Making Medicare+Choice Real: Understanding and Meeting the Information Needs of Beneficiaries at the Local Level

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EXECUTIVE SUMMARY

The Balanced Budget Act (BBA) of 1997 created the Medicare+Choice program, one of the most dramatic changes in Medicare policy in the past 30 years. This legislation sought to do more than promote managed care to the Medicare program. It was designed to create a market-based insurance system that would enable beneficiaries to choose among a variety of competing public and private insurance products for their Medicare coverage rather than to simply receive a government-designed package of benefits. Such a system, however, requires educated “consumers,” not just “beneficiaries,” and therefore needs educational efforts to provide information to help beneficiaries make informed choices. To facilitate this, the legislation included provisions for federal, state, and local activities to educate beneficiaries about the options they have and the implications of selecting from among their various options.

THIS REPORT EXAMINES HOW “CHOICE” TRANSLATES INTO ACTUAL OPTIONS FOR MEDICARE BENEFICIARIES

The focus of this report is on the implementation of the Medicare+Choice program at the local level. It reports on the view of Medicare+Choice (“M+C”) from the perspective of those in six communities around the country. Health care, like politics, is local. Medicare beneficiaries do not make their choices in the abstract. Rather, they choose among the physicians, hospitals, and health plans that are available where they live. Therefore, a local “lens” must be used to study choice among Medicare options, because that is how beneficiaries see it. Only by understanding how M+C is being implemented and experienced on the local level is it possible to understand whether, and why, it is working or failing to meet its goals.

This study is part of the larger research effort “Monitoring of Medicare+Choice: Early Effects on the Insurance Decision Process of Medicare Beneficiaries,” sponsored by the Robert Wood Johnson Foundation. This effort includes targeted studies of M+C in six communities around the country, a national survey of 6,500 Medicare beneficiaries in spring 2000 (with over sampling of key “vulnerable” subgroups within the beneficiary population), and several education and dissemination efforts.

¹The survey took place in spring 2000 and the data are currently being analyzed. One report on the impact of M+C MCO plan withdrawals has been released (Gold and Justh 2000).
In order to explore how Medicare “choices” look to beneficiaries, we visited six communities between January and March 2000: Albuquerque, New Mexico; Baltimore, Maryland; Detroit, Michigan; New Orleans, Louisiana; Orange County, California; and Orlando, Florida. The site visits were designed to obtain detailed insights about the impact of the BBA changes from those on the “front lines.” The study team met with a range of stakeholders, including insurance counselors (formