The Bridgespan Group

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National Council on Aging

Widening the Net for the Medicare Drug Benefit

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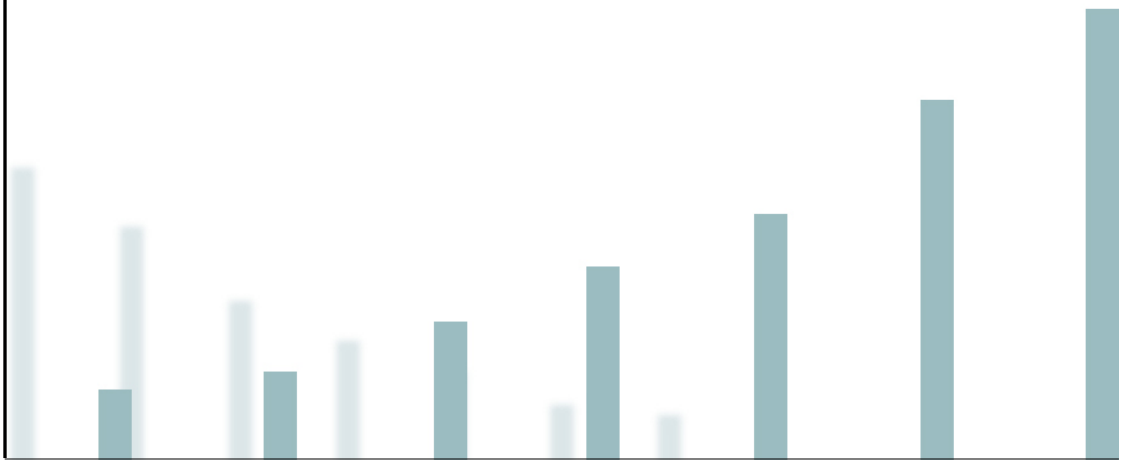

In a 2003 national survey of Medicare beneficiaries ages 65 and older, one-quarter reported that they had forgone needed medications in the past year because of the cost. For those with low incomes and no drug coverage, the number jumped to nearly 45 percent.[1] Stories abound of seniors cutting pills in half to stretch the medication, waiting for weeks to fill a prescription until their Social Security checks arrive, or even avoiding visits to the doctor, knowing that the medication prescribed will be out of reach.

Improving this situation is a priority of the National Council on Aging (NCOA), a nonprofit which has been working since 1950 to enhance the health and independence of older persons. NCOA has built a reputation as a leader in the benefits-outreach field. In 2001, for example, the organization introduced an innovative benefits-screening software tool called BenefitsCheckUp, to help individuals determine easily if they are eligible for over 1,000 public benefits programs.

NCOA's CEO Jim Firman and his management team watched with great interest in December 2003 as Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which included a drug benefit called Medicare Part D.[2] The legislation, which for the first time made all Medicare beneficiaries eligible for prescription drug coverage, represented the largest expansion of government benefits in 40 years.

While press coverage of Part D's value to the average beneficiary often has been negative, there is widespread agreement that low-income beneficiaries will be better off with it. Part D includes a Low-Income Subsidy (LIS), which covers between 85 and 100 percent of a prescription's cost.[3] With an average annual value estimated to be at least $2,100, the LIS stands to make a major difference in the lives of its beneficiaries: individuals whose annual incomes are less than $14,700 per year (i.e., no more than 50

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[1] Dana Safran et al, "Prescription Drug Coverage and Seniors: Findings from a 2003 National Survey," Health Affairs web exclusive (April 19, 2005): 152-166.

[2] See "About Medicare" in the appendix of this case study for an overview of Medicare.

[3] Applicable costs include monthly prescription plan premiums, deductibles, and co-pays.

percent above the federal poverty rate) and whose assets, not including a home, are less than $11,500.[4]

In the passage of the LIS Part D legislation, Firman and his team saw an exciting opportunity to advance the issue of benefits access in a major way. They were buoyed by all the enthusiasm on Capitol Hill, but past experience told them that enrolling eligible seniors would not be easy:

- This group tends to be less educated and more mobile than the general population—and thus harder to reach;
- Applying for the LIS and selecting a prescription drug plan would be a complex process;
- Implementing the benefit would require the coordinated efforts of dozens of government agencies and nonprofit organizations;
- The timeline would be tight, with just two years between the legislation's passage and full implementation and with a narrow active prescription drug plan enrollment period (January 1, 2006 to May 15, 2006).

