Testimony of Robert M. Hayes
President, Medicare Rights Center
Before the United States Senate
Finance Committee
"Medicare Drug Card: Delivering Savings for Participating Beneficiaries"
June 8, 2004

Good morning, Mr. Chairman, Senator Baucus, Committee members. My name is Robert M. Hayes, and I am the President of the Medicare Rights Center. We appreciate the opportunity to bring to this Committee the real life experiences of men and women with Medicare who are grappling with the opportunities, and with the frustrations, of the new Medicare discount drug card program.

The context of today's hearing is important. Drug pricing and discount cards need not be the subject of partisan rancor. The focus must be on the humanitarian life and death crises that older and disabled Americans face because they cannot afford the medicine that their doctors prescribe.

Without doubt, the greatest and gravest unmet need of older and disabled Americans is the unavailability of affordable prescription medicine. From the trenches in which we work, Mr. Chairman, the unaffordability of prescription medicine is a national emergency. It is within that reality that we approach the Medicare discount card program, and it is the needs of men and women who cannot afford needed medicine that we bring to you.

The Medicare Rights Center

The Medicare Rights Center ("MRC") is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities get good affordable health care. Day in and day out we work to assist people with Medicare access needed health care. Tens of thousands of callers use our help-lines annually, and we reach out to assist people with Medicare enroll in programs that can help them.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent. We are not supported by the pharmaceutical industry, drug companies, insurance companies or any other special interest group. Our mission is to serve the 41 million men, women and children with Medicare.

Through national and state telephone hotlines, casework and both professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. By way of example, MRC currently is providing, in partnership with the American Society on Aging, a series of web-based tele-trainings on the Medicare discount cards to social workers and other professionals across the country. You can access that training at www.asaging.org/medicare/about.cfm.

We are also bringing to counselors and consumers across the country Medicare Interactive, a web-based counseling tool—developed with major support from the United States Department of Commerce—that assists people with Medicare access the health care they need. **Invitation: every Congressional constituent service office that requests it will be provided a password to access Medicare Interactive to assist voters with Medicare problems or questions.** Trust me, your district offices will need it – Medicare is not getting simpler.

MRC also gathers data on the health care needs of the elderly and disabled Americans that we serve. We share that data with researchers, policy makers and the media. Just one of MRC's services, its New York State Health Insurance Assistance Program (SHIP), offers counseling support to one out of every 14 Medicare recipients in the nation. Each year, the Medicare Rights Center receives over 70,000 calls for assistance from people with Medicare. By far, the greatest numbers of callers are seeking help in finding ways to pay for medicines that their doctors have prescribed. Our counselors are trained to assist consumers with complex problems and we complement the basic services offered by the 1-800-MEDICARE hotline operated by the Centers for Medicare and Medicaid Services (CMS). 1-800-MEDICARE is the largest source of referrals to our hotline, and CMS provides about 25 percent of the financial support for the MRC hotline: the rest we raise privately. To date, we have received no new support from CMS, or any other public agency, in the wake of the widespread and desperate demand for information triggered by the Medicare prescription drug discount card program.

Needless Pain, Lost Lives

For many, many years this Committee, this Congress, our nation have been numbed by the overwhelming data documenting the human hardship, the needless pain, the lost lives caused by the unaffordability of prescription medicine. I cannot shake from my memory the elderly woman who tearfully told me that she lies to her husband whenever her doctor gives her a prescription. If she told him about the prescription, she said, her husband would insist that she fill it. She wants him to keep taking his heart medicine, and she knows they could not afford another prescription. That is an obscenity in America in the 21st Century, and I know that is why we are here today.

I will take just a few minutes to outline what consumers are experiencing in the wake of the Medicare discount card roll out. This evidence already has been widely reported and well established.

One, the men and women who turn to us for help are in a state of high anxiety: they are confused or frustrated or angry – or all three.

Two, most people with Medicare will receive little if any benefit from the Medicare discount card program. This is not a political statement and it is not a point in dispute. As you know, CMS itself is aiming to enroll about seven million people, 17 percent of people with Medicare into the discount card program over the next 17 months.

