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Evaluation of the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance Program

Interim Evaluation Report

Final Report

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Prepared for
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Executive Summary

Under a task order from the Centers for Medicare and Medicaid Services (CMS), Abt Associates Inc. is evaluating the impact of the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance (T.A.) program for people with Medicare. This Interim Evaluation Report synthesizes focus group and survey findings to identify lessons for the Medicare Prescription Drug Coverage (Part D) implementation.

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.

The evaluation research questions addressed thus far in the evaluation include:

- Whether and how beneficiaries heard about the Medicare-Approved Drug Discount Card and Transitional Assistance program;
- Whether card enrollees were aware of having a Medicare-approved drug discount card, and were aware that they had many cards from which to choose;
- How and why they enrolled and why some beneficiaries who heard about the program didn't enroll;
- Where they got information when choosing a card, what factors were important in deciding on a card, and why they chose the card they did;
- How much beneficiaries know about how the program is supposed to work;
- What early experiences card enrollees were having with the cards, whether they were satisfied with their cards and with savings, or have had problems using cards; and
- Whether beneficiaries are aware that changes are coming (Part D).

Fifty-four focus groups with drug card enrollees and non-enrollees were conducted in the fall of 2004 (30 groups) and the winter of 2005 (24 groups). A survey of 32,434 Medicare beneficiaries enrolled in drug discount cards was conducted in the fall of 2004. (See Appendices for focus group and survey methodologies.)

Awareness

Almost all non-enrolled focus group participants had heard of the drug discount card program, most through a combination of media attention and CMS mailing(s). The widespread awareness of this new program was achieved in just a few months.

The majority of survey respondents reported that they had enough, or more than enough, information to make an enrollment decision. At the same time, more than half the survey respondents did not consider more than one drug card, or did not realize that there was more than one to choose from.

Many focus group participants enrolled in the first card they heard about. The fact that many beneficiaries were so easily satisfied with limited information, and enrolled in the first card they heard about, indicates the challenge of educating beneficiaries about choices.

A minority (21 percent) of those surveyed who were enrolled in drug discount cards, believed they were not enrolled. A smaller percentage of those with the T.A. credit (according to CMS administrative files) believed they did not have the $600 credit and others were unsure. There are many plausible explanations for this lack of awareness. One explanation may be that Medicare beneficiaries are inundated with unsought/unwanted insurance mailings and discard most of them unopened – some may have inadvertently discarded their new Medicare drug discount cards unopened. Some of those who were auto-enrolled by State Pharmacy Assistance Programs or had their enrollment facilitated by CMS[1] may have been unsure of their status because they did not fill out applications. And it is possible that some beneficiaries' insurance issues were handled by a family member, with the beneficiaries (survey respondents) being unaware of their insurance details.

Information Sources and Choice

Most focus group participants reviewed information that came to them rather than searching for information themselves. There was only modest evidence of active information-seeking among the hundreds of focus group participants.

The most frequently used source of information was pharmacists, according to both survey respondents and focus group participants. Pharmacists played a key role in helping Medicare beneficiaries understand the program, enroll in drug cards, and use their drug cards. Other commonly mentioned sources of information were mass media (especially television), insurers and health plans with which beneficiaries already had relationships, and AARP and its publications.

Focus group participants were asked specifically about their use of the CMS information channels. About half of focus group participants recalled receiving mailing(s) from CMS about the drug discount card program. About a quarter of focus group participants had used the Medicare helpline to get information about the drug discount card program, and a smaller proportion of focus group participants got information from the Medicare website, either directly or with the help of a family member, friend or counselor who accessed the website for them. Almost no one in any of the focus groups had used (or recognized the name of) their local State Health Insurance Program (SHIP), and very few survey respondents indicated any "health insurance counseling service" as an information source. At the same time, many focus group participants expressed a strong preference for receiving information one-on-one and in-person from someone with whom they could discuss their own personal circumstances. Thus although many beneficiaries seemed to want this sort of personalized counseling, they did not seem to know where to find it. CMS is therefore promoting SHIP resources and services as a feature of the 200-2006 National Medicare Education Program (NMEP)

Reasons for Not Enrolling

Most non-enrolled focus group participants had heard about the drug discount card program, but held misperceptions that kept them from enrolling, or did not think they would benefit from enrollment. The most common misperception was that only persons with limited incomes could enroll in a Medicare-approved drug discount card. Apparently the eligibility for T.A. and the eligibility for the card itself were conflated in the minds of some beneficiaries. Some low-income beneficiaries who

[1] Throughout this report the term "auto-enrollment" is used to refer to group enrollment, facilitated enrollment, and automatic enrollment.

were not enrolled were under the mistaken impression that they would have to pay a monthly premium to obtain a card and the T.A. benefit; they did not know whether they would save enough to warrant the (mistaken) monthly premium.

There were a number of other reasons for not enrolling. Several focus group participants reported that the prices they paid at discount retailers (Costco, Sam's Club) were lower without the card than with it. Others had few prescriptions to fill or felt that the senior discount offered by their local pharmacy was better than the discount offered by drug cards. Some focus group participants got information about cards but found the multiplicity of choices to be overwhelming. A few focus group participants knew that the program would be temporary and did not want to engage in a complicated choice process for a program that would last little more than one year.

Experiences with Drug Discount Cards

Enrollment

Focus group card enrollees reported no difficulties in enrolling in drug discount cards by phone, mail or over the Internet. A number of them did, however, report lengthy delays in receiving their drug discount cards in the mail (although some may not have recognized the mailing that contained their cards, and inadvertently discarded them).

Satisfaction

Most survey respondents expressed overall satisfaction with their cards. They were especially satisfied with the choice of pharmacies at which they could use their cards and with the enrollment process. Satisfaction with savings was a little lower. Those getting the T.A. credit were much more satisfied with savings than were those without the T.A. credit.

Survey respondents who had considered more than one discount drug card were only a little more likely to be satisfied with their card compared with those who had not considered more than one card. Apparently engaging in the choice process made only a small difference in respondents' satisfaction with the cards they chose.

Those taking more prescription medications were somewhat more satisfied overall and more satisfied with savings, than were those with fewer prescriptions.

Savings

Two-thirds of survey respondents expected (before they received their cards) that they would save "some" or "a lot" of money with their cards – high expectations. Nearly half of survey respondents reported that they have saved "some" or "a lot" of money using their cards; those with T.A. were the most enthusiastic about savings, probably because most had not yet exhausted their $600 credit. Nearly a third of those without T.A. reported that they saved "some" or "a lot" of money using their cards, indicating that the discounted prices available through cards are bringing tangible benefits. With Medicare prescription drug coverage, potential benefits for those who are not low-income will be greater, and for those with limited-incomes, greater yet (especially if they were previously uninsured); as a result, perceived savings are likely to rise even more.

Many focus group participants with T.A. wanted to be able to track their $600 credit, to anticipate when it would run out. Some pharmacists were able to relay balances, but others said that they could not provide this information (even though pharmacists could access this information, electronically or by telephone, from any drug card sponsor).

Prescription Filling Practices

Most survey respondents (especially those with T.A.) used their cards every time they filled prescriptions.

Nearly half of all survey respondents acknowledged that at some time in the past they had decided not to fill prescriptions due to cost concerns, and a somewhat smaller percentage had at times skipped doses or taken smaller doses to stretch their medications. Fewer people reported these practices after receiving their Medicare-approved drug discount cards, at least for the few months immediately after they received their cards, especially among those with T.A. There is potential for enhancing appropriate use of prescription medications through reduced prices and subsidies, especially for lower income beneficiaries who do not currently have prescription drug coverage.

Implications for Part D

Awareness of upcoming changes in Medicare drug coverage was high, but detailed understanding about the new prescription drug coverage program was quite low. The main information sources beneficiaries turned to in the past, and will probably continue to rely on are: pharmacists, media (especially television), insurers/agents/plans they already have relationships with, and AARP and its publications.

It will be important that beneficiaries understand that Part D drug plans are not only for those with limited incomes, that enrollment is not automatic (except for those who are auto-enrolled), and that there are many plans to choose from which are not all alike.

Part D drug plans should be aware that Medicare beneficiaries receive myriad mailings from insurance companies, which are often discarded unopened. Drug plans will need to find effective ways to communicate with their enrollees (including getting them their new drug plan cards or other proof of coverage) in a timely manner.

Most beneficiaries with transitional assistance felt that their savings were as great or greater than expected, and many of those without T.A. had similar perceptions. With greater benefits available under Part D drug coverage, perception of savings could improve even more.

As with the drug discount cards, drug plan enrollees who in the past found it unaffordable to always take their drugs as prescribed, may see an improvement and be better able to take their drugs properly; this may be especially true for those with limited incomes.

Satisfaction overall was high and satisfaction with pharmacy networks was especially high; if Part D drug plans can maintain these robust networks, high satisfaction should continue.

Many beneficiaries have learned that they can at times get lower prices from certain retailers by not using their drug discount cards; they have become attuned to seeking the lowest possible price. Under Part D, some beneficiaries may similarly find lower prices during coverage gaps by going outside their drug plan network; if so, they will need to understand how to report any out-of-plan expenses to their drug plans, so that these expenses can be counted toward their TrOOP costs.

Beneficiaries will want to be able to track their benefits and anticipate when coverage gaps will begin and end. Drug plans will be sending monthly notices to plan members who fill prescriptions, containing benefit information. Since beneficiaries often turn to their pharmacists for this information, it will be helpful if pharmacists provide this information to beneficiaries, in addition to drug plans sending regular benefit explanations to their members.

1.0 Background and Methods[2]

Under a task order from the Centers for Medicare and Medicaid Services (CMS), Abt Associates Inc. is evaluating the impact of the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance (T.A.) program for people with Medicare. This Interim Evaluation Report synthesizes focus group and survey findings to identify lessons for the Medicare Prescription Drug Coverage (Part D) implementation.

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- How much beneficiaries know about how the program is supposed to work;
- What early experiences card enrollees were having with the cards, whether they were satisfied with their cards and with savings, or have had problems using cards; and
- Whether beneficiaries are aware that changes are coming (Part D).

Fifty-four focus groups were held in 15 cities: 30 focus groups in eight cities during the fall of 2004 and 24 focus groups in seven cities during the winter of 2005. Cities were selected for geographic variety and to concentrate on places where card enrollment was highest. Participants were selected using CMS administrative and card enrollment data. The final number and types of groups were as follows:

[2] See the Appendix for complete, detailed methodologies.

Exhibit 1: Focus Group Participants in 15 Cities

Type of Participants	# Groups	# Participants
Drug Discount Card Enrollees	16	151
Card Enrollees with T.A.	12	88
Non-Enrollees	12	89
Non-Enrollees with limited incomes (T.A. eligible)	6	32
Card Enrollees Medicare eligible due to disability	4	37
Card Enrollees with T.A., eligible due to disability	4	38
TOTAL	**54**	**436**

Participants received $60 ($80 for those with disabilities) to cover travel and other costs. All focus groups were videotaped and audiotaped. (See Appendix B for full focus group methodology.)

A survey of drug discount card enrollees was conducted in the fall of 2004. The target population was all Medicare beneficiaries who were enrolled in a Medicare-approved drug discount card before July 2004 and who thus had at least a few months during which to receive and begin using their cards before the survey was fielded in September 2004. The survey sampling frame therefore included beneficiaries who enrolled within the first 6-8 weeks after the cards became available; these beneficiaries might be considered 'early adopters'. The sample selection was done in two stages. For the first stage, a purposive sample of 27 drug discount cards was selected. The second stage required selection of an independent sample of 600 T.A. card enrollees and 600 non-T.A. enrollees, from each of the 27 drug discount cards, for a total sample of 32,400. The survey, with an advance letter from CMS, was mailed in mid-September, followed one week later by a reminder postcard. Three additional rounds of mailings were sent to non-respondents and the field period lasted 12 weeks. A 76 percent response rate was achieved. Responses were weighted to reflect the size and composition of each of the 27 cards' enrolled populations, and adjusted for non-response. (See Appendix A for full survey methodology.)