There was no way NCOA could address these challenges on its own; the magnitude of the effort dwarfed NCOA's $40 million annual budget. If it was going to make a significant difference, the organization would need to invest its resources in a leveraged way. As a first step, in late 2003 NCOA joined with AARP, Alzheimer's Association, National Alliance for Hispanic Health, and Easter Seals to build a nationwide coalition of more than 100 organizations (called the Access to Benefits Coalition, or ABC) to focus on maximizing LIS enrollment. Then in early 2005, with funding from The Atlantic Philanthropies, NCOA teamed up with the Bridgespan Group to develop a comprehensive plan for maximizing LIS enrollments.

[4] For couples, the relevant cutoffs are $19,800 in income and $23,000 in assets.

Key Questions

In January of 2005 a project team consisting of key members of NCOA's management team, senior staffers from the Access to Benefits Coalition, and five Bridgespan consultants set out to develop a plan for maximizing LIS enrollment. Among the questions they addressed:

- What are the true dimensions of the challenge? How many individuals need to enroll, and what scale of effort would that require?
- How can NCOA and the ABC make the most difference with the limited resources available to them?
- How can NCOA and the ABC influence other funders—government and private—to use their resources in the most effective ways?

Scoping the Challenge

NCOA's leadership knew that they needed to mobilize enrollment agencies and funders. What was less clear was the magnitude of resources they would need to harness. The project team set out to understand the two main factors that would provide an answer: how many individuals were eligible for the LIS subsidy and how hard it would be to enroll each one.

SIZING THE TARGET AUDIENCE

Two primary groups of individuals were eligible for the LIS. One, the "dual eligibles," consisted of people who already were enrolled in Medicare and Medicaid. These beneficiaries would be enrolled in the LIS automatically. The other group included individuals who were eligible for the LIS because of their limited incomes and assets, but who currently were not enrolled in an assistance program like Medicaid. These individuals would need to learn about the benefit and enroll on their own. It was this latter group that NCOA needed to size.

The project team realized quickly that sizing this group accurately would take some work. Published articles citing government sources had pegged it at anywhere from 2 to 7 million people. NCOA needed a much more specific target around which to plan.

Digging into Part D data that the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration (SSA), the U.S. Administration on Aging (AoA), and other government agencies had provided to the Congressional Budget Office proved illuminating: the numbers differed because the agencies each had defined their target differently. Some had excluded from their tally individuals they deemed unreachable. Others had excluded individuals who they predicted would enroll on their own. Still others had applied a yield rate to the people who were expected to be contacted successfully (e.g., only 70 percent of eligible individuals contacted will actually enroll). As the various estimates circulated through policy circles and the press, they had lost these accompanying descriptors, creating a great deal of confusion about the magnitude of the challenge.

Given its ambitious objective, NCOA needed a figure that included all eligible people, no matter how difficult they would be to reach. Taking the data from the government agencies' original reports and marrying it with census projections and CMS enrollment data, the team arrived at a total of 7.2 million individuals who would need enrollment assistance.