Three, some people –those with low incomes, those without any drug coverage and those who learn about and sign up for the Medicare discount card program – will be able to afford some medicine thanks to the Medicare discount program's transitional assistance. This is far too important a point to lose.

In many ways we are critics of a hopelessly complex and wasteful program because all it would take to help everyone at much less cost is for the government to negotiate fair drug prices with the pharmaceutical industry. Yet some people will have improved health and a better life once they enroll in the discount program's transitional assistance. We join with groups like the National Council on Aging, and other groups more critical of the Medicare Modernization Act, in meeting our responsibility to help enroll as many people as possible, and to push this Administration into making enrollment as feasible as possible.

How can that be done?

First, recognize that web sites and voice automated phone systems are – even when they work – a sliver of a solution. We know that, despite hearings like this, news coverage, tens of millions of dollars in advertising by CMS, most people with Medicare do not even know about the discount cards. Confused and frustrated seniors are among the most knowledgeable.

The need to understand the discount card program is most important for low income people who have the most to gain – $600 annually from transitional assistance. But last week's survey by the Kaiser Family Foundation found that only 15 percent of seniors – that's one in seven – with incomes below $20,000 have ever *used* the internet. Twenty-six million seniors with Medicare have incomes below $20,000.

A "Wild West" Marketplace

Here's how complicated the drug market is for an actual consumer, including the most sophisticated consumers with the best of support. Last month I sat at a witness table like this with Stan Baumhofer, a gentleman from Portland, Oregon, while we were testifying before the Health Subcommittee of the House Energy and Commerce Committee. Mr. Baumhofer testified quite enthusiastically about the savings he would enjoy using his Medicare Approved Drug Discount Card. At the Medicare Rights Center we are really more social workers than political analysts, so I gave Mr. Baumhofer my card and offered our help in reviewing his drug needs as time goes forward. In fact, had Mr. Baumhofer been prudently counseled to look beyond the Medicare approved drug discount cards for help, he would have found much deeper savings.

If you look at Table A attached to this testimony, you will see the results of our analysis showing that Mr. Baumhofer could save over $2,700 more using existing drug assistance programs than he could using the best Medicare approved discount card for his prescription drug needs. Of course Mr. Baumhofer is correct in appreciating the value of the discount card that, he said, would save him $1,750 a year. But when existing drug programs can save him over $4,500 annually, he needs to know that as well. After all, those savings are over 25 percent of his $16,000 annual income.

The point of Mr. Baumhofer's tale is not to diminish the value of any program that helps a single person afford a single prescription. And of course we intend no criticism of the House members who assisted Mr. Baumhofer in his testimony. Our own experts at the Medicare Rights Center are struggling mightily to assist people in the best way possible.

The point of this analysis is to show just how complex the prescription drug marketplace has become, how Byzantine the process of finding discounts can be, and how utterly helpless the savviest of consumers – including those assisted by the best intentioned professionals – become in the face of layer upon layer of pricing changes, discount programs and assistance programs. This is not a marketplace where willing buyers meet willing sellers to establish price. It's the Wild West, and the consumer is without ammunition.

The Baumhofer tale also raises another interesting point: if the Administration could use its influence with the pharmaceutical industry to maintain its patient assistance programs, would it not better serve the American public to promote these assistance programs and enroll eligible Americans in them? As the chart shows, Mr. Baumhofer is far better served by assistance programs than by any Medicare approved card. And all people eligible for

transitional assistance are eligible for each of the major drug companies' assistance programs.

No Surprise

Absolutely no one should be surprised that very few people have signed up for Medicare-approved discount cards to date. The program's structure is hopelessly complex, and for most people the benefit is meager. Permit me to spend a moment reviewing the structure of the program.

The design of the discount benefit, and even worse the design of the 2006 Part D drug benefit, draws all the wrong lessons from decades of experience with existing income-tested programs, especially the Medicare Savings Programs known by their acronyms QMB, SLMB and QI-1. It is well established that the design of the enrollment process for any public benefit will determine whether more than a small percentage of eligible individuals enroll in and benefit from the program.

