beneficiaries.

The Price Comparison Website

As noted in those previous sections, most respondents believe the web to be a poor communication tool for at least the seniors their organizations work with. Specific concerns about use of the price comparison website were that it is a complicated, multi-step process that requires seniors to have a good understanding of the specifics of their medications. Some commented that the end result of 4 –8 card options was also unwieldy, since each of these then had to be additionally researched. One

respondent noted that to use the price comparison website, seniors need have access to good computer equipment, ideally including a printer, which could be a barrier for those who are trying to use the website in a library or senior center environment.

6.2.6 Organizational Impacts

All but one of the respondents reported that the program had had a significant impact on their organization in terms of demands for additional time and resources; some had been forced to use non-Medicare resources in order to respond to the program. Various respondents reported details on the extensive time spent on the program: one estimated 120/hours a week; another noted that 50percent of his time and a full-time call center staff person, plus a portion of time for almost 40 SHIP volunteers, was devoted to the card program; another that, just on his time alone, it took 8-10 hours/week to handle the administrative tasks associated with the outreach activity, and 5-6 hours/week for beneficiary contact. One of these respondents commented that for his agency, located in an urban area, the cost for assisting seniors with all of the MMA transitional issues would be $400,000 through 2006.

A few respondents have tracked the amount of time needed to fully assist beneficiaries with the program. One estimated that it takes 20 minutes to get a beneficiary to understand the program and then another 45 minutes to work with him/her on the decision process. Another estimated that it takes two hours in his agency to work through the decision process for choosing a card.

6.2.7 Suggestions for CMS

The lessons for the Part D drug benefit expressed by these eight respondents group naturally into three topic areas:

Many respondents stressed the importance of beginning outreach and information about the Part D drug benefit as soon as possible. These respondents have a sense of urgency about the outreach efforts needed to prepare beneficiaries for the decisions they will face under the Part D drug benefit. Three also singled out the dual eligible and low-income populations as needing information sooner than other populations because of the nature of the decisions that these groups will have to make and the efforts that will be needed to educate them regarding their choices and the implications of their decisions. Two respondents noted that should the timeframe for education and outreach be compressed, the result will be large numbers of beneficiaries turning to their agencies for help all at the same time, resulting in long waiting lines for assistance and hampering beneficiaries' abilities to meet the enrollment deadlines. Three respondents also noted that **since the likely timeframe for the the drug benefit launch and education program will be "compressed," as it was for the discount card program, the penalty for late beneficiary enrollment should be delayed or eliminated.**

Most respondents recommended that CMS improve its outreach strategies and mechanisms to prepare beneficiaries for the Part D drug benefit. Respondents suggested that information and messages needed to be clearer, more concise, and tailored to specific needs and literacy/comprehension levels, so that all beneficiaries can understand how to decide if participation in the drug benefit is worthwhile for them, how to make choices, and the consequences of non-participation. One respondent specifically pointed to the 1-800-Medicare line and website as needing improvement. Three respondents commented on CMS's involvement with community-based agencies: CMS needs to decide whether it wants to work with local groups that are ready to participate, and needs to equip them and get information to them before it is distributed to beneficiaries.

Many respondents suggested that the Part D benefit design, as far as it is known in the field, has features that are unattractive to beneficiaries. Two respondents suggested that CMS get input from beneficiaries and information intermediaries regarding product design. Others commented that there is a perception among some beneficiaries that the benefit doesn't outweigh the costs, and many beneficiaries are wary of monthly premiums, the "donut" hole, high deductibles, high co-pays, and uncertainty about prices. One respondent noted that the financial disclosure requirement for some low-income beneficiaries is a disincentive to participate. In his program, when income questions are asked, 60 percent of seniors will not reveal the information.

6.3 Analysis of Secondary Sources Concerning State Pharmacy Assistance Programs (SPAPs)

This section describes the results of an analysis of secondary information regarding the impact of the Medicare-approved drug discount card program on state pharmacy assistance programs (SPAPs).

6.3.1 Current SPAPs

State Pharmacy Assistance Programs (SPAPs) are state-sponsored programs designed to lower the cost of prescription drugs for seniors and persons with disabilities. These programs are funded mainly with state dollars, although some receive additional funding from other sources.[19] As of December 2004, 32 states had pharmacy assistance programs in operation and five had enacted laws to create SPAPs that are not yet in operation. Two additional states had enacted laws for SPAP programs but have halted implementation indefinitely.[20]

State Pharmacy Assistance Programs take two forms: a direct pharmacy benefit and a pharmacy discount program. In direct benefit programs, the state pays most of the costs of prescriptions while enrollees are responsible for co-payments, and sometimes other forms of cost sharing (e.g. premiums and deductibles). Discount programs provide participants with lower drug prices by using a discount card or through a purchasing pool. As of December 2004, most operating SPAPs (18) provided direct benefits, nine provided discounts, and five provided both direct benefits and discounts.[21]

Eligibility requirements for SPAPs vary widely by state. Income requirements range from 100 percent of the federal poverty level (FPL) to 500 percent of FPL[22]. In 2004, all state pharmacy assistance programs covered individuals aged 65 and older while half covered individuals with disabilities under age 65.[23]

6.3.2 SPAPs and Medicare-Approved Drug Discount Card Program

Medicare beneficiaries enrolled in SPAPs – except Medicaid waiver programs – may also enroll in the Medicare-approved drug discount card program. Because SPAPs often have income limits that

[19] In addition to its state-funded programs, Delaware has an SPAP funded by the Nemours Foundation. Four states (FL, IL, SC, WY) operate SPAPs under Medicaid waivers and receive federal funds to help pay for these programs.

[20] National Conference of State Legislatures, December 2004, p.1.

[21] Analysis of data from National Conference of State Legislatures, December 2004, pp. 3—20.

[22] State Pharmaceutical Transition Assistance Commission, p. 13.

[23] National Health Policy Forum, p. 1.

are higher than those allowed by Medicare, some SPAP enrollees are ineligible for the Medicare T.A. program.

Value of the Drug and Transitional Assistance Program for SPAP Enrollees: The value of the Medicare-approved drug discount card and transitional assistance program varies widely among SPAP enrollees. According to Fox and Crystal, the benefits offered by many SPAP programs are better than the discounts that beneficiaries not eligible for the $600 credit would receive using the drug card. In these circumstances, many SPAPs are advising their program members not to participate in the Medicare program.[24] Jack Hoadley also found this to be true.[25] These findings are consistent with comments received from SHIP directors during the interview portion of this study.

State Approaches to Enrollment: States have taken various approaches to enrolling SPAP members in the Medicare approved discount card and transitional assistance program. Two states have mandated enrollment in the Medicare-approved discount card program as a condition of eligibility in the state-sponsored assistance program. Ten states have automatically enrolled or facilitated SPAP members' enrollment in a preferred Medicare-approved drug discount card.[26] By one prediction, perhaps 90 percent of T.A.-eligible SPAP enrollees could eventually be auto-enrolled into Medicare-approved drug discount cards.

Benefit coordination between SPAP and T.A. programs takes different forms in the states that employ it. The following are some examples of how states have coordinated benefits[27]:

- Seven states wrapped the 5 - 10 percent Medicare co-pay up to the level of the SPAP co-pay.
- Two states (Michigan and Pennsylvania) pay all the coinsurance for the Medicare-approved drug discount card. Pennsylvania also waived renewal applications for its SPAP program for those beneficiaries enrolled in the Medicare-approved discount program.
- New York has waived its annual SPAP fee.
- Missouri applies the $600 credit towards the SPAP deductible.
- Indiana increased the benefit cap for their SPAP program and decreased the coinsurance requirement for its SPAP enrollees.

Coordination of Benefits: The states have considerable incentives to coordinate SPAP benefits with the Medicare-approved drug discount card and transitional assistance program. By providing a $600 credit under the T.A. part of the program, Medicare assumes responsibility for some drug costs that would otherwise be borne by the state or by SPAP enrollees.

According to Fox, SPAPs have faced a number of administrative challenges in coordinating benefits with the Medicare-approved drug discount card and transitional assistance program.[28] Most of these

[24] Fox and Crystal. Forthcoming publication.

[25] Hoadley, Jack. State Lessons on the Drug Card. Presentation before the Medicare Payment Advisory Commission, September 10, 2004. www.medpac.gov

[26] Fox, August 17, 2004.

[27] Fox and Crystal. Forthcoming publication.

challenges relate to new tracking and auditing functions necessary to ensure smooth and proper payment of bills. Administrative challenges deterred six states from coordinating with the Medicare-approved drug discount card.[29]

Education and Outreach to Enrollees: The Medicare-approved drug discount card and transitional assistance program has created education and outreach challenges for SPAP programs. Fox found that SPAPs have not had adequate informational materials to use in education and outreach to Medicare beneficiaries and to pharmacists. Medicare's standard discount and T.A. information does not clearly describe the SPAP programs, which makes it challenging to explain the interaction of the two programs. Some SHIP directors made similar comments during our interviews with them.

6.3.3 Implications for the Part D drug benefit

States are considering their role in providing pharmacy assistance to low-income persons once the Medicare Part D drug benefit is implemented in 2006. In May/June 2004, most SPAPs planned to continue pharmacy assistance to Medicare beneficiaries in 2006. Two states had decided to eliminate their SPAP program with the introduction of the Part D drug benefit.[30]

Those that continue to provide pharmacy assistance will need to decide how their program will be designed, how it will operate, and how it will coordinate with. Many of these issues are similar as those faced with the Medicare-approved drug discount card program. States will need to make decisions on the following issues with regard to their SPAP programs[31]:

- Mandatory versus voluntary enrollment of SPAP members into the Part D drug benefit.
- Auto-enrollment of SPAP beneficiaries into the Part D drug benefit.
- Passing legislation to give state authority to conduct auto-enrollment.
- Working with multiple plans or one preferred plan.
- Designing the payment and benefit structures for SPAP programs.
- Coordination issues between SPAPs and the drug benefit could include:
  - Paying for all or some of the drug benefit premiums.
  - Paying coinsurance up to current state cost-sharing.
  - Providing coverage during the "donut-hole".
  - Wrapping around formularies and pharmacy networks.
  - Permitting enrollees to use out-of-network pharmacies.

[28] Fox, October 7, 2004.

[29] Ibid.

[30] Fox, July 7, 2004.

[31] Fox, August 17, 2004.

7.0 Results: Expert Observers

7.1 Interviews with Professional Associations

This section is based on analysis of interviews with representatives from 10 professional associations.

7.1.1 Description of Respondents

Types of Organizations

Respondents represented ten professional organizations whose constituents include physicians, pharmacists, pharmacologists, pharmacy technicians, pharmacy students, nursing homes, home health agencies, biotechnology firms, pharmaceutical manufacturers, health insurance plans, owners and operators of chain pharmacies, and pharmacy benefit managers. Names of the organizations that participated in this study may be found in the Appendix E.

Roles of Respondents

Most respondents oversaw federal policy development and participated in lobbying the Congress and CMS on behalf of their membership. Nearly half (4) of respondents provide education and information to their association's membership on federal policy issues also. Two respondents are responsible for strategic planning for their organization and one of these is also in charge of his association's research activities.

7.1.2 Reasons for Participation

The majority of respondents described a variety of factors influencing their members' decisions about participating in the Medicare-approved drug discount card and transitional assistance program. **Three respondents reported that their members chose to participate because they wanted to be perceived favorably by the Administration and the public.** Members of two associations chose to participate because they wanted to gain experience with Medicare before the implementation of the Part D drug benefit. Two other respondents reported their members joined the program through passive contracting arrangements, that is, some of their other business relationships depended on participation the Medicare-approved drug discount card program.

Reasons for not participating varied. **Three respondents reported that high start-up costs were a reason that some of their association's members chose not to participate.** Two mentioned that the duration of the program was too short to justify the inherent costs. Another respondent reported that some of her association's membership chose not to participate for fear of losing enrollment in their own pharmacy benefit programs. Two mentioned that some members perceived the drug card as not being successful so they decided not to participate. One respondent commented that some of his association's members chose not to participate in the program because they did not see the discount card as being valuable to beneficiaries who did not qualify for the $600 credit.

7.1.3 Overall Experience

Successes and Perceptions of Program Strength

All respondents reported at least one successful aspect of the drug discount card program. Half of the respondents mentioned beneficiary savings and three were pleased with the way CMS' launched and operated the program. One commented that the Open Door Forums and other conference calls

provided valuable opportunities for stakeholders to share information with CMS and vice-versa. Another stakeholder complimented CMS for having "lifted a mountain" in a very short time period.

Most respondents viewed the transitional assistance component of the program as one of its overall strengths. Half of the respondents commented that the cards provided valuable savings on drugs for persons who did not have prescription insurance coverage or other options for receiving discounts.

Challenges and Perceptions of Program Weakness

Respondents identified a number of challenges related to the implementation of the drug discount card, the most common of which was educating beneficiaries about the program. **More than half of respondents mentioned that their members found it challenging to educate beneficiaries about their choices.** Two mentioned that beneficiaries were unaware of potential savings related to the card. Two commented that CMS needed to reconsider the information beneficiaries require to make decisions. And two respondents mentioned that providers do not have enough time to adequately educate beneficiaries about their card options. One respondent commented that providers should not be in the business of educating beneficiaries about insurance options and another mentioned that senior health insurance assistance programs (SHIPs) are best able to educate beneficiaries.

Half of the respondents mentioned the negative media publicity surrounding the program, which created an image problem. Some also described the short timeframe in which CMS and stakeholders had to implement the program as a challenge, though they did not fault the agency for this fact and appreciated CMS efforts in the compressed time available.

Comments on the complexity of the program were mixed: four respondents thought there were too many choices for beneficiaries and one respondent thought the number of choices was appropriate but beneficiaries needed information to help them "navigate the choices specifically."

Three associations stated that they wished CMS had done a better job creating a positive public image for the drug card program. The following responses were made by at least one person:

- CMS should have limited the number of card options.
- The drug card program should have had a longer implementation period.
- CMS should have involved pharmacists earlier so that they could help with beneficiary choice.
- The program should have provided real discounts to beneficiaries.

Four respondents mentioned poor promotion of the drug card as a weakness, and two mentioned the temporary nature of the program as a weakness.

7.1.4 Experience with Beneficiary Choice

Most respondents described challenges their members faced related to beneficiary choice. **These respondents all mentioned the large number of cards, and how difficult it is to help beneficiaries make a choice.** Two respondents reported that Medicare beneficiaries do not believe the cards provide valuable discounts, which poses another challenge to educating beneficiaries about the cards. Another respondent mentioned that members have discovered that counseling beneficiaries takes a long time.

Three respondents shared their members' positive experiences with beneficiary choice. One respondent reported that his members were happy to provide information that would help Medicare beneficiaries make decisions. Another respondent reported that his members found the program to be a good deal for low-income beneficiaries and were happy to encourage them to enroll. The third respondent commented that the enrollment form for the program was straightforward and he had not heard of any complaints from association members.

7.1.5 Experience Working With CMS

This section describes respondents' experience working with CMS including overall experience, communications, informational material, 1-800-Medicare, and the price comparison website.

All respondents reported that their organizations had good experiences working with CMS on the drug card. Some experiences were good from the start, while others evolved in a positive way over time.

Most respondents offered positive comments about CMS' communications toward their sector. Respondents felt that CMS was responsive to their questions about the drug card program. One respondent mentioned that the training program provided by CMS was very helpful. Two respondents commented that the teleconference sessions were useful forums for learning about the program. One mentioned that the open door forums provided an opportunity for his organization to provide input into the process. While generally pleased with CMS' communications, a small number of association representatives commented that their members did not receive information about the drug card as early as they needed it. Two respondents suggested that CMS could improve its communication towards healthcare providers by giving them information/materials to provide to beneficiaries. One suggested that providers could put stickers advertising the drug card program on materials they give to beneficiaries.

Two respondents commented on the informational materials and those comments were mixed. One respondent reported that the basic booklet on the drug card program was "excellent." One respondent thought that CMS' informational materials were not objective.

1-800-Medicare Helpline

Very few respondents commented about 1-800-Medicare. Two respondents described the helpline as a challenging aspect of the program, because the helpline wasn't operational when the program was first introduced and was shortly overrun by a huge volume of calls.

Price Comparison Website

When asked about the usefulness of the price comparison website, **all respondents mentioned that they or someone they know had found the website difficult to navigate.** One respondent described two situations where members had difficulty getting accurate information using the price comparison website and 1-800-Medicare. In both instances, information given through the helpline did not match information provided on the price comparison website, although customer service representatives at 1-800-Medicare access the price comparison website during calls just like outside users. Three respondents commented that CMS responded to their organizations' concerns about the

website by correcting errors quickly.[32] One respondent mentioned that the information contained on the website was excellent for those who could navigate the site.