GAUGING THE INVESTMENT REQUIRED

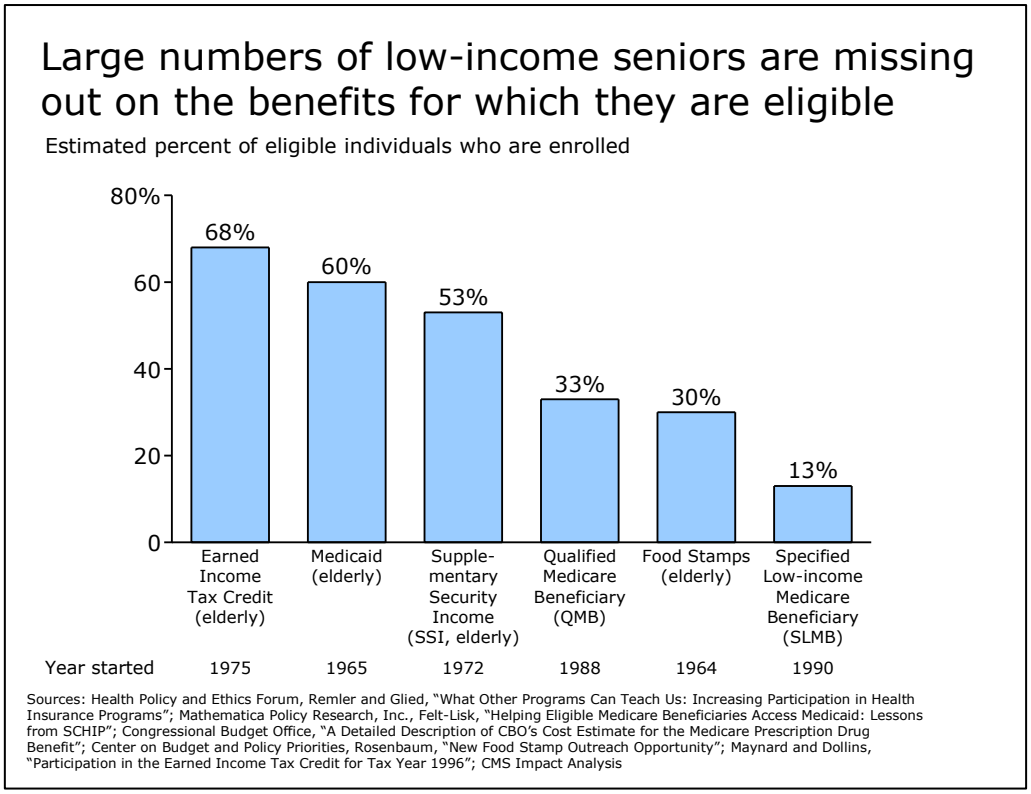
The next step was developing a better understanding of what it would take to enroll these 7.2 million prospective beneficiaries. The cost would be nontrivial, given that this group was likely to need personalized support to navigate the complex enrollment process. Prospective beneficiaries had to provide detailed personal information (e.g., the cash value of life insurance policies, the cash value of food or heating assistance provided by a relative, the expected amount of funeral or burial expenses) and to select the prescription drug plan that matched best with their drug needs and preferred pharmacies.

To put a stake in the ground regarding the scale of effort required to reach full enrollment, the project team gauged how far typical levels of government investment could move enrollment rates. They analyzed historical enrollment in government benefit programs,

piecing together data from a variety of public sources. The historical rates fell far short of full enrollment, even for benefits that had been available for decades (see Figure 1). Only 60 percent of seniors who were eligible for health care coverage under Medicaid were enrolled. The food stamps enrollment rate was half that level. For the benefit with the most similar eligibility requirements to Medicare Part D—the Qualified Medicare Beneficiary (QMB) program—the enrollment rate of eligible individuals was only 33 percent fully 17 years after it was introduced.

Faced with these figures, NCOA's leadership decided to keep its enrollment goal at 7.2 million people, even though they were under no illusions that full enrollment would be easy to achieve. If NCOA and its partners were going to make progress on LIS enrollment, their efforts would have to represent a major improvement over historical efforts. NCOA saw two complementary paths to doing better: mobilizing more resources and investing those resources more effectively. The project team started with the latter category and set out to find the most effective ways to enroll people in the LIS.

Figure 1: Percentage of eligible seniors enrolled in various government benefits



Increasing Effectiveness

From the organization's previous work on benefits enrollment, NCOA's leadership knew that there had not been much codifying and sharing of best practices in this arena. Most enrollment activities were undertaken independently by relatively small organizations (e.g., senior centers) or local government outposts (e.g., local agencies on aging). These entities used a wide variety of techniques, such as publishing newsletters, holding special enrollment events, operating enrollment phone centers, or driving enrollment vans around rural areas.

Were some of these approaches inherently more effective than others? Did the best approach for a given senior depend on his or her specific circumstances? With the literature on the subject being thin, the project team would need to unearth the answers themselves.