"A Dirty Secret"

It is a dirty secret to most of the American people that the design of most low-income programs excludes about half of the people eligible for the benefit. It's common knowledge to all of us experts. But when political leaders speak of the safety net for poor Americans – be it in health care, housing, food – they only rarely acknowledge that half the people in need go unassisted. Tragically, in many ways the people in greatest need – that is those least aware of government programs that can help and least able to navigate bureaucratic hurdles to assistance – most frequently lose out. We thank Senator Bingaman and other members of this Committee who have been leaders in working aggressively to correct this.

The good news is that if we want full enrollment in public benefit programs, we know how to do it. Since 1966, enrollment in the voluntary Part B Medicare program has hovered between 95 and 97 percent. Automatic enrollment, with voluntary opt-out is the simple but magic solution.

Please review Table B which compares Medicare Part B enrollment with the take-up rates for Medicare Savings Programs, which require people to apply, in various states. In North Dakota, only one in four people are receiving the assistance to which they are entitled. Even in the relatively high enrollment states of Senator Lott, Senator Frist, Senator Grassley and Senator Snowe (Mississippi, Tennessee, Iowa and Maine, respectively), where enrollment is above 70 percent, thousands of poor people are going without needed health care because of their inability to enroll in Medicare Savings Programs. Senator Baucus, the story in Montana pretty much tracks national data – only about half of the people eligible for assistance receive it.

For today's discount card enrollment effort, here's a modest prescription: The single most useful step to assist people access the $1200 transitional benefit -- as it is now designed -- is to require automatic enrollment of anyone who has established eligibility through an existing program, principally the Medicare Savings Programs. That alone could bring nearly a million very low income Americans into the discount card program. It is a humanitarian act, and it is a prudent political act. It will do what the Administration repeatedly says it wants to do: help bring affordable prescription drugs now to the neediest men and women with Medicare.

We understand, but hardly appreciate, that there is a debate within the Administration about the wisdom of automatic enrollment. We have heard from some in the Administration that auto-enrollment would undermine the voluntary nature of the drug card. To that, from the perspective of the real world, we say, "Come on." Neither the White House nor the Internal Revenue Service forced Americans to jump through hoops to claim their tax refunds two summers ago. The checks were just mailed to you. People with Medicare eligible for the $1200 in transitional assistance should be treated similarly.

While there are a million Americans who will benefit from automatic enrollment in transitional assistance, there are an additional 18 million people with Medicare who have incomes under $20,000 a year who will not be helped by automatic enrollment and who remain largely without assistance in affording the medicines their doctors prescribe. The push to enroll eligible Americans in transitional assistance is a noble one. But that push cannot obscure the reality that many, many medically needy Americans will be unable to afford prescription drugs until this Congress requires the federal government to bargain for best prices with the major pharmaceutical companies.

The CMS Website and 1- 800-MEDICARE

I won't speak about the difficulties of the CMS web site or the 800-MEDICARE phone line now; we have quietly provided CMS with a good deal of feedback since late last month, and we will continue to do so as partners in the effort to maximize consumer understanding of the discount card program.

We recognize that CMS is trying, but CMS – just like people with Medicare -- has been dealt a cruel hand by the structure of this discount card program. At the end of the day, a reasonably informed choice for most people with Medicare will be impossible. It is wasteful to spend tens of millions of tax dollars in futile attempts to explain nuanced choices involving scores of plans offering hundreds of medical products and services. Rather than offering multiple card choices with scant benefits, a useful drug assistance program would provide a truly meaningful benefit with multiple medication and pharmacy choices. The

structure of the discount program, and we expect the 2006 benefit as currently designed, does not work and no magic by a CMS webmaster can change that.

It is not premature to look ahead to 2006. As currently designed, we fear that the Part D Medicare drug benefit will be so complex to navigate that today's drug card program will look like child's play. If the 2006 Medicare drug benefit is to be both a humanitarian and political victory, Congress and the Administration must revamp the structure of the benefit with three words in mind: simplify, simplify, simplify.

To that end, I will conclude with six points of essential reform so that the 2006 drug benefit can meet its stated purpose – to assist the neediest older Americans secure medicine that they can afford.