7.1.6 Organizational and Business Impacts

Half of the respondents described the impacts of the drug discount card program on their organization and their members. All of these respondents mentioned that their organization spent time educating their members about the discount card program, shifting resources as necessary to meet the demand for information. No one described the drug card as particularly burdensome for his/her association. As one respondent said, "I don't mean to complain – this is our job." The impact on pharmacists was perceived to be more acute. One respondent reported that pharmacists absorb a huge administrative role in the program, particularly with respect to coordination of benefits, beneficiary education, and enrollment. Another mentioned that his association's members experienced a financial loss at the beginning of the program because pharmacists were paid less than their costs for some drugs. (Prices were adjusted upward after some delay.)

7.1.7 Suggestions for CMS

Over half of the respondents commented that CMS needs to educate beneficiaries about Part D benefits and how the system will work. To emphasize the importance of beneficiary education, two respondents mentioned that beneficiaries do not know the important fact that 1 in 3 will have coverage during the so-called donut hole. Some respondents suggested that information about the Part D drug benefit needs to be distributed to beneficiaries and stakeholders well before the program begins. A few respondents mentioned that CMS needs to do a better job reaching out to health care providers who can help with beneficiary education and enrollment. Each of the following suggestions were offered by at least one respondent:

- CMS will need to align low-income definitions with those used for other government programs such as subsidized housing and Medicaid.
- Communication and outreach to beneficiaries should focus on a regional or local area.
- Auto-enrollment is effective.
- Communications regarding the program must not be so narrowly focused toward the low-income population as to mislead others about the value of the program to them.
- CMS must be able to effectively counter negative publicity about the program.
- CMS must anticipate challenges with low-income population, nursing home residents, and the dually eligible.

CMS should focus its efforts on providing information to their members on the Part D drug benefit. Four respondents commented that improving beneficiary education would be most helpful to their organizations. Other respondents mentioned improving pharmacist education through regional training and providing new information to stakeholders on a timely basis (1 each).

[32] CMS has made numerous improvements to the website over the past year to improve navigation and ease of access to information based on feedback received from public users.

7.2 Interviews with Thought Leaders

7.2.1 Description of Respondents

This section reports on interviews conducted with ten thought leaders. Five described their place of employment as a consulting firm, two as think tanks, one as a policy center at a university, one as a foundation, and one as a state department of elderly affairs. The names of these individuals and the names of their organizations appear in Appendix E. All had significant expertise in the area of Medicare policy and drug benefits. Three were presidents of their organizations.

Respondents were asked to identify an area of expertise among the major stakeholder groups (sponsors, pharmacies, manufacturers, states, and beneficiaries). Two respondents claimed expertise related to both sponsors and manufacturers; one named pharmacies; two cited manufacturers only; two chose states; two chose beneficiaries, and one resisted characterization and described himself as a policy expert.

Because of the small numbers of respondents and their disparate areas of expertise, many of the views documented below are based on a very small number of respondents, often one to three. However, these views are included in the report because these experts typically based their views on extensive research including many stakeholders, or extended and intense engagement in the drug card program.

7.2.2 Reasons for Participation

Several thought leaders commented that **sponsors' primary reason for participating the Medicare-approved drug discount card program was to position themselves to participate in the Part D drug benefit**. Three added that the drug card program represented a substantial extension of pharmacy benefit managers' business activities; both working directly with beneficiaries and working with CMS were new.

A few observed that **pharmacies had no choice** but to participate in order to retain customers. One also cited pharmacies' desire to help their customers.

Some thought leaders described **manufacturers' participation as driven by a blend of humanitarian and public relations motives.** Three noted financial motivations for manufacturers, as the $600 credit would help to fund full-price purchase of drugs that might otherwise have been forgone or purchased at discount through another program.

7.2.3 Overall Experience

Successes and Perceptions of Program Strength

Thought leaders described the following positive experiences:

- The successful implementation of the program on a tight timeline.
- The widespread participation among sponsors, pharmacies, and manufacturers.
- The auto-enrollment of SPAP members into the drug cards, in states where that occurred, brought T.A. benefits to many who might otherwise not have enrolled.

Thought leaders also mentioned many strengths of the drug card program:

- Valuable assistance to beneficiaries with access and affordability.
- Voluntary participation.
- Philosophy of choice and competition.
- Incentives for beneficiaries to research and control their own drug costs.
- Public access to individualized information about drugs prices and card choices via the price comparison website.
- Focus the lowest income people.
- Creation of new partnerships between the private and public sectors.
- Good preparation for the Part D drug benefit.

Challenges and Perceptions of Program Weakness

Thought leaders cited a number of program features and that posed challenges or emerged as weaknesses of the Medicare-approved drug discount card program:

- The rapid implementation timeframe and the learning required were substantial for all involved.
- The politicization of the program and the negative press coverage impaired credibility from the start and may have reduced beneficiary trust and enrollment.
- The initial difficulties with the price comparison website and questions regarding the accuracy and comparability of the data posted there also reduced credibility.
- There was considerable beneficiary confusion about the program.
- Published prices subject to change.
- Short program lifetime prior to the Part D drug benefit lessened 'investment' and interest in the program.
- Beneficiary satisfaction was not high; one expert cited survey data in which only 20 percent of Medicare-approved drug discount card cardholders said that they would recommend their card to a friend.
- Imperfect co-ordination and integration with other programs.
- Negative experiences in the drug card program meant that some stakeholders are now discouraged about the Part D drug benefit.

7.2.4 Sponsors' and Pharmacies' Experience Working Together

When asked to describe sponsors and pharmacies' experiences working together on the Medicare-approved drug discount card program, thought leaders saw this as a simple extension of a pre-existing and fairly one-sided relationships: card sponsors tended to work with existing networks and to offer "take-it-or-leave-it" contracts. One expert speculated that there might have been some level of negotiation with large pharmacy chains but not with small chains or independent pharmacies. Three respondents described this relationship as acrimonious.

7.2.5 Sponsors' and Manufacturers' Experience Working Together

Similarly, three thought leaders described sponsors' and manufacturers collaboration on the Medicare-approved drug discount card as an extension of their existing relationships, in which they adapted policies and procedures from their existing contracts. One thought leader commented that the relationship worked well and set a good precedent for the Part D drug benefit. Two others noted that both sponsors and manufacturers wanted the program to succeed and to generate a positive customer response and positive publicity. One attributed this to their shared interest in preserving market-determined drug prices and avoiding government-imposed pricing.

According to four thought leaders, the initial process of establishing agreements among the many card sponsors and many manufacturers was complex and time-consuming. In addition, one said that manufacturers found the initial strategic decision-making quite challenging, especially deciding how to adapt and integrate their existing drug discount cards and pharmacy assistance programs in response to the program, although ultimately this integration was reasonably successful. Another remarked that some manufacturers were still struggling with it.

Three thought leaders described tension between sponsors and manufacturers in the initial period, when there were concerns about the accuracy of the data submitted by sponsors and posted on the price comparison website. The presence of inaccurate price data on the website created large problems for manufacturers, however sponsors had submitted these data and only sponsors were in a position to correct the data.

Two thought leaders commented that the Medicare-approved drug discount cards received strong rebates from manufacturers. One viewed this as a by-product of manufacturers' and card sponsors' shared interest in program success and positive publicity. A third emphasized that there was variation in the level of manufacturer rebates across different sets of sponsors, with the PBMs enjoying more favorable terms from the pharmaceutical industry (primarily via the wrap-around programs). He added that card sponsors with ties to the retail pharmacy sector received better term/discounts there.

An interesting dimension of the Medicare-approved drug discount card program was the emergence of wrap-around programs in which the pharmaceutical industry and the card sponsors co-operated to co-ordinate the federally-sponsored Transitional Assistance with manufacturer-sponsored pharmacy assistance programs. Several experts described a combination of humanitarian and public relations motivations that led to the emergence of these coordinated programs. One stated that manufacturers wanted to continue their existing pharmacy assistance programs but also wanted to take advantage of the $600 T.A. credit before offering access to drugs at deeply discounted prices.

7.2.6 Experience of State Pharmacy Assistance Programs

According to thought leaders, the Medicare-approved drug discount card program offered a unique opportunity to states, especially SPAP programs. It offered beneficiaries access to the $600 T.A. credit, and **enabled states to conserve resources, because many potential SPAP clients could**

access the T.A. credit first and then fall back on the state program. About eight to ten states with SPAPs took full advantage of this opportunity and auto-enrolled their SPAP members into the Medicare-approved drug discount card program. Two thought leaders agreed that auto-enrollment was a very effective and positive strategy for these states.

Not all states enacted auto-enrollment, due to the need to make statutory changes in order to act as the beneficiary's representative in the enrollment process. One expert cited research that indicated that in states with voluntary enrollment, enrollment is very low. For example, in Missouri, only 20 percent of SPAP clients are enrolled in the Medicare-approved drug discount card program, while 50 percent are eligible.

One expert believed that there would be significant gains if SPAP and Medicare-approved drug discount card plans were able to share data. If this were the case, then states with voluntary enrollment could be more effective in targeting beneficiaries who were not enrolled in drug cards, but likely to be eligible. In addition, under this scenario, if card sponsors and SPAPs had integrated information systems, then pharmacies would only have to submit one request for payment and payment could be streamlined. Instead, pharmacies must submit a separate request to each payer, leading to additional transaction charges (imposed by the sponsors) and to potential billing errors related to co-ordination of benefits. Auto-enrollment and the use of a preferred plan for each SPAP would create the economies of scale necessary for SPAPs and plans to invest in the necessary infrastructure for coordinated billing.

7.2.7 Beneficiaries' Experience with Choice

Seven of ten thought leaders stated that the Medicare-approved drug discount card program confused beneficiaries. According to one thought leader, survey data indicated that while more than three-quarters of households have heard about the Medicare-approved drug discount card program; less than one quarter understood it. Thought leaders alluded to several sources of beneficiary confusion including:

- The concept of choice, including the fact that beneficiaries can only select one card.
- The number of cards.
- Complexity of the program rules.
- The difficulty of establishing the level of savings available from the cards.

Thought leaders cited several other factors that led beneficiaries to hesitate before enrolling in the cards:

- The inherent difficulty of adapting to new ideas.
- The target population's skepticism of government programs.
- The negative press surrounding the program.
- Beneficiaries' doubts regarding the value of program savings especially relative to other available programs.

- Beneficiaries' frustration regarding the fact that prices could change but they could only change cards once each year.

- The level of effort and information required to fully evaluate card choices.

Two thought leaders commented on factors beneficiaries considered when choosing cards. They agreed that these factors were: out of pocket costs, access to preferred drugs, and access to preferred pharmacies.

Two respondents did say that they found the concept of choice very appealing, but two others concluded that choice was not the right concept for this population. One continued that if "choice" was the direction that Medicare was going in other regards, then this program is a good way to ease beneficiaries into this model.

Six of ten thought leaders expressed either their own or stakeholders' disappointment that the enrollment in the cards was so low.

7.2.8 Beneficiaries' Experience with Enrollment Process and Cards at Point-of-Sale

In response to questions about beneficiaries' experiences with the cards at the point-of-sale, two thoughts leader said that the enrollment process has been very confusing for many beneficiaries and those trying to help them. Another said that many beneficiaries and organizations working on their behalf did not fully understand the program's eligibility criteria.

Program Value

This project did not ask any group of respondents directly about the level of beneficiary savings or the value of the card program, however, many thought leaders touched on this subject in the course of other discussions. **Eight of the ten thought leaders said that the cards were a good value or offered substantial savings.** Three also explicitly stated that the transitional assistance program offered a good value. One thought leader cited research indicating that some cards were better value than others but agreed that the key factor was for beneficiaries to be enrolled in the program, not to be enrolled in a specific card. One thought leader suggested that the substantial discounts provided are evidence of the effectiveness of choice and market competition as a mechanism to reduce drug prices. Two thought leaders pointed to the particular savings beneficiaries could achieve when Medicare-approved drug discount cards were integrated with manufacturers' pharmacy assistance programs. One added that, for many beneficiaries, the most important aspect of card selection was to choose a card that had a partnership with the manufacturers of his most important drugs.

7.2.9 Stakeholders' Experience Working With CMS

Many thought leaders praised CMS staff for having a good attitude, working hard, and wanting to help. Two acknowledged that CMS had a very difficult job and three specifically applauded CMS' support for private sector stakeholders in the implementation of this program.

Thought leaders offered mixed reviews of CMS overall responsiveness. One said CMS contacts had been helpful and had responded in a timely manner. Two others reported that CMS had not been responsive and that it was difficult to get answers. One expanded to say that CMS seemed understaffed and CMS' efforts seemed poorly coordinated internally.

Thought leaders also offered mixed responses regarding the sponsor application and approval process with one saying that approval went well and another commenting that applying and getting CMS

approval was hard work, especially for PBMs who were unaccustomed to working with CMS. Two thought leaders believed that too many cards had been approved.

Three thought leaders reported that **sponsors and manufacturers were disappointed the CMS did not allow more freedom to market their programs and partnerships**.

A few stakeholders suggested the CMS' general public relations and outreach had been weak. One stakeholder expressed disappointment that CMS did not have a strong strategy to respond to the immediate criticism of the program that emerged from political opponents and the press. Another believed that CMS had not clarified who the audience was for the cards and what the essential value proposition was.

CMS Communications with Beneficiaries

Three thought leaders highlighted the importance of strong education and outreach campaigns for the Medicare-approved drug discount card program. One, in particular believed that these campaigns should continue throughout to 2005 to ensure that beneficiaries reaped the advantages of the program and that this program could be used as a "feeder" program for the Part D drug benefit.

Thought leaders made several suggestions concerning the choice of channels for CMS' education and outreach activities:[33]

- Do market research and conduct focus groups to figure out how to reach target audiences.
- Use multiple channels.
- Emphasize face-to-face contact using vocabulary and settings that are comfortable to beneficiaries. Orient marketing materials towards providing information and promoting discussion rather than towards creating awareness and brand image.
- Engage public figures and trusted authorities as spokespeople.
- Work through pharmacists and doctors.
- Get employers involved in marketing to their older workers and retirees.
- Do not rely on direct mail and mass media.
- Reach out to the general public. Beneficiaries turn to their children for help.
- Apply more resources at the state level.
- Develop simple, well-crafted messages and simplify materials.
- Combat negative public perceptions of the program.
- Develop state-specific materials or, at the very least, encourage beneficiaries to gather information about state-level policies and options before making decisions.

[33] This is a comprehensive list of suggestions that were made both in the context of the drug card and in the context of Part D. Respondents tended to view marketing for the two programs as closely related.

- Allow sufficient time for education.

- Develop a website oriented to professionals in addition to the website oriented to beneficiaries.

One thought leader suggested that, given the fact that CMS is in a position to offer information but not advice, CMS should invite third parties, such as the SHIPs and *Consumer Reports,* to get involved in providing useful, credible information to help beneficiaries with card selection.

The Price Comparison Website

Experts had a lot to say about the Price Comparison Section of the Prescription Drug & Other Assistance Programs Database on Medicare.gov. Two experts were extremely enthusiastic about the concept of the price comparison website, because it offered the public comprehensive and accessible information on pharmaceutical pricing and might inspire cost-consciousness on the part of consumers. Another believed the true breakthrough lay in the fact that the price comparison website is personalized, to assist in decision-making at the individual level. One expert mentioned that manufacturers and sponsors had also been users of the price comparisons, for the purposes of competitive analysis.

Half of thought leaders mentioned that there had been a lot of initial problems with the website, and that these had posed problems for stakeholders in the sponsor and manufacturer sectors. One mentioned the importance of allowing additional time for testing if CMS ever launched a similar initiative.

Four thought leaders expressed the view that **the website was not the right way to get information to this population.** They mentioned that the elderly tend to be less computer-literate than the rest of the population and that rates of computer usage are lower among the Medicare-approved drug discount card program enrollees than among pharmacy customers as a whole. Also, many members of the target population have cognitive limitations. One thought leader pointed out that the next generation of elderly will be more computer literate.

Even for those with strong computer skills, four experts believed that the price comparison website was difficult to use. A lot of information was needed in order to work with the application. Furthermore, the website presents an overwhelming amount of information and choices. Two thought leaders commented that some beneficiaries might appreciate an option in which the price comparison website narrowed the choices to a much smaller number based on the greatest discounts; another cited a general need for a tool to help with decision-making. One thought leader believed that CMS' reliance on the Internet probably hurt enrollment with the target population.

7.2.10 Program Impacts

Two thought leaders reported that **sponsors put in more money than they got out, particularly in terms of systems development.** One continued that sponsors are hoping (but are not sure) that investments in systems and operations for the drug card will also be relevant to the Part D drug benefit.

One commented that for pharmacies the reductions in the number of full price, cash-pay customers led to further reductions in pharmacy margins.

Two thought leaders believed that the program had been educational for manufacturers. One mentioned insight into competitors' pricing gleaned via the website. Another said that the drug card

had opened manufacturers' eyes to potential problems in the Part D drug benefit, notably low enrollment levels.