BENCHMARKING ENROLLMENT EFFORTS

The team studied 25 enrollment agencies that worked with a benefit similar to the LIS, comparing what it cost each one to enroll a low-income senior.[5] They derived this figure by first calculating, for a defined period of time, each project's total cost—direct costs (e.g., staff compensation, postage) and overhead costs (e.g., building rent)—and then dividing that amount by the number of individuals enrolled. They amassed the necessary data by interviewing project leaders, collecting and analyzing financial reports, and, in certain cases, reviewing published data.

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[5] A temporary benefit was put into place between Part D's passage in December 2003 and its full implementation in January 2006. It allowed Medicare beneficiaries with low incomes and no other source of drug coverage to purchase drug discount cards with a $600 credit that could be used to help pay for their medications. In 2004 and 2005, the Access to Benefits Coalition funded projects in 56 communities to enroll individuals in this benefit. The benchmarked agencies described in this case study included 13 of these projects, eight others that the ABC had not funded, and four projects focused on different benefits for seniors.

The team discovered a surprisingly wide range of costs, with a low of $24 per person enrolled and a high of $280 (see Figure 2). Moreover, cost disparities existed even between agencies that were serving a similar population or using a similar approach—a sure sign that there was more at play than simple variations in population served or approach used (see Figure 3). Some agencies clearly were enrolling seniors more efficiently than others, suggesting that efficiencies could be gained by codifying strong practices and sharing them among those tasked with enrolling LIS beneficiaries.

Figure 2: Enrollment cost comparison by project

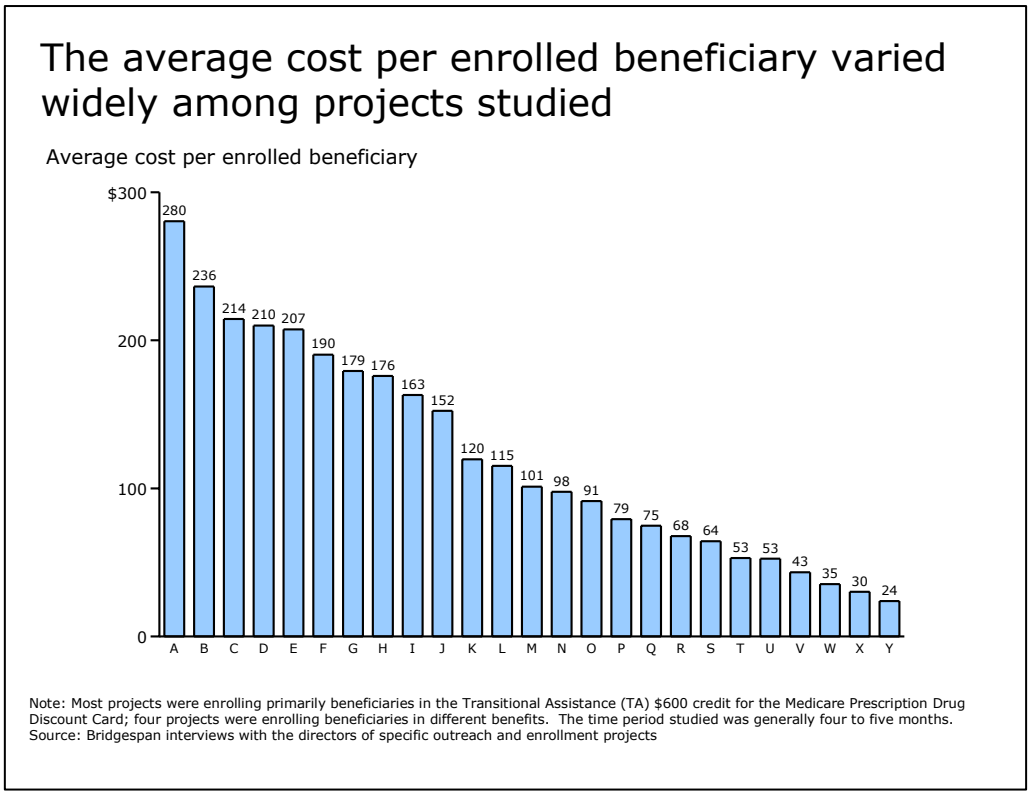
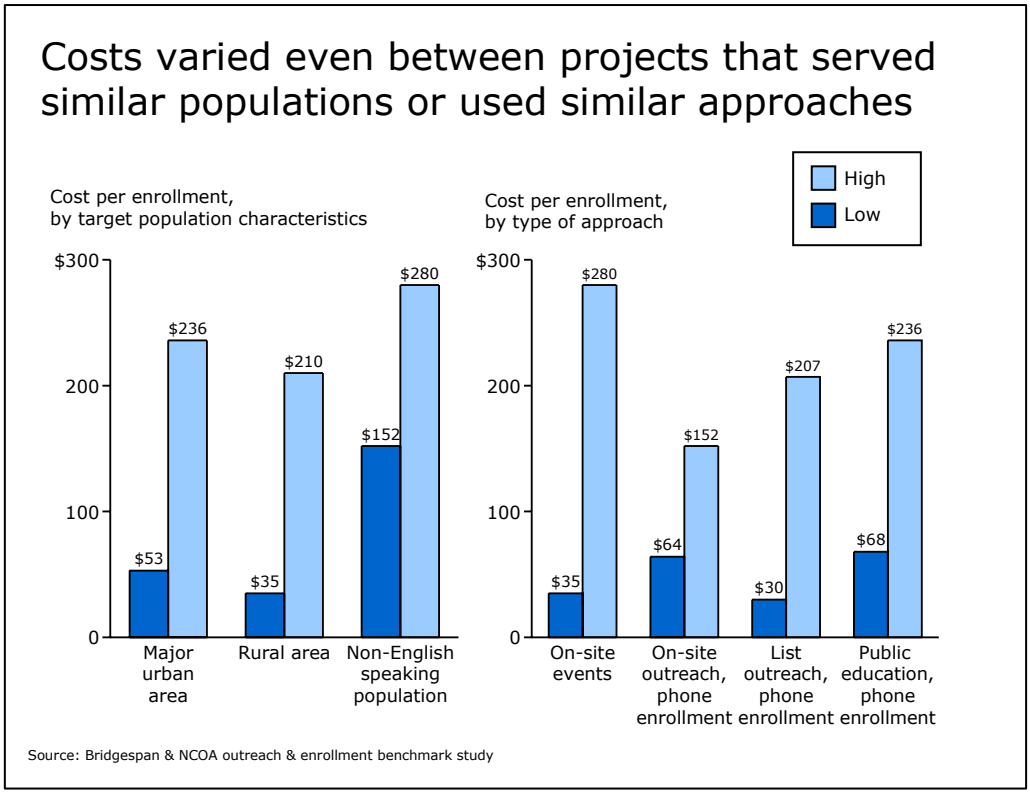


