Part D Enrollment: Facilitating Informed Decision Making

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*Some current Medicare beneficiaries and all new Medicare beneficiaries need to decide whether to participate in the Medicare Part D prescription drug program. To determine which beneficiaries might need assistance and what information would be most helpful to them, we examined the distribution of beneficiaries' previous sources of prescription drug coverage and their satisfaction with that coverage before Medicare Part D was implemented. The purpose of this article is to consider how the new Medicare Part D benefit has changed the relative options for beneficiaries with and without prior prescription drug coverage, and how communication with Part D beneficiaries might be enhanced. (*Drug Benefit Trends. *2007;19:149-163)*

Key words: Medicare Part D • Prescription drug plans

Since January 1, 2006, Medicare beneficiaries have had access to a wide range of prescription drug plans (PDPs), encompassing many more options than previously available. The Medicare Part D program, authorized by the Medicare Modernization Act (MMA) of 2003 and administered by the Centers for Medicare & Medicaid Services (CMS), provides optional prescription drug coverage through either private stand-alone PDPs or as an added benefit through Medicare Advantage (MA) plans.

There was initial concern that the number and types of prescription drug options available to Medicare beneficiaries would be insufficient. However, insurers and PBMs have responded with significant interest and product offerings. Stand-alone PDPs are offered on a "regional" basis; CMS has designated 34 such regions in the United States. PDPs that offer coverage must do so throughout an entire region. Most regions have about 40 PDP options available.

Medicare beneficiaries can also receive Part D coverage through either a local or regional MA plan. Regional MA PPO plans are required to be offered across an entire MA region, of which 26 such regions have been designated. Most MA regions have at least 1 PPO plan available. The existence of ample plan choices provides a key element necessary for successful competition in the marketplace, but it has also led to widespread concern that beneficiaries may have too many options to consider. At a minimum, the range of Part D options—each with its own unique benefit features and costs—suggests the need for high-quality information so that beneficiaries can make informed choices about whether the benefit is right for them and, if so, which plan to choose.

Informed decision making requires that beneficiaries not only have access to accurate information but can understand the trade-offs of the options available to them.[1] Earlier research has suggested that certain consumer characteristics, such as type of insurance carried previously, be taken into account when presenting information to facilitate Part D decision making.[2] To ease the transition and encourage enrollment in the new benefit, the CMS and numerous consumer groups have developed a variety of informational materials and decision support tools. However, the complexity of the issues and the uncertainties associated with decision making in this area require ongoing and careful analysis of what information should be disseminated, how it is targeted, and its effectiveness.

Although some beneficiaries did not have any prescription drug coverage before implementation of the Part D program, others did have some type of coverage[3] and were faced with reevaluating their options. As new beneficiaries qualify for the Medicare program, they will also need to make decisions regarding Part D participation. The purpose of this article is to consider how availability of the Part D benefit changes the relative options of beneficiaries with and without existing drug coverage, and how messages concerning Part D might be targeted to sustain existing enrollment and facilitate informed decision making,

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including decision making by new beneficiaries. We explore the following research questions:

- How does previous insurance and drug coverage influence the decision to participate in Medicare Part D?
- How interested will new Medicare beneficiaries be in participating in Medicare Part D?
- How can information about Part D be targeted to facilitate informed decision making among different audience segments?

Data and Methods

We used the 2003 Access to Care file of the Medicare Current Beneficiary Survey (MCBS) as the data source for this study. Information on health insurance was derived from Round 37 of the MCBS that asked beneficiaries if they had prescription drug coverage and, if so, their source(s) of coverage, as well as whether they had 1 or more prescription drug discount cards. We also examined some new prescription drug coverage "generosity" questions that RTI International developed in collaboration with CMS and fielded for the first time in Round 38 of the MCBS.[4] Overall, the sample includes 12,353 Medicare beneficiaries and represents community-dwelling Medicare recipients of all ages, including disabled persons.

A few definition issues are noteworthy. For the income category, there was a specific dollar amount for some beneficiaries but only an indication of whether income was less than or greater than $25,000 for others. Thus, we were constrained to using the binary category of under or over $25,000 for the income variable. Health status was self-reported general health. The index of preventive care was constructed as the proportion of preventive care used by beneficiaries in the past year for the selected preventive care services, including measurement of blood pressure and blood cholesterol levels, colonoscopy, bone mass/density measurement, mammogram (for women), and prostate surgery or prostate-specific antigen testing (for men). Separate disease-specific indicators of chronic care were constructed if beneficiaries reported having any of the following conditions: hypertension, myocardial infarction, angina pectoris/coronary heart disease (CHD), other heart conditions, diabetes, emphysema/asthma/chronic obstructive pulmonary disease (COPD), or Parkinson disease (PD). To avoid problems associated with beneficiary recall of specific dollar amounts for copayments for drugs, we used categorical variables reflecting amounts greater or less than $15.

We created detailed measures of supplemental health insurance using self-reported information on the MCBS, augmented by CMS records on Medicaid coverage.* We allowed for the possibility that some beneficiaries had more than 1 type of supplemental coverage, as shown in previous research.[5,6] Beneficiary-level indicators were created for health care coverage provided by any of the following: original Medicare coverage with no supplementation (fee-for-service [FFS]), employer-sponsored plans, MA plans (formerly Medicare managed care), individually purchased private supplemental plans (mostly Medigap), Medicaid, TRICARE for Life (administered by the Department of Defense and covering retired military veterans), or other types of public assistance (mainly state pharmaceutical assistance plans).