- **Automatically enroll all eligible persons in the low-income drug benefit.** The MMA already provides that full benefit Medicaid recipients be enrolled in the low-income subsidy and a prescription drug plan if they fail to enroll themselves. Persons can then opt-out of the program so the benefit is still voluntary. Likewise, automatic enrollment procedures should be applied to all state pharmacy assistance program and Medicare Savings Programs recipients. (CMS has permitted states to automatically enroll state pharmacy assistance recipients in transitional assistance and is now considering extending automatic enrollment to Medicare Savings Programs enrollees.)

Automatic enrollment procedures, such as those used for Medicare Part B, are the best way to maximize enrollment in health insurance programs.[1] Persons automatically receive Part B when they turn 65 and sign up for Social Security[2] unless they affirmatively decline Part B enrollment. As a result, Part B has a 95.5 percent participation rate. In contrast, national participation in the Medicare Savings Programs stands at about 50 percent because persons must affirmatively apply for benefits.[3] This is despite fifteen years of efforts by the federal government, states, and community organizations to increase awareness of the programs and to ease application and eligibility requirements.

- **Remove the asset tests, which represent a leading barrier to enrollment in low-income programs**. The onerous task of verifying the worth of certain items (including burial accounts, life insurance policies,

[1] Dahlia K. Remler and Sherry A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health,* January 2003.
[2] Persons who qualify for Medicare based on a disability are automatically enrolled in Part B when they sign up for Medicare after r two year waiting period.
[3]. In 2001, CMS found that 40.5 percent of those eligible for the QMB and SLMB programs were not enrolled. Actuarial Research Corporation, *Dual Eligible Buy-In Status*, prepared for the Centers for Medicare and Medicaid Services, May 2001. Nationally, only about 145,000 (10%) of the estimated 1.4 million eligible individuals are enrolled in the QI-1 program. 68 Fed. Reg. 50792 (Aug. 22, 2003).

bank accounts, and vehicles) prevents many eligible older Americans and Americans with disabilities from completing applications for the Medicare Savings Programs. [4] Additionally, people who would qualify for the low-income assistance programs based on income, but not assets, are hardly well-off. The median value of assets for persons with incomes between 100 and 135 percent of poverty is 8,000.[5]

- **Require the use of simplified application procedures and allow self-certification of income and assets**. Cumbersome enrollment processes represent a leading barrier to participation in low-income assistance programs. In particular, face-to-face interviews and income and asset verifications pose insurmountable hurdles for many older people, especially those with low literacy, limited English-speaking skills, and cognitive impairments. [6] Simplified enrollment should include easy-to-complete mail-in and online application forms, prohibit requirements for in-person interviews, allow applicants to self declare the value of their income, and minimize verifications for assets. CMS should also use presumptive eligibility to allow persons who appear to be eligible to apply in pharmacies and doctor's offices and receive benefits immediately. Persons are more likely to enroll in benefits if they can access them immediately.

- **Streamline the renewal process.** Burdensome renewal procedures, like complicated enrollment procedures, can undermine participation in low-income assistance programs.[7] Easing renewal requirements also makes sense because most persons with Medicare have fixed incomes, and most persons remain eligible for the programs from year to year.[8] Streamlined renewal should involve:

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[4] Kim Glaun, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs: Case Study Findings* (Washington, Kaiser Commission on Medicaid and the Uninsured, December 2002) [Hereafter *Glaun Medicare Savings Programs*]

[5] Laura Summer and Lee Thompson, *How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits* (Commonwealth Fund, May 2004) [Hereafter: *Summer Asset Tests*]. About 30 percent of persons with incomes at or below poverty are disqualified for the Qualified Medicare Beneficiary Program because they have a modest life insurance policy or vehicle valued at more than $4,500. Seventy-five percent of these persons have assets that exceed the life insurance limit by $8,500 or less. *Id.*[

[6] *Glaun Medicare Savings Programs*.

[9] Glaun *Medicare Savings Programs;* Michael J. Perry, Susan Kannel, and Adrianne Dulio*, Barriers to Medicaid Enrollment for Seniors:Findings From 10 Focus Groups With Low-Income Seniors* (Washington, the Kaiser Commission on Medicaid and the Uninsured, January 2002).