2.0 Findings

This Chapter of the report reviews the major findings of the evaluation to date, synthesizing focus group and survey results, and points out both strong themes and any inconsistencies. Differences between T.A. and non-T.A. respondents were analyzed for statistical significance and only statistically significant differences between these two groups of respondents are discussed in the text.[3] Chi-square tests were used to determine statistically significant differences between these two groups. All statistics presented here have been weighted to adjust for non-response and to reflect the populations of the 27 cards from which respondents were sampled.

2.1 Awareness

2.1.1 Awareness of the Drug Card Program and T.A.

In addition to all the enrolled focus group participants and survey respondents, almost all non-enrolled focus group participants had heard of the drug discount card program, most through a combination of media attention and CMS mailing(s). The high level of awareness of this new program was achieved in just a few months.[4] Awareness of the T.A. subsidy was also very high overall, but slightly lower than awareness of the drug discount card program itself. Some focus group participants who were not enrolled and had limited incomes, would probably have qualified for T.A. but were unaware of the availability of the $600 credit.

2.1.2 Reasons for Not Enrolling

All findings concerning non-enrollees are from focus groups because the survey was only sent to beneficiaries who were enrolled in a Medicare-drug discount card.

Most non-enrolled focus group participants had heard about the drug discount card program; the information they received/reviewed led them to decide against enrolling in a drug discount card. Many non-enrolled focus group participants were misinformed or held mistaken impressions about drug discount card program features, and these misperceptions kept them from enrolling. The most common misperception was that only persons with limited incomes could enroll in a Medicare-approved drug discount card. Apparently the eligibility for T.A. and the eligibility for the card itself were conflated in the minds of some beneficiaries. Once convinced that their incomes were too high to qualify, these people stopped paying attention to additional information about the program.

There were also misperceptions about the cost of obtaining a card in order to receive the T.A. credit. Some focus group participants with limited incomes, who were not enrolled, were under the mistaken impression that they would have to pay a monthly premium to obtain a card and the T.A. benefit. For those with low or unpredictable prescription costs, a monthly premium was not acceptable.

Some beneficiaries who knew they did not qualify for T.A. saw little benefit in enrolling in a card. Several focus group participants reported that the prices they paid at discount retailers (Costco, Sam's Club) were lower without the card than with it. Some focus group participants who paid an annual

[3] There were both regional and national cards in the sample but they were not selected to reflect the entire set of regional and national cards. Comparisons of regional vs. national findings are not included here because the sample of regional cards was too small to support reliable comparisons.

[4] The visibility of the program during the 2004 political season may have contributed to the very rapid learning about the program.

enrollment fee for their cards were unhappy that prices with their cards were no better than through other sources and felt that they had purchased a card with little value and which they do not use. Others had few prescriptions to fill and felt that the senior discount offered by their local pharmacy was better than the discount offered by drug cards.

Some focus group participants got information about cards, but found the multiplicity of choices to be overwhelming; they learned enough to be confused and more or less gave up. Finally, a few focus group participants knew that the program would be temporary and did not want to engage in the complicated choice process for a program that would last little more than one year.

2.1.3 Awareness of Being Enrolled and of Having T.A.

During the process of recruiting focus groups, we spoke with thousands of people listed in CMS files as being enrolled in Medicare-approved drug discount cards. Many told us that they were not aware that they had a Medicare-approved drug discount card. This was true in recruiting the 2004 focus groups and persisted in 2005, when nearly half of the enrollees we tried to recruit stated that they did not have a Medicare-approved drug discount card. It is possible that some were confused by our question or were simply trying to end the recruiting call, but many truly seemed to be unaware that they were enrolled.

This issue was quantified by the survey, where the first question was "Do you have a card with this logo on the front of it?" followed by a display of the standard *Medicare Approved Rx* card logo. All survey respondents had enrolled at least two months prior to being surveyed (most 3-4 months prior) and thus most should have received their cards[5] and been able to check their cards for this logo. However 21 percent of survey respondents indicated that they did not have a drug discount card with this logo, and another 2 percent did not know if they had such a card (Exhibit 2). This problem was more evident among those without T.A. than among those with T.A.

Exhibit 2: Awareness of Enrollment in Medicare-approved Drug Discount Card

Question A1: Do you have a card with this logo on the front?	All Respondents n=24,639	T.A. Enrollees n=12,457***	Non-T.A. Enrollees n=12,182
Have Card with Medicare Logo	77.4%	86.2%	72.4%
Do Not Have Card with Medicare Logo	20.9%	12.1%	25.9%
Do Not Know if Have Card with Medicare Logo	1.7%	1.7%	1.7%
Total	**100.0%**	**100.0%**	**100.0%**

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

It is possible that some of the survey respondents who were unaware of their card enrollment had been auto-enrolled, rather than taking action on their own.[6]

Focus group participants in 2004 who appeared to have been auto-enrolled were more likely to be unaware of their enrollment status than were 2005 focus group participants; perhaps because they had

[5] Some focus group participants reported delays in receiving their cards. Lengthy delays were mentioned more by 2004 focus group participants than by those attending in 2005.

[6] CMS administrative data do not indicate which beneficiaries were auto-enrolled and which enrolled on their own.

had only a few weeks or months to use their cards by the time the 2004 focus groups were held. For example, some focus group participants were auto-enrolled by their State Pharmacy Assistance Program (SPAP) and did not notice the (tiny) Medicare Rx logo on the front of their regular cards, until they arrived at the focus groups and moderators pointed out the new logo. Similarly, some focus group participants were enrolled into exclusive cards by their Medicare Advantage Plans and hadn't noticed the new logo on the front of their insurance cards. Apparently the informational materials that reached auto-enrolled people were not always noticed, read, or well-understood.

Some people may not have realized that a mailing they received was in fact their new Medicare-approved drug discount card, and may have discarded it. Many focus group participants explained that they are inundated by sales materials from insurance companies; many no longer even open such materials and routinely discard them. Some people filled out card enrollment forms for a card whose sponsor was unfamiliar to them; when the card arrived weeks later in the mail they did open the mailing but did not recognize the name of the sponsor on the envelope (often an insurance company) and discarded the card – not realizing what it was.[7] It is also possible that some people were uncertain of their enrollment status because their prescriptions (and their cards) were being handled by a family member. And it is possible that some beneficiaries' insurance issues were handled by a family member, with the beneficiaries (survey respondents) being unaware of their insurance details. All of these factors probably contributed to some beneficiaries, both focus group participants and surveyed card enrollees, being unaware of their enrollment status.

Survey respondents were asked whether they had received the $600 T.A. credit. Thirteen percent of those who are listed in CMS administrative files as having the T.A. credit reported that they did not have it, and another 17 percent of those with T.A. were not sure if they had it (Exhibit 3).

Exhibit 3: Awareness of Having $600 Credit

Question A12: Whether or not you applied, did you get this $600 credit from Medicare?	All Respondents n=21,002	T.A. Enrollees n=10,976***	Non-T.A. Enrollees n=10,026
Received $600 credit	28.9%	64.0%	5.6%
Did Not Receive $600 credit	48.8%	13.0%	72.6%
Do Not Know	12.2%	16.7%	9.2%
Did Not Answer	10.1%	6.2%	12.6%
Total	**100.0%**	**100.0%**	**100.0%**

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

The same factors that contributed to lack of awareness of enrollment (i.e. auto-enrollment, family members handling prescriptions, discarding mailings, not noticing the card logo) probably also contributed to uncertainty about T.A. status. Some of those with T.A. (as identified by CMS files) who indicated they did not have the $600 credit, may not yet have had a prescription to fill; they might become aware of the benefit when filling their first prescription using their Medicare-approved drug discount card.

[7] Participants told us, however, that they were less likely to throw away mailings from a known and trusted source such as the Social Security Administration, AARP or their insurance carriers. When beneficiaries do eventually become familiar with their Part D drug plans, they may be more likely to open mailings.

Some of those who were auto-enrolled into a card by another program (an SPAP or a Medicare Advantage Plan) could use their familiar prescription cards and obtain discounts when pharmacists filled their prescriptions, without realizing it. Even those who were using the $600 credit may not have been aware that the credit was being accessed, if they were also in an SPAP or Medicare Advantage Plan. Thus some people who were unaware of being enrolled or unaware that they had T.A,. may in fact have been getting some benefit from their Medicare-approved drug discount plans, without knowing that it was happening.

2.2 Information and Choices

The Medicare drug discount card program, and the upcoming Part D Medicare drug coverage program, feature an annual choice among many competing options offered by private sector firms. A private sector market in Medicare Prescription Drug Plans under Part D would seem to require that a) Medicare beneficiaries are aware that they have choices, b) they are able to obtain and understand information about differences among plans so that they can make an appropriate choice, and c) they exercise their choice and select plans which they perceive as having better value. The next several sections explore these issues.

2.2.1 Common Information Sources

Most focus group participants reviewed information that came to them, rather than seeking it themselves.

Survey respondents, all of whom were enrolled in Medicare-approved drug discount cards, were asked to indicate all of the sources of information they used when deciding about a Medicare-approved drug discount card. The most frequently used source of information was pharmacists (30 percent of survey respondents mentioned pharmacists as an information source) (Exhibit 4).

Focus group participants were also asked about information sources; pharmacies and pharmacists were mentioned in more focus groups than any other information source. Medicare beneficiaries felt comfortable asking pharmacists about the program, and often pharmacists offered information without being asked. Pharmacists played a key role in helping beneficiaries Medicare understand the program, enroll in drug cards, and use their drug cards.

It is not clear whether people who relied on pharmacists for enrollment information understood that some pharmacists work for companies that sponsored their own Medicare-approved drug discount cards, making these pharmacists a potentially biased source of information. For example, a national pharmacy chain sponsors a Medicare-approved drug discount card and many focus group participants reported that their pharmacists at the chain's outlets simply gave them the application for that chain's card, but did not explain that there were many card choices (all of which would be accepted by this chain).

Other commonly mentioned sources of information were mass media (especially television), insurers and health plans with which people already had relationships, and AARP and its publications. T.A. survey respondents were more likely than those without T.A. to get information from family and friends, and less likely to get information from an insurance company or agent (perhaps because they were less likely to have private insurance).

Exhibit 4: Sources of Information

Question A4: Please Check all the places where you got information when you were deciding about your Medicare-approved drug discount card. (Check all that apply)	All Respondents n=21,002	T.A. Enrollees n=10,976	Non-T.A. Enrollees n=10,026
Newspapers or Magazines	15.2%	14.7%***	15.6%
Television or Radio	29.9%	28.3%***	31.0%
Family or Friends	14.2%	17.9%***	11.8%
Doctor or Other Medical Person	6.5%	8.7%***	5.1%
Pharmacist or Pharmacy	30.2%	33.7%	27.8%
Website Showing Price Comparisons	8.8%	7.8%***	9.5%
Other Internet Websites	2.1%	2.6%*	1.7%
Health Insurance Company or Agent	12.8%	5.4%***	17.7%
Health Insurance Counselor or Information Service	3.5%	3.2%***	3.7%
AARP	9.6%	10.8%***	8.9%
Employer or Former Employer	0.4%	0.3%	0.4%
State / County / City Agency	5.5%	11.2%***	1.7%
Other Source of Information	14.0%	16.5%	12.3%
Got No Information When Choosing Card	8.0%	7.8%**	8.1%
Did Not Answer	4.3%	4.2%	4.3%

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
*Note: Respondents could check more than one category. Therefore tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.** 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

2.2.2 Use of CMS Information Channels

Focus group participants were asked specifically about their use of the CMS information channels. About 50 percent of focus group participants recalled receiving mailing(s) from CMS about the drug discount card program. Some seemed to recall the separate CMS mailing about the program while others recalled mention of the program in the Medicare Handbook. Among those who recalled getting a CMS mailing, but who did not enroll in a card, most commented that the material they received from CMS was either difficult to understand or not sufficiently detailed. Some also reported that they don't actually read through these mailings when they arrive, but rather "file" them for later reference.