We first examined the percentage of beneficiaries with each type of health insurance and how the distribution changes when only low-income beneficiaries were considered. Next, we examined the percentage of beneficiaries with prescription drug coverage by insurance type and the variation in the prevalence of drug coverage across the 34 PDP regions. We also assessed premium data by type of insurance and how satisfied beneficiaries were with their drug coverage in 2003. This descriptive analysis was followed by a multivariate analysis to examine beneficiary characteristics predictive of having prescription drug coverage.

Specifically, we estimated a multinomial logit model[7] that distinguished among 3 categories of supplementation: (1) having only original Medicare FFS and no additional insurance coverage; (2) having some insurance coverage beyond Medicare FFS but no prescription drug coverage; or (3) having some insurance coverage beyond Medicare FFS that includes some prescription drug coverage. Explanatory variables in the model included age, sex, race, ethnicity, education, income level, marital status, self-reported health status, an index of use of preventive care services, indicators of chronic health conditions, an indicator for whether the person had a drug discount card, and the beneficiary's geographical location.†

The reported statistics were weighted to be nationally representative. We conducted the analyses using RTI International's SUDAAN software, which adjusts for the complex sample design of the MCBS, as well as for survey nonresponse.

Study Findings: Descriptive Analyses

Non-Medicare sources of health insurance coverage. Before implementation of the Part D program, Medicare beneficiaries obtained health insurance coverage from a variety of sources in addition to Medicare (Figure 1). In 2003, employers were the most common source of ad-

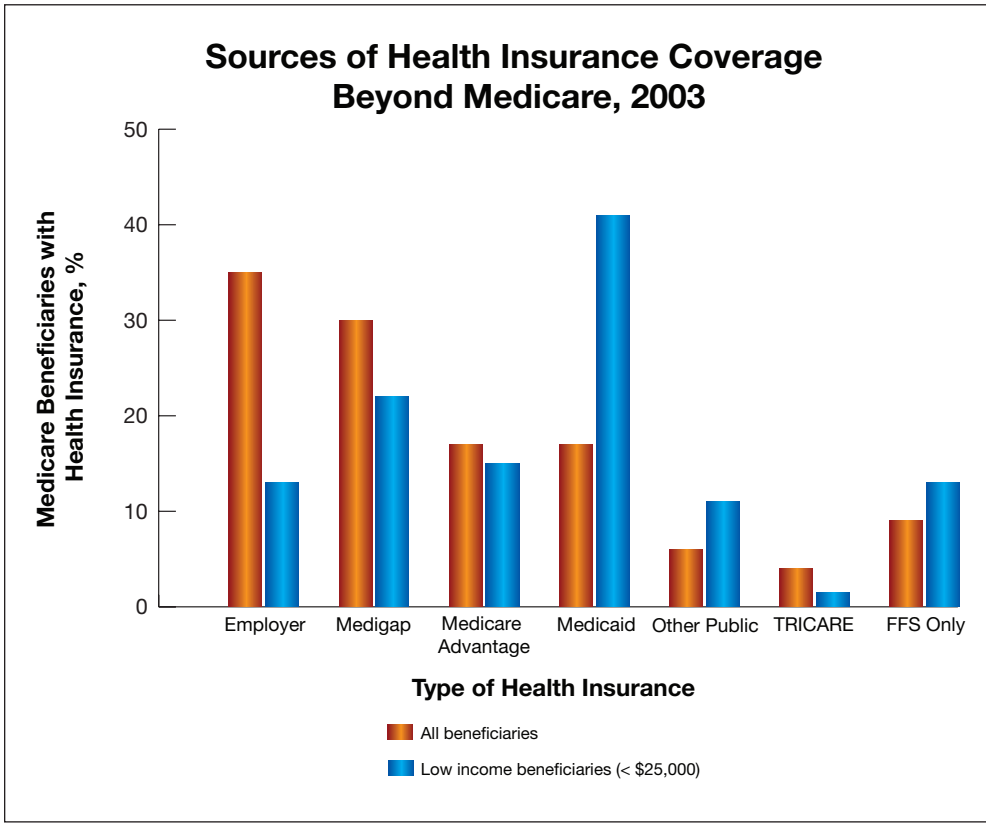

Figure 1. In 2003, before implementation of Part D, employers were the most common source of additional health care coverage for Medicare beneficiaries. (FFS, fee-for-service)

ditional coverage for the "all beneficiaries" category (35%). An individually purchased privately sponsored supplement plan, usually a Medigap plan, was the next most common source of additional coverage (30%), followed by MA plans (16%). Another 16% of beneficiaries were enrolled in Medicaid. Six percent reported some other source of public coverage, including state prescription drug plans, and 4% were enrolled in TRICARE for Life.

Overall in 2003, all but 9% of Medicare beneficiaries had some form of supplemental health insurance (FFS only). Seventeen percent of beneficiaries reported holding multiple policies beyond Medicare (not shown). The most frequent combinations included those with an MA plan, employer coverage, and Medigap. The distribution of coverage was somewhat different for lower-income beneficiaries.