[8] See *Summer Asset Tests*; Susan Haber, et. al, Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs (commissioned by the Centers for Medicare and Medicaid Services, October 2003) [Hereafter *Haber Evaluation of QMB*]

- Yearly, rather than quarterly or semi-annual renewals and
- Passive renewal procedures whereby states send enrolled individuals a recertification form with all of their eligibility information filled in and ask them to return the form only if some of their information is incorrect. Persons who do not return the form would be automatically retained in the program.

- **Increase SHIP funding so eligible persons can cut through the red tape and receive benefits.** Even when application processes are simplified, many older persons and persons with disabilities need personalized assistance to complete the application process.[9] Moreover, a recent study commissioned by CMS identifies personalized assistance as a key factor in getting persons enrolled in the Medicare Savings Programs.[10] SHIPs are uniquely equipped to provide this personalized help.[11]
- **Federalize enrollment in the low income drug benefit and the Medicare Savings Programs.** The MMA requires that Medicaid offices and the Social Security Administration determine eligibility for the new low income drug benefit. The Medicare Savings Programs are now administered by Medicaid offices. But applying through Medicaid offices presents multiple obstacles, including Byzantine documentation requirements, traveling to often inaccessible offices, and long waits for service once persons get arrive.[12] Federalizing both administration of the low-income drug benefit and the Medicare Savings Programs would improve participation in both programs because Social Security is generally more user-friendly and accessible for older persons and persons with disabilities. Also, having enrollment administered by one agency will promote accountability and reduce confusion.

These modest steps, even standing alone, can play a significant role in fulfilling the legislative purpose behind the MMA creation of the Part D drug benefit.

In sum, the discount cards will do some people some important good, but the discount cards are leaving the overwhelming majority of people with Medicare without help and angry. There are lessons to be learned from the frustrations of this spring:

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[9] *See* Glaun *Medicare Savings Programs*
[10] *Haber Evaluation of QMB*
[11] In a 2002 report on the effectiveness of SHIPs, the Health and Human Services Office of Inspector General (HHS OIG) wrote, "The SHIPs are uniquely positioned to provide personal locally-oriented counseling and assistance services with trained counselors who often have similar backgrounds, cultures, and experiences as the beneficiaries they serve." HHS OIG, February 2002.
[12] Medicare Rights Center, A*n Investigative Report on Medicare Savings Programs in New York City: Local Involvement in Federal Programs Impedes Access for People with Low Incomes*, December 2001.

- humanitarian and political goals converge when a drug benefit provides meaningful relief in a structure that most people with Medicare can understand;
- if there is the will, there are straight forward ways to increase substantially enrollment in low income benefit programs; and
- until the federal government is willing to use its market power to drive down drug prices for all Americans, most people with Medicare will not see a drug benefit that provides them with what they need – the ability to afford the medicines that their doctors prescribe.

TABLE A

Prescription Drug Cost Comparison for Stan Baumhofer
Portland, OR
Annual Income: $16,000
All prices are for a month's supply

	Current[13]	Retail[14]	Medicare-Approved Card[15]	Manufacturer Pharm. Asst
Lipitor[16]		$105.73	$97.01	$0[17]
Lisinopril[18]		$45.16	$19.23	$0[19]
Plavix[20]		$127.34	$112.97	$0[21]
Toprol xl[22]		$26.87	$21.39	$6.00[23]
Total Costs	$403.31	$305.10	$250.60[24]	$6.00
Total Savings[25]		$98.00	$152.71	**$397.31**

We found that Mr. Baumhofer could get his drugs for just $6 if he took advantage of the drug companies' assistance programs. In contrast, he would pay $250.60 using the best of the Medicare-approved drug discount card programs.