About 27 percent of focus group participants reported that they had used the Medicare helpline to get information about the drug discount card program. Some sought help to identify an appropriate card, while others wanted more general information about the program. These helpline users generally reported that the Customer Service Representatives were helpful and that they received the information they were looking for. Most of those who used the helpline did enroll in a Medicare-approved drug discount card. Almost none of the focus group participants who had not enrolled in a card had called the Medicare helpline for information.

About 13 percent of focus group participants mentioned getting information from the Medicare website, either directly or with the help of a family member, friend or counselor who accessed the website for them. (A majority of focus group participants reported that they did not have Internet access.) Use of the website was highest, proportionately, among people eligible for Medicare due to disability, who were younger than others with Medicare and may therefore be more comfortable with Internet/computer use in general. Many of those who did access the website were enthusiastic about it and found the information they needed, while a few found the website confusing due to the large number of card options listed. Those who did not have printer access found the website less useful because they could not print out the several pages of card options the website generated for them. Nine percent of survey respondents reported that they had used a website showing price comparisons, and another 2 percent had used other Internet websites in researching the drug card program. This total of 11 percent is very close to the estimated 13 percent of focus group participants who used the Medicare website.

We asked focus group participants whether they had contacted their local SHIP organization – and we used the local name of that organization since people may not have been familiar with the SHIP acronym. Almost no one in any of the focus groups had received information from this source, and the great majority had never heard of their local SHIP. Survey respondents were asked whether they got information from any "health insurance counselor or information service" which is a broader category than just the SHIPs, and less than 4 percent indicated this was among their information sources. At the same time, many focus group participants expressed a strong preference for receiving information one-on-one and in-person from someone with whom they could discuss their own personal circumstances. Thus although many people with Medicare want this sort of individualized counseling, they do not seem to know where to find it and are not receiving it.

2.2.3 Adequacy of Information

Survey respondents were asked whether they had enough information at the time they enrolled in a drug card, to make the necessary decision. Fifty-four percent responded that they had enough, or more than enough, information to make this decision (Exhibit 5). At the same time, more than half the survey respondents did not consider more than one drug card (or did not know there was more than one to choose from). Many focus group respondents clarified that they enrolled in the first card they heard about. The fact that people were so easily satisfied with information about only one card, and enrolled in the first card they heard about, indicates the challenge of educating beneficiaries about drug discount card/plan choices.

Exhibit 5: Adequacy of Information to Made Card Enrollment Decision

Question A5: When you signed up for your Medicare-approved drug discount card, do you feel you had all the information you needed to make a decision?	All Respondents n=21,002	T.A. Enrollees n=10,976***	Non-T.A. Enrollees n=10,026
Had More Than Enough Info	14.9%	20.6%	11.0%
Had About the Right Amount	39.1%	42.6%	36.8%
Wanted More Information	23.1%	16.2%	27.6%
Do Not Know	16.2%	14.1%	17.6%
Did Not Answer	6.7%	6.4%	6.9%
Total	**100.0%**	**100.0%**	**100.0%**

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

2.3 Comparing Medicare Drug Discount Cards

2.3.1 Awareness of Choices

Survey respondents were asked in two different ways about whether they considered more than one Medicare-approved drug discount card; focus group participants were asked whether they knew that there were many cards to choose among. Survey respondents were first asked why they enrolled in their particular card; respondents could check more than one reason and 43 percent said that theirs was the only card they looked into or considered (Exhibit 7, next page). Survey respondents were asked a separate question about whether they considered and compared more than one card before making a choice; 63 percent said they did not consider more than one card (Exhibit 6).

Exhibit 6: Comparing Multiple Medicare-Approved Drug Discount Cards

Question A3: Did you consider and compare more than one Medicare-approved drug discount card before settling on the one you have now?	All Respondents n=21,002	T.A. Enrollees n=10,976***	Non-T.A. Enrollees n=10,026
Yes	26.9%	25.4%	27.9%
No	62.7%	63.7%	62.0%
Do Not Know	4.2%	4.7%	3.8%
Did Not Answer	6.3%	6.2%	6.4%
Total	**100.0%**	**100.0%**	**100.0%**

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Depending on the focus group, one-quarter to one-half of participants were unaware that there was more than one Medicare-approved drug discount card; nearly half of those who had not enrolled did not realize that there were choices. Based on these strong and consistent findings, it appears that many people were either unaware of choices, or did not engage in a choice process but simply enrolled in the first card they encountered. A key feature of the program – choice – which is supposed to move the market toward value, may not be having an optimal effect.

2.3.2 Comparing Choices

Survey respondents mentioned many reasons for enrolling in their particular card, in addition to the fact that many did not consider any other cards. The most common reason that survey respondents mentioned was that the card they chose was accepted by their pharmacies (73 percent). Twenty percent reported that their pharmacist recommended the card they enrolled in. Many focus group participants said that they asked their pharmacist about the program (or the pharmacist offered information) and they signed up for the card their pharmacist recommended. These findings are consistent with the important role pharmacists play in providing information about the program.

Exhibit 7: Reasons for Choosing Medicare-Approved Drug Discount Card Have Now

Question A2: Please Check all of the reasons that you Chose the Medicare-approved drug discount card You now have. (Check all that apply)	All Respondents n=21,002	T.A. n=10,976	Non-T.A. n=10,026
Pharmacies I Use Will Accept My Card	72.8%	77.6%***	69.7%
Only Card I Looked Into or Considered	43.4%	41.2%***	44.9%
Pay Less With This Card Than With Other Drug Cards	30.6%	40.3%***	24.2%
Annual Enrollment Fee for Card Was Acceptable To Me	33.9%	28.2%***	37.7%
My Pharmacist Recommended This Card	20.4%	23.1%***	18.6%
A Doctor or Other Medical Person Recommended This Card	6.0%	8.0%***	4.7%
A Friend or Family Member Recommended This Card	11.5%	15.1%***	9.0%
A Medicare Counselor or Information Service Recommended	11.1%	15.5%***	8.2%
A Health Insurance Agent or Company Recommended	10.1%	5.2%*	13.3%
Other Reason	4.4%	6.1%***	3.6%
Did Not Answer	3.7%	3.6%	3.8%

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
Note: Respondents could check more than one category. Therefore tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Costs were also important to survey respondents; 31 percent said they paid less with the card they chose than they would have with other cards, and 34 percent said that the annual enrollment fee for their chosen card was acceptable to them. Some focus group participants agreed, saying that they signed up for a free card (no annual fee) figuring that they had nothing to lose.

2.4 Experiences with Medicare Drug Discount Cards

2.4.1 Enrollment

Focus group participants, both those with T.A. and those without, reported no difficulty with the enrollment process. Whether they enrolled via a paper form, by telephone, or online, or got help from someone else to enroll, all agreed that the process was straightforward and clear.

Some focus group participants, particularly in 2004, reported that although enrollment was smooth they did not receive their cards in a timely manner. Some made many calls (and waited many weeks) before getting their cards in the mail.

2.4.2 Using Cards

Survey respondents were asked whether they always used their Medicare-approved drug discount cards when filling prescriptions. Seventeen percent had never used their cards and 65 percent said they used their cards every time they filled a prescription.

At the time of the survey, most respondents with T.A. probably had not yet exhausted their $600 credit, and 75 percent of those with T.A. reported always using their card. Among the 9 percent with TA who reported that they had never used their cards, some may have been auto-enrolled and may not have understood what portion of their costs are being paid by the $600 credit and what was being paid by their SPAP or MA plan. In these cases, the $600 in TA was being utilized, but the beneficiary

was experiencing a seamless coordination of benefits between the drug card transitional assistance and the other benefit. That is, beneficiaries may not have understood that the $600 credit was being accessed and applied to the costs of their drugs, whether they "used" their actual drug card or not.

Seventeen percent of survey respondents without T.A. had never used their cards. As discussed above, some focus group participants reported that there are other ways to get reduced prices on prescription drugs, which yield a lower price than does a Medicare-approved drug discount card; this may be one reason that some of the survey respondents without T.A. are not using their cards. Focus group participants also explained that they don't actually have to "use" their cards when they fill prescriptions. After their first visit to the pharmacy, the information from their cards is recorded in the pharmacy data system and every subsequent prescription is processed through the card sponsor. Some survey respondents may be experiencing the same practice, and thus may have reported that they are not using their cards, even though their pharmacies are using the card sponsor information to process discounts and T.A. credit on their behalf.

Survey respondents who reported never using their cards were asked why they had not. The main reasons for not using cards were the same for those with or without T.A. Overall, 25 percent reported that they have another card or discount program that gives better prices than their Medicare-approved drug discount card (Exhibit 8). This finding is consistent with reports from many focus group participants who had found better prices through other means. Another 27 percent of survey respondents who never used their cards said that they had had no prescriptions to fill since getting their card. Finally, 18 percent said their card does not offer discounts on their particular drugs or at the doses prescribed. Since most did not compare cards, they did not try to find another card that might have offered discounts on their drugs.

Exhibit 8: Reasons for Not Using Medicare-Approved Drug Discount Card When Filling Prescriptions

Question A7A: IF NEVER USED THE CARD: Why have you not used your Medicare-approved drug discount card when filling a prescription?	All Respondents n=2,860	T.A. Enrollees n=1,032	Non-T.A. Enrollees n=1,828
No Prescriptions To Fill Since Getting Card	26.9%	45.6%***	21.9%
Pharmacy Would Not Accept Card	8.5%	9.0%	8.4%
Card Does Not Offer Discounts on Drugs I Buy	18.3%	13.8%***	19.6%
Forgot Card or Did Not Have Card With Me	4.4%	4.9%**	4.2%
Usually Use Another Card Which Gives Me Better Price	25.0%	12.1%***	28.5%
Did Not Answer	1.3%	0.6%***	1.8%
No Prescriptions To Fill Since Getting Card	26.9%	45.6%***	21.9%

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 200

Note: Respondents could check more than one category. Therefore tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.