Sources of prescription drug coverage. Overall, 65% of beneficiaries in 2003 reported having insurance that covers prescription drugs, although the actual proportion is likely to be somewhat higher.[8] The type of supplemental coverage held varied significantly (Figure 2). Among those with a Medigap plan, only 25% reported having drug coverage. This finding is consistent with the fact that only a few of the standardized Medigap plans cover prescription drugs. Clearly, this group of beneficiaries stands to benefit from availability of Part D coverage.

In contrast, beneficiaries with other types of supplements often reported having prescription drug insurance through that plan. Nearly all beneficiaries (90%) with TRICARE for Life, for example, reported they had drug coverage, as did 86% of beneficiaries who had Medicaid. More than three fourths of those with employer-sponsored coverage (78%) reported having prescription drug coverage, and more than four fifths (83%) of MA plan enrollees also said they had it. Among beneficiaries in other public plans, 89% reported having prescription drug coverage, presumably because most of these plans are state-based drug insurance plans, and drug coverage is the key component.

Although these percentages may seem high, we believe they actually underestimate the prevalence of prescription drug coverage within the Medicare population. TRICARE for Life[9] and Medicaid, for example, universally cover pharmacy benefits. That not all persons in these programs reported having drug coverage indicates that these beneficiaries either were not well informed about their health insurance or they misunderstood the question asked.

Depending on the richness of

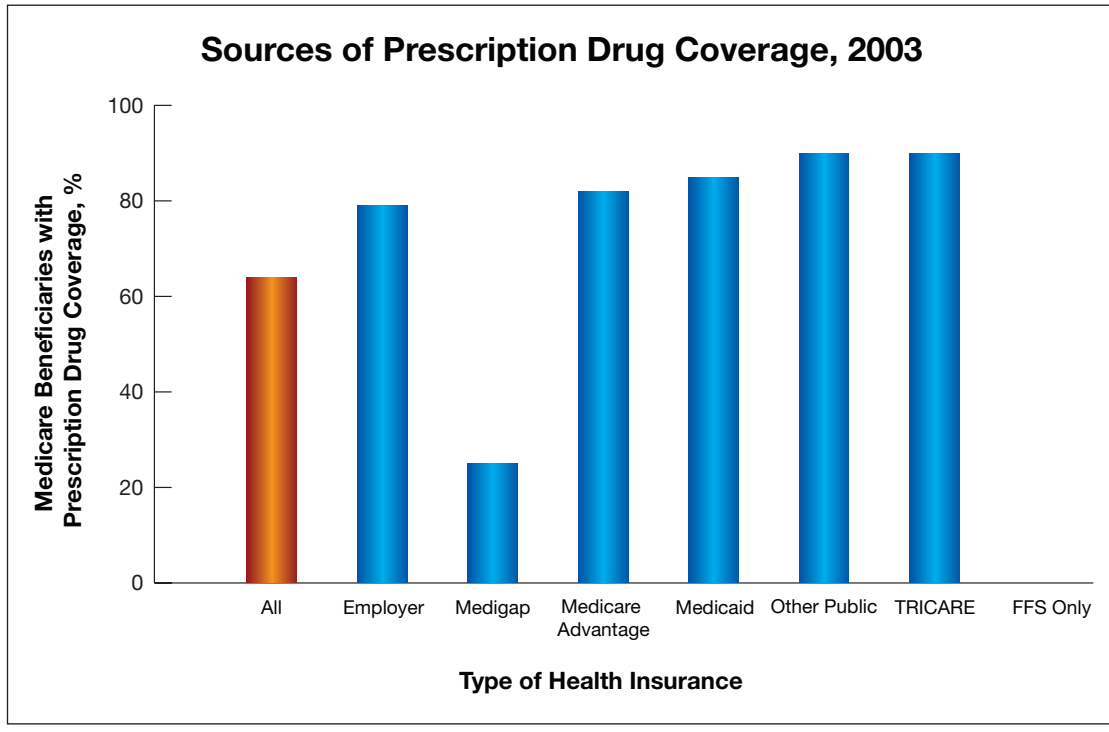

Figure 2. Nearly two thirds of Medicare beneficiaries had some type of prescription drug coverage in 2003, before Medicare Part D was implemented. (FFS, fee-for-service.)

employer-sponsored coverage, beneficiaries with retiree coverage including prescription drug benefits will probably continue to receive benefits through their employers. However, although the MMA provided some incentives for employers to continue to provide drug coverage, it is uncertain how many will do so over the long term. Over time, employers have moved toward greater reliance on enrollment in MA plans with additional supplements negotiated directly with insurers.[10] These so-called employer-only plans have become popular among employers, replacing the more traditional parallel retiree coverage or employer-sponsored private FFS supplemental plans. Therefore, it is not unreasonable to predict that employers might be changing their benefit packages to rely on Medicare Part D instead of providing prescription drug coverage on their own.