Figure 3: Enrollment cost comparisons



Adding to the enthusiasm about the potential of codifying and sharing best practices, the cost benchmarking analysis underscored just how isolated the enrollment agencies were from one another. For example, one agency initially declined to share its data, convinced it would appear inefficient. After receiving assurances that all data would be presented in an anonymous fashion, the agency provided the necessary information. Far from being inefficient, it had the lowest cost per enrollment of any agency studied. This top performer had no sense that it was doing things well or that it had valuable information to share.

CODIFYING AND SHARING STRONG PRACTICES

Looking at the agencies' data more closely, certain activities consistently seemed to drive down costs. Such practices could be found throughout the enrollment process, from the time when an agency first identified a prospective enrollee or group of eligible individuals, to when it connected with them, to when it actually enrolled them. They included:

- Qualifying leads before the enrollment process began by identifying individuals who were most likely to be eligible (e.g., using a pre-existing list of individuals who participate in another program which serves a primarily low-income, elderly population, such as Meals on Wheels);
- Planning carefully the method, frequency, and format of the contact (e.g., placing follow-up phone calls three to four days after an informational mailing);
- Incorporating technology into the enrollment efforts by using well-executed phone-based outreach, online eligibility screening tools, or wireless Internet access;
- Coordinating the efforts of multiple agencies in a region and dividing roles (e.g., one agency performs outreach and publicity, while another specializes in the actual enrollment).

Looking at these cost saving opportunities through the lens of the enrollment process phases (i.e., identification, connection, enrollment) underscored the importance of focusing on the first phase—identification. Getting better at identifying qualified leads brought higher potential for dramatic cost savings, for two main reasons. First, the process of identifying leads could be automated, thereby realizing significant labor cost savings. Connection and enrollment, in contrast, could be automated to a much lesser extent, given that the seniors often required personal support to navigate these processes.