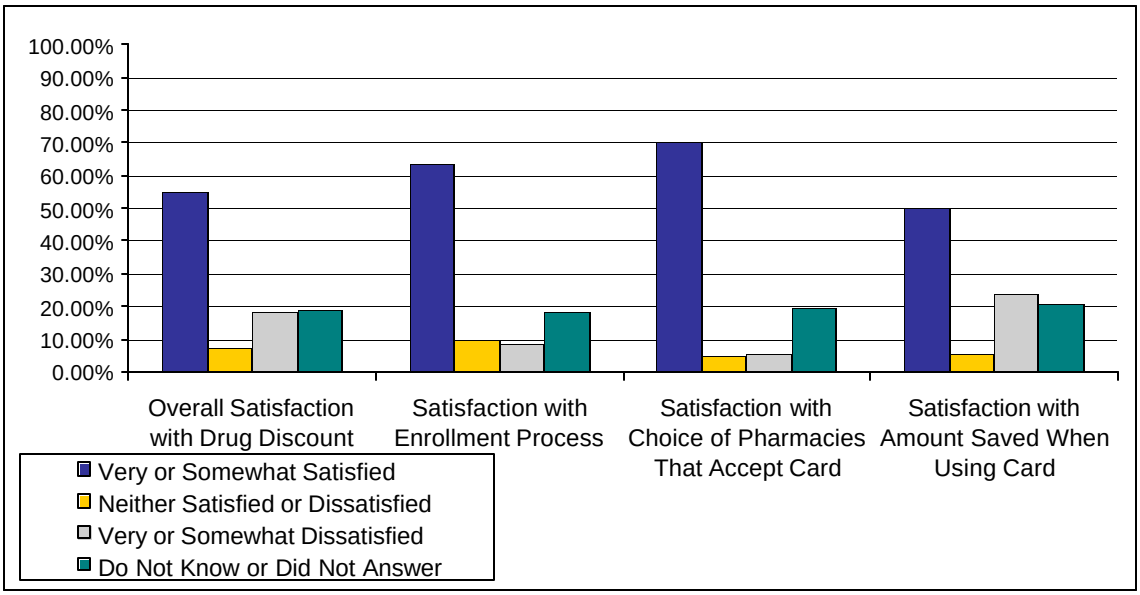
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

2.4.3 Satisfaction

Survey respondents were asked how satisfied they were with various aspects of the Medicare-approved drug discount cards (Exhibit 9). Most (55 percent) expressed overall satisfaction with their

cards. They were especially satisfied with the choice of pharmacies (70 percent) and with the enrollment process (64 percent). Satisfaction with savings was a little lower (50 percent); those getting the T.A. credit were far more satisfied with savings than were those without the T.A. credit.

Exhibit 9: Satisfaction with Medicare-Approved Drug Discount Cards



Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates, Fall 2004

Survey respondents with T.A. were more satisfied than were those without T.A., on every satisfaction measure. This is consistent with findings from focus group T.A. participants, who were very positive about their experiences with their drug cards and especially their savings with the $600 credit.

Survey respondents who had considered more than one drug discount card were only a little more likely to be satisfied with their card, compared with those who had not considered more than one card. Apparently engaging in the choice process made only a small difference in respondents' satisfaction with the cards they chose. Current health status did not have much affect on satisfaction with drug cards.

Respondents who used their cards every time they filled a prescription were much more likely to be satisfied with their cards than were those who used their cards only rarely. Again, this is in part a reflection of the greater satisfaction among those with T.A., who always used their cards and were also quite satisfied.

Respondents who were currently taking more prescription medications were a little more satisfied with the amount saved when using the drug discount card, than those with just a few prescription medications. Fifty percent of respondents who were taking one or two medications were somewhat or very satisfied with the amount saved, and 54 percent of respondents who were taking three or more medications were somewhat or very satisfied with the amount they saved when using the drug discount card (Exhibit 10). Twenty percent of respondents who reported currently taking no prescription medications at all were somewhat or very satisfied (and 40 percent did not know how satisfied they were). It is not clear why this group was so satisfied, since they apparently had no prescription costs and hence gained nothing from the available discounts and T.A. subsidy. Perhaps these respondents were largely enrolled in free cards and appreciated having the discounts and subsidy available at no cost, should they need them.

Exhibit 10: Satisfaction with Drug Card Savings, by Number of Prescriptions

	Question B4: Satisfaction with Amount Saved When Using Card				
Question A6: How many different prescription medications are you regularly taking right now?	**Somewhat or Very Satisfied**	**Neither Satisfied or Dissatisfied**	**Somewhat or Very Dissatisfied**	**Do Not Know**	**Did Not Answer**
0 Medications	19.8	5.2	9.2	39.8	25.9
1 to 2	49.5	6.5	24.0	11.2	8.8
3 to 4	53.6	5.3	26.9	7.8	6.4
5 or more	53.7	5.3	24.8	7.7	8.6
Do Not Know	28.0	0.0	15.6	56.4	0.0
Did Not Answer	14.3	0.3	7.9	3.0	74.5
All Respondents	50.0	5.3	24.0	9.5	11.2

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004

Satisfaction and dissatisfaction varied considerably across the individual drug discount cards, on all four satisfaction measures. Overall drug card satisfaction (defined as being somewhat or very satisfied) varied greatly by card, ranging from 31 percent to 76 percent (Exhibit 11). Those who were somewhat or very dissatisfied ranged from five percent to 29 percent. The portion of respondents who indicated that they were either somewhat or very satisfied with the enrollment process ranged from 35 percent to 79 percent and satisfaction with the choice of pharmacies ranged from a low of 55 percent to a high 85 percent depending on the card. The greatest range was for satisfaction with savings, which ranged from a low of 24 percent to a high of 75 percent.[8]

Exhibit 11: Range of satisfaction, Across Sampled Medicare-Approved Drug Discount Cards

	Somewhat or Very Satisfied	Neither Satisfied or Dissatisfied	Somewhat or Very Dissatisfied
Overall Satisfaction	31.4-76.2	5.25-10.04	4.9-29.4
Enrollment Process Satisfaction	34.9-78.7	6.33-13.83	3.8-16.8
Choice of Pharmacies Satisfaction	55.2-85.4	2.83-8.83	1.8-11.7
Amount Saved Satisfaction	23.6-74.7	2.52-7.73	5.9-37.7

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004

2.4.4 Problems Using Drug Cards and Getting Help

Survey respondents were asked whether they had any problems using their Medicare-approved drug discount cards. Fewer than 22 percent of survey respondents reported having trouble finding satisfactory prices, figuring out when the card was advantageous to use, or any other problems (Exhibit 12).

[8] We were not able to assess the variation in experiences across cards in focus groups, because there were too few enrollees from any given card in the groups to permit card-level analyses.

The most commonly mentioned problem, cited by 54 percent of survey respondents, was finding a pharmacy that would accept their card. Respondents with T.A. faced this problem more than those without (64 percent vs. 48 percent). Those who used their cards every time they filled prescriptions cited this problem more than those who were infrequent card users.

Exhibit 12: Problems Using Medicare-Approved Drug Discount Card

Question B6: Have you had any of the following kinds of problems when trying to use your Medicare-approved drug discount card?	All Respondents n=21,002	T.A. Enrollees n=10,976	Non-T.A. Enrollees n=10,026
Finding Pharmacy to Take Card	54.2%	63.6%***	47.9%
Getting Prices I am Satisfied With	20.8%	9.7%***	28.2%
Figuring Out When Card Helps	16.3%	9.0%***	21.1%
Other Problem Using Card	17.3%	21.4%	14.6%
Did Not Answer	0.9%	0.4%***	1.2%

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
Note: Respondents could check more than one category. Therefore tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Although 54 percent of respondents indicated that they had difficulties finding a pharmacy that would accept their drug discount card; 70 percent of respondents reported being very or somewhat satisfied with the choice of pharmacies that were available to them. These two findings appear to be contradictory and reflect inconsistencies in responses: respondents who said they had problems finding a pharmacy were more likely than others to say they were very or somewhat satisfied with the choice of pharmacies that accept the drug discount card. One explanation may be that finding a pharmacy that would accept a card was an early problem that quickly resolved (these survey respondents being among the earliest card users). Or it could be that respondents taking many different medications had problems finding a pharmacy that would give a discount on all of their medications.

Problems with using cards varied somewhat across the selected cards in the survey, although the variation across cards was not nearly as great as the variation in satisfaction measures discussed above. Difficulty finding a pharmacy that would accept the card was the most common type of problem reported, and variation in difficulty ranged from a low of 43 percent to a high of 62 percent.

Focus group participants who were enrolled in Medicare-approved drug discount cards were also asked about any problems they had experienced when using their cards. In 2004, participants in several focus groups mentioned that their pharmacists didn't seem to fully understand how the program worked, particularly the T.A. credit and how it should be applied in conjunction with SPAP or other benefit/discount programs. By the winter of 2005, however, few focus group participants reported any problems at all and said they simply took their cards to their pharmacists who entered the data into the computer systems. When these beneficiaries had other discount cards from other programs, they trusted their pharmacists to figure out which would be most advantageous for a given prescription. It appears that pharmacist confusion was an early problem that was quickly overcome. In addition, many beneficiaries rely on pharmacists to figure out how to achieve the lowest out-of-pocket costs, rather than trying to figure this out themselves.

A few focus group participants reported difficulty in figuring out what they would have to pay for a specific drug, or whether their card would cover all their medications. And a number of those with T.A. wanted to track their benefit balance but reported problems in finding out how much of their $600 credit remained. Some reported seeing their balance printed on their pharmacy receipts, others said that they asked their pharmacists for this information but their pharmacists did not provide it.[9]

Survey respondents were asked where they would turn for help if they had problems with their Medicare-approved drug discount cards. Forty-three percent said they would contact the sponsor of their card, 43 percent would call 1-800-MEDICARE, and 48 percent would ask their pharmacist for help. The latter supports previous findings that beneficiaries rely on their pharmacists when accessing pharmacy assistance/benefit programs.

Although survey respondents experienced occasional problems in using their drug cards, and knew where they would turn for help if they had a problem, few had sought any sort of help. Those few respondents who did contact their card sponsor were largely satisfied with the customer service offered by their card sponsor; respondents with T.A. were more likely to have contacted their card sponsor and also more likely to be satisfied with the customer service their sponsor provided, than those without T.A.

2.4.5 Savings

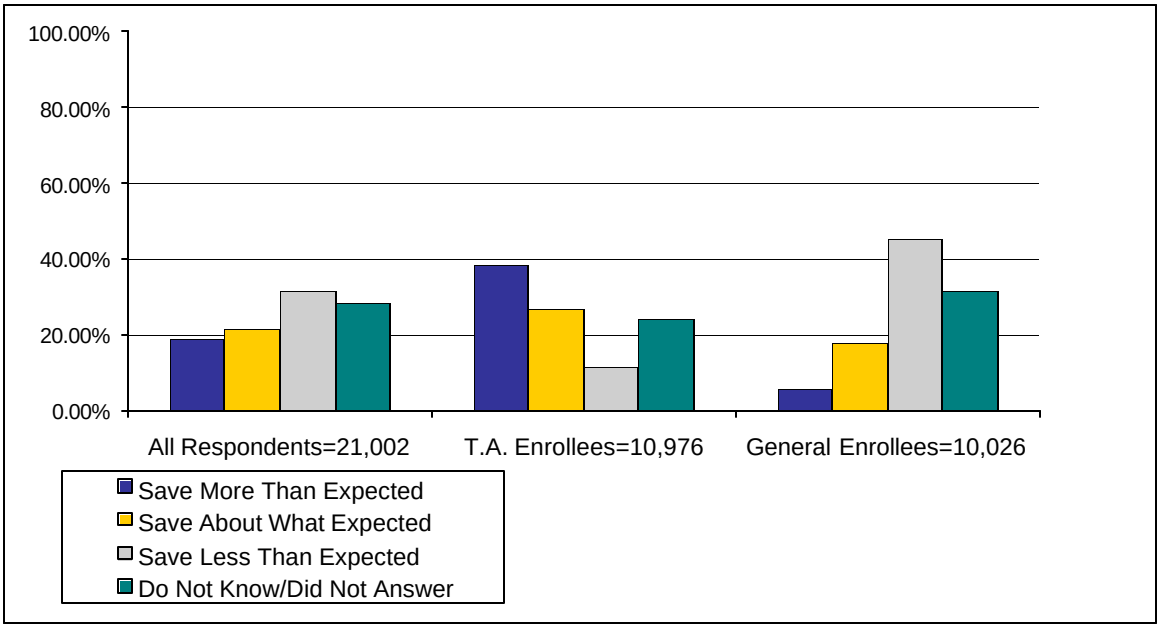
Many survey respondents said that before receiving their cards, they expected the cards would yield real savings. Twenty-nine percent expected to save a lot of money when using the card and 37 percent expected to save some money; a total of 66 percent expected to see savings – very high expectations. Survey respondents with T.A. expected to save more, which is reasonable since they were looking forward not only to discounts, but the $600 credit.