Medigap insurance with drug coverage (plans H, I, and J)—although technically still available to persons already enrolled in those plans—may now be a relatively less appealing option based on cost, particularly given significant increases in premiums for these plans in the last decade. For example, costs for Medigap plans in a medium-sized city ranged from a low of $57 per month for Medigap plan A (the least comprehensive plan, with no prescription drug coverage) to $326 per month at the upper end of the range for plan J (the most comprehensive plan, with some drug coverage). Therefore, beneficiaries who obtain drug coverage through the more expensive Medigap plans may consider changing to a less expensive Medigap (with no drug coverage) supplemented by a PDP plan.

Existing beneficiary coverage for the Medigap H, I, and J plans (which can no longer be offered with prescription drug coverage) only qualify as creditable coverage if they are actuarially equivalent to the basic Part D benefits. Not all continuing Medigap plans may meet this threshold, and beneficiaries must be informed annually by their individual plans if they do (or do not) have creditable coverage under Medigap. Beneficiaries who continue to enroll in these plans that do not qualify as creditable must therefore also enroll in a stand-alone Part D plan or be subject to a financial penalty if they participate in a Medicare Part D plan in the future.

Implementation of the Part D program has had a positive effect on access to drug coverage for MA enrollees according to early assessments. Preliminary estimates also suggest that compared with 2003, the prevalence of drug coverage among elderly persons has increased to about 90%.[11-16] Enrollments have increased in the new regional MA plans with drug coverage, while decreasing in older locally managed care plans.[13] MA plans are now required to offer at least a standard Part D option as part of their benefit package and for the first time will re-

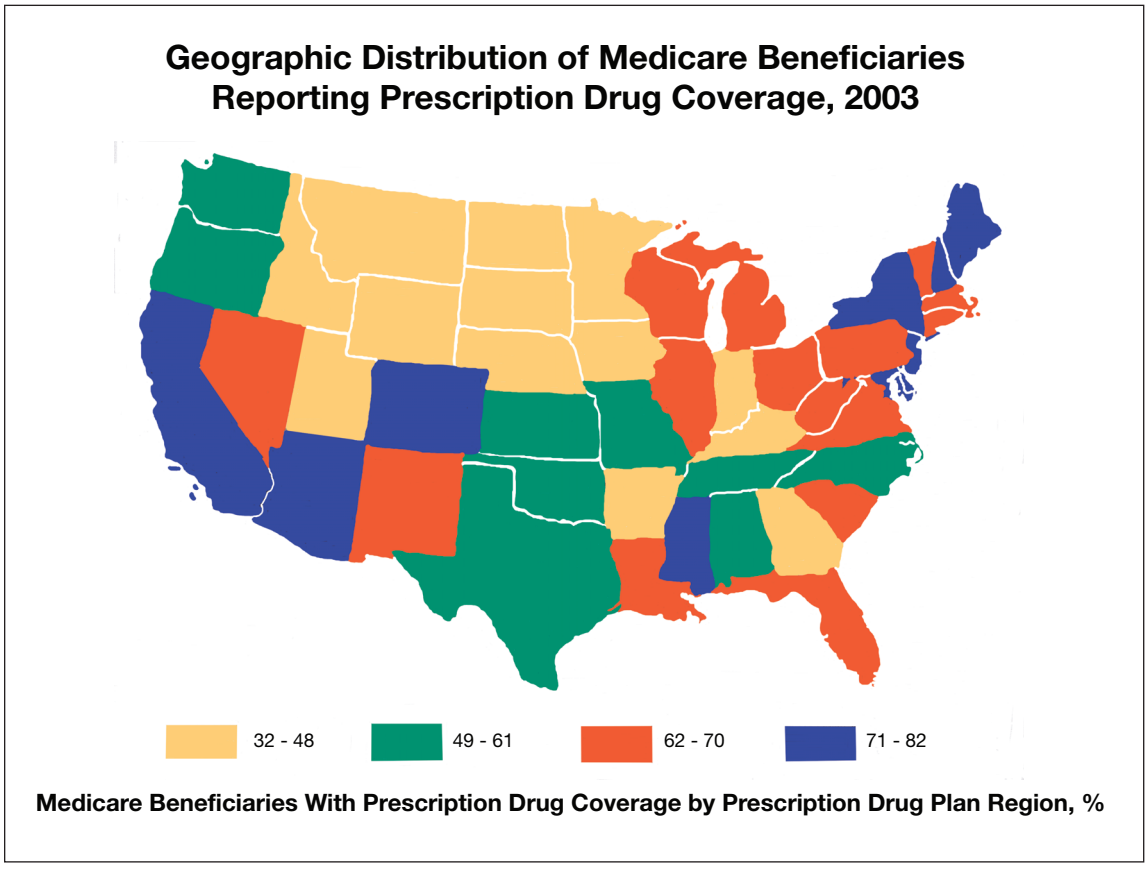

Figure 3. Participation by Medicare beneficiaries in plans with prescription drug coverage in 2003 varied significantly by region.