[13] This is the amount, according to Mr. Baumhofer's May 20, 2004 testimony to the House Energy and Commerce Committee, that he spent for his prescription drugs without a Medicare-approved drug discount card or other assistance. His testimony did not include the prices for individual drugs.
[14] Prices on June 2, 2004 including a 10% senior discount available at Bowman's Hillsdale Pharmacy, 6256 SW Capitol Hwy Portland, OR 97201.
[15] Using Envision Rx Plus Medicare-Approved Drug Discount Card at Bowman's Hillsdale Pharmacy
[16] 20 MG 30 TABS
[17] Pfizer Connection to Care (Annual income cap is $16,000 (single)).
[18] 30 MG 30 TABS
[19] Merck Patient Assistance Program. Merck produces Prinivil, which is the trade name for the generic drug Lisinopril. Mr. Baumhofer could receive Prinivil, in place of Lisinopril, for no cost. (Annual income cap is $18,000 (single))
[20] 75 MG 30 TABS
[21] Bristol-Myers Squibb Patient Assistance Program. Bristol-Myers has not set down the qualifications for its Patient Assistance Program in writing. However, in a personal conversation with Medicare Rights Center staff on June 2, 2004, a Bristol-Myers Squibb representative indicated that based upon her experience with similar applications, Mr. Baumhofer would qualify to receive Plavix for free through the company's patient assistance program.
[22] 50 MG 30 TABS
[23] AstraZeneca Together Rx Program (Annual income cap is $28,000 (single)). See: Freudenheim, Milt and Robert Pear. "Drug Discounts Beginning Tuesday, but Sign-Ups Lag." *New York Times* 1 June 2004.
[24] See Mr. Baumhofer's testimony.
[25] Total savings are calculated in comparison to Mr. Baumhofer's current prescription drug cost expenditure.

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TABLE B

Enrollment Rates in the Medicare Savings Programs* After More Than A Decade

Program	Take-up rate**	Enrollment	Steps to facilitate participation		
			Liberalized asset requirements***	Self-certification of assets and income allowed	Mail-in applications
Part B Medicare	95.5%	Automatic with application for Social Security Retirement Benefits or Medicare; individuals may opt out	N/A	N/A	N/A
Mississippi Medicare Savings Programs	84%	Individuals must apply for benefits	Yes (Disregard all assets)	No	Yes
Tennessee Medicare Savings Programs	77%	Individuals must apply for benefits	Yes (Liberalized procedures for counting assets)	Yes	Yes
Iowa Medicare Savings Programs	71%	Individuals must apply for benefits	No	No	No
Maine Medicare Savings Programs	71%	Individuals must apply for benefits	Yes (Disregard savings of $8,000 (single)/$12,000 couple)	No	Yes
Connecticut Medicare Savings Programs	64%	Individuals must apply for benefits	Yes (Disregard all assets for QI1s)	Yes	Yes
Louisiana Medicare Savings Programs	60%	Individuals must apply for benefits	Yes (Increased limits for burial accounts, life insurance to $10,000)	Yes	Yes
New Mexico Medicare Savings Programs	56%	Individuals must apply for benefits	No	Yes	Yes
Arizona Medicare Savings Programs	47%****	Individuals must apply for benefits	Yes (Disregard all assets)	No	Yes
Montana Medicare Savings Programs	47%	Individuals must apply for benefits	No	No	Yes
North Dakota Medicare Savings Programs	26%	Individuals must apply for benefits	No	No	Yes

* The Medicare Savings Programs (MSPs), which Congress enacted in 1988 and expanded in the 1990s, include: the Qualified Medicare Beneficiary (QMB) Program for persons with incomes at or below the Federal Poverty Limit (FPL), the Specified Low Income Beneficiary (SLMB) Program for persons with incomes at or below 120 percent of FPL, and the Qualifying Individual (QI-1) Program for persons with incomes at or below 135 percent of FPL. The assets limits for all of the programs are $4,000 for a single person and $6,000 for a couple.

**The take-up rate is the percentage of eligible individuals enrolled in the program. Part B take-up rate from "Dahlia K. Remler and Sherry A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health,* January 2003 . State MSP take-up rates from 2001 figures in Susan Haber, et. al., "Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs," Volume 1 (Commissioned by the Centers for Medicare and Medicaid Services, October 2003). Estimates do not include QI-1.

*** Medicare Savings Programs employ the SSI methodology for counting assets, but states can adopt more liberal rules.

****From 1999-2001 Arizona MSPs experienced a 4% increase in enrollment after instituting practices to promote enrollment, while the national mean increase was 2%.