When asked how much they had actually saved using their cards, 23 percent reported that they had saved a lot of money and 23 percent reported saving some money, for a combined total of 46 percent reporting savings. T.A. respondents were more likely to report having saved a lot of money with their cards.

The survey also asked whether respondents had saved more or less than expected. As displayed in Exhibit 13, 32 percent (mostly those without T.A.) saved less than they'd expected, 21 percent saved about what they'd expected, and 18 percent (mostly those with T.A.) saved more than expected. These findings are all consistent with the greater satisfaction with savings expressed by those receiving the T.A. credit.

[9] All pharmacists should have been able to access this information from card sponsors, either electronically or by phone, and were required (per their contracts with card sponsors) to provide this information to card enrollees at point of sale, when asked.

Exhibit 13: When you use your Medicare-approved drug discount card, do you save as much money as you expected? (survey Question C3)



Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004

Focus group participants were asked whether they thought they were getting the best price possible with their cards and whether they had done any comparison shopping among pharmacies to see which gave the best price for their medications. Most participants did not know if they were getting the best possible price, and did not know how to figure this out. Focus group participants who did try to comparison shop (about 25-30 people) reported that this was rather difficult to do. Some pharmacists would not (perhaps could not) provide prices unless the customer went in-person and gave the pharmacist their card and their prescription to process. Some pharmacists explained to these "shoppers" that there was an administrative fee each time they queried a card sponsor's database, and they were not willing to incur this fee unless a sale was pending. Other pharmacists said they were simply too busy to provide information for comparison shoppers. Those few beneficiaries who were able to get information and really comparison shop, were generally pleased with the results, although some found that prices varied so little that comparison shopping was not worth the effort.

Focus group participants with T.A., while generally quite satisfied with savings and with their drug cards overall, often had difficulty determining how much of their $600 credit remained and thus did not know when it would run out. Although this was more of a problem in 2004, some participants in the 2005 focus groups continued to report that they could not get this information from their pharmacists, while others saw this information printed out on their pharmacy receipts. Many beneficiaries with T.A. wanted to track their benefit and know when it would run out, and were frustrated when they thought this would not be possible. Some with T.A. also worried about how they would continue to pay for their prescriptions when the $600 credit was exhausted.

2.4.6 Prescription Filling Practices

Approximately 11 percent of survey respondents had in the past purchased drugs via mail order; this is apparently not a common practice among Medicare beneficiaries who enrolled in drug discount cards. Almost none had bought drugs over the Internet and focus groups findings indicate that most

beneficiaries do not have Internet access. While some beneficiaries had helpful relatives or friends who were Internet-comfortable, this does not appear to have translated into making prescription drug purchases online.

Survey respondents were asked if they had ever delayed/skipped filling prescriptions, or delayed/skipped taking medication doses, prior to getting their Medicare-approved drug discount cards, and then were asked if they were doing these things after getting their cards. (Note that the *before* period was life-long compared to the *after* period of only two to four months.) Forty-six percent reported that before getting their cards, they had at times decided not to fill a prescription because they couldn't afford it; T.A. card respondents were more likely than those without T.A. to indicate that they had at time not filled prescriptions. A much smaller proportion indicated that they still found it necessary to sometimes delay/avoid filling a prescription because they couldn't afford it, since receiving their Medicare-approved drug discount card (20 percent). The practice of not filling prescriptions due to cost declined (from 46 percent down to 20 percent). The improvement for T.A. card respondents (from 58 percent down to 14 percent) was so great that they became less likely to not fill a prescriptions than were respondents without T.A. This may have been because most of those with T.A. had probably not yet exhausted their $600 credit at the time of this survey.

A number of focus group participants with T.A. were enthusiastic about their ability to fill their prescriptions and take their medications as prescribed. Many had in the past skipped doses of costly drugs, decided against filling prescriptions, shared prescriptions with friends, etc. and knew that this was sub-optimal. Others had dropped prescription insurance they previously held, because they could no longer afford the premiums, and a few had experienced a decline in a former employer's retiree benefits that reduced or eliminated their prescription coverage. The $600 credit eased all of these situations, at least temporarily, and many beneficiaries reported real relief at being able to afford to take their medications properly.

2.5 Detailed Programmatic Knowledge

2.5.1 Understanding Programmatic Features

Ideally, participants in any insurance or benefit program would have a fairly complete understanding of how the program works – the "rules of the road". Focus group participants were asked how they would explain the Medicare drug discount card program to a friend: how it works and what one can get through the program. Few were able to explain the program; even those who had enrolled and were using their cards were not able to fully explain the program, although most could describe a few features such as the $600 credit, discounts, and the temporary nature of the program. The aspect of the program beneficiaries understood most clearly was that they needed to present their Medicare-approved drug discount card to the pharmacist when filling a prescription (at least the first time), in order to receive a discount. Card enrollees often had experience with other discount programs/cards that worked the same way. There was considerable confusion among T.A. participants in terms of how the $600 credit works in conjunction with discounts/benefits from other programs, SPAPs, etc. Focus group participants in fall 2004 were more confused than those participating in 2005, probably because the program was so new in 2004.

To assess survey respondents' understanding of programmatic features, they were asked to evaluate whether five specific statements about the program were correct or incorrect. These questions were: whether having a Medicare-approved drug discount card is the same as having insurance; whether a beneficiary can have only one Medicare-approved drug discount card at a time; whether the cards yield discounts on all prescription drugs at any pharmacy; whether a card enrollee can also have other discount cards sponsored by drug manufacturers or drug store chains; and whether the price paid when using a card depends on generic vs. brand name purchases.

A slight majority of respondents answered one of the five questions correctly (prices differing for generic vs. brand name drugs), but only a minority answered the other questions correctly (Exhibit 14). Of perhaps most concern were the 16 percent who were under the mistaken impression that if they had a Medicare-approved drug discount card they could not also have a discount card from another source like a drug manufacturer or drug store. It appears that some fairly basic aspects of the program are not well understood, even by those who are enrolled.

Exhibit 14: Understanding of Programmatic Features (correct answers indicated by asterisk)

Survey Questions	Agree	Disagree	Do Not Know	Did Not Answer
C8: A Medicare-approved drug discount card is the same as having insurance for prescription drugs.	24.3%	33.7%*	29.6%	12.4%
C9: You can only have one Medicare-approved drug discount card at a time.	47.4%*	10.4%	28.3%	14.0%
C10: With a Medicare-approved drug discount card you get discounts on all prescription drugs, at any pharmacy.	19.5%	34%*	33.0%	13.5%
C11: If you have a Medicare-approved drug discount card, you can also have other discount cards sponsored by drug manufacturing companies or drug store chains.	23.3%*	16.2%	46.6%	13.9%
C12: When you use your Medicare-approved drug discount card, the price you pay will depend on whether you are buying a generic drug or a brand name drug.	52.4%*	6.6%	27.7%	13.3%

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc, Fall 2004
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

2.5.2 Medicare Drug Coverage Program (Part D) Knowledge

During focus groups held in winter 2005, participants were asked whether they had heard about changes coming in the drug program, and what they had heard or knew about these changes. Again, awareness was quite high, but few participants had specific information about upcoming changes. Seventy-six percent of those without T.A. in the focus groups knew changes were coming, 74 percent of non-enrollees knew changes were coming, and 55 percent of those with T.A. were aware of upcoming changes. In eight of the 24 focus groups held in 2005, not a single person could describe anything they had heard about upcoming changes, or were so confused about what they had heard that they were not comfortable trying to relay this information. Among those who had heard about changes, some knew that the drug cards they now hold would no longer be valid, that the program would remain voluntary, that there would be a monthly premium, that there would be a coverage gap, and that those with very high drug costs could qualify for more help. A very few mentioned more precise details like the deductible amount or the penalty for waiting to enroll, which was perceived by a few as being much higher than it actually will be.

Since awareness of impending change was high, but detailed understanding quite low, few focus group participants had formed any opinions about the upcoming changes and therefore had not decided whether they would participate in Part D. They did not know whether they would stay with

the same sponsor (assuming that the card sponsor intends to offer a drug plan in 2006) and most were waiting to learn more before forming any opinions or making decisions.

3.0 Implications for Medicare Drug Coverage (Part D)

3.1 Awareness of the Program

Based on focus groups held in fall 2005 and winter 2005, the media and CMS channels were quite successful in ensuring that most beneficiaries quickly became aware of the Medicare drug discount card program. Some beneficiaries failed to enroll due to misperceptions about eligibility and likely savings. Some who were aware of the program did not realize that they had to take action to enroll, or how to do so (some were expecting a card, like their Medicare Part A&B card, to simply arrive in the mail). Others thought the program was for low-income beneficiaries only. These misperceptions and confusions underscore the importance of the key messages CMS is promoting to beneficiaries in 2005, in preparation for the Medicare drug coverage program (Part D), which include:

- Medicare prescription drug coverage is available to all people with Medicare
- Additional help is available for those who need it most (those with limited incomes and/or high drug costs)
- More information and assistance is available at 1-800-MEDICARE, medicare.gov, and local SHIPs.

3.2 Awareness of Enrollment

Three to five months after enrolling (or being auto-enrolled) in Medicare-approved drug discount cards, 21 percent of survey respondents reported that they did not have a card. Nearly half of card enrollees contacted during focus group recruiting in 2005 stated that they did not have a card. We believe the correct estimate is closer to 21 percent. Thirteen percent of those who had the T.A. credit (according to CMS administrative files) thought they did not have the $600 credit and another 17 percent were not sure. There seems to be some level of uncertainty among enrollees about their status, and some confusion among those with T.A. as to whether they do indeed have the $600 credit. It will be important that everyone enrolled in a Part D drug plan (or whomever is purchasing drugs on their behalf) is aware of their enrollment; the fact that they will be paying monthly premiums may increase awareness of enrollment but may not entirely eliminate this problem. Uncertainty about whether a T.A. application was approved raises concern that the same could occur among people who apply for the low-income subsidies under Part D and remain unsure about whether their application was approved.

Based on focus groups, it appears that uncertainty about enrollment and T.A. status were highest among those who were auto-enrolled (or whose enrollment was facilitated) by an SPAP, by their Medicare Advantage plan, or by CMS. Some portion of those who were auto-enrolled apparently did not understand (or may never have opened) the informational materials they received explaining their auto-enrollment. The same may occur when people are auto-enrolled into Part D drug coverage plans. Those who are deemed eligible and automatically enrolled may require more than a mailing from their Part D drug plan, in order to understand their enrollment and benefits and their options for switching if they are not satisfied with their drug plan.

Part D drug plans will need to be cognizant of this persistent problem of some people being unaware of their enrollment and not necessarily paying attention to mailed materials. The envelopes

containing Part D drug plan mailings may need a more obvious external message, for example, drawing attention to the Medicare-related contents. Focus group participants reported that they were less likely to throw away mailings from a known and trusted source such as the Social Security Administration, AARP or their insurance carriers. This suggests that over time, as beneficiaries become accustomed to their new drug plan sponsors, they may be more likely to recognize and open mailings.