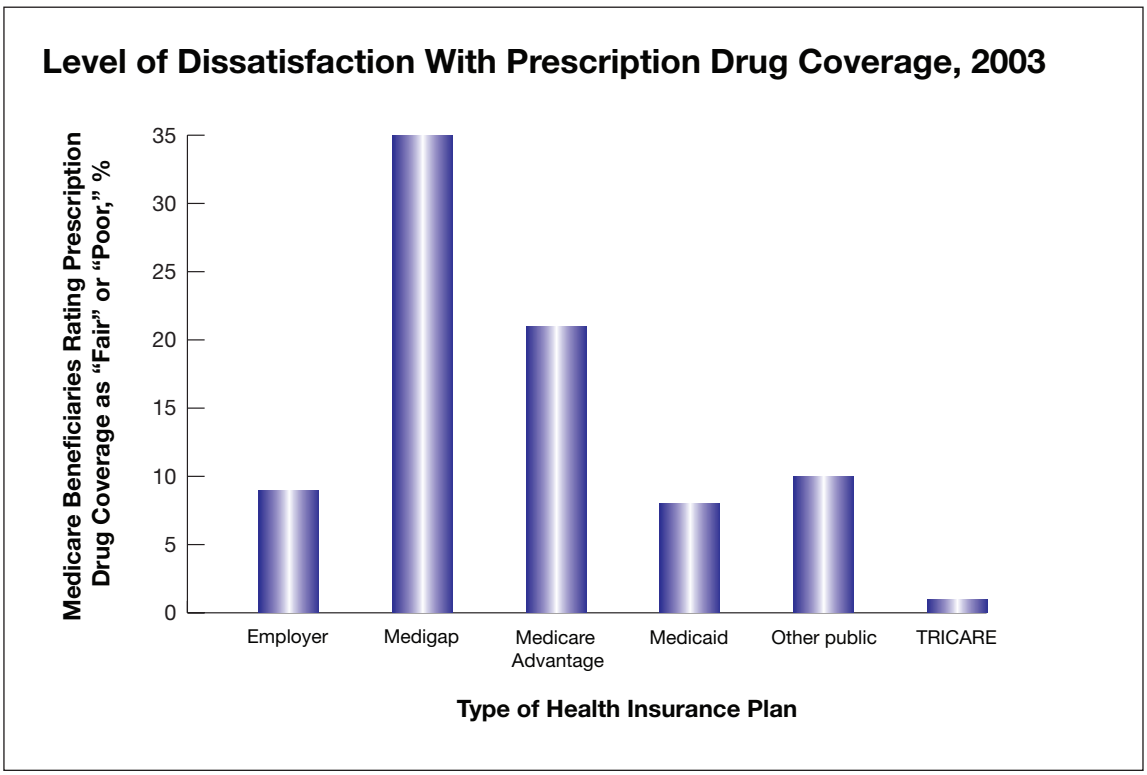

Figure 4. Medicare beneficiaries with prescription drug coverage provided through TRICARE in 2003 had the lowest dissatisfaction levels.

Table 1. Multinomial Logistic Regression Predicting Prescription Drug Coverage Using Beneficiary Characteristics, 2003

	Comparison to FFS only (N = 11,328)				Comparison to coverage without drugs (N = 11,328)			
Covariate	Coverage with drugs (n = 6760) vs FFS only (n = 1355)		Coverage without drugs (n = 3213) vs FFS only (n = 1355)		Coverage with drugs (n = 6760) vs coverage without drugs (n = 3213)		FFS (n = 1355) vs coverage without drugs (n = 3213)	
Type of Insurance	Odds ratio	*P* value	Odds ratio	*P* value	Odds ratio	*P* value	Odds ratio	*P* value
Age group								
< 65	0.17	< .001	0.06	< .001	2.97	< .001	17.29	< .001
65 - 70	0.59	< .001	0.40	< .001	1.49	< .001	2.51	< .001
71 - 80	0.72	.002	0.58	< .001	1.24	< .001	1.71	< .001
81+	1.00		1.00		1.00		1.00	
Sex								
Male	0.43	< .001	0.51	< .001	0.85	< .001	1.97	< .001
Female	1.00	1.00		1.00		1.00		
Race/ethnicity								
White	1.00		1.00		1.00		1.00	
Nonwhite	0.56	< .001	0.49	< .001	1.13	.200	2.02	< .001
Education								
< 9th grade	1.00		1.00		1.00	1.00		
High school/ vocational	1.68	< .001	1.54	< .001	1.09	.330	0.65	< .001
Some college	2.04	< .001	1.79	< .001	1.14	.185	0.56	< .001
Income								
< $25,000	0.30	< .001	0.42	< .001	0.71	< .001	2.37	< .001
≥ $25,000	1.00		1.00		1.00		1.00	

ceive Medicare payment for these now statutory benefits. Therefore, MA enrollees who are satisfied with their current plans may have little reason to change options to obtain drug coverage.

Some Medicare beneficiaries who are also entitled to Medicaid services, however, are likely to continue to face significant changes in their level and source of coverage. Under Part D, dually entitled Medicare beneficiaries now receive basic prescription drug coverage through Medicare, replacing their prior state-sponsored coverage. Some lower-income Part D enrollees also receive a subsidy that covers all or part of their premium.