Two thought leaders agreed that the states (SPAPs) had reaped considerable savings from the program due to the $600 credit federal offset, however one mentioned that these savings were lower than expected due to the fact that enrollment rates were lower than expected.

Two thought leaders agreed that this program had required significant investments on the part of organizations working on behalf of beneficiaries. It was expensive and time-consuming to train volunteers and staff. In addition, it was time consuming to educate beneficiaries and support them in making choices.

7.2.11 Suggestions for CMS

Two thought leaders emphasized that CMS had done a very good job. Thought leaders offered suggestions for how CMS could improve the drug discount card program:

- Develop a stronger plan for design and implementation.
- Promptly and decisively support auto-enrollment for individuals in SPAPs, and allow states to work with a preferred plan sponsor for the Part D drug benefit and support information-sharing between state programs and sponsors.
- Provide enrollment data to states to enable states to reach out to those who were likely to be eligible for the $600 credit.
- Simplify the program; the elderly need help with choice.
- Focus on beneficiary education and communication.
- Give plans maximum flexibility. The Medicare-approved drug discount card program demonstrates the power of choice and competition.
- Structure the program to support the retail pharmacy sector, especially independent pharmacies.
- Invest more in the design of the website, and build decision making-tools into the website.
- Set policy that would level the playing field between chain and independent pharmacies.
- Extend the enrollment period for the Medicare-approved drug discount card and make this into a "feeder" program for the Part D private drug plans.
- Allow drug card sponsors and state pharmacy assistance programs to share data.
- Promote the Medicare-approved drug discount card and, by extension, promote the value of privately negotiated prices and reduce public pressure for administered prices in Medicare.
- Allow sponsors to confirm data before posting it on the Internet.

Finally, two respondents emphasized that the Part D drug benefit will be very different from the discount card combined with transitional assistance; CMS should be wary of over-extrapolating from one program to the next.

8.0 Cross-Stakeholder Analysis and Summary of Main Findings

In chapters 3.0-7.0, this report presented the themes that surfaced from interviews with each of the stakeholder groups under study: sponsors, retail pharmacies, manufacturers, organizations that work on behalf of beneficiaries, professional associations, and expert thought leaders. In this chapter, we revisit the major themes and summarize results across all stakeholder groups, highlighting areas of convergence and divergence across them, to create a three dimensional view of the program. The emphasis here is on the stakeholders themselves (sponsors, pharmacies, manufacturers, and organizations that work on behalf of beneficiaries), but the discussion is also informed by comments made by representatives of professional associations and by expert thought leaders.

Reasons for Participation

All stakeholders, including sponsors, pharmacies, manufacturers, and organizations that worked on behalf of beneficiaries, cited humanitarian motivations for participating in the Medicare -approved drug discount card program. They wanted to meet the needs of their customers and to help Medicare beneficiaries attain better access to prescription drugs and lower out-of-pocket costs. Exclusive card sponsors wanted to ensure that their members had access to the $600 T.A. credit. Manufacturers and independent pharmacists believed it was the right thing to do for their elderly and disabled customers.

Stakeholders also had some competitive or financial motivations. Card sponsors sought to maintain or expand their current client bases and their typical financial objective was to break even. Members of the retail pharmacy sector sought to boost sales or to at least retain their customers. Manufacturers sought to reach new customers or to enable customers who would otherwise receive free or reduced-price products to purchase drugs at full price using federal (T.A.) dollars.

State Pharmacy Assistance Programs (SPAPs) had a strong financial incentive to enroll their members in the program in order to use the $600 T.A. credit to offset their own program expenses. They had to balance this interest against their interpretation of "voluntary enrollment" and against logistical and systems challenges involved in coordinating their own programs with the Medicare-approved drug discount cards.

Finally, sponsors, chain pharmacy executives, and manufacturers saw the drug card program as an opportunity to establish relationships and gain experience, particularly with CMS, that will be useful in 2006 when the Part D Medicare drug benefit will be launched.

Successes and Perceptions of Program Strengths

Stakeholders consistently mentioned several program strengths and things that went well with the drug discount card program. Some sponsors and many manufacturers appreciated **the program's philosophical orientation and its emphasis on private sector provision of a public benefit.**

However, some respondents in the retail pharmacy sector saw it as a program weakness that pricing decisions were made by sponsors and manufacturers and not the government and called for additional regulation in this area.

Some stakeholders, notably sponsors and manufacturers, commented that **the fact the program was launched at all was a significant success**. Sponsors were particularly pleased that manufacturers were willing to offer generous rebates.

Many stakeholders also noted that the program had precipitated **positive working relationships among sponsors, manufacturers, and CMS**. Both sponsors and manufacturers mentioned improved working relationships. Organizations that worked on behalf of beneficiaries cited positive partnerships among themselves, their partners, and CMS. Some respondents believed existing relationships were strengthened as a result of the program. In contrast, respondents in the retail pharmacy sector noted dissatisfaction in their relationships with some sponsors, notably PBMs.

In addition, consistent with sponsors', pharmacy executives', and manufacturers' goals, the Medicare drug discount card program was viewed as **a learning experience preparatory to the Part D drug benefit**. Organizations that worked on behalf of beneficiaries also mentioned that this program had created an opportunity to begin to educate and prepare their clients for the Part D drug benefit.

Two other successes will be discussed later in this chapter, namely the auto-enrollment of SPAP members into the drug cards and the value of the program to Medicare beneficiaries, although there was not unanimity on the latter point.

8.1 Challenges and Perceptions of Program Weaknesses

Stakeholders also raised several program weaknesses and things that were challenging about the Medicare-approved drug discount card program. **The rapid implementation timeline was particularly problematic**, especially for sponsors and organizations working on behalf of beneficiaries. Sponsors found it very difficult to launch and maintain a program on the necessary schedule, especially given the many and changing CMS requirements. Beneficiary organizations found it challenging to master the program in the limited lead-time, and then to give beneficiaries needed assistance. Many stakeholders also mentioned that the politicization of the program and the early negative publicity had hurt the program.

Two other related topics will be discussed below. One is program implementation, including both stakeholders' own experience and stakeholders' comments about CMS' communications with the general public; areas where many stakeholders see room for improvement. The other is the high level of beneficiary confusion, which was a major theme among all stakeholder groups.

8.2 Sponsors' Experience

Chapter 3.0 offers a full description of sponsors' experience, based on both telephone interviews and site visits with sponsors. One key theme from that chapter is that **sponsors found program implementation to be far more time-consuming and costly than expected.** The other is that **sponsors found the target population far more challenging to reach than expected.** Sponsors found that the target population did not respond to traditional marketing methods, notably mailings.

There was not much direct competition among sponsors. Many general card sponsors did not emphasize direct marketing but worked through new or existing partnerships to gain access to beneficiaries. These might be partnerships with health plans, insurers, employers, or unions. The one site of direct marketing and direct competition was CMS's price comparison website. General card sponsors did not have many opportunities to compete on product features because most cards received similar manufacturer discounts and offered discounts on all drugs. Nor did these sponsors have many opportunities to differentiate their marketing materials. Most used the CMS model materials due to the need to conform to CMS' specifications, limited time available to adapt materials, and the burden of the review process.

By definition, exclusive card sponsors were marketing their cards to an existing membership base.

8.3 Sponsors' and Pharmacies' Experience Working Together

Both sponsors and independent pharmacists agreed that contracting related to the drug card represented an extension of existing relationships. **Respondents in the retail pharmacy sector expressed dissatisfaction with the nature of the relationship. They felt they were offered one-sided contracts and had no opportunity to negotiate with sponsors.**

Respondents in the retail pharmacy sector also expressed dissatisfaction with the financial terms offered by sponsors. They felt that they were asked to provide drugs to beneficiaries at a discount but that the rebates that sponsors negotiated with manufacturers were not passed through to ensure that they could receive a fair contract rate at the same time that beneficiaries received the discount. At the same time, sponsors imposed transactions fees for the use of their claims-processing networks that pharmacy executives and independent pharmacists found excessive. Finally, the retail pharmacy sector believed that card sponsors (notably PBMs owning mail order businesses) sought to steer business to mail order thus cutting in to pharmacies' customer base.[34] **The net effect, in the eyes of the retail pharmacy sector, was that they were bearing the financial burden of delivering discounts to Medicare beneficiaries without having any say in the process.**

Some chain executives and independent pharmacists decided not to accept the most deeply discounted cards due to the low payment rates. In contrast, few sponsors mentioned any tension, and some sponsors reported that the retail pharmacy sector was satisfied with the contracts they received.

Relative to other cards, the retail pharmacy sector was more pleased with cards supported by the retail pharmacy industry and with cards that did not create strong incentives for beneficiaries to use mail order pharmacies owned by the sponsor. However, sponsors and beneficiary organizations expressed concern that pharmacists should not be involved in enrolling beneficiaries into Medicare-approved drug discount cards because of the inherent conflict between the beneficiary's interest in choosing the card with the lowest out-of-pocket cost, and the pharmacy's interest having people choose the card with the highest profit margin for the pharmacy. In fairness, though, the same objection can be raised about marketing and enrollment processes dependent upon card sponsors.

Independent and chain pharmacists were generally satisfied with the cards' ease of use at point-of-sale and with coordination of benefits between the cards and various other pharmacy assistance programs. Pharmacy executives agreed that the cards were easy to use at the point of sale but felt that

[34] At least one sponsor stated that part of its business strategy was to encourage card holders to use its mail order house.

resolving co-ordination of benefits issues was a burden imposed on the retail pharmacy sector that should have been born elsewhere.

8.4 Sponsors' and Manufacturers' Experience Working Together

Sponsors had some latitude in whether to discount all drugs or to discount certain drugs selectively. Virtually all sponsors reported that they discounted all drugs.

Sponsors' and manufacturers' relationship was essentially cordial. Many sponsors and manufacturers shared a commitment to the program's philosophy of private sector provision and an interest in the program success. Pharmacy benefits managers and sponsors had a pre-existing history of working well together.

The drug card program did create several points of stress between sponsor and manufacturers. First, the process of negotiating rebates was initially complex and burdensome; this point was emphasized by manufacturers but not by sponsors. Negotiations were easier for large organizations; the major PBMs already had contracts with all or almost all manufacturers, and the large manufacturers already had contracts with almost all sponsors. Second, there was some early acrimony between sponsors and manufacturers concerning the price data that sponsors submitted and that was initially posted on the price comparison website.

A third point of stress concerned certain sponsors' initial approaches to rebates and fees. Two thirds of manufacturers reported dissatisfaction with sponsors' initial approaches to discounts and fees. **More than half of the manufacturers interviewed wanted the rebates that were offered to drug card sponsors to be passed through to the customer in full.** Several of these mentioned a perception that sponsors' high transactions or administrative fees had cut into the value of the net discount that reached the customer.

Most sponsors and manufacturers agreed that manufacturers did not discriminate among sponsors and offered a uniform rebate to all. Manufacturers agreed that, in general, all sponsors were offered a similar level of rebates regardless of size of enrollment or formulary status. A few sponsors believed that other sponsors received better rebates than they did from the manufacturers. They may have been referring to some sponsors having wrap-around relationships with major manufacturers' pharmacy assistance programs.

8.5 Experience of State Pharmacy Assistance Programs

As stated above, **the Medicare-approved drug discount program offered a significant benefit to states** because the $600 credit could be used to subsidize expenditures that otherwise would probably be funded by a state's pharmacy assistance program. Some states chose to automatically enroll eligible SPAP members into a preferred drug card program, typically one that had a relationship with the State or its SPAP program. In states that took this approach, **the auto-enrollment process generally worked well for both the sponsor and the SPAP**. Other SPAPs did not use auto-enrollment, often because they did not believe they had the authority to enroll their members into a program intended to be voluntary. This process is discussed in detail in Section 6.3 (Results: Secondary Data About State Pharmacy Assistance Programs) and 7.2.5 (Results, Thought Leaders, SPAPs' Experience) above.

8.6 Stakeholders' Comments on Beneficiaries' Experience

When asked to comment on beneficiaries' experience with card choice, **all stakeholders consistently emphasized the theme of beneficiary confusion, especially confusion stemming from the large number of available cards.** The program rules, the enrollment process, and the difficulty of determining actual out-of-pocket savings were also frequently noted as sources of beneficiary confusion.

Sponsors and beneficiary organizations raised other issues that they believe led to low levels of program enrollment. Beneficiary organizations highlighted **negative publicity from program opponents; beneficiaries' doubts (at time legitimate in the respondent's view) about the ultimate value of the card** relative to other options for reducing drug expenditures; **characteristics of the target population**, including low literacy and low computer literacy, skepticism about government programs, and resistance to change; **the amount of information and effort required to make an informed choice; and certain program features,** including sponsors' ability to change preferred drugs versus the fact that beneficiaries, once enrolled, were locked into a card for a year. Sponsors tended to note **shortcomings of CMS' outreach and education efforts** as being responsible for low enrollment.

Manufacturers stated that the enrollment process was complex (perhaps relative to their own pharmacy assistance cards.) Beneficiary organizations mentioned that beneficiaries were frustrated by the long period of time that it took for card applications to be processed. At the same time, a majority of pharmacists commented that the cards worked smoothly at the point of sale. However, pharmacists noted that they had to spend a lot of time (up to 30 minutes) with a beneficiary that asked for help understanding the drug card.

Despite these negative observations, **most members of all stakeholder groups believed that the program was valuable for the target population.** Stakeholders were especially positive about the value offered by the transitional assistance program. Some respondents in beneficiary organizations and the retail pharmacy sector did suggest that the discounts were minimal and the program's value was limited for beneficiaries who were not eligible for the $600 credit. Some respondents in these sectors also observed that other options (state and manufacturer pharmacy assistance programs) often offered greater savings than the Medicare-approved drug discount card program.

Sponsors, manufacturers, and organizations working on behalf of beneficiaries all expressed disappointment with the low levels of program enrollment. Pharmacy executives had a mixed reaction to the low enrollment; some were pleased that enrollment was low because of the program's negative effect on their margins.

8.7 Experience of Organizations Serving Beneficiaries

Organizations working on behalf of beneficiaries were generally satisfied with their ability to help beneficiaries take advantage of the program. Both they and pharmacists remarked that it was challenging and time-consuming to explain the Medicare drug discount card program and its potential value to the target audience. The individualized nature of decision-making added considerably to this challenge. Also, for pharmacists, there was no time and no financial compensation for this new responsibility. Chain pharmacists often recommended a specific drug discount card that their corporate office was promoting, rather than spend time discussing the options of different cards with beneficiaries.

8.8 Stakeholders' Experience Working with CMS

Stakeholders were universally positive about the dedication of CMS staff. Sponsors, manufacturers, and beneficiary organizations agreed that CMS staff worked hard and wanted to help. They understood that the drug card program represented a new venture for CMS staff and that the timetable was tough for them too. Stakeholders commented that CMS performed well given the constraints and manufacturers appreciated CMS' commitment to private sector solution.

Stakeholders did note that the way that the program was implemented created challenges for them. Many of these challenges stemmed from CMS' apparent lack of clarity and frequently changing policies regarding program rules and requirements. Sponsors found it difficult and burdensome to respond to changing reporting requirements. Also, beneficiary organizations found it challenging to keep abreast of the program and counsel their clients appropriately, as program features continued to evolve. Some beneficiary organizations believed that the fact that they could not always keep up with the program also hurt their credibility with their clients. In a similar vein, pharmacy executives believed that lack of information about the program had hurt their pharmacists credibility with customers. Some stakeholders relayed a perception that the program's implementation was chaotic and poorly managed. Some sponsors of exclusive cards mentioned that, in the rush to implement, CMS did not pay enough attention to how the requirements and challenges might be different for exclusive cards than for general card sponsors.

Stakeholders' comments on their communications with CMS tended to build on these themes. **Generally speaking, both sponsors and beneficiary organizations stated that CMS staff were accessible but that they could be unreliable and inconsistent in terms of providing accurate and timely information**. Questions often remained unanswered, and CMS appeared to have flaws in its internal coordination. **All stakeholder groups wished that they had more opportunities to provide input and offer feedback to CMS.**

Sponsors did appreciate CMS' efforts to develop communications channels for them, including the assignment of card managers, the sponsor conference calls, and the sponsor website. They also offered specific suggestions on these channels, which are presented in Chapter 3.0. Sponsors felt they could have helped CMS with program implementation if they had been consulted.

Pharmacies felt that their communications with CMS had been insufficient. Most pharmacy executives and most independent and chain pharmacies reported no direct contact from CMS; this was a point of resentment for some executives who felt that they had been left out of the process while sponsors and manufacturers had been invited in. Increased communications from CMS to pharmacists could have improved pharmacists' sense of engagement in the program and their ability to educate beneficiaries. Pharmacists expressed a need for communication tools that explained the drug card program overall and that could assist a beneficiary in choosing one drug discount card over others.