3.3 Information and Choices

A large percentage of beneficiaries we surveyed and met in focus groups did not consider more than one Medicare-approved drug discount card, and many did not realize that there were multiple cards to choose from. Some of these people were auto-enrolled and did not understand that they could make alternative enrollment decisions, but most simply did not look beyond the first card they encountered, especially if it was recommended by their pharmacist. Even though many survey respondents did not consider more than one card, most felt that they had enough, or more than enough, information when enrolling in their Medicare-approved drug discount card. Some beneficiaries reported that they were not using their cards because the cards did not offer discounts on the drugs they take; they might have benefited by exploring other cards that possibly used different formularies. If all cards were essentially identical, this probably would not matter, but cards were not identical and people may not have enrolled in the card best suited to their particular circumstances. If the same occurs under Part D and many people do not compare options and make choices in their best interests, the feature of the program – choice – that is intended to exert market pressure toward enhanced value, may not have an optimal effect.

Pharmacists played a critical role in providing information, encouraging enrollment, and helping people use their Medicare-approved drug discount cards. Pharmacists were the most cited source of information when survey respondents were considering drug cards, and were also a trusted source respondents would turn to if they had problems with their drug cards. Focus group participants relied on pharmacists to figure out the best combination of their various discounts, cards and benefits for each prescription they filled. Given this key role, pharmacists will need to understand the Part D drug plan program and CMS is working to educate pharmacists.

Very few survey respondents mentioned Medicare counseling services (SHIPs or others) as an information source when they were considering drug discount cards. Similarly, almost no focus group participants had contacted their local SHIP (or even recognized its name). At the same time, many focus group participants expressed strong preferences for receiving personally-tailored information from an unbiased source, one-on-one. They appear to want what the SHIPs have to offer, but very few are locating this resource. CMS is therefore highlighting SHIP resources and services in the 2005-2006 (NMEP). As the Part D enrollment period approaches, most beneficiaries will need to be reached through sources that they are more accustomed to using. The most often mentioned sources of information on the drug discount card program were pharmacists, media, AARP, and insurance companies and agents with whom beneficiaries had existing relationships (in addition to family and friends). Building on existing trusted relationships may be a useful strategy for reaching out to beneficiaries as the Medicare drug coverage program approaches.

Only a few focus group participants could describe important program features, and many survey respondents could not correctly answer questions about features of the Medicare drug discount card program. Failure to understand some programmatic features is probably of little practical importance, but for other features an incorrect understanding could have important implications. For example, many focus group non-enrollees were under the impression that the drug discount cards were only available to those with limited incomes. And 16 percent of survey respondents held the erroneous belief that having a Medicare-approved drug discount card meant not being able to have cards from

other sorts of discount programs sponsored by drug companies, pharmacies, or others. These sorts of misunderstandings indicate a need not only for outreach concerning enrollment and general information about Part D, but also an ongoing need for detailed information and education so that beneficiaries are best able to coordinate their new drug plans with other sources of assistance as SPAPs or manufacturer assistance programs.

3.4 Enrollment

Most focus group participants who enrolled in a drug discount card felt that the enrollment process went smoothly; this was true for those who enrolled online, over the phone, or by mailing an application form. T.A. participants reported no difficulty with the application process, although a few experienced delays in getting approved for T.A. There were also reports, especially in 2004, of lengthy delays in actually receiving cards in the mail. Under Part D, beneficiaries are going to expect to be able to use their cards in the first month that they are paying premiums. It will be important for drug plan sponsors to minimize delays in getting cards (or other proof of coverage) into the hands of their enrollees. It will also be important for beneficiaries and pharmacists to understand that drug plan enrollees can begin receiving plan benefits in the month after they enroll, even if they have not yet received their new drug plan insurance card in the mail.

3.5 Using Medicare-Approved Drug Discount Cards

Focus group participants reported that sometimes the lowest purchase price for a drug was not the price offered by a discount drug card sponsor, but a lower price available through some other means (drugstore senior discounts, manufacturer discounts, etc.)[10] Sometimes a retail club (Costco, Sam's Club) offered a lower price without the drug discount card than with it. Focus group participants were beginning to learn how to get the best price for each of their drugs, which sometimes meant *not* using their Medicare drug discount cards. Survey respondents with T.A. were far more likely to use their cards every time they filled prescriptions, probably because most had not yet exhausted the $600 credit at the time the survey was fielded. Similar patterns might be anticipated under Part D, with low-income beneficiaries receiving greater benefits and continuing to use their cards, while others discontinue use (particularly during coverage gaps) if their cards are not bringing the lowest possible price.

Some beneficiaries' shopping strategies, aimed at minimizing out-of-pocket costs for prescription drugs, may need to change under Part D, when tracking out-of-pocket spending for covered drugs will be important for people who might qualify for catastrophic coverage. Under Part D, some beneficiaries may find lower prices during coverage gaps by going outside their drug plan network; if so, they will need to understand how to report any out-of-plan expenses to their drug plans, so that these expenses can be counted toward their TrOOP costs. This aspect of the Part D program is different from most drug insurance or discount programs with which beneficiaries (or their pharmacists) are familiar.

T.A. focus group participants wanted to be able to track their $600 credit and to know when it was about to run out. In 2004 and early 2005, pharmacists did not always provide information about the T.A. credit balance; some pharmacies' systems were able to print this information on sales receipts, but some pharmacists told beneficiaries that they could not provide this information.[11] Part D drug

[10] A few focus group participants bought drugs from Canada or Mexico.

[11] All pharmacists should have been able to access this information from card sponsors, either electronically or by phone, and were required (per their contracts with card sponsors) to provide this information to card enrollees at point of sale, when asked.

plan members are likely to want to track their benefits as well, to know for example, when they're about to reach a coverage gap and when it will end. Drug plans will be sending monthly notices to plan members who fill prescriptions, containing benefit information; it will be helpful if pharmacists also provide this information to beneficiaries at point of sale and inform them that this information is available from their drug plans.

3.6 Prescription Filling Practices

A small percentage of survey respondents had in the past purchased drugs via mail order; this is apparently not a common practice among Medicare beneficiaries who enrolled in drug discount cards and may not be common among those enrolling in Part D drug plans either. To the extent that drug plans intend to rely on mail order to achieve savings, this may meet with limited acceptance among beneficiaries, who will probably continue to fill prescriptions at their local pharmacies.

Nearly half of all survey respondents acknowledged that at some time in the past they had decided not to fill prescriptions due to cost concerns, and a somewhat smaller percentage had at times skipped doses or taken smaller doses, to stretch their medications. Fewer people reported these practices after receiving their Medicare-approved drug discount cards, at least for the few months immediately after they received their cards, especially among those with T.A. Focus group participants, especially those with the T.A. credit, similarly appreciated their new ability to purchase and take their medications properly. This indicates that there is real potential for enhancing appropriate use of prescription medications through reduced prices and subsidies, especially for lower income beneficiaries who did not previously have any drug coverage. With even greater benefits available under Part D, these patterns of improved use of prescribed drugs are likely to continue and even increase.

3.7 Satisfaction and Savings

More than half of survey respondents were satisfied with their Medicare-approved drug discount cards overall, and most were satisfied with the list of pharmacies at which they could use their cards. It appears that pharmacy networks were broad and accessible enough to satisfy a large majority of card enrollees. If Part D drug plans are able to maintain these broad pharmacy networks, access will likely be an issue for a relatively small percentage of enrollees.

Respondents who indicated that they had considered more than one drug discount card, were only a little more likely to be satisfied with their drug discount cards than were those who did not consider more than one card. Apparently engaging in the choice process made only a small difference in the satisfaction respondents felt with their cards. This may be true for Part D drug plans as well; beneficiaries who are auto-enrolled or who enroll in the first drug plan they learn about may be nearly as satisfied as those who consider multiple plans.

Satisfaction and dissatisfaction varied considerably across the individual drug discount cards, on all four satisfaction measures. Overall drug card satisfaction (defined as respondents who were somewhat or very satisfied) varied greatly by card, as did satisfaction with the enrollment process and with the pharmacies at which cards were accepted. The greatest range was for satisfaction with savings. The substantial variability in satisfaction, and especially satisfaction with savings, might be expected to continue under Part D, with various plans' enrollees experiencing differing levels of satisfaction.

Nearly half of survey respondents reported that they have saved "some" or "a lot" of money using their cards; those with T.A. were the most enthusiastic about savings, probably because most had not

yet exhausted their $600 credit. Nearly a third of those without T.A. reported that they saved "some" or "a lot" of money using their cards, indicating that the discounted prices available through cards are bringing tangible benefits. With Medicare prescription drug coverage, potential benefits for those who are not low-income will be greater, and for those with limited-incomes, greater yet (especially if they were previously uninsured); as a result, perceived savings are likely to rise even more.

3.8 Changes in 2006

Although a high percentage of focus group participants were aware that there will soon be changes in Medicare drug coverage, almost none had any information or understanding about the new program. This should improve as NMEP outreach and education increases, and CMS will continue to monitor beneficiary awareness and understanding during the prescription drug plan initial enrollment period of November 2005 through May 2006.

Appendix A: The Medicare-Approved Drug Discount Card - Real Successes and Some Lessons Learned[12]

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 currently using brand name drugs who are able to switch to generics can achieve even

[12] 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.

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: Survey Sampling and Methods

Sample Selection

The target population for this survey was all Medicare beneficiaries who were enrolled in a Medicare-approved drug discount card before July, 2004 and who thus had at least a few months during which to receive and begin using their cards before the time the survey was fielded in September, 2004. The survey sampling frame therefore included beneficiaries who enrolled within the first 6-8 weeks after the cards became available; these were beneficiaries who might be considered 'early adopters'.

The names and addresses of beneficiaries enrolled in various Medicare-approved drug discount cards were retrieved from the Enrollment, Eligibility, and Verification System (EEVS) along with dates of card enrollment and the specific card each beneficiary enrolled in. Enrollees in national and regional cards were retained, while those enrolled in Special Endorsement and Exclusive cards were removed. In addition, enrollees whose reason for Medicare entitlement (Original Entitlement Reason) or whose Medicare status included ESRD, were removed from the sampling frame because their renal drugs are covered under Part B and their other drug use patterns are likely to differ dramatically from those of non-ESRD beneficiaries. Finally, those who had effective card enrollment dates after July 1, 2004 were removed since they would not have had enough experience using the discount cards at the time of the survey.

The sample selection was done in two stages. At the first stage, a non-random sample of 27 drug discount cards was selected.[13] Two different populations were identified among enrollees in the 27 cards selected for the survey: 600 card enrollees without T.A. and 600 card enrollees with T.A. Only cards with at least this enrollment of 1200 were eligible for the survey. Most of the largest national cards were included among the 27 selected for sampling, and geographic balance was sought among the 27 cards selected. A few regional cards with the requisite number of enrollees were also included so that the survey would have some representation of beneficiaries who chose regional rather than national cards. Enrollment in the 27 selected cards represents 72.5 percent of all card enrollees who met eligibility criteria for the survey (not ESRD, not exclusive or special endorsement cards, not Medicaid, with card enrollment effective dates before 7/1/2004). Our selected sample of 32,434 represents 3.06 percent of all eligible card enrollees, across all cards.