Variation in drug coverage by geographical location. Prescription drug coverage available through health plans varies considerably across Medicare PDP regions (Figure 3). Region 25 (Iowa, Montana, Minnesota, Nebraska, North Dakota, South Dakota, and Wyoming), whose monthly average premiums (not shown) were among the highest, is among the lowest in percentages of beneficiaries with prescription drug coverage through any plan (32% to 49%). On the other hand, regions 1 (Maine and New Hampshire) and 20 (Mississippi) had among the highest average cost for health insurance but have among the highest rates of persons with some drug coverage (70% to 82%). Other states, like California, exhibit both low average costs for health insurance and high rates of drug coverage. It seems reasonable

Table 1. *continued*

Covariate	Comparison to FFS only (N = 11,328)				Comparison to coverage without drugs (N = 11,328)			
	Coverage with drugs (n = 6760) vs FFS only (n = 1355)		Coverage without drugs (n = 3213) vs FFS only (n = 1355)		Coverage with drugs (n = 6760) vs coverage without drugs (n = 3213)		FFS (n = 1355) vs coverage without drugs (n = 3213)	
Type of Insurance	Odds ratio	*P* value	Odds ratio	*P* value	Odds ratio	*P* value	Odds ratio	*P* value
Marital status								
Married	1.88	< .001	1.85	< .001	1.02	.759	0.54	< .001
Not married	1.00		1.00		1.00		1.00	
Index of preventive care	8.94	< .001	5.79	< .001	1.54	< .001	0.17	< .001
Chronic condition								
Hypertension—yes	1.09	.258	0.92	.384	1.19	.002	1.09	.384
Hypertension—no	1.00		1.00		1.00		1.00	
CHD—yes	1.43	.004	1.43	.005	1.00	.989	0.70	.005
CHD—no	1.00		1.00		1.00		1.00	
Other heart—yes	1.20	.078	1.00	.969	1.20	.015	1.00	.969
Other heart—no	1.00		1.00		1.00		1.00	
Diabetes—yes	1.11	.374	0.90	.368	1.23	.002	1.11	.368
Diabetes—no	1.00		1.00		1.00		1.00	
Drug discount card								
Yes	0.19	< .001	1.14	.357	0.17	< .001	0.88	.357
No	1.00		1.00		1.00		1.00	

FFS, fee-for-service; CHD, coronary heart disease.

to expect that states with previously high premium rates may witness increases in enrollment given the comparatively lower average premiums for Part D plans.

Possession of a drug discount card. Overall, 6% of beneficiaries reported having 1 or more drug discount cards in 2003, with nearly all beneficiaries having just 1 card (not shown). By the summer of 2004, 9% of beneficiaries had drug discount cards (personal communication with Nyna Williams of CMS). Of the 6%, there was some variation in the probability of drug card ownership by insurance status. The highest percentage of beneficiaries who reported having a drug discount card included those with an individually purchased private plan (10%) and those with Medicare FFS coverage only (10%). This is intuitive because these groups of beneficiaries reported the lowest proportion of prescription drug coverage through their primary plan. We expect the cards to decline in popularity given increased enrollment levels in the Part D drug benefit program.

Health insurance premiums. In 2003, 47% of beneficiaries paid a monthly premium in addition to their Medicare Part B premium (not shown). The remaining 53% of beneficiaries reported a $0 premium. For those with a premium (ie, excluding those with Medicaid, public coverage, and Medicare FFS only who reported $0 premiums), the average monthly premium paid by a beneficiary was $128.

continued

Beneficiary cost-sharing mechanisms used. Most beneficiaries with prescription drug coverage reported that their plan requires them to pay a copayment for drugs, with Medicaid being least likely to do so. Requiring a higher copayment for brand-name versus generic drugs is common. Based on beneficiary self-reporting, the tiered copayment approach is most prevalent among employer plans (71%) and TRICARE for Life (59%), and least common among Medicare managed care plans (2%). This is presumably because many managed care plans cover only generic drugs. Most beneficiaries with MA, employer, other public, or TRICARE for Life report copays for generic drugs that are less than $15 per prescription. Only TRICARE for Life appears more likely to require less than $15 copays for brand-name drugs. MA, employer, and other private plans seem more likely to establish copay amounts in excess of $15 for brand-name drugs.

Satisfaction with prescription drug coverage. Beneficiaries with prescription drug coverage were asked to rate their overall satisfaction with their plans' drug coverage using a scale from "excellent" to "poor" (Figure 4). Beneficiaries who have drug coverage through Medicaid, other public, or TRICARE for Life rated their level of satisfaction higher, with TRICARE for Life receiving the highest rating. More than a third (35%) of those with Medigap plans rated their level of satisfaction as "fair" or "poor," while 21% of those in MA plans rated their coverage this way, compared with only 9% of those in employer plans. If those rating their plans less favorably are candidates for purchasing and retaining Part D coverage, then new enrollees are more likely to come from MA and Medigap plans than from employer plans. Those with military-based insurance are apparently satisfied with their drug coverage and presumably remain uninterested in the new benefit.

Study Findings: Multivariate Analysis

The multivariate analysis provides insight regarding who tended to go without insurance beyond Medicare FFS and/or without prescription drug coverage before Part D was available (see Table 1). The first comparison in Table 1 presents odds ratios for the probability of having insurance beyond Medicare FFS that covers drugs relative to Medicare FFS only (first column of figures), and then the probability of having insurance beyond Medicare FFS that does not cover prescription drugs relative to Medicare FFS only (second column). The second comparison presents odds ratios for the probability of having insurance beyond Medicare FFS that covers drugs relative to having insurance beyond Medicare FFS that does not cover drugs (third column), and then the probability of having no insurance beyond Medicare FFS relative to having coverage beyond Medicare FFS that does not cover drugs (fourth column).