Due to limited communication from CMS, members of the pharmacy sector learned about the program from other sources such as trade organizations or sponsors, including those with direct ties to the member's pharmacy.

Manufacturers also reported insufficient communication with CMS. Some believed that although they had been asked for advice, this advice was not incorporated into policy. Some smaller

manufacturers (and especially, generic manufacturers) believed that CMS had only reached out to the larger brand name manufacturers.

Nearly all SHIPs reported a favorable experience in their communications with CMS. They spoke highly of the conference calls, materials, and trainings they received. SHIPs would have preferred more pro-active communication; i.e. they wanted to learn about policy changes at the time of decision rather than the time of implementation. Information Intermediaries had a more mixed experience in their communications with CMS. Some were pleased with the assistance they received using the call center and with printed information materials from CMS, while others thought the communication could improve.

Stakeholders, especially sponsors, made comments about specific aspects of program implementation. The comments are discussed at length in the stakeholder chapters but are summarized here. The themes of rushed implementation, lack of clarity, and frequent change surfaced in their discussion of the RFP and approval process. Some sponsors and many manufacturers believed that CMS had approved too many plans.

For general card sponsors, systems interfaces and reporting requirements were areas of particular concern. This issue was less acute for exclusive card sponsors, both because they already had relationships with CMS and because they were exempt from some requirements. Again, rushed implementation and frequent changes in reporting requirements created challenges in this arena. Some sponsors mentioned that, had they been consulted, they could have shared their expertise regarding industry standards (e.g., NCPDP standards) in information processing, which might have reduced burden for both CMS and themselves.

A second area of particular concern was CMS' oversight of sponsors' marketing material. Both sponsors and manufacturers felt that CMS had been overly restrictive in this area. Manufacturers, in particular, believed that they had the expertise to reach the target populations, if given the freedom to do so. Sponsors argued that CMS' required mailings were very expensive and provided more information to beneficiaries than was necessary or even useful. Sponsors also reported extremely negative experiences with the approval process for marketing materials. This process seemed time-consuming and inconsistent to them.

A final area of concern was the MSP program. This was an optional program in which sponsors were invited to reach out to people CMS had automatically enrolled and help them activate their T.A. credits. CMS provided sponsors with some contact information for the beneficiaries and specific guidelines for how to contact these beneficiaries. Unfortunately, due in part to flaws in the contact information and the high cost of the mailings, this program was very expensive for sponsors and few of the auto-enrolled people activated their T.A. credit, leaving sponsors rather frustrated.

CMS Communications with Beneficiaries

Stakeholders agreed that CMS' communications directed at beneficiaries and the general public were a key ingredient to program success. They also tended to suggest that there was room for improvement in this area. Sponsors stated that, based on their experience with the drug discount card, traditional marketing methods, notably the heavy use of print materials, do not reach this population. They also commented that CMS' required materials had been overly lengthy and confusing. Many stakeholders from all groups also commented upon the well-publicized delays and queues for people calling 1-800-Medicare.

Many respondents commented on the price comparison website on the CMS Website. Some experts and some other respondents recognized that it was an innovative feature of the drug card program, both because it offered accessible information on drug prices and because it supported individualized decision-making. Organizations working on behalf of beneficiaries reported that **the price comparison website was a very good concept** and that it was helpful to have a personalized decision-making tool. Manufacturers, some pharmacies, and beneficiary organizations all referred to the initial problems with the price data, which caused consternation for both beneficiaries and other stakeholders and damaged the image of the program. Stakeholders across all groups agreed that, whatever the website's strengths, **CMS could not rely on the website as a primary mode for beneficiary communication**. Many members of the target population do not have the access to and facility with computers required to take advantage of this tool. Many stakeholders, notably manufacturers and SHIPs, commented that the website was hard to use both because of the numbers of inputs required and because of the amount of output generated.

8.9 Program Impacts

All stakeholders reported some level of program impact. **The overwhelming majority of sponsors who described a financial impact described that impact as negative.** The program required a major systems effort and high marketing costs, and generated a low financial return.

Respondents in the pharmacy sector also reported a neutral or negative financial impact. The use of Medicare drug discount cards by customers who formerly paid full price reduced their margins. Most pharmacists also noted an increased workload due to the need to advise beneficiaries about the program.

For manufacturers, the reported impact was negligible , despite the fact that they had offered rebates, perhaps because total enrollment was relatively low. Some noted an increased workload due to the need to negotiate rebate agreements with so many card sponsors.

State Pharmacy Assistance Programs enjoyed a positive financial impact because the $600 credit covered the cost of some drugs that might otherwise have been covered by their programs. This impact was greatest where SPAP enrollment into the cards was greatest, i.e. where auto-enrollment was used.

Finally, other organizations that worked on behalf of beneficiaries reported that the Medicare-approved drug discount card program had a major impact on their organizations because of the significant efforts needed to educate and assist beneficiaries. In addition to the direct work with their client populations, these organizations needed to train, and often retrain, their staff and volunteers.

All stakeholder groups reported that one impact of the Medicare-approved drug discount card program was learning and insight that would be relevant in 2006, when the Part D Medicare prescription drug benefit is launched.

8.10 Suggestions for CMS

Drawing on their experience, stakeholders offered many suggestions to CMS regarding both the drug card program and the Part D drug benefit, many echoing themes raised already in this report.

Stakeholders, especially sponsors, called for improved implementation, in particular finalizing program rules and reporting requirements once and for all, rather than allowing them to evolve over time. All stakeholders requested that CMS release rules and reporting requirement for the Part D drug benefit with adequate lead time so that they could prepare for the program in a thorough and systematic way. Sponsors suggested that CMS might seek to increase levels of staffing, improve training, and decrease turnover. Card sponsors in particular suggested that the process for reviewing and approving marketing materials needed redesign. The current process is seen as inconsistent and arbitrary, as well as excessively lengthy. Those conducting the reviews require better training, consistent guidelines, and better supervision, in the opinion of these stakeholders.

Many stakeholders suggested that CMS offer more opportunities for stakeholders and CMS to communicate. Sponsors, pharmacy executives, pharmacists, manufacturers, and beneficiary organizations all believed that the Medicare drug benefit programs could be strengthened if CMS invited more input from their sectors. Stakeholders also asked CMS to communicate in a clear, timely, and systematic fashion. Members of the retail pharmacy sector felt left out of the drug card communications and wanted to be included for the Part D drug benefit. Manufacturers, especially small (and generic) manufacturers, wanted to receive more communications from CMS. Professional Associations wanted to be involved early so they could best facilitate education and enrollment.

Stakeholders also had ideas for how communications with beneficiaries and the general public could be improved, both in terms of communication modes and in terms of messages. They suggested that CMS reach out to beneficiaries through a wide range of intermediaries, including pharmacists (who see the beneficiaries face-to-face every month), manufacturers (who have experience reaching the target populations on the subject of prescription drugs), beneficiary organizations, physicians, other community organizations such as churches and community agencies, and respected celebrities and public officials.

When discussing potential improvements to CMS' messages, many respondents in all stakeholder groups cited **the need for simplification** and for recognizing the nature and limitations of the target population. Beneficiary organizations and experts highlighted the importance of adapting messages to local conditions and options. Exclusive card sponsors reminded CMS that its messages should offer adequate information about managed care options; they were concerned that this could get lost in the shuffle. Beneficiary organizations and experts also suggested that CMS use focus groups and other market research techniques to craft its messages.

Across stakeholder groups, respondents were concerned about the potential for negative publicity about the program and suggested the CMS develop plans to respond directly to such publicity and attempt to correct incorrect or incomplete messages.

Finally, stakeholders offered a number of suggestions for program design, some of which may be beyond CMS' actual purview. **One cluster of suggestions pertained to a desire for CMS to simplify the process of choice for beneficiaries.** Manufacturers, pharmacy executives, and beneficiary organizations emphasized that beneficiaries needed help to manage the large number of choices, to understand the differences among cards or plans, and to feel confident that there were not other hidden differences among the cards or plans that they did not understand.

A second cluster of suggestions pertained to the retail pharmacy sector's desire for CMS to regulate sponsors more actively. This sector asked CMS to require drug card sponsors to pass all rebates through to the customer at the point of sale, to prevent sponsors from imposing excessive administrative or transaction fees, and to prevent sponsors from using incentives to encourage

beneficiaries to purchase drugs via the sponsor's own mail pharmacy. Manufacturers expressed a desire for rebates to be passed through in full but did not specifically suggest the CMS impose regulations here.

Beneficiary organizations offered a very concrete suggestion. Given how difficult the target population is to reach and given the penalties for not enrolling during the initial period, CMS should extend the enrollment period for the Part D drug benefit.[35]

8.11 Ratings of the Drug Card Program

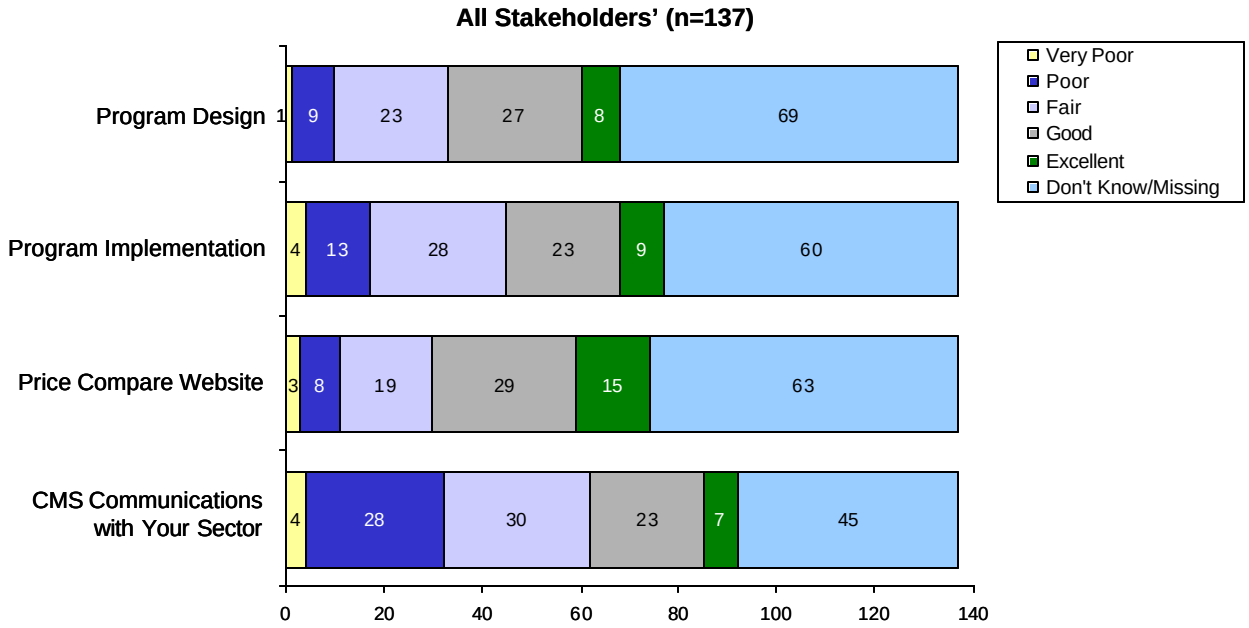
As part of the interview, each stakeholder was asked to evaluate up to eleven aspects of the drug card program from his own point of view; these were closed-ended questions using a five-point Likert scale (excellent, good, fair, poor, very poor). Respondents were also offered a "don't know" option.

Exhibit 4 shows the 137 respondents' ratings of the program's design, its implementation, the price comparison website, and CMS' communications with the respondent's own sector. Exhibit 5 shows ratings of the program's eligibility checking and enrollment process both for beneficiaries who enrolled in the cards but not the T.A. and for beneficiaries who enrolled in T.A., the ease of verifying the T.A. balance, and the coordination of benefits. Exhibit 6 shows ratings of the program's overall value both for beneficiaries who held cards but were not eligible for T.A. and for beneficiaries who did have access to T.A. Exhibit 6 also presents stakeholders' assessment of beneficiary satisfaction. Appendix E shows these same ratings by individual stakeholder group.

The discussion that follows summarizes the findings for respondents in all stakeholder groups. It also notes which program features were salient for particular groups, defined as items in which a majority of respondents within one group either gave an excellent/good rating or gave a poor/very poor rating.

[35] The final rule, published in January of 2005, establishes special enrollment periods for beneficiaries dually eligible for both Medicare and Medicaid and for beneficiaries residing in long-term care facilities.

Exhibit 4: Ratings of the Medicare Drug Discount Card Program Features



Source: Interviews Conducted by Abt Associates Inc., 2004-2005.

Program Design: Of 137 stakeholders, 133 evaluated program design. Fifty considered it excellent or good, 61 fair, and 22 poor or very poor.

The majority of responding sponsors (16/29) rated program design as an excellent or good rating and the majority of information intermediaries (6/8) gave it a poor or very poor rating.[36]

Program Implementation: Stakeholders' assessment of program implementation was somewhat lower than their assessment of program design. Of the 133 respondents to this item, 40 rated the implementation as excellent or good, 51 rated it fair, and 42 rated the implementation poor or very poor. The majority of information intermediaries (7/8) gave a poor or very poor rating to program implementation.

Price Comparison Website: One hundred and eighteen respondents rated the price comparison website, with 45 rating it as excellent or good, 37 as fair, and 36 as poor or very poor. A significant minority of respondents (17) believed this tool was excellent. This is consistent with comments in certain interviews suggesting that the price comparison website was an important innovation in terms of offering transparency regarding prices and individualized support to beneficiary choice.

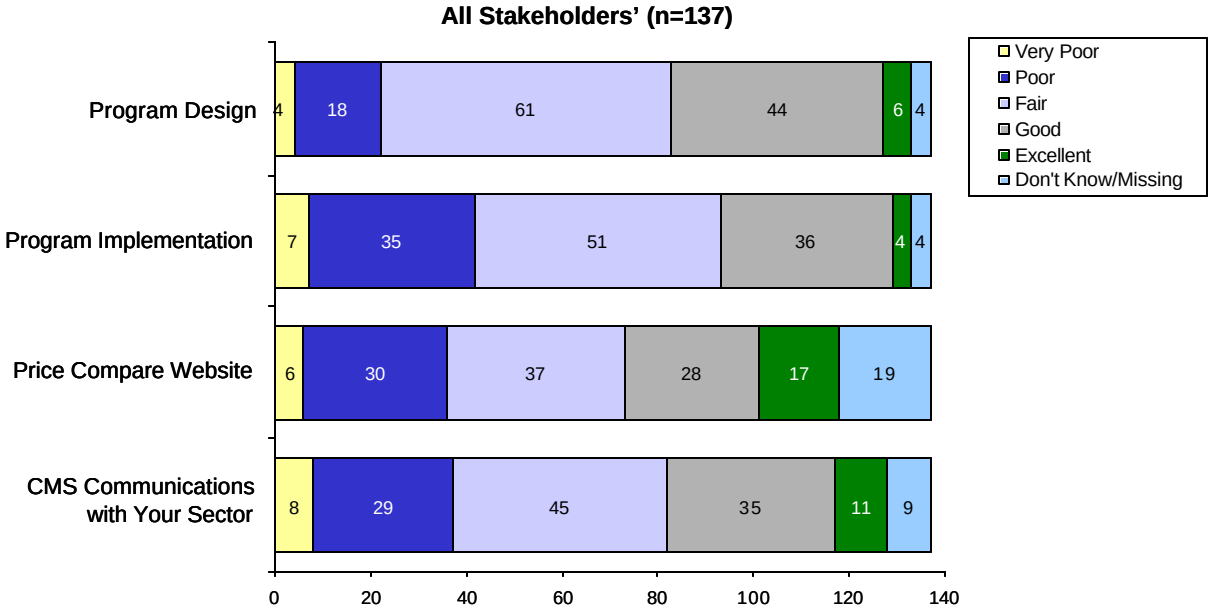
In addition, the majority of SHIPs program directors (17/22) believed the website was excellent or good. This group of respondents had hands-on experience using the website in support of beneficiary choice. Also, the majority of chain pharmacy executives (10/17) believed the website was very poor or poor.

Communications With Stakeholders: One hundred and twenty-eight of the 137 respondents offered an assessment of communications between CMS and themselves/their sector. Forty-six deemed

[36] The numbers in parentheses refer to the number of individuals giving the rating mentioned and the total number of individuals within the stakeholder group who responded to the item in question.

communications excellent or good, 45 deemed them fair, and 37 poor or very poor. The majority of SHIPs program directors (12/22) gave an excellent or good rating; the majority of respondents at information intermediaries (5/8) offered a rating of poor or very poor rating.

Exhibit 5: Ratings of the Medicare Drug Discount Card Program Features



Source: Interviews Conducted by Abt Associates Inc., 2004-2005.