The second stage required selection of independent samples of 600 T.A. and 600 non-T.A. drug discount card enrollees, from each of the 27 drug discount cards. The number of cards that had the requisite 1200 enrollees was less than 27. To arrive at the total of 27 cards we therefore had to divide some of the largest cards into separate populations. In Exhibit 1, there are three national cards with 4 regions each 1200 x 4 = 4800 total sample, rather than just 1200. These three were the national cards with the highest enrollment; their populations were divided into the four census regions and samples were then drawn from each as if it was a discrete national card.[14] Each of the two strata was further stratified into two substrata: disabled and not disabled (aged). The sample of 600 non-T.A. enrollees was first allocated to each of the two substrata in proportion to the number of enrollees in the population in each substratum. Then, a systematic random sample was selected in each substratum after sorting the enrollees by age group, gender and race/ethnicity. The same was done for the sample of 600 T.A. enrollees from each drug discount card. The distribution of the population and sample by strata and substrata for each of the 27 selected drug card programs is shown in Exhibit 1.

[13] The number of cards to be sampled was based on budget considerations.

[14] In addition, one card that had different enrollment fees in different states, had a total sample of 2400 divided between 'High' and 'Low' annual enrollment fee.

Exhibit 1: Survey Sample by Drug Card

Card	UNIVERSE					SAMPLE				
	T.A. - Disabled	T.A. - Aged	Non-T.A. - Disabled	Non-T.A. - Aged	Total in Universe	T.A. - Disabled	T.A. - Aged	Non-T.A. - Disabled	No-T.A. - Aged	Total Sampled
Regional – 1	112	763	966	8,570	10,411	77	523	61	539	1,200
Regional – 2	193	520	802	5,387	6,902	162	438	78	522	1,200
Regional – 3	6,247	21,638	8,370	58,984	95,239	134	466	75	525	1,200
Regional – 4A Low (MN, MT, ND)	58	636	78	1,209	1,981	50	550	36	564	1,200
Regional – 4B High (NE, OK, TX, WY)	207	1,697	329	4,967	7,200	65	535	37	563	1,200
Regional – 5	265	699	207	1,571	2,742	165	435	70	530	1,200
National – 1	266	368	305	918	1,857	266	368	150	450	1,234
National – 2	18,151	47,113	50	774	66,088	167	433	36	564	1,200
National – 3	652	963	160	596	2,371	242	358	127	473	1,200
National – 4	2,864	7,083	1,074	7,688	18,709	173	427	74	526	1,200
National – 5	6,069	22,525	10,657	120,670	159,921	127	473	49	551	1,200
National – 6	2,411	3,384	51,474	105,161	162,430	250	350	197	403	1,200
National – 7	1,232	1,983	119	1,130	4,464	230	370	57	543	1,200
National – 8	4,056	5,985	1,560	5,793	17,394	242	358	127	473	1,200
National – 9	2,229	7,908	734	5,408	16,279	132	468	72	528	1,200
National – 10 Region 1	663	1,521	206	1,493	3,883	182	418	73	527	1,200
National – 10 Region 2	1,087	4,364	292	2,636	8,379	120	480	60	540	1,200
National – 10 Region 3	3,745	9,567	542	3,491	17,345	169	431	81	519	1,200
National – 10 Region 4	653	2,188	163	1,298	4,302	138	462	67	533	1,200
National – 11 Region 1	2,287	2,273	528	2,249	7,337	301	299	114	486	1,200
National – 11 Region 2	1,861	5,865	1,200	7,521	16,447	145	455	83	517	1,200
National – 11 Region 3	8,309	16,169	3,757	14,472	42,707	204	396	124	476	1,200
National – 11 Region 4	1,549	3,657	844	4,019	10,069	179	421	104	496	1,200
National – 12 Region 1	576	778	544	2,024	3,922	255	345	127	473	1,200
National – 12 Region 2	1,535	6,451	1,550	9,511	19,047	115	485	84	516	1,200
National – 12 Region 3	9,079	20,785	4,886	18,616	53,366	182	418	125	475	1,200
National – 12 Region 4	881	2,760	722	3,493	7,856	145	455	103	497	1,200

Survey Methods

Questionnaire

The questionnaire was produced in booklet form and was 14 pages long including the cover and an instruction page. It showed the standard Medicare Approved Rx logo on Page 1, to orient respondents. The same questionnaire was sent to drug discount card enrollees those with T.A., and those without. The questionnaire included questions in the following domains:

- Reasons for choosing a card and sources of information when making this decision
- Use of the card and reasons for not using it all the time, including other sources of insurance or assistance that help pay for prescription drugs
- Applying for, and being approved for, Transitional Assistance, and problems using T.A.
- Satisfaction with Medicare-drug discount cards and plans to continue with same card
- Problems using cards and where to turn for help, as well as satisfaction with customer service offered by drug discount card sponsors
- Expectations for savings and whether savings were more/less than expected
- Changes in prescription filling practices and skipping/delaying filling prescriptions or doses to reduce costs
- Knowledge of drug card programmatic features
- Current insurance, current health status, demographics

Survey Implementation

A beneficiary survey was conducted by mail. A survey ID number was created for each of the 32,434 beneficiaries in the sample file; these ID numbers were linked to name and mailing address to create the survey mailing list. The mail survey was conducted following a modified "Dillman approach"[15], with a 12-week field period from first mailing to final receipt of returned questionnaires. A toll free helpline was staffed by bilingual interviewers to answer any questions respondents had about the survey and to send a Spanish-language version of the questionnaire if requested. If respondents stated that they had no Medicare-approved drug discount card, or had not yet used their card, but refused to mail back the questionnaire, this minimal information was collected by the phone along with the survey ID number, and entered into the study database.

A cover letter from CMS was enclosed in the first mailing (envelope customized with CMS logo). Each mailing included the questionnaire, a toll-free number to phone with any questions, and the offer of a Spanish version of the questionnaire, upon request.

- First mailing of the questionnaire with full cover letter
- Follow-up post-card 1 week later
- Second mailing of questionnaire, with abbreviated cover letter, 3 weeks after first mailing
- Follow-up post-card 1 week later

[15] Dr. Dillman suggests several rounds of mailings with cover letters followed by reminder postcards, to achieve the highest possible response rate. *Mail and Internet Surveys*, D. Dillman, 2000 Wiley, New York.

- Third mailing of questionnaire, with abbreviated cover letter, 6 weeks after first mailing
- Follow-up post-card 1 week later
- Fourth mailing of questionnaire, sent Priority Express, 10 weeks after first mailing
- Follow-up post-card 1 week later

As questionnaires were returned they were logged in, checked for legibility and 'cleaned' to force skip patterns and back-code open-ended answers. All questionnaire data were entered twice and the two files compared for 100 percent verification; any discrepancies were resolved by survey staff. CMS Administrative datan (card number, T.A. or not, age, eligibility (aged vs. disabled), etc.) were appended to each record, then names, addresses and HIC numbers were removed from the file to protect respondent anonymity.

Survey Response Rates

Out of the 32,434 sampled enrollees, 23,985 returned a survey with at least the first question answered ("Do you have a Medicare-approved drug discount card?") (Exhibit 2). In addition, 654 enrollees didn't return the survey but instead phoned or sent a note to tell us that they either had no drug card (490 respondents) or indicated that they had a card but had not yet used it (164 respondents). We asked these 654 respondents to mail back a survey indicating this information, but these two categories of respondents did not.

CMS is interested in knowing the percentage of beneficiaries who are unaware that they are enrolled in a card; regardless of whether respondents answer this important question by phone or by mail, their responses are valid. Therefore, the survey response rate includes those who didn't mail back the survey but did phone or send a note to answer the first question. With these responses included as completes, the total number of respondents was 24,639 and the survey response rate was 76 percent.

The survey analyses in this report use the entire set of completes, including those who provided minimal information by phone or a note, rather than by filling out the survey and mailing it back. This "analysis population" totals 24,639 respondents; a response rate of 76 percent.

Exhibit 2: Respondents

	T.A. Enrollees	Non-T.A. Enrollees	Total
Returned Completed Surveys	12,194	11,791	23,985
Phone Response: Have not yet used card	63	101	164
Phone Response: Do not have card	200	290	490
TOTAL RESPONSE	12,457	12,182	24,639

Response rates varied among the different Medicare-approved drug discount cards sampled, as shown in Exhibit 3, ranging from 51 percent to 82 percent. National cards as a group did not differ significantly from regional cards in their response rates.

Exhibit 3: Response Rate by Card

Card	Responses per card		T.A. Enrollee Responses		Non-T.A. Enrollee Responses		Aged Enrollee Responses		Disabled Enrollee Responses	
	N	%	N	%	N	%	N	%	N	%
Regional 1	877	73.1%	464	52.9%	413	47.0%	779	88.8%	98	11.1%
Regional 2	779	64.9%	427	54.8%	352	45.1%	623	79.9%	156	20.0%
Regional 3	921	76.8%	456	49.5%	465	50.4%	764	82.9%	157	17.0%
Regional 4 – high & low	1,946	81.1%	1,006	51.6%	940	48.3%	1,797	92.3%	149	7.6%
Regional 5	920	76.7%	465	50.5%	455	49.4%	740	80.4%	180	19.5%
National 1	880	73.3%	491	55.7%	389	44.2%	577	65.5%	303	34.4%
National 2	613	51.1%	287	46.8%	326	53.1%	520	84.8%	93	15.1%
National 3	930	77.5%	469	50.4%	461	49.5%	658	70.7%	272	29.2%
National 4	937	78.1%	475	50.6%	462	49.3%	736	78.5%	201	21.4%
National 5	824	68.7%	381	46.2%	443	53.7%	715	86.7%	109	13.2%
National 6	818	68.2%	436	53.3%	382	46.6%	515	62.9%	303	37.0%
National 7	948	79.0%	476	50.2%	472	49.7%	727	76.6%	221	23.3%
National 8	957	79.8%	481	50.2%	476	49.7%	676	70.6%	281	29.3%
National 9	920	76.7%	455	49.4%	465	50.5%	772	83.9%	148	16.0%
National 10 – all 4 regions	3,790	79.0%	1,896	50.0%	1,894	49.9%	3,085	81.3%	705	18.6%
National 11 – all 4 regions	3,662	76.3%	1,856	50.6%	1,806	49.3%	2,741	74.8%	921	25.1%
National 12 – all 4 regions	3,917	81.6%	1,936	49.4%	1,981	50.5%	3,010	76.8%	907	23.1%
Total	24,639		12,457		12,182		19,435		5,204	
Card Type (Regional/National)										
National	19,196	76.1%	9,639	50.2%	9,557	49.7%	14,732	76.7%	4,464	23.2%
Regional	5,443	75.6%	2,818	51.7%	2,625	48.2%	4,703	86.4%	740	13.5%

Proxy Respondents

The survey could be completed by a proxy if the actual drug discount card enrollee was unable to do so; 4 percent of all responses were completed by proxy. The percent completed by proxy varied little among the four major strata of Transitional Assistance vs. Non-T.A., card enrollees, and Aged vs. Disabled. In all survey analyses, proxy respondents and beneficiary respondents were combined.

Adjusting for Non-Response and Post-Weighting to Reflect Card Size and Composition

The weighted sample represents the enrollee population of the 27 drug discount cards chosen for the survey (which together account for 72.5% of all drug discount card enrollees).

For producing population-based estimates, each respondent in the sample was assigned a sampling weight. This weight combines a base sampling weight which is the inverse of the probability of selection of the respondent, and an adjustment for non-response to account for those who did not respond to the survey. The base weight assigned was in accordance with the sampling procedure used for the selection of the sample. A sample of 1,200 persons was selected from the population in each of the 27 cards. The population of persons using a card was stratified into two categories of cards: T.A. and Non-T.A. A sample of 600 persons was selected from each of the two strata. For the selection of 600 persons from the T.A. stratum, we further stratified the population of persons in T.A. disabled and T.A. aged. The sample of 600 was allocated in proportion to the population in each of the two

substrata. A similar allocation of 600 persons was done for the Non-T.A. stratum. In summary, there were 108 strata created for sample selection.