Second, getting better at identifying qualified leads also brought downstream cost savings. By using lists to qualify leads, agencies could reduce the amount of resources spent on connecting with and attempting to enroll individuals who were not eligible for the LIS. Furthermore, staff could partially complete a pre-qualified individual's enrollment form even before the enrollment process began—saving staff time in the long run.

To spread these lessons throughout the benefits enrollment field, NCOA's leadership and the Access to Benefits Coalition decided to develop a training program for enrollment agencies based on the strong practices that had emerged. And given the high potential of list-based strategies, NCOA's leadership decided to create a national-level list management operation. The entity would cross-reference lists of potentially eligible individuals, target those most likely to be eligible for the benefit, and either pass the resulting qualified leads on to community-based groups for follow up and enrollment or

directly reach out to those individuals. By providing this resource to the network of organizations involved in the ABC, NCOA hoped to help them focus their outreach and enrollment efforts on those most likely to need assistance.

Influencing Others

NCOA's and the ABC's resources constituted a modest portion of the total Part D enrollment dollars being deployed. Federal and state government agencies were investing hundreds of millions of dollars. Other nonprofits were planning their own efforts. Major philanthropic groups were poised to contribute. Private companies, including health insurance and pharmaceutical companies, were getting involved. NCOA wanted to encourage these entities to adopt the enrollment methods that the project team had found to be most effective.

The linchpin here would be influencing government agencies—most notably CMS. Fortunately, NCOA was positioned well to open LIS enrollment conversations with CMS and SSA. Over the previous year, NCOA had worked actively to enroll low-income individuals in the transitional assistance credit for prescription coverage. NCOA's lengthy track record of benefits-related work and more recently its efforts with the ABC added to its standing.

The findings from the benchmarking study provided the final critical piece to NCOA's credibility. While NCOA's leadership planned to release its report at a press conference in June of 2005, they previewed the results with CMS officials. The officials' response was encouraging.

Making Change and Moving Forward

NCOA has made great strides in marshalling resources towards effective LIS enrollment activities. The organization has conducted numerous training sessions for community-based organizations, national nonprofits, government officials, and private companies. It has deepened its relationship with CMS, with CMS now providing a link to NCOA's BenefitsCheckUpRx software to help beneficiaries understand their options.

Recognizing the ultimate importance of list strategies to a national solution, NCOA teamed up with a Philadelphia-based philanthropist with extensive experience in the credit card industry to create a new non-profit organization, the Benefits Data Trust (BDT), which would be capable of implementing large scale direct mail and call center operations as well as list management and manipulation services. CMS is playing an important role here, too, by allowing NCOA and BDT to cross-reference lists purchased through commercial data houses against CMS' enrollment rosters for Medicaid and the LIS—a crucial step in making the list strategy work.

NCOA also has forged significant partnerships with private health care institutions. The Kaiser Permanente health system is using BDT's new list management operation to identify LIS-eligible individuals among its membership. The result promises to be a win-win situation, with Kaiser Permanente's LIS-eligible members gaining access to the prescription subsidy and the HMO lowering its prescription costs. Separately, a pharmaceutical company has used NCOA's findings as the basis for its charitable campaign strategy to provide information to all Medicare beneficiaries and to increase LIS enrollment through the My Medicare Matters campaign. NCOA and BDT also are helping the trade association of pharmaceutical manufacturers to assist prospective beneficiaries in enrolling in the LIS.

The knowledge and traction that NCOA now demonstrated was also key to obtaining significant support from private philanthropic funders, such as The Atlantic Philanthropies, which pledged $7.9 million towards its outreach and enrollment efforts over three years. NCOA now is focusing on three approaches to maximize LIS enrollment:

- Using sophisticated list strategies to "drive" qualified leads to trusted, local intermediary organizations and national call centers that will provide one-on-one counseling and assistance with application forms;
- Creating a broad-based partnership involving government, corporations, philanthropy and national voluntary organizations that can finance and execute a large-scale nationwide campaign;
- Continuing to foster and diffuse innovations that lower the cost per LIS enrollment.