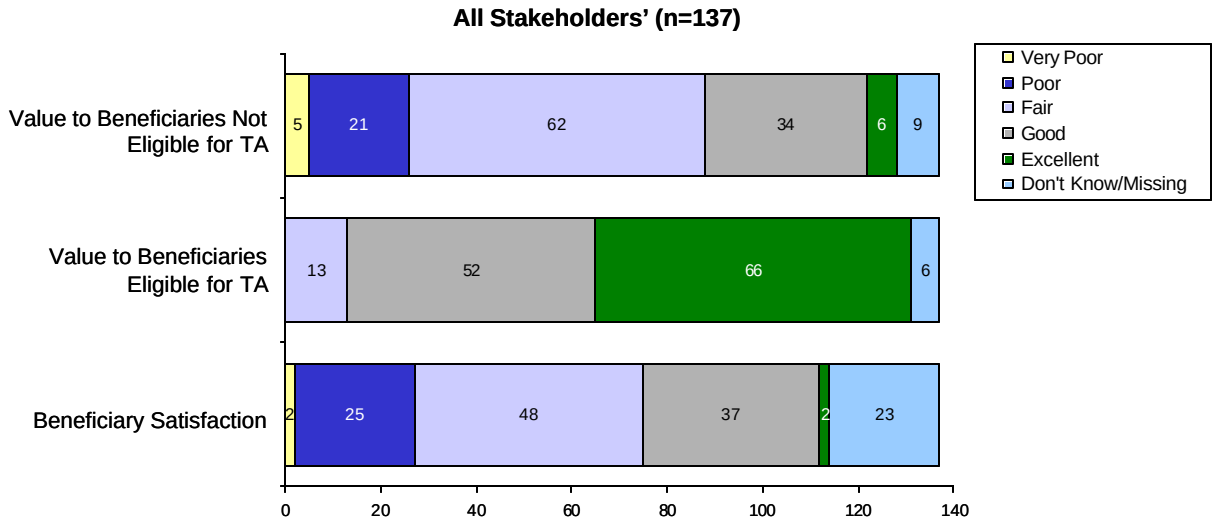
Enrollment Process (Card but No T.A.): Of the 68 respondents who offered a rating about the enrollment process for beneficiaries who enrolled in the cards but not the transitional assistance program, 35 gave an excellent or good rating, 23 gave a rating of fair, and 10 gave a rating of poor or very poor. A majority of sponsors (16/28) and a majority of SHIPs program directors (12/18) stated that this process was excellent or good.

Enrollment Process (Card With T.A.): Of the 77 individuals who evaluated the enrollment process for beneficiaries seeking transitional assistance, 32 chose excellent or good, 28 fair, and 17 poor or very poor. The majority of SHIPs program directors (12/20) reported that this process was excellent or good from their point of view.

Ease of Verifying T.A. Balances: More than half of our respondents were unable to assess the ease of verifying T.A. balances, but of the 74 that offered a rating, 44 (more than half) rated this as excellent or good; this included the majority of sponsors (22/30) and the majority of independent pharmacists (6/12). Approximately 40% of both chain and independent pharmacists could not assess the ease of verifying T.A. balances despite their experiences processing cards at the point of sale.

Coordination of Benefits: Ninety-two respondents were able to rate the coordination of benefits between the Medicare drug discount cards and other pharmacy assistance programs, including state and manufacturer PAPs. Of these 92, 30 rated coordination of benefits as excellent or good, 30 as fair, and 32 as poor or very poor. More than half of sponsors (11/18) believed that coordination was excellent or good. Conversely, more than three-fourths of the chain pharmacy executives thought that coordination was very poor or poor (13/17).

Exhibit 6: Ratings of the Medicare Drug Discount Card Program Features



Source: Interviews Conducted by Abt Associates Inc., 2004-2005.

Program Value (Card but No T.A.): One hundred and twenty-eight respondents rated the value of the program for those who were not eligible for T.A. (i.e. those who get discount cards but not the $600 credit). Forty of these deemed it excellent or good, 62 fair, and 26 poor or very poor. The majority of manufacturers (8/16) indicated that the value of the discounts alone was excellent or good, possibly reflecting their own belief in their efforts to offer a significant rebate for humanitarian reasons. In contrast, few pharmacists (3/22) indicated that the value of the discount card to beneficiaries with no T.A. was good and none rated it as excellent, perhaps reflecting the limited value of the card relative to other alternatives available at the retail level.

Program Value (Card with T.A.): Of the 131 respondents who assessed the program's value for beneficiaries who were eligible for the $600 credit, 118 rated the value as excellent or good, 13 rated it as fair, and none rated it as poor or very poor. **Half of the respondents (66) said that the program's value for beneficiaries who received transitional assistance was excellent. 90 percent said this value was excellent or good.**

This finding was consistent across all stakeholder groups. The majority of respondents in four stakeholder categories, sponsors (23/32), manufacturers (9/16), professional associations (7/9), and thought leaders (6/10) considered the program's value to T.A. beneficiaries to be excellent. The majority of chain pharmacy executives (16/17), pharmacists (17/22), and SHIPs (17/22) considered it either excellent or good.

Beneficiary Satisfaction: Of 137 possible respondents, 114 evaluated beneficiary satisfaction. Thirty-nine rated satisfaction as excellent or good, 48 rated satisfaction as fair, and 27 considered it poor or very poor.

9.0 Discussion and Conclusion

The Phase I Report for the project entitled "Evaluation of the Medicare-Approved Drug Discount Card Program: Stakeholder Analysis" documents the motivations, experience, and program impacts

of key stakeholder groups in the Medicare-approved prescription drug discount card program. The purpose of the report is to offer insight that could be productively applied both to the drug card program and to the Part D drug benefit.

This report is based on 137 individual in-depth interviews, 32 with card sponsors, 12 with independent pharmacists, 10 with chain pharmacists, 17 with executives of chain pharmacies, 16 with prescription drug manufacturers, 22 with State Health Insurance Programs, 8 with information intermediaries, 10 with representatives of professional associations, and 10 with thought leaders. The research design also featured four site visits to drug card sponsors and an analysis of secondary data sources related to the impact of the drug card program on state pharmacy assistance programs. The main findings are summarized in the previous chapter.

The drug card program embodies many of the concepts that are intended to modernize Medicare. On the supply side, the drug cards are provided by the private sector, and there is competition among multiple plans. For beneficiaries, enrollment is voluntary, and there is the opportunity to choose among the competing cards. This concluding chapter discusses how those concepts played out in the drug card program, develops potential implications for the Part D private drug benefit, and comments upon the potential opportunities for CMS to continue to support private provision, competition, voluntary enrollment, and choice under the Part D drug benefit. It also describes the project team's plans for Phase II of the Evaluation.

The Drug Card Program

In the drug card program, the private sector was both willing and able to provide the benefit, in this case the cards. Many sponsors offered cards; many manufacturers offered rebates; many pharmacies accepted the cards, albeit reluctantly. Some tension did exist among these private sector actors due to their conflicting interests. Card sponsors' desire to increase their profit margins was in conflict with manufacturers' desire for rebates to be passed through in full and with the pharmacy sector's desire to retain its profit margins.

Although inter-card competition was a key aspect of the program's conceptual design, this was not a theme that surfaced frequently when card sponsors discussed their strategy. Sponsors tended to use existing partnerships to market to defined groups of beneficiaries with whom they or their partners had an existing relationship, i.e. they did not rely on direct marketing. The one locus of significant direct competition among sponsors was the price comparison website.

In addition, competition among cards may have been dampened by the lack of differences among the drug cards. Most cards offered discounts on all drugs. Most of our interviews suggested that sponsors all received comparable manufacturer rebates. Finally, sponsors' marketing materials tended to be very similar due to the reliance on CMS' model materials.

While the private sector was willing to offer the drug cards, beneficiaries were reluctant to sign up for them. Many sponsors attributed this low enrollment to poor program promotion on the part of CMS and excessive restrictions on sponsors' and manufacturers' marketing efforts. Respondents in all stakeholder groups emphasized beneficiary confusion as a contributing factor to low levels of enrollment, especially confusion created by the large number of cards. Some also cited beneficiaries' doubts about the value of the drug card program especially the doubts of those beneficiaries who were not eligible for subsidies or who had access to alternative sources of assistance with prescription drug expenses such as state or manufacturer pharmacy assistance programs. Finally, some attributed low

enrollment to the nature of the target population, including beneficiaries' skepticism regarding government programs, reluctance to embrace new things, and low levels of literacy and computer literacy.

For choice to succeed, the drug cards must differ in ways that are meaningful to beneficiaries, and individual beneficiaries must be able to understand these differences and make the choice that is best for them. This project did not assess the extent of variation in drug card offerings. It did find that information intermediaries, SHIPs and pharmacist reported that beneficiaries were confused by the complexity of the program and by the number of card offerings, the implication being that it was not easy for beneficiaries to make choices with confidence. (While the intent of the price comparison website was to facilitate choice, many stakeholders commented that not all beneficiaries could use this tool due to low levels of computer literacy and access.)

Implications for the Part D Drug Benefit

As was the case with the drug card, the supply side of the Part D drug benefit features private sector provision and competition; the demand side features voluntary enrollment for beneficiaries and choice among competing plans. However, under the Part D drug benefit, private sector engagement may be quite different from what it was for the drug card program. Private drug plans need different capabilities from those of drug card sponsors, namely the abilities to administer a drug benefit and to bear risk. Very few organizations have these capacities at the scale required. In particular, the pharmacy benefits managers (the PBMs) who have the experience in benefit administration do not have the risk-bearing experience. Even those organizations that do have the risk-bearing experience may be cautious in an environment where there are little data upon which to base projections.

Manufacturers also may respond to the Part D benefit opportunity rather differently from the way they responded to the drug card program. In the drug card program, manufacturers offered unconditional rebates primarily for humanitarian reasons. Typically, their intent was for their rebate to be passed through at point of sale and to directly offset beneficiaries' out-of-pocket costs. Many manufacturers indicated that they gave a similar rebate to all plans. Under the Part D drug benefit, the impact of rebates on beneficiaries is less direct, i.e., they will affect beneficiaries' costs through premiums and cost sharing only.

Under the Part D drug benefit, manufacturers may use rebates to private drug plans the way that they are currently used with PBMs. Rebates are a payment that is made conditional on an organization including a drug on a preferred drug list or attaining a certain volume or level of market share for a drug. Based on the drug card experience, one might expect manufacturers to offer uniform rebates to all sponsors, at least initially.

The retail pharmacy sector is likely to be a reluctant participant in the Part D drug benefit, as they were in the drug card program, because they view the program as one that may steer some of their customers into mail order and reduce the profit margins on the remaining retail prescriptions. While it is also possible that more widespread drug coverage among seniors would increase pharmacies' customer base, no respondent in the retail pharmacy sector mentioned this possibility.

The dynamics of inter-plan competition under the Part D drug benefit may differ from the dynamics of inter-card competition in the drug card program. The longer life of the program and the more significant resources at stake may motivate more active competition than was observed under the drug card. The drug card experience (including sponsors' lack of success with direct marketing)

suggests that private prescription drug plans may choose to emphasize marketing via partners rather than direct marketing in the initial period.

Some of the factors that contributed to low beneficiary enrollment in the drug card program are likely to persist into the Part D drug benefit, namely, the potential for doubts and confusion on the part of beneficiaries regarding program value (especially for beneficiaries who are not eligible for subsidies and for beneficiaries whose current drug utilization is low) and the nature of the target population. The Part D drug benefit differs from the drug card because the financial stakes are higher, both in terms of the level of premiums for beneficiaries who are not eligible for subsidies and in terms of the potential net benefit resulting from comprehensive coverage. Also, unlike the drug card program, the Part D drug benefit incorporates strong financial incentives to enroll within the first six months. Finally, differences in plans' competitive behavior will affect beneficiaries' experiences.

As with the drug card program, the potential value of choice in the Part D drug benefit depends on whether the private drug plans differ in ways that are meaningful to beneficiaries and whether beneficiaries are able to evaluate their choices.

Opportunities for CMS

There are several ways that CMS could continue to support private sector provision, competition, voluntary enrollment, and choice under the Part D drug benefit. For instance, CMS could support private sector provision by seeking input from sponsors, manufacturers, and pharmacies on an ongoing basis and by treating the private sector as a partner; the agency may wish to pay special attention to retail pharmacies' concern that they have been left out of the process and lack leverage with sponsors. CMS could also make all possible efforts to ensure that implementation processes are as smooth as possible for participating organizations. This effort would include releasing all rules, regulations, and requirements with adequate lead-time and keeping mid-course corrections to a minimum. Manufacturers might be encouraged to offer rebates if CMS requires public reporting of the level of rebates and the extent to which they are either retained by the plan or passed through to beneficiaries; however, implementing such reporting is complex in practice, and it may be in the public interest for plans to retain a direct financial incentive to negotiate maximum rebates.

In order to support competition, CMS might allow sponsors and manufacturers to undertake more active and diverse marketing campaigns. (Such campaigns might also promote enrollment.) Through the provisions for alternative and supplemental coverage, CMS might seek to facilitate variation in benefit design on dimensions that are meaningful but comprehensible to beneficiaries. Some obvious examples include the levels of premiums, the extent of cost sharing, and the nature of pharmacy networks, but other opportunities may also exist.

In addition to supporting private sector provision and creating competition, CMS could promote enrollment in Part D drug plans through optimally designed outreach and education. Five key features of such a campaign would be 1) beginning early, 2) emphasizing the potential value of the program and clearly identifying who is most likely to benefit, 3) using state-of-the-art methods to reach hard-to-reach populations, 4) working with many partners including States, pharmacists and pharmacies, physicians, and beneficiary organizations, and 5) carefully crafting simple, concise, and clear messages.

Another important way to raise enrollment is to maximize the value of the program. CMS could continue to facilitate coordination and cooperation between private drug plan sponsors and state and

manufacturer pharmacy assistance programs (PAPs), for example state PAPs can offer wrap-around programs to PDP enrollees.

In order to facilitate choice, CMS could continue to invest significant resources in tools, such as the price comparison website, that assist beneficiaries with the process of choosing among plans. The ideal tools would be simple and easy-to-use. The inputs would be personalized, i.e. the tools would incorporate information about beneficiaries' current conditions and medication use, their eligibility for subsidies, their risk tolerance, and other key parameters. The output would be clear, concise, personalized, and in a format that enabled the beneficiary to assess the relative merits of candidate plans in light of his own personal situation. Ideally, these tools would be available on paper, in person, or by phone, as well as over the web. CMS should also recognize the large role that beneficiary organizations, pharmacists, and families play in supporting beneficiaries during the choice process and offer these tools and other informational materials to these parties as well. In considering these activities, CMS will have to balance its program development role with its regulation and oversight role with the need to conform to its Congressional mandate.

Phase II of the Evaluation

During Phase II, we will build upon these findings. As currently planned, Phase II will include repeat interviews with many of the Phase I respondents, focus groups with pharmacists, and community case studies. Repeat interviews will enable us to gather additional detail on key topics and to understand how stakeholders' perspectives are evolving over time. Focus groups with pharmacists will add additional depth to the evaluation's examination of this key sector. The community case studies will generate in-depth information about program implementation at the local level including the coordination of benefits between the Medicare drug benefit initiative and the SPAPs and the roles of various other organizations serving beneficiaries. Taken together, these efforts will enable us to develop further insight regarding the themes of greatest interest.

Appendix A: The Medicare-Approved Drug Discount Card - Real Successes and Some Lessons Learned[37]

Overview

The Medicare-Approved Drug Discount Card program has met the challenge of providing significant savings on the cost of prescription drugs for millions of American seniors. The savings offered are real, beneficiaries report high levels of satisfaction with the program and the enrollment process, and the drugs offered through the program have remained stable. The drug card program has offered substantial value to Medicare beneficiaries in terms of dollar savings. We also believe it has assisted millions of beneficiaries, particularly those currently without prescription drug insurance, learn more about comparing prices, the role of formularies, the potential benefits of generic medicines and lower cost alternatives, and the balance between enrollment fees and drug prices and other program features.

The program was designed as a stop-gap measure, providing assistance to Medicare beneficiaries for the 19 months prior to implementation of the Medicare drug benefit on January 1, 2006. Over 6.3 million seniors are getting significant discounts on their medicines – and over 1.8 million of these individuals are also getting $600 in 2004 and 2005 toward the purchase of their prescription drugs, and often qualify for special manufacturer discounts in addition to the Medicare discount and $600. Most drug card enrollees are satisfied with their drug card savings, and beneficiaries with limited incomes had even higher approval ratings of the drug card program. The evaluation also found that beneficiaries were especially satisfied with the choice of pharmacies at which they could use their cards and with the enrollment process.

Medicare-approved Drug Discount Card Program Highlights

- **Discounts of 12 to 21 percent on common brand name drugs**. CMS analysis of Medicare-Approved Drug Discount Cards shows beneficiaries can obtain discounted prices that are about 12 to 21 percent less than the national average prices actually paid by Americans for commonly used brand-name drugs at retail pharmacies.