The base weight assigned to a sampled person in a stratum is simply the number of persons in the population in the stratum divided by the number selected in the sample. Therefore, a person selected in a stratum which has a very large population will have a much larger weight than a person selected from a stratum with a smaller population. In other words, the base sampling weights reflect the fact that some cards are very large and some are small.

The weights were also adjusted for non-response (which varied by card and stratum within card) such that the sum of the respondent weights equal the total population in each stratum. As Exhibit 2 (above) indicates, there were several hundred card enrollees who did not complete a survey either by mail or by phoning in the answer to the first question. Survey non-respondents were classified as ineligible (the sampled person had died and therefore could not respond), non-response (refusals), or unknown (the survey was not returned despite repeated mailings). The eligibility percentage of those whom we did reach was applied to the 'unknowns' as an estimate for how many of the unknowns would likely have been eligible, had we been able to reach them. This may be an over-estimate since the fact that we didn't reach these people may be related to their ineligibility (institutionalized or deceased). This is, however, the best assumption we can make about the eligibility rate for those we could not reach. To adjust the data, the proportion of ineligible to non-response was calculated and applied to the unknown category. Finally, a non-response adjustment was calculated for each stratum by dividing respondents by the sum of respondents and non-respondents, omitting ineligibles.

The calculated weights, adjusted for non-response, were used for all tabulations in the remainder of this report.

Appendix C: Focus Group Methodology

Sampling

Two rounds of focus groups were conducted, the first in September-October 2004 and the second in February-March 2005.

Focus groups were conducted with two major types of beneficiaries: (1) Medicare beneficiaries who were enrolled in the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance (T.A.) Program in fifteen specified counties[16], and (2) Medicare beneficiaries in those same counties who were not enrolled in the drug card program or T.A. Information about drug card enrollment came from CMS' EEVS data system.

The target population for these focus groups was all Medicare beneficiaries in a total of fifteen specified counties. The sampling frame containing the names, addresses, and drug card program enrollment status of Medicare beneficiaries was provided by the Centers for Medicare and Medicaid Services (CMS) for the eight selected counties. First, we deleted Medicare beneficiaries who were considered out of scope for the focus groups: (1) beneficiaries enrolled in special endorsement cards (at CMS' request); (2) enrollees whose reason for Medicare enrollment (Original Entitlement Reason), or whose Medicare status included end stage renal disease (ESRD); (3) extremely elderly (over age 85) enrollees (because they might find it difficult to participate in a focus group); (4) drug card program enrollees who had effective card dates after July 1, 2004 (since they would not have had enough experience using the discount cards at the time of the focus groups).

The sample selection was done separately for drug card program enrollees and non-enrollees.

Selection of Enrollees

In order to recruit participants for the focus groups in each county, records had to be telematched to obtain telephone numbers for each drug card program enrollee. Following the deletion of out-of-scope records from the drug card program/T.A. enrollee file, the entire file of records was downloaded and sent out to obtain the necessary contact information. The file was returned with accompanying telephone numbers for approximately 70 percent of the records across all fifteen counties. The file was then prepared for sampling.

[16] "Counties" are referred to as cities. New York City encompassed three separate counties, so that eleven counties worth of enrollee and non-enrollee data was provided by CMS, representing eight "cities." In some areas, the converse is true, and more than one city or town may be present in a county, as in Oakland/Alameda county.

Two different populations were identified among enrollees in the fifteen counties selected for focus groups: non-T.A. card enrollees and T.A. enrollees. The variable used to determine these populations was the drug card subsidy indicator (SBSDY_IND_CD). The population of beneficiaries in each of the two strata (non-T.A. card versus T.A. enrollee) was further stratified into two substrata (disabled and not disabled). The variable for original entitlement reason (ORGNL_ENTLMT_CD) was used to determine these substrata. Some of those originally entitled due to disability have since aged and were over age 65 so focus group facilities were asked to recruit those under 65 first and then turn to the elderly disabled to complete recruitment. These four substrata within each county constituted (Non-T.A.– Aged), (T.A. – Aged), (Non-T.A. – Disabled) and (T.A. – Disabled).

Selection of Non-enrollees

We identified two different populations among the non-enrollees: beneficiaries who were probably eligible for T.A. but not enrolled ("T.A. eligible non-enrollees") and non-T.A. card non-enrollees. In order to maximize the chance of recruiters calling a beneficiary with limited income for the T.A.-eligible group, we selected zip codes within the county with a high percentage of residents with low income. Poverty levels from the 2000 Decennial Census were obtained for each zip code in the fifteen counties. The average poverty level for all zip codes in each county was calculated, and used to determine whether a given zip code in a county was above or below the average poverty level for that county. Enrollees in zip codes below the average poverty level were considered potentially eligible for focus groups with T.A. eligible non-enrollees, while enrollees in zip codes at or above the average poverty level were considered eligible for focus groups with non-T.A. non-enrollees. Final income status (i.e. eligibility for T.A.) was ascertained during focus group telephone recruiting. The file of non-enrollees in the fifteen selected counties was pre-sampled prior to sending out to telematch.

An additional consideration to facilitate recruitment for focus groups was the physical location of the focus group facility in a particular zip code in each county. Beneficiaries living closer to the facility would have less difficulty getting there. Potential participants in the focus group facility zip code were flagged to ensure the selection of at least some potential participants in each county in the focus group facility zip code. The focus group zip code variable added additional substrata to the sampling. Substrata in focus group facility zip codes were sampled with certainty (i.e. all were selected) to ensure the potential recruitment of nearby participants.

Focus Groups and Participants, by Type of Participant and City

Final strata were based on group type. Each county had 3-4 focus groups, spread among the six group types as shown below. The final sampling strategy was to select 500-750 potential participants for each focus group in each city, from which 12 were to be recruited (in the expectation that 10 would actually attend).

Table 1: Number of Focus Groups and Participants, by Group Type and City

City	Non-T.A. Card Enrollees	Non-T.A. Card Non-Enrollees	T.A. Enrollees	T.A. Eligible Non-Enrollees	Disabled Non-T.A. Card Enrollees	Disabled T.A. Enrollees
New York City	22 in 2 groups		3 in 1 group			10 in 1 group
Chicago	19 in 2 groups		8 in 1 group		9 in 1 group	
Greenville	10 in 1 group	10 in 1 group	9 in 1 1 group	10 in 1 group		
Cincinnati	10 in 1 group	11 in 1 group	10 in 1 group	7 in 1 group		
Denver	7 in 1 group	7 in 1 group	10 in 1 group	1 in 1 group*		
Houston		10 in 1 group	7 in 1 group		9 in 1 group	10 in 1 group
Allentown	6 in 1 group	6 in 1 group	7 in 1 group			
Oakland	8 in 1 group	7 in 1 group	6 in 1 group	6 in 1 group		
Birmingham		7 in 1 group	6 in 1 group		8 in 1 group	8 in 1 group
Indianapolis	9 in 1 group	8 in 1 group		2 in 1 group*		
Jacksonville	10 in 1 group	3 in 1 group	10 in 1 group			
Nashville	19 in 2 groups	8 in 1 group				
Pittsburgh	9 in 1 group	3 in 1 group	5 in 1 group	4 in 1 group		
San Antonio			8 in 1 group	3 in 1 group	11 in 1 group	10 in 1 group
Wichita	22 in 2 groups	8 in 1 group				

* T.A. Eligible non-enrollees were the hardest group to recruit. In these two cities, fewer than 10 were recruited and only 1-2 actually attended; these people were interviewed separately rather than as a 'group' and the interviews were not video-taped.

The sample of 500-750 beneficiaries was first allocated to potential participants living within the focus group facility zip code if available, and then to the remainder using a systematic random sample via the SAS® Institute's PROC SURVEYSELECT.

After the sample was selected, it was determined that there were some exclusive card enrollees among the enrollee groups who were not eligible for the focus groups. In addition, recruitment difficulties were encountered in certain group and city combinations. For example, many potential focus group

participants in Oakland and Allentown refused to attend due to transportation difficulties because of the large size of this rural county and the absence of public transportation or taxis. In Allentown, where the sampling frame was very small to begin with, there were problems meeting income restrictions in the T.A. eligible non-enrollee group; recruiters had trouble finding enough people for a focus group who agreed that their incomes were below the T.A. cut-off. In all these cases, resampling occurred whenever possible to maximize participation in the focus groups. While the same SURVEYSELECT procedure featuring systematic random sampling was used for resampling, in most cases either all of the remaining eligible records were used so that in effect resampling was done with certainty, or the "sampling" was limited to a specific subgroup (for example, resampling in Oakland was limited to those potential participants who lived within the city limits.

Screening and Recruiting

Screening questions were used to verify the status of each beneficiary during recruitment, and to be sure that those we had listed as enrollees were in fact aware that they had a Medicare-approved drug discount card. Unfortunately, people sometimes were confused and answered questions incorrectly. For example, some card enrollees who acknowledged having a card during recruitment, arrived at the groups saying that they did not have a card; or they came to the groups confused and showed us all their prescription cards, none of which were Medicare-approved drug discount cards.

Recruiting scripts varied for each type of focus group. For example, the script for low-income non-enrolled T.A. eligible beneficiaries included questions about whether the individual believed himself/herself to be enrolled, whether their income was at or below the T.A. eligibility limit, and whether they had Medicaid or other private insurance coverage for prescription drugs.

Recruiters tried to recruit groups that would be mixed in terms of age, gender, and race/ethnicity for all group types. For the groups that were to consist of beneficiaries eligible for Medicare due to disability, we focused on recruiting participants who were under 65 years old because many other groups were being held entirely with seniors. Our lists extended to disabled beneficiaries over age 65 only when there were not enough under 65 who were enrolled in drug cards to fill the necessary focus groups.

Quantifying Awareness of Enrollment During Second Round Recruitment

During recruitment for the first round of focus groups, many people we reached who were listed in CMS administrative files as having Medicare-approved drug discount cards, told us that they did not have cards. During recruiting for the second round of focus groups we collected information on each recruitment call to quantify the extent of this problem. We reached many beneficiaries for each potential focus group. All those who were willing to speak with us, and to at least consider focus group participation, were asked a series of screening questions to be sure that they were eligible for the focus groups. The first screening question asked of candidates we were recruiting for enrollee focus groups, was whether the person was enrolled in a Medicare-approved drug discount card. Recruiters asked this question of beneficiaries without T.A. and also of those with the T.A. credit. We had this information from CMS databases, but wanted to recruit only people who were aware of their enrollment status. Recruiters noted responses to this question and then asked other screening questions to determine suitability for the focus groups.

Focus group candidates we spoke with, whom we knew to be enrolled based on CMS data but who answered that they were not, we have termed "unaware of enrollment." We calculated the percent "unaware of enrollment " as the number who told us they did not have a Medicare-approved drug discount card, divided by the total number of candidates reached by recruiters. The total number reached, or the denominator, was the sum of the total number recruited to attend the focus groups, the

total number who said they were unaware of enrollment, and the total number who were asked to attend but had conflicts and could not do so.

Individuals excluded from analysis were those with whom recruiters could not communicate due to language barriers or impairment, those who had passed away or were in a nursing home or hospital, those whose name/birth date did not match the records (i.e. we were not certain of their identity and eligibility), those who hung up before any screening questions could be asked, and those who refused to consider participating in a focus group and would not speak with us further. Birmingham recruiting data were also excluded from the analysis because recruiters there did not record the sample disposition information accurately enough to calculate the percentages "aware" and "unaware" with certainty.