Age, sex, race/ethnicity, education, and income were all statistically significant predictors of holding insurance coverage beyond Medicare FFS. Younger beneficiaries were less likely than the oldest old (age 81-plus) to hold additional insurance with or without drug coverage, and this disparity increased with the age difference. The odds of holding additional insurance with drug coverage (or being in a FFS plan) decreased with age. Women were more likely than men to hold additional coverage, especially those with drug benefits. Whites were also more likely to hold additional coverage; their odds of holding it were approximately twice that of nonwhites. The odds of holding additional coverage increased with education and income. Better educated persons were equally likely to have additional coverage with drugs than without, but lower-income beneficiaries were less likely to have additional coverage with drugs than without. Married beneficiaries had significantly higher odds of holding additional health insurance, which can probably be attributed to the option of spousal coverage available through employer plans. However, married persons were not more likely to have additional coverage with drugs.

Other personal traits had significant effects. Persons with CHD more often held additional coverage beyond basic Medicare FFS, with or without prescription drug coverage, and beneficiaries with hypertension, other heart conditions, or diabetes had about 20% higher odds of having supplements that covered drugs. A beneficiary's use of preventive care services was positively correlated with additional coverage and also positively correlated with having drug coverage in that policy. Not surprisingly, persons with drug discount cards were much less likely to have additional coverage that includes drugs. This finding suggests that the drug cards helped fill a drug coverage gap, substituting for plan coverage that was not attainable by some beneficiaries.

Finally, the multivariate analysis suggests that location was an important predictor of having drug coverage in 2003 (Table 2). According to the model, beneficiaries in only 6 of the PDP regions had similar odds of coverage to Californians (California was chosen as the reference group because it had a large number of survey respondents and a higher proportion of persons with drug coverage). These 7 regions (and other insignificant regressors) were omitted from Table 2: New York, New Jersey,

Table 2. Odds of Choice in Two Models by PDP Region*

PDP region (California is reference)		Regression A		Regression B	
		Coverage with drugs vs FFS	Coverage without drugs vs FFS	Coverage with drugs vs coverage	FFS vs coverage without drugs
1	Maine, New Hampshire	0.49			
2	Connecticut, Massachusetts, Rhode Island, Vermont			0.54	
6	Pennsylvania, West Virginia			0.59	
7	Virginia	0.48			
8	North Carolina	0.39		0.56	
9	South Carolina	0.31		0.32	
10	Georgia	0.16		0.29	
11	Florida	0.48		0.53	
12	Alabama, Tennessee	0.57		0.35	
13	Michigan	0.47			
15	Indiana, Kentucky	0.54		0.33	
16	Wisconsin			0.52	
17	Illinois	0.56		0.49	
18	Missouri	0.35		0.30	
19	Arkansas	0.10		0.12	
20	Mississippi	0.21	0.16		6.13
22	Texas	0.29	0.54	0.54	1.85
23	Oklahoma	0.28		0.30	
24	Kansas		2.11	0.21	0.47
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	0.43	1.80	0.24	
26	New Mexico	0.69			
29	Nevada		0.39		2.54
30	Oregon, Washington	0.33		0.31	
31	Idaho, Utah	0.06	0.28	0.20	3.53
33	Puerto Rico	0.21		0.15	

*Statistically significant estimates only.

Note: In the first 2 columns of figures, the omitted group is Medicare fee-for-service (FFS) only. In the second 2 columns of figures, the omitted group has insurance in addition to Medicare but without prescription drug coverage.

Delaware-Washington, DC-Maryland, Ohio, Louisiana, Colorado, and Arizona. The remaining 26 regions had significantly different odds of supplemental coverage compared with California, with odds of drug insurance that were often half or less than the odds for Californians. Other variables with insignificant impacts not shown include urban/rural county of residence, Hispanic ethnicity, self-reported health status, and 3 chronic disease indicators (myocardial infarction, COPD, PD).

Discussion

Here we explored how a person's Medicare Part D drug coverage decision may differ depending on the type and level of insurance and drug coverage he or she had before Part D was implemented, and how new beneficiaries are likely to respond to availability of Part D prescription drug coverage. Using 2003 data, we found that all but 9% of beneficiaries had some type of previous supplemental coverage, and that employer plans and MA plans were the most commonly held options. Overall, at least two thirds of all beneficiaries had some form of prescription drug coverage in 2003, but it varied by type of supplemental coverage, with Medigap-covered persons least likely to have drug coverage among those with some insurance beyond basic Medicare FFS. Others, such as those with employer coverage or MA plans that have now added Part D benefits, still have little reason to make changes. To date, 90% of Medicare beneficiaries have enrolled in Medicare Part D; this is likely to include the nearly two thirds of persons who already had prescription drug coverage.