- **Limited-income beneficiaries can save 44 to 92 percent**. Limited-income beneficiaries can save much more, almost 44 to 92 percent over national average retail pharmacy prices, when using the Medicare-Approved Drug Discount Card with the best prices and the $600 in transitional assistance. Also, many limited-income beneficiaries can get significant special manufacturer discounts once the $600 credit is exhausted. There are over 1.8 million drug card enrollees with transitional assistance. Beneficiaries receiving $600 in transitional assistance were the most enthusiastic about drug card savings.

- **Substantial savings on generic drugs**. Beneficiaries currently using generic drugs can also obtain large savings using a Medicare drug discount card, saving 45 to 75 percent below typical prices paid by Americans for commonly used generic drugs. Beneficiaries

[37] Appendix A is a document created by CMS that further describes how lessons learned from operating the Medicare Prescription Drug Discount Card have been applied by CMS toward implementation of the Part D drug benefit.

currently using brand name drugs who are able to switch to generics can achieve even greater savings of 46 to 92 percent. These results underscore the potential for savings when individuals who are able to switch to generic medications do so.

- **Savings confirmed by independent analyses**. The Lewin Group, American Enterprise Institute and Kaiser Family Foundation have conducted studies confirming savings through use of the Medicare-Approved Drug Discount Card. Savings were found in the same range as or even higher than CMS analyses**.** With varying methodologies, Lewin found a discount of more than 20 percent, Kaiser found 8 to 61 percent savings depending on the specific drug, card program and pharmacy location and AEI found limited-income seniors can save half to three quarters of drug costs compared to other private alternatives.

- **Stable formularies**. CMS designed the drug card program to produce consistent savings and consistent availability of drugs over time for enrollees. A CMS analysis shows Medicare drug discount cards' formularies have remained very stable since the program was implemented. All card sponsors provided discounts on the top 100 drugs most commonly used by the Medicare population, and those drugs have been retained on the formularies since the program was implemented.

The Medicare-Approved Drug Discount Card program successfully achieved prescription drug savings so that people with Medicare no longer have to pay among the highest prices for prescription drugs. CMS has applied relevant lessons learned from administration of the drug card program in implementing the Part D benefit. The following section summarizes the highlights of major lessons learned from the drug card experience.

Highlights of Lessons Learned

The Medicare-Approved Prescription Drug Discount Card program was created as a stop-gap measure, especially aimed at Medicare beneficiaries with limited incomes, in order to provide relief on the cost of prescription drugs until the Medicare Part D drug benefit begins. With hindsight and expert internal and external evaluation, CMS has been able to apply relevant lessons learned from operating the drug card toward implementation of Part D.

It is worth noting that, in many respects, the CMS experience with the drug card program reinforced the direction the agency had planned to take with respect to implementation of Part D. For example, while marketing and outreach for the drug card focused on national efforts and messages, the focus for Part D has been regional and local. Given the differences in scope and potential impact on beneficiaries of the drug card versus Part D, sometimes CMS' plans for communication or beneficiary outreach were different for Part D, yet informed by our experience under the drug card. Aside from its very positive value for beneficiaries, the drug card has informed CMS on important aspects of the Part D benefit.

Finally, the points presented here represent highlights of the learning opportunities for CMS. There are many more lessons that may or may not be of interest to a general audience. Overall, the drug card experience was a valuable learning curve for CMS and for the many organizations which will offer, or assist in offering, Part D benefits.

The following lessons learned are derived from an internal CMS information collection process involving CMS Central Office and Regional Office staff as well as sponsors, contractors, and other external partners affiliated with the drug card program (212 individuals total). In addition, CMS has learned much from the work of the Government Accountability Office (GAO), Department of Health and Human Services Office of Inspector General (OIG) and other independent studies, some of which are ongoing.

- **Beneficiary communications should be simple, carefully keyed to the target audiences, timely and adapted to local conditions and insurance options.** When possible, face-to-face training workshops and webcasts are most effective. The five target audiences identified for Part D are: Medicare Advantage enrollees, retirees with drug coverage, people with Medicaid, other limited-income individuals, and the remaining general population. CMS is conducting targeted outreach with national, regional and community-based outreach efforts as well as with all sister agencies at HHS and federal agencies that directly contact people with Medicare to promote awareness of the new prescription drug benefit at the grassroots level. The outreach strategy for Part D will include a broad array of organizations that have direct contact with beneficiaries, including local affiliates of national partner organizations, local extensions of some federal agencies, and the Aging Network.

- **Pharmacists play a key role in educating beneficiaries.** Beneficiaries cite pharmacists as the most frequently used source of information to learn more about the drug card program. Pharmacists played a key role in helping Medicare beneficiaries understand the program, enroll in drug cards, and use their drug cards. Within parameters, Part D Marketing Guidelines encourage health care providers (e.g., pharmacists, physicians, etc.) to take an active role in educating and providing beneficiaries with information regarding options available under Part D. In addition, CMS is supplying information and resources to pharmacists and providers through an extensive outreach campaign starting in the summer of 2005.

- **The U.S. Territories present special issues related to beneficiary outreach.** The Territories are a unique circumstance under both the drug card and Part D. A special team has been assigned to work on outreach to the territories for Part D to maximize understanding of the benefit and ways to access it.

- **Grassroots education efforts should start early.** Efforts are well underway to have community-level organizations recruited, trained, and ready to assist beneficiaries as soon as beneficiaries start receiving marketing material from Part D plans. In additional, Regional Offices are extending their partnerships and collaborating with the Aging Network to ensure a sufficient network is in place to assist beneficiaries with enrollment issues and other questions.

- **Ensure Medicare beneficiaries with low-incomes realize the benefits of choosing or being auto-enrolled in a Part D plan.** One of the most commonly cited best-practices relative to the drug card was allowing State Prescription Assistance Programs and Medicare Savings Programs (MSPs) beneficiaries to be auto-enrolled into the drug card and transitional assistance. Under the Medicare prescription drug benefit, CMS is implementing a similar strategy for people who qualify for extra help with their Medicare prescription drug coverage costs. CMS will help beneficiaries such as those in MSPs, those who receive SSI benefits, and others who apply and qualify for extra help, learn about their choices and join a Medicare drug plan on their own. However, if they do not choose a plan, CMS will auto-enroll the lowest income beneficiaries in a plan effective

January 1, 2006, consistent with the statute. These beneficiaries will also have a special election period where they can change plans any time.

- **Coordinate CMS communication and outreach plan with sponsors' communication and outreach plans.** CMS is proactively communicating with sponsors regarding Part D outreach messages and resources through the CMS website at http://www.cms.hhs.gov/partnerships/, frequent User Group calls, and the Health Plan Management System (HPMS).

- **The drug card outreach campaign highlighted the critical role of direct assistance in enrollment.** CMS is building an extensive grassroots outreach campaign for Part D that utilizes community based organizations' experience to tailor messaging and support to the needs of specific populations. CMS welcomes and will facilitate plan sponsors to actively support this important and challenging task.

- **Implement clear guidance, with public comment, on drug benefit marketing such that sponsors have the opportunity to devise clear, effective marketing materials from the start of the program and within budget.** CMS has sponsored Part D Marketing Materials Guidelines Training and has addressed all known policy issues. The review process has been streamlined by the expansion of the File & Use program. Contracted Part D sponsors can forego a prospective review of certain categories of marketing materials. CMS has contracted with BearingPoint to develop Part D marketing guidelines and the review process of PDP marketing materials to help assure consistency in marketing reviews. This contractor's experience with the Medicare-Approved Discount Drug Card program will provide valuable knowledge and skills to improve the Part D marketing materials review process. CMS has developed additional model materials that will further simplify the review process if they are used without modification.

Appendix B: Interview Methods

This draft report is based on 109 individual in-depth interviews with members of the four stakeholder groups and an additional 28 in-depth interviews with other individuals with important perspectives on key issues of the Medicare prescription drug discount card program. This appendix offers details regarding the methods used in these interviews.

Overview and Sample Sizes

For each type of stakeholder, we selected an initial target number of respondents based on our expectations regarding how many interviews would be necessary to get a full and complete perspective about the Medicare-approved drug discount card program. (See Exhibit B.1: Sample Development.) We sent recruitment letters to about twice as many respondents as we hoped to interview, because we assumed a 50 percent cooperation rate. For most stakeholder groups, in conjunction with the CMS PO, we decided to truncate data collection once we reached "saturation"—that is, once the findings from interviews began to be repetitive and additional interviews were not likely to provide new information.

Exhibit B.1: Sampling, Recruitment, and Numbers of Completed Interviews

	Source (A)	Size of Universe	Original Target	# of Letters Sent	# of Completed Interviews
Card Sponsors	**HPMS/CMS**	**76**	**56**	**76**	**32**
General endorsement (7)		30 (B)	25	30	18
Special endorsement (7)		6	6	6	4
Exclusive (7)		40	25	40	10
Manufacturers	**AARP Research/ HDMA Directory**		**20**	22	**16**
Pharmacies	**NCPDP**	**5,000**	**75**		**39**
Pharmacy Executive		20	15	20	17
Pharmacists in chain pharmacies		2,500	25	48	10
Pharmacists in independent pharmacies		2,500	25	47	12
States and Territories	**SHIP resource center**	**51**	**30**	**51**	**22**
SHIPs program directors		51	30	51	**22**
Others	**CMS, public sources**		**42**		
Info intermediaries and beneficiary advocates		13	10	13 (C)	8
Professional associations		12	12	12	10
Thought leaders		11	10	11	10
Grand Total of Interviews included in report					**137**

(A) All sources will be explained in depth in Section 2.1

(B) Sponsors were only assigned to one interview list (general, special endorsement, or exclusive). Therefore, the universe of each list was reduced to prevent sponsors receiving duplicate invitation letters for our study.

(C) Information intermediaries were sent emails rather than letters inviting them to participate.

Sample Sources and Selection Methods

Card Sponsors

Our design called for interviews with general, exclusive and special endorsement card sponsors. CMS provided us with all sponsor contact information from a current run of the Health Plan Management System (HPMS) on October 20, 2004. CMS recommended that the Medicare Compliance Officer listed in the database for each sponsor would be the most appropriate representative for the interview. The HPMS data contained contact information for the Medicare Compliance Officers of 30 general card sponsors, 6 special endorsement card sponsors, and 40 exclusive card sponsors. We sent recruitment letters to all of these 76 card sponsors in order to reach our target number of interviews. More than half of the time, the Medicare Compliance Officer in our sample referred our recruiter to a more appropriate person to approach for the interview. We reached the point of saturation and concluded data collection after completing interviews with 15 general, 4 special endorsement and 10 exclusive drug card sponsors (total 29).[38]

Pharmacies

Our design called for interviews with lead pharmacists in independent pharmacies, executives at pharmacy chains, and pharmacists in chain pharmacies. We purchased data on 5,000 pharmacies in the U.S. from the National Council for Prescription Drug Programs, Inc. (NCPDP) in November of 2004.[39] This list consisted of 2,000 chain retail pharmacies, 500 chain grocery pharmacies, and 2,500 independent retail pharmacies.[40] From this list, we excluded pharmacies in Guam, Puerto Rico and the Virgin Islands because our evaluation was limited to U. S. states where the drug card program was implemented.

Independent Pharmacists: We selected a random sample of 50 independent pharmacies from the NCPDP list in order to meet our initial goal of 25 interviews, called these 50 to identify the names of the lead pharmacist or owner of the pharmacy, and sent these pharmacists recruitment letters. After completing 12 interviews we reached the point of saturation and concluded data collection.

Pharmacy Executives and Chain Pharmacists: We selected a random sample of 50 chain pharmacies from the NCPDP list in order to meet our initial goal of 25 interviews,[41] including no more than six stores from any one chain in our sample. Our sample of 50 chain pharmacies contained stores from 20 unique chains. Project staff called the pharmacies in order to identify the names of the lead pharmacist or owner of the pharmacy.

Before sending out the recruitment letters to pharmacists, our recruitment strategy was to interview the pharmacy executive of the chain first in order to ask the executives to encourage the chain pharmacists to participate in our study.

We sent recruitment letters to the pharmacy executives of all 20 unique chain pharmacies in our sample. A representative from the National Association of Chain Drug Stores (NACDS) provided us

[38] The special endorsement sponsors also sponsored national cards and therefore we were able to discuss issues regarding their experiences with both general and special endorsement cards during interviews

[39] The NCPDP list has over 70,000 licensed pharmacies and is updated annually.

[40] Our sampling of chain pharmacies was based on market share of prescription drug sales from the National Association of Chain Drug Stores website: www.nacds.org.

[41] We only included up to 6 stores from one chain in our sample.

with contact information for the pharmacy executives of the chain pharmacies. After completing 17 interviews with pharmacy executives we reached the point of saturation.

Once an interview with a pharmacy executive from a chain pharmacy was completed, we sent recruitment letters to the sampled chain pharmacist from his/her chain.[42] After completing 10 interviews with chain pharmacists, from 7 unique chains, we reached the point of saturation.

Manufacturers

Our design called for 20 interviews with representatives of drug manufacturers. An initial list of manufacturers was based on research done by the American Association of Retired Persons' (AARP) on the Top 200 National Drug Codes (NDCs) by number of Rxs for the elderly in 2003[43,44]. From this list we selected the top 12 brand-name manufacturers and randomly selected another 5 brand-name manufacturers from those remaining on the list; we also selected the top 5 generic manufacturers. For each manufacturer we identified the appropriate contact person by referring to the 2004 Healthcare Distribution and Management Association Directory (HDMA) and sent these individuals recruitment letters. After completing 16 interviews with manufacturers, we reached the point of saturation and concluded data collection.

SHIPs

State Health Insurance and Assistance Programs (SHIPs): Our design called for 30 interviews with representatives of SHIPs program directors from the state-level offices. We obtained the April 2004 list of 51 state SHIP project directors (50 states and the District of Columbia) from the SHIP Resource Center. We sent recruitment letters to all 51 in order to reach our target. After completing 22 interviews with SHIPs project directors we concluded data collection.

Other Stakeholders

Thought Leaders: An initial list of thought leaders was developed using individuals cited in the news, professional contacts of the project team, and recommendations of CMS. We then used a snowball strategy (asking each respondent for names and qualifications of other potential respondents) to generate additional names and to identify the most promising candidates. The final list of ten respondents was selected with an eye to balance in terms of expertise, to intellectual distinction, and to the ability to speak in an informed and candid way about the drug card program.

Professional Associations: We interviewed 10 individuals who represent prominent national and regional professional associations for the stakeholders in our study; these individuals were public policy directors for their respective professional associations, who specialize in Medicare issues[45]. Once the list of professional associations was compiled in conjunction with CMS, we used public data sources to identify individuals to interview, sent them recruitment letters, and completed the interviews.

---

[42] Three pharmacy executives did not grant us permission to interview their line pharmacists and therefore we did not recruit these pharmacists.

[43] May 2004. AARP "Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Older Americans, 2000 through 2003. David J. Gross, Stephen W. Schondelmeyer, and Susan O. Raetzman.

[44] Because the data were collected in this way, drugs administered in a physicians' office and covered by Part B were not included.

[45] See Appendix E for a List of the Professional Associations

Beneficiary Advocates: We interviewed 8 representatives of advocacy organizations for Medicare beneficiaries. We consulted with CMS, SHIPs coordinators and state representatives to identify appropriate organizations, and selected those with the greatest national prominence. Once organizations were selected, individual respondents were identified from public data sources and were interviewed.

Recruitment Procedures

All interviews included in this draft report were conducted between November 11, 2004 and February 28, 2005. Potential respondents from all interview groups except beneficiary advocates were mailed an advance recruitment letter cosigned by the CMS Project Officer or another CMS staff member and Abt's Project Director, as well as a disclosure statement (described below). Recruitment documents were tailored for each stakeholder group. A member of the project staff followed up with a telephone call to answer questions about the study and to schedule an interview if the respondent was interested in participating.[46]

At the end of interviews with pharmacy executives of chain pharmacies, we asked respondents if they would be supportive of us contacting pharmacists from their pharmacies for an interview. If yes, we encouraged the pharmacy executive to contact these pharmacists directly to encourage them to participate in the telephone interview, and simultaneously contacted the chain pharmacists ourselves with a recruitment letter and follow-up telephone call, mentioning the executive's support if permission was granted.

All respondents received a reminder telephone call or email 24 hours in advance of their scheduled interview. Interviews were conducted by seven of Abt's senior project staff. Many interviews also had a note-taker for quality control purposes and for assistance with writing the interview summary. Respondents were informed that an additional researcher was listening in on the interview to take notes. After the interview was complete, respondents were sent a thank you email.

Confidentiality and Informed Consent

The Abt Associates Institutional Review Board (IRB) reviewed and approved the study protocol, including the disclosure statement (see below), interview discussion guides, recruitment strategies and materials, and a data security plan. We used a disclosure statement rather than a signed informed consent form due to the difficulties inherent in obtaining a signed form prior to a telephone interview.