NCOA's leaders view maximizing enrollment in the LIS as just the beginning. They plan to apply what they have learned to enroll seniors in other important benefits. Moreover, NCOA's CEO Jim Firman asserts that this work has helped bring rigor to a field that desperately needed it: "This project is a great example of the potential of benchmarking to help social sector organizations to achieve ambitious goals. For the past 40 years, there were many isolated efforts to find and enroll low-income people in public benefits, but there was no real learning going on about the most cost-effective and scalable strategies. As a result of this project, we now know what works and what doesn't and we have the evidence to prove it."

Appendix: About Medicare

Medicare is the U.S. government's health insurance coverage program for people ages 65 and older and selected younger individuals with disabilities. Begun in 1965 as part of Lyndon Johnson's "Great Society" program, Medicare was expanded in 1972 to provide coverage to younger individuals with permanent disabilities. Medicare provides health insurance for nearly 42 million individuals: 36 million seniors and 6 million under-65 disabled. Medicare is administered by the Centers for Medicare & Medicaid Services, part of the Health and Human Services department of the federal government.

THE A-B-C'S OF MEDICARE

Medicare consists of four parts. The first, Part A, provides hospital and skilled-nursing care coverage, including hospice care. Funds for Part A come primarily from payroll deductions. It requires no monthly premiums if participants have accrued the requisite number of work credits, but they must pay a deductible and sometimes co-payments when they consume services. Most Americans are enrolled automatically in Part A when they turn 65.

Part B provides medical insurance for doctors' fees and outpatient care. As of 2006, monthly premiums for Part B are approximately $89 per month, with an annual deductible of $124. Enrollment in Part B is optional and must take place between three months before and three months after an individual's 65th birthday month. Enrollment after that date is possible at set times each year, but the cost increases by 10 percent for each year the individual delays enrollment (unless he or she has been covered during that period by a qualifying employer-sponsored plan).

Medicare's Part C—now known as "Medicare Advantage"—offers an alternative to traditional fee-for-service Medicare (also called "Original Medicare") through private health plans, such as HMOs and PPOs. Roughly 13 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans. Such plans must provide all Medicare-covered benefits, and many provide additional coverage. Premiums and deductibles vary widely from plan to plan.

Approximately 88 percent of Medicare beneficiaries have some type of supplemental insurance (employer-sponsored and private “Medigap” insurance are the most common) to help pay for Medicare’s premiums and deductibles, and to cover benefits that Medicare does not. Medicare beneficiaries with very low incomes can also qualify for Medicaid, which helps with many of these costs and, until Part D went into effect, also provided prescription drug coverage.

MEDICARE PART D

The newest element of Medicare is Part D. Enacted as part of the Medicare Prescription Drug, Improvement and Modernization Act in 2003 and launched in January of 2006, Part D makes prescription drug coverage available to all Medicare beneficiaries. Participation is voluntary.

Private companies provide prescription coverage. The companies must cover at least one drug in each therapeutic drug class, but otherwise are free to select which drugs will be covered in their specific plans. Participants in a Part D plan pay a monthly premium and a share of their prescription costs. The portion paid by the participant varies according to the plan chosen, but generally is similar to the following “standard” cost schedule (see Figure A1 for an illustration):