Beneficiaries who had previously chosen (explicitly or by default) not to obtain drug coverage as well as those with limited drug coverage likely to be modified as a result of Part D implementation need to understand how their previous or current coverage differs from the new options. Beneficiaries most likely to benefit from Part D availability are the 1 in about 10 who had no prescription drug coverage at all before Part D was implemented. Clearly, these persons who had the option to move from no coverage to some coverage for a fairly modest financial outlay were the group most likely to adopt a Part D plan.

Beneficiaries with Medigap coverage also stand to benefit because a Part D plan is generally a more cost-effective and available alternative and may also provide additional benefits. Our analysis reveals that current Medigap enrollees were also least satisfied with their prescription drug coverage in 2003. Medigap plans H, I, and J are likely to be phased out of existence within the next decade or two as the cohort currently holding them ages.

Under Part D, MA plans must offer prescription drug benefits that are, at a minimum, actuarially equivalent to the basic plan defined by CMS. Therefore, implementation of the Part D program will probably continue to have a positive effect on access to drug coverage for MA enrollees, particularly those in areas that offer either no prescription drug coverage or limited benefit, generic-only packages. However, beneficiaries in MA plans will need to compare their plan's costs relative with standalone Part D plans on an ongoing basis as premiums and formularies may change. They will also need to simultaneously consider other possible changes to the package of services to make optimal decisions. Regardless of the options available now, if Part D coverage is still unaffordable to some beneficiaries and a person does not qualify for the low-income subsidy, their drug coverage status is not likely to change.

Most beneficiaries with employer-sponsored coverage will probably remain unaffected by implementation of Part D if they perceive that their current situation is a relatively good one and their employer has decided to continue to sponsor coverage. However, only time will tell how many employers will be swayed by the incentives embedded in the legislation and offer equal or better coverage. Those who are eligible for supplemental services through TRICARE for Life should not be affected by Part D, because their current Medicare supplement is relatively generous and there is little reason for them to change. Yet, it will be important to continue to convey to beneficiaries with employer-sponsored coverage—especially those with coverage from the Department of Defense—that their best alternative is to remain with their current plan. Messages from CMS should suggest that those with employer-sponsored coverage consult their employers. This will be particularly important for new beneficiaries as they age into the Medicare program, and whose employer-sponsored coverage may be less comprehensive given employers' own cost-containment efforts.

Because a goal of the MMA is to expand the prevalence of prescription drug coverage, reaching out to those who had none is a natural place to put emphasis as the Medicare Part D education campaign continues. According to our multivariate results, these persons will include beneficiaries who are new to Medicare who will be less likely to hold other coverage. To facilitate this process, audiences can be segmented by insurance type as exemplified above and messages targeted accordingly based on what each group perceives as important and their level of satisfaction with their current situation.

We suggest also segmenting the audience and targeting messages to other beneficiary subgroups for greater campaign effectiveness. Principles of social marketing suggest that messages may be best received and acted on by those who are already more receptive to them.[17] Beneficiaries who have some insurance beyond basic Medicare FFS, but not including prescription drug coverage, may be more receptive to Part D enrollment information. By obtaining some coverage beyond Medicare, these persons have demonstrated that they value insurance, but they may not recognize the importance of prescription drug coverage and/or could not afford the additional premium cost to cover drugs. Likewise, new beneficiaries who are currently insured in some way may be more receptive and interested.

Subgroups of beneficiaries who have coverage beyond Medicare FFS but do not have drug coverage are older, male, have lower incomes, are less likely to seek preventive care, and are less likely to have certain chronic conditions. Part D messages could be crafted to appeal to the oldest generation who may feel as though their health risks are too great and do not understand that their current health status does not affect eligibility. Clear emphasis should be placed on the relatively affordable premiums. Part D messages could also be combined with health promotion messages about preventive services or the importance of having drug coverage given the high probability of developing at least 1 chronic condition as one ages.

The health behavior literature emphasizes that what people know, what they think and what they observe affect whether they take action, what actions they take, and if they feel empowered or motivated to act.[18] Beneficiaries who do not think they need the drug benefit now may not see the value of enrolling given uncertain future benefits. When faced with too many choices, beneficiaries may also feel overwhelmed and not take action. Thus, Part D messages should convey the importance of having the coverage for the future and simplify the decision process by clearly explaining who are good candidates for it. These kinds of messages could be used by CMS in various components of the Medicare Part D education campaign and in educational efforts by insurers and PBMs that administer PDPs.

Conclusion

The wide variety of prescription drug coverage options now available implies that we should strive to help beneficiaries understand the benefits and costs of Part D relative to the costs and benefits of their current coverage to stimulate and maintain enrollment. Policy makers may also learn important information by continuing to monitor beneficiary satisfaction with coverage across the wide range of options. As our findings suggest, beneficiary satisfaction can vary widely, and focusing research and educational efforts on beneficiaries enrolled in options with high levels of dissatisfaction is most likely to result in improvements. ■

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Additional Resources and Author Contact

*For details about variable creation and other findings, see McCormack L, Mobley L, Kuo M, et al. *Analysis of MCBS Questions About Prescription Drug Coverage and Drug Discount Cards.* September 2005. RTI final report 07964.002.012.

†Definitional boundaries for each of the PDP regions, once posted on the CMS Web site, are available by contacting Dr McCormack, the corresponding author, at: lmac@rti.org.

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