Respondents were given information related to the disclosure statement several times. When they were first recruited, potential respondents received the disclosure statement along with the recruitment letter. During the scheduled time for the interview, interviewers read the consent script, which described the purpose of the study and other key points from the disclosure statement (e.g. that participation in the study was voluntary and that participants did not have to answer questions they did not want to). Respondents were not given any monetary or other compensation for participating.

All respondents, with the exception of thought leaders and representatives of professional associations, were assured that their confidentiality was protected and that their names and organizations would not be included in our report. In order to add credibility to the study, thought leader's names and organizations, as well as a list of the professional organizations represented in our study, are included in an appendix (below), if the respondent granted permission.

[46] The representatives of beneficiary advocacy groups and investment analysts were emailed a recruitment letter followed by a telephone call to explain the study and schedule an interview if the participant was willing.

Interview Protocol Design

And interview discussion guide in collaboration with CMS, based on CMS's research questions. Each stakeholder group's discussion guide contained the same set of core question, as well as questions specific to each group. The discussion guides contained open-ended and close-ended questions. The open-ended questions asked about overall experience with the drug discount card program, experience with beneficiary choice, experience working with CMS, strengths and weaknesses of the program, and lessons for the Part D drug benefit. The close-ended questions asked respondents to rate aspects of the drug discount card program (on a 5-point Likert scale from "very poor" to "excellent") such as the design of the program, its implementation, communications with CMS, and the value and benefit of the program for beneficiaries.

After Abt developed the initial discussion guide, it was pre-tested. Using our network of personal contacts, we identified two sponsors, two independent pharmacists, one chain pharmacist, a former SHIP program director, an industry consultant, a representative from PhRMA (the pharmaceutical manufacturers' lobbying organization), and a manufacturing. We also received comments on the discussion guide from project consultants, including individuals who specialize in the PBM industry, SHIPs, and pharmaceutical manufacturers. The pretest was useful in assessing the length of the interview and assuring that critical topics could be covered in the time allotted to the interviews (30-45 minutes). The pretest was also useful in determining whether the protocols generated a robust discussion of the issues. Following the pretests, we revised the protocols to reduce length, because the pretest interviews indicated that interviews were likely to exceed 45 minutes. All changes were consistent across stakeholder groups, in terms of questions and language.

Interview Procedures

The interviews were designed to take 30 minutes, with the exception of sponsors' interviews, which required 45 minutes because more topics needed to be covered. Most interviews took longer than anticipated, however, so interviewers attempted to at least ask priority questions (determined with CMS), including the close-ended questions, and skipped others as necessary to shorten the interviews.

All interviewers and note-takers participated in a one-day training. This training oriented staff to the substantive issues related to the project, data collection and recording processes, and informed consent procedures. Interviewers and note takers also participated in a second half-day training focused on interviewing skills, reviewing the interview protocols and recruitment criteria. All interviewers were carefully trained to ensure that they would maintain a neutral position throughout the interview.

Analytic Methods

When two staff members conducted an interview, the more senior person led the interview and the junior staff member took notes. Immediately after the interview, the note taker summarized the interview using a report summary template called the 'recording form.' The senior interviewer reviewed the summarized notes in the recording form to ensure accuracy. The recording form was formatted for importing into an NVivo (version 2.0) software database.[47] Responses to close-ended questions were also imported into NVivo to enable linkage of close-ended responses to open-ended responses. A coding scheme for the interviews was developed to assist in the data analysis. The final

[47] Software like NVivo is commonly used to manage and review a large volume of qualitative data in an objective and scientific manner and to document the basis for any conclusions.

coding scheme consisted of structural codes that mirrored major sections in the interviewer's protocol, and were similar for all interview groups. NVivo was used to sort the data by question for each interview group. Some stakeholder groups with a larger number of interviews were further coded for sub-themes of each major topic. Using NVivo allowed all interviewers to analyze how many times a particular theme was raised and by whom, in order to ad rigor to the process of documenting widely held views.[48]

The senior staff member responsible for doing the majority of interviews for a stakeholder group was assigned to write the related chapter for this report. All the interviewers who conducted interviews with a given stakeholder group together discussed emergent themes several times before and while writing a chapter on a stakeholder group.

[48] Note: a few final interviews with manufacturers were conducted just as this draft report was being completed; these interview findings are included in the report but the close-ended responses from these final interviews are not – they will be included in the final version of this report.

Appendix C: Interview Discussion Guide

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
1	**Describe Self**		**1**	**1**	**1**	**1**	**1**	**1**
1.1	Briefly describe your organization (mission, products, clientele, as applicable).		1	1	1	1	1	1
1.2	Probe for PBM, insurance company, health plan/MCO, other type of organization.	PBM, insurance company, health plan/MCO, other						1
1.3	Using sampling source, confirm whether pharmacy is a chain or is independent.	chain, independent			1	1	1	
1.4	Would you say your pharmacy is in an urban, a suburban, or a rural area?	urban, suburban, rural			1	1		
1.5	Using sampling source, confirm number of chain's outlets.	update information if necessary					1	
1.6	Briefly describe your own role in your organization (title and responsibilities.)		1	1	1	1	1	1
1.7	Using sponsor summary - confirm number of general cards, number of exclusive cards, number of special endorsement cards.	# general cards, # exclusive cards, # special endorsement cards						1
1.8	Using sponsor summary, confirm general levels of enrollment in each Medicare-approved drug discount card.	update information if necessary						1
1.9	Using sponsor summary, confirm service area.	update information if necessary						1
1.91	Did you offer a drug discount card before the Medicare discount drug card program?	y/n						1
1.92	Did you offer a funded drug benefit before the Medicare-approved drug discount card program?	y/n						1
1.93	Now I want to ask a few questions about your partnering arrangements. Using sponsor summary, confirm sponsor's major partners (PBM, etc.)							1
1.94	What are the roles/responsibilities of your partnering orgs in administering the Medicare-approved drug discount card?							1
1.95	What are the roles/responsibilities of your org in administering the Medicare-approved drug discount card?							1
1.96	Does your partnering org negotiate agreements with pharmacies?							1
1.97	Does your partnering org negotiate agreements with manufacturers?							1

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
2	**Reasons for Participation and Objectives**			**1**	**1**		**1**	**1**
2.1	Why did you decide to participate/not to participate?** Probe: What did you want to achieve? What did you hope to learn? Take appropriate openings to probe for: Market objectives? Financial objectives? Other objectives? How did you want to position yourself relative to your competition? To what extent were you motivated to participate because you were looking ahead to the Part D drug benefit?							1
2.2	Presumably, your organization has had the opportunity to participate in various Medicare-approved drug discount cards. Why have you decided to participate or not? What have you hoped to achieve? (For pharmacies, "participation" means accepting the Medicare-approved drug discount card. For manufacturers, "participation" means offering rebates.)			1	1		1	
3	**SHIP Role and Partnership Arrangement**		**1**					
3.1	What do you see as your organization's role in the Medicare-approved drug discount card program?		1					
3.2	Now I want to ask a few questions about your partnering arrangements. CE: Do you have partnerships with other organizations related to the Medicare-approved drug discount card?	y/n	1					
3.3	Did you form these partnerships specifically in response to the Medicare-approved drug discount card or did they previously exist?	new partnership, prev existed	1					
3.4	What were their roles and what were your roles?		1					
4	**Overall Experience**		**1**	**1**	**1**		**1**	**1**
4.1	I'd like to hear about your personal experience with the Medicare-approved drug discount card program so far, in terms of what's been challenging and what's gone well. What's been challenging?		1	1	1		1	1
4.2	What's gone well?		1	1	1		1	1
5	**Sponsor/Pharmacy Experience**				**1**		**1**	**1**
5.01	At sponsors, ask these questions if sponsor works with pharmacies directly.							1
5.1	Medicare-approved drug discount card sponsors are asked to obtain pharmacy discounts. Describe how this process has worked.				1		1	1
5.2	Please comment on the Sponsor/Pharmacy relationship. What has been challenging?				1		1	1
5.3	What has gone well?				1		1	1
5.4	Please comment on the level of pharmacy compensation that emerged from this process and compare it compensation in funded products.				1		1	1
5.5	CE: Please rate your satisfaction with the relationship between sponsors and retail pharmacies.	excellent, etc.			1		1	1

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
5.6	Please describe the role of mail order in your Medicare-approved drug discount card. (Probe: please describe any incentives, financial or otherwise for beneficiaries to use mail order rather than retail.)							1
6	**Role of Discount Drug Lists**							**1**
6.1	As you know, sponsors had some latitude in whether and how to develop discount drug lists. Please describe the role of discount drug lists in your product design. (Probe: how does this compare to formularies in your insurance products.)							1
6.2	How have beneficiaries reacted to the discount drug lists?							1
7	**Sponsor/Manufacturer Experience**			**1**				**1**
7.01	At sponsors, ask these questions if sponsor works with manufacturers directly.							1
7.1	Medicare-approved drug discount card sponsors are required to obtain rebates from manufacturers. Talk a little bit about how this process has worked.			1				1
7.2	Please comment on the Sponsor/Manufacturer relationship. What has been challenging?			1				1
7.3	What has gone well?			1				1
7.4	Please comment on the rebates that emerged from this process. Compare them to the rebates in covered products. (Probe: does that apply to branded drugs? Does that apply to generic drugs? Which drugs receive greater rebates and why? If manufacturers have refused to provide rebates, or offer rebates well below the insured market, what reason do they provide? Have manufacturers made any special pricing arrangements related to low-income persons?)			1				1
7.5	CE: Please rate your satisfaction with the sponsor/manufacturer relationship.	excellent, etc.		1				1
7.6	We have just discussed general patterns with interactions with manufacturers. Have any manufacturers deviated from these general patterns? Who has and how?							1
8	**Experience with Beneficiary Choice**		**1**		1	1		
8.1	Please comment on your experiences helping beneficiaries to understand the Medicare-approved drug discount card program, decide whether to enroll, and decide which card to choose. What has been challenging?		1		1	1		
8.2	What has gone well?		1		1	1		
8.3	Based on your experience, what factors do beneficiaries consider the most important when choosing a Medicare-approved drug discount card?		1		1	1		

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
9	**Experience with Enrollment and with Cards at Point of Sale**		**1**		**1**	**1**		
9.1	Please comment on your experiences with Medicare-approved drug discount cards at the point-of-sale. What has been challenging? (Probe: Can beneficiaries and pharmacists attain current information on the balance of the $600 for T.A. enrollees? Explain any coordination problems with other drug insurance discounts.)				1	1		
9.11	What has gone well?				1	1		
9.2	Please comment on what you have heard from beneficiaries about the process of enrolling in the Medicare-approved drug discount cards. What has been challenging?		1					
9.21	What has gone well?		1					
9.3	Please comment on what you have heard from beneficiaries about their experiences with Medicare-approved drug discount cards at the point-of-sale. What has been challenging? (Probe for $600 balance and coordination of benefits)		1					
9.31	What has gone well?		1					
9.4	Please comment on the process of checking the balance of a beneficiary's $600 credit.		1		1	1		
9.5	Please comment on any coordination of benefits issues between the Medicare-approved drug discount cards and other drug benefits.		1		1	1		
10	**Experience Working with CMS**		**1**	**1**	**1**	**1**	**1**	**1**
10.1	Please talk about your experiences working with CMS on the Medicare-approved drug discount card program		1	1	1		1	1
10.2	Please comment on the RFP process.							1
10.3	Please comment on CMS' communications directed toward your sector and on CMS' technical assistance during Medicare-approved drug discount card implementation		1	1	1	1	1	1
10.4	Tell me how CMS could improve its communications plan and informational materials directed at your sector. (Record comments here.)		1	1	1	1	1	1
10.5	Please comment on CMS reporting requirements							1
11	**Experience Working with the States**		1		1	1	1	1
11.1	Many states are encouraging their residents to participate in Medicare-approved drug discount cards and to apply for the $600 credit. Some states have auto-enrolled participants in their state assistance programs into the Medicare-approved drug discount cards. Have you worked with states as part of your Medicare-approved drug discount card? Please comment on this experience.							1

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
11.2	Many states are encouraging their residents to participate in the Medicare-approved drug discount cards and to apply for the $600 credit. Some states have auto-enrolled participants in their state assistance program into the Medicare-approved drug discount cards. Have you worked directly with the states on the Medicare-approved drug discount card program? Please comment on this experience.		1		1	1	1	
12	**Interaction of Medicare-approved drug discount cards and other State Prescription Assistance Programs**		1	1				
12.1	Before the Medicare-approved drug discount card program, what other programs did your firm offer to help needy customers, particularly seniors and the disabled? Please describe briefly.			1				
12.2	How have you integrated these programs with the Medicare-approved drug discount card and the $600 credit?			1				
12.3	How well has this worked?			1				
12.4	Do you have any plans to change this in the future?			1				
12.5	Before the Medicare-approved drug discount card program, what other programs were available in your state to help needy customers? Please describe briefly. (Probe for state, manufacturer, and other programs.)		1					
12.6	In your state, how are these programs integrated with the Medicare-approved drug discount card and the $600 credit?		1					
12.7	How well has this worked?		1					
13	**Impacts on Own Organization**		1	1	1	1	1	1
13.1	In general terms, what have been the business impacts of the Medicare-approved drug discount card for your org? (Probe: If reluctant to discuss, ask --- Have the financial results been in line with your original expectations? If not, how have they differed? What are the implications of those differences in terms of your card program?)			1	1		1	1
13.2	What have been the impacts on image and marketing?			1	1		1	1
13.3	What have been the operational/systems impacts?				1		1	1
13.4	Please talk about the changes (if any) in customer base/product sales as a result of the Medicare-approved drug discount card program.				1		1	1
13.5	What have been the impacts of this program on your SPAP programs?			1				
13.6	What have been the other impacts of this program on your business?			1	1		1	1
13.7	What have been the impacts of this program on your pharmacy?					1		
13.8	What about the impacts of selling directly to beneficiaries?							1

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
13.9	As you know, the card program design assumes a level of competition between cards. Where does your card stand now in relation to your initial objectives regarding positioning and the competition? Explain any variance.							1
13.91	What have been the impacts of this program on your organization?		1					
13.92	What have been the impacts of this program in terms of the time you and your colleagues have spent helping beneficiaries to understand and make decisions regarding their Medicare-approved drug discount cards?		1		1	1		
14	**Overall Strengths and Weaknesses**		**1**	1	1	1	1	1
14.1	We have been talking about your experiences. Let's take a step back and assess the program as a whole. What do you see as the strengths of the Medicare-approved drug discount card program?		1	1	1	1	1	1
14.2	What do you see as the weaknesses of the Medicare-approved drug discount card program?		1	1	1	1	1	1
15	**Lessons for the Part D drug benefit**		**1**	**1**	**1**	**1**	**1**	**1**
15.1	What are the lessons that CMS needs to learn before implementing Part D?		1	1	1	1	1	1
16	**Overall Rating of Program**		**1**	**1**	**1**	**1**	**1**	**1**
16.01	Please rate the following, from the point of view of your organization:		**1**	1	1	1	1	1
16.1	CE: the overall design of the Medicare-approved drug discount card program	excellent, good, fair, poor, very poor, don't know.	1	1	1	1	1	1
16.2	CE: the implementation of the Medicare-approved drug discount card program.	excellent, good, fair, poor, very poor, don't know.	1	1	1	1	1	1
16.3	CE: the Medicare-approved drug discount card program's eligibility checking and enrollment process, for beneficiaries who enroll in Medicare-approved drug discount cards but not the $600 credit.	excellent, good, fair, poor, very poor	1					1

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
16.4	CE: the Medicare-approved drug discount card program's eligibility checking and enrollment process, for beneficiaries who enroll in the $600 credit.	excellent, good, fair, poor, very poor, don't know.	1					1
16.5	CE: the Medicare-approved drug discount card program's price comparison website (usefulness of the content)?	excellent, good, fair, poor, very poor, don't know.	1		1	1	1	1
16.6	CE: the ease of verifying the beneficiary's balance for the $600 credit	excellent, good, fair, poor, very poor, don't know.	1		1	1	1	1
16.7	CE: the coordination of benefits between the Medicare-approved drug discount card/$600 credit and other benefits and PAPs	excellent, good, fair, poor, very poor, don't know.	1	1	1	1	1	1
16.8	CE: CMS' communications plan and informational materials directed toward your sector.	excellent, good, fair, poor, very poor, don't know.	1	1	1	1	1	1
16.901	Please rate the following, from the point of view of beneficiaries:		1	1	1	1	1	1
16.91	CE: Medicare-approved drug discount card program's overall value, for beneficiaries who hold cards but are not eligible for the $600 credit	excellent, good, fair, poor, very poor, don't know.	1	1	1	1	1	1

Question Number	Full Question	CE responses	SHIPs	Manufax	Ind Ph	Ch Ph	Ph Execs	Sponsors
16.92	CE: Medicare-approved drug discount card program's overall value, for beneficiaries who are eligible for the $600 credit	excellent, good, fair, poor, very poor, don't know.	1	1	1	1	1	1
16.93	CE: beneficiaries' satisfaction with the Medicare-approved drug discount card program.	excellent, good, fair, poor, very poor, don't know.	1	1	1	1	1	1
17	**Closing Question**		**1**	**1**	**1**	**1**	**1**	**1**
17.1	Is there anything you would like to add? Anything important that has not come up?		1	1	1	1	1	1
17.2	From your perspective, what is the one thing you wish CMS had done differently or better with the Medicare-approved drug discount card?		1	1	1	1	1	1
17.3	What could CMS do to most help you in regards to Medicare-approved drug discount card?		1	1	1	1	1	1
17.4	You mentioned that you worked with XXX (key sponsor/ state partner). We may wish to talk with someone there. Could you suggest an appropriate individual who works with you on the Medicare drug card?		1					1
17.5	Is there anyone else that you think we should talk to?		1	1	1	1	1	1

Appendix D: Secondary Sources Concerning Implications of Drug Card Program for SPAPs

Fox, Kimberley. *Making it work: State Leadership on Medicare Rx Implementation and Coordinating with State Pharmacy Assistance Programs*. Presentation for the National Conference of State Legislatures August 17, 2004. www.cshp.rutgers.edu

Fox, Kimberley and Stephen Crystal. *Coordinating Medicare Prescription Drug Benefits with Existing State Pharmacy Assistance Programs Partnership or Crowd-Out?* Publication forthcoming.