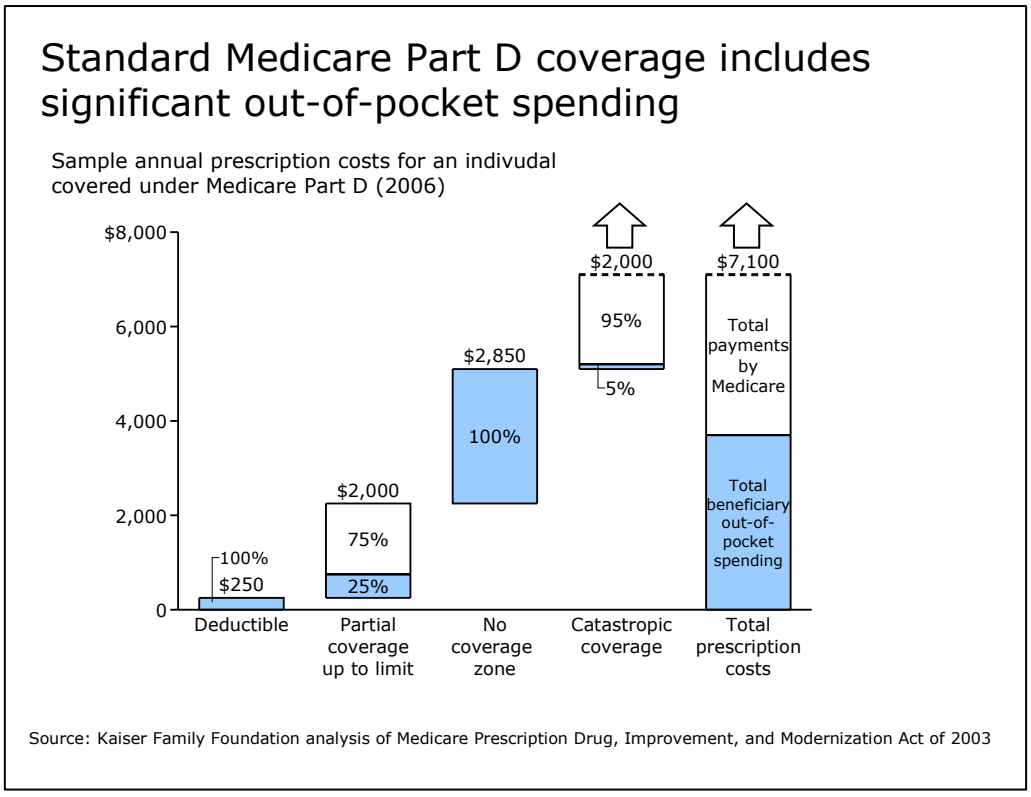
- All of the first $250 in costs (the deductible);
- Twenty-five percent of costs above $250 and below $2,250 (an additional $500 out of pocket);
- All costs between $2,250 and $5,100 (an additional $2,850 out of pocket);
- Five percent of any additional costs.

Plans vary in the specific monthly premiums, co-payments and deductibles required but must be actuarially equivalent to or better than this standard plan. Most plans that offer enhanced coverage (for example, that cover a higher proportion of costs at a lower threshold) are also more costly on a monthly basis. Similar to Part B, if a qualified beneficiary delays enrollment in Part D, premium increases of up to one percent per month apply.

THE LOW-INCOME SUBSIDY

For Medicare beneficiaries with incomes no more than 50 percent above the federal poverty level ($14,700 for an individual or $19,800 for couples) and with limited assets ($11,500 for an individual or $23,000 for couples), Medicare Part D offers extra help with Part D's co-payments, premiums, and deductibles. The level of subsidy varies with one's specific income and asset levels. Those with the lowest incomes and assets will have no annual deductible or monthly premiums and will pay no more than $5 per prescription. Those with the highest qualifying incomes and assets will pay an annual deductible of $50, sliding scale premiums based on their income, and co-insurance of 15 percent of a prescription's cost.

Figure A1: Medicare Part D standard coverage



SOURCES

- The National Council on Aging.
- “Medicare 101” prepared by Tricia Neuman for the Henry J. Kaiser Family Foundation, January 2005.
- “Brief History of the Medicare Program,” SeniorJournal.com: http://www.seniorjournal.com/NEWS/2000%20Files/Aug%2000/FTR-08-04-00MedCarHistry.htm.
- “Medicare Overview,” Centers for Medicare and Medicaid Services: http://www.cms.hhs.gov/MedicareGenInfo/.
- “Medicare Chart Book 2005,” The Henry J. Kaiser Family Foundation: http://www.kff.org/medicare/7284.cfm.
- “Medicare Advantage Fact Sheet,” September 2005, The Henry J. Kaiser Family Foundation: http://www.kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf.
- “Medicare and the New Prescription Drug Benefit,” prepared by Tricia Neuman for the Henry J. Kaiser Family Foundation, January 2005.
- “Medicare Fact Sheet: Low-Income Assistance Under the Medicare Drug Benefit,” The Henry J. Kaiser Family Foundation: http://www.kff.org/medicare/upload/Low-Income-Assistance-Under-the-Medicare-Drug-Benefit-Fact-Sheet.pdf.