Fox, Kimberley. Testimony before the State Pharmaceutical Assistance Transition Commission, July 7, 2004. www.cms.gov

Fox, Kimberley. *States' Experience Coordinating with Medicare Discount Cards and Lessons for Part D. Presentation for the Invitational State Summit on Medicare Part D Implementation Issues.* Presentation for the Invitational State Summit on Medicare Part D Implementation Issues October 7, 2004. www.cshp.rutgers.edu

Hoadley, Jack. State Lessons on the Drug Card. Presentation before the Medicare Payment Advisory Commission, September 10, 2004. www.medpac.gov

National Conference of State Legislatures. *2004 Medicare Prescription Drug Law State Adjustment Bills*, August 31, 2004.

National Conference of State Legislatures. *State Pharmaceutical Assistance Programs*, January 12, 2005. http://www.ncsl.org/programs/health/drugaid.htm

National Health Policy Forum. *The Basics: State Pharmacy Assistance Programs*, April 26, 2004, www.nhpf.org.

State Pharmaceutical Assistance Transition Commission. *Report to the President and Congress*, December 20, 2004. U.S. Department of Health and Human Services.

Appendix E: Respondents (Expert Observers Only)

Professional Associations

American Medical Association

American Pharmacists' Association

America's Health Plan

Association of Homes and Services for the Aging

Association of Managed Care Pharmacy

BIO

National Association of Chain Drug Stores

Pharmaceutical Care Management Association

Pharmaceutical Research and Manufacturers of America

Visiting Nurse Association of America

Thought Leaders

Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute

Jennifer Bryant, Vice President, and Allison Sydlaske, Research Analyst, The Lewin Group

Juliette Cubanski, Senior Policy Analyst, Kaiser Family Foundation

Kim Fox, Research Associate, Center for State Health Policy, Rutgers

Larry Grimaldi, Chief of Information and Public Relations, Rhode Island Department of Elderly Affairs

Julie James, Principal, Health Policy Alternatives

Don Muse, President, Muse & Associates

John Richardson, Director of Medicare Practice, Health Strategies Consultancy

Grace Marie Turner, President, Galen Institute

Jim Wilson, President, Wilson Health Information, LLC

Appendix F: Responses to Closed-Ended Questions

SPONSORS

Sponsors' Ratings of their Relationships with Pharmacists and with Drug Manufacturers	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Relationships with Pharmacists	0	0%	0	0%	0	0%	15	47%	4	13%	13	41%	32
Relationships with Manufacturers	0	0%	1	3%	1	3%	14	44%	3	9%	13	41%	32

Sponsors' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	0	0%	0	0%	13	41%	15	47%	1	3%	3	9%	32
Program Implementation	1	3%	9	28%	12	38%	7	22%	0	0%	3	9%	32
Price Comparison Website	1	3%	6	19%	7	22%	7	22%	4	13%	7	22%	32
CMS Communications With Your Sector	1	3%	4	13%	15	47%	9	28%	1	3%	2	6%	32

Sponsors' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	1	3%	4	13%	7	22%	13	41%	3	9%	4	13%	32
Enrollment Process, Card, with TA	3	9%	7	22%	11	34%	8	25%	1	3%	2	6%	32
Ease of Verifying TA Balance	0	0%	0	0%	8	25%	14	44%	8	25%	2	6%	32
Coordination of Benefits	0	0%	2	6%	5	16%	8	25%	3	9%	14	44%	32

Sponsors' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	2	6%	4	13%	13	41%	9	28%	1	3%	3	9%	32
Value to Beneficiaries Eligible for TA	0	0%	0	0%	0	0%	7	22%	23	72%	2	6%	32
Beneficiary Satisfaction	0	0%	2	6%	10	31%	14	44%	1	3%	5	16%	32

CHAIN PHARMACY EXECUTIVES

Chain Pharmacy Executives' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	0	0%	1	6%	8	47%	8	47%	0	0%	0	0%	17
Program Implementation	1	6%	5	29%	6	35%	5	29%	0	0%	0	0%	17
Price Comparison Website	3	18%	7	41%	6	35%	1	6%	0	0%	0	0%	17
CMS Communications With Your Sector	1	6%	5	29%	6	35%	5	29%	0	0%	0	0%	17

Chain Pharmacy Executives' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	0	0%	0	0%	0	0%	0	0%	17	100%	17
Enrollment Process, Card, with TA	0	0%	0	0%	0	0%	0	0%	0	0%	17	100%	17
Ease of Verifying TA Balance	1	6%	3	18%	3	18%	8	47%	1	6%	1	6%	17
Coordination of Benefits	1	6%	12	71%	3	18%	0	0%	0	0%	1	6%	17

Chain Pharmacy Executives' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	0	0%	2	12%	9	53%	5	29%	1	6%	0	0%	17
Value to Beneficiaries Eligible for TA	0	0%	0	0%	1	6%	8	47%	8	47%	0	0%	17
Beneficiary Satisfaction	0	0%	5	29%	9	53%	3	18%	0	0%	0	0%	17

INDEPENDENT PHARMACISTS

Independent Pharmacists' Ratings of their Relationships with Sponsors	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Relationships with Sponsors	2	17%	0	0%	5	42%	3	25%	0	0%	2	17%	12

Independent Pharmacists' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	2	17%	2	17%	3	25%	4	33%	1	8%	0	0%	12
Program Implementation	1	8%	3	25%	2	17%	6	50%	0	0%	0	0%	12
Price Comparison Website	0	0%	3	25%	5	42%	1	8%	0	0%	3	25%	12
CMS Communications With Your Sector	1	8%	4	33%	1	8%	2	17%	2	17%	2	17%	12

Independent Pharmacists' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	0	0%	0	0%	0	0%	0	0%	12	100%	12
Enrollment Process, Card, with TA	0	0%	0	0%	0	0%	0	0%	0	0%	12	100%	12
Ease of Verifying TA Balance	1	8%	0	0%	0	0%	4	33%	2	17%	5	42%	12
Coordination of Benefits	0	0%	1	8%	2	17%	4	33%	0	0%	5	42%	12

Independent Pharmacists' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	2	17%	1	8%	7	58%	2	17%	0	0%	0	0%	12
Value to Beneficiaries Eligible for TA	0	0%	0	0%	3	25%	6	50%	3	25%	0	0%	12
Beneficiary Satisfaction	1	8%	1	8%	3	25%	5	42%	1	8%	1	8%	12

CHAIN PHARMACY PHARMACISTS

Chain Pharmacy Pharmacists' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	0	0%	2	20%	5	50%	3	30%	0	0%	0	0%	10
Program Implementation	0	0%	1	10%	7	70%	2	20%	0	0%	0	0%	10
Price Comparison Website	0	0%	2	20%	1	10%	2	20%	1	10%	4	40%	10
CMS Communications With Your Sector	1	10%	2	20%	1	10%	4	40%	0	0%	2	20%	10

Chain Pharmacy Pharmacists' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	0	0%	0	0%	0	0%	0	0%	10	100%	10
Enrollment Process, Card, with TA	0	0%	0	0%	0	0%	0	0%	0	0%	10	100%	10
Ease of Verifying TA Balance	0	0%	2	20%	2	20%	1	10%	1	10%	4	40%	10
Coordination of Benefits	0	0%	0	0%	2	20%	3	30%	0	0%	5	50%	10

Chain Pharmacy Pharmacists' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	0	0%	2	20%	6	60%	1	10%	0	0%	1	10%	10
Value to Beneficiaries Eligible for TA	0	0%	0	0%	1	10%	5	50%	3	30%	1	10%	10
Beneficiary Satisfaction	0	0%	1	10%	5	50%	4	40%	0	0%	0	0%	10

MANUFACTURERS

Manufacturers' Ratings of their Relationships with Sponsors	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Relationships with Sponsors	0	0%	0	0%	5	31%	10	63%	0	0%	1	6%	16

Manufacturers' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	0	0%	1	6%	9	56%	5	31%	0	0%	1	6%	16
Program Implementation	0	0%	4	25%	6	38%	5	31%	0	0%	1	6%	16
Price Comparison Website	1	6%	5	31%	3	19%	3	19%	0	0%	4	25%	16
CMS Communications With Your Sector	2	13%	4	25%	6	38%	4	25%	0	0%	0	0%	16

Manufacturers' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	1	6%	5	31%	3	19%	0	0%	7	44%	16
Enrollment Process, Card, with TA	0	0%	1	6%	4	25%	4	25%	1	6%	6	38%	16
Ease of Verifying TA Balance	1	6%	0	0%	1	6%	1	6%	0	0%	13	81%	16
Coordination of Benefits	1	6%	2	13%	4	25%	3	19%	0	0%	6	38%	16

Manufacturers' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	0	0%	1	6%	6	38%	7	44%	1	6%	1	6%	16
Value to Beneficiaries Eligible for TA	0	0%	0	0%	2	13%	4	25%	9	56%	1	6%	16
Beneficiary Satisfaction	0	0%	4	25%	3	19%	4	25%	0	0%	5	31%	16

SHIPs

SHIPs' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	0	0%	3	14%	14	64%	4	18%	1	5%	0	0%	22
Program Implementation	2	9%	4	18%	11	50%	5	23%	0	0%	0	0%	22
Price Comparison Website	0	0%	1	5%	4	18%	8	36%	9	41%	0	0%	22
CMS Communications With Your Sector	0	0%	1	5%	9	41%	7	32%	5	23%	0	0%	22

SHIPs' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	0	0%	6	27%	9	41%	3	14%	4	18%	22
Enrollment Process, Card, with TA	1	5%	1	5%	6	27%	7	32%	5	23%	2	9%	22
Ease of Verifying TA Balance	0	0%	1	5%	3	14%	1	5%	3	14%	14	64%	22
Coordination of Benefits	1	5%	4	18%	8	36%	1	5%	4	18%	4	18%	22

SHIPs' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	0	0%	6	27%	12	55%	3	14%	0	0%	1	5%	22
Value to Beneficiaries Eligible for TA	0	0%	0	0%	4	18%	10	45%	7	32%	1	5%	22
Beneficiary Satisfaction	0	0%	5	23%	10	45%	5	23%	0	0%	2	9%	22

INFORMATION INTERMEDIARIES

Information Intermediaries' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	2	25%	4	50%	2	25%	0	0%	0	0%	0	0%	8
Program Implementation	1	13%	6	75%	1	13%	0	0%	0	0%	0	0%	8
Price Comparison Website	0	0%	3	38%	1	13%	3	38%	1	13%	0	0%	8
CMS Communications With Your Sector	2	25%	3	38%	2	25%	1	13%	0	0%	0	0%	8

Information Intermediaries' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	0	0%	3	38%	1	13%	1	13%	3	38%	8
Enrollment Process, Card, with TA	0	0%	1	13%	4	50%	1	13%	1	13%	1	13%	8
Ease of Verifying TA Balance	0	0%	0	0%	1	13%	0	0%	0	0%	7	88%	8
Coordination of Benefits	1	13%	3	38%	2	25%	1	13%	0	0%	1	13%	8

Information Intermediaries' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	0	0%	3	38%	3	38%	2	25%	0	0%	0	0%	8
Value to Beneficiaries Eligible for TA	0	0%	0	0%	1	13%	7	88%	0	0%	0	0%	8
Beneficiary Satisfaction	0	0%	4	50%	2	25%	0	0%	0	0%	2	25%	8

PROFESSIONAL ASSOCIATIONS

Professional Associations' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	0	0%	1	10%	5	50%	3	30%	1	10%	0	0%	10
Program Implementation	1	10%	1	10%	3	30%	3	30%	2	20%	0	0%	10
Price Comparison Website	0	0%	2	20%	5	50%	0	0%	2	20%	1	10%	10
CMS Communications With Your Sector	0	0%	2	20%	2	20%	2	20%	2	20%	2	20%	10

Professional Associations' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	1	10%	1	10%	1	10%	1	10%	6	60%	10
Enrollment Process, Card, with TA	0	0%	1	10%	0	0%	1	10%	1	10%	7	70%	10
Ease of Verifying TA Balance	0	0%	1	10%	0	0%	0	0%	0	0%	9	90%	10
Coordination of Benefits	0	0%	3	30%	2	20%	0	0%	0	0%	5	50%	10

Professional Associations' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	1	10%	1	10%	2	20%	2	20%	2	20%	2	20%	10
Value to Beneficiaries Eligible for TA	0	0%	0	0%	0	0%	2	20%	7	70%	1	10%	10
Beneficiary Satisfaction	0	0%	2	20%	3	30%	1	10%	0	0%	4	40%	10

THOUGHT LEADERS

Thought Leaders' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	0	0%	4	40%	2	20%	2	20%	2	20%	0	0%	10
Program Implementation	0	0%	2	20%	3	30%	3	30%	2	20%	0	0%	10
Price Comparison Website	1	10%	1	10%	5	50%	3	30%	0	0%	0	0%	10
CMS Communications With Your Sector	0	0%	4	40%	3	30%	1	10%	1	10%	1	10%	10

Thought Leaders' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	0	0%	3	30%	1	10%	0	0%	0	0%	6	60%	10
Enrollment Process, Card, with TA	0	0%	2	20%	3	30%	2	20%	0	0%	3	30%	10
Ease of Verifying TA Balance	0	0%	1	10%	1	10%	0	0%	0	0%	8	80%	10
Coordination of Benefits	0	0%	1	10%	2	20%	3	30%	0	0%	4	40%	10

Thought Leaders' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	0	0%	1	10%	4	40%	3	30%	1	10%	1	10%	10
Value to Beneficiaries Eligible for TA	0	0%	0	0%	1	10%	3	30%	6	60%	0	0%	10
Beneficiary Satisfaction	1	10%	1	10%	3	30%	1	10%	0	0%	4	40%	10

ALL STAKEHOLDERS

All Stakeholders' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Program Design	4	3%	18	13%	61	45%	44	32%	6	4%	4	3%	137
Program Implementation	7	5%	35	26%	51	37%	36	26%	4	3%	4	3%	137
Price Comparison Website	6	4%	30	22%	37	27%	28	20%	17	12%	19	14%	137
CMS Communications With Your Sector	8	6%	29	21%	45	33%	35	26%	11	8%	9	7%	137

All Stakeholders' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Enrollment Process, Card, No TA	1	1%	9	7%	23	17%	27	20%	8	6%	69	50%	137
Enrollment Process, Card, with TA	4	3%	13	9%	28	20%	23	17%	9	7%	60	44%	137
Ease of Verifying TA Balance	3	2%	8	6%	19	14%	29	21%	15	11%	63	46%	137
Coordination of Benefits	4	3%	28	20%	30	22%	23	17%	7	5%	45	33%	137

All Stakeholders' Ratings of Drug Discount Card Program Features	Very Poor		Poor		Fair		Good		Excellent		DK/Missing		Total
	n	%	n	%	n	%	n	%	n	%	n	%	
Value to Beneficiaries Not Eligible for TA	5	4%	21	15%	62	45%	34	25%	6	4%	9	7%	137
Value to Beneficiaries Eligible for TA	0	0%	0	0%	13	9%	52	38%	66	48%	6	4%	137
Beneficiary Satisfaction	2	1%	25	18%	48	35%	37	27%	2	1%	23	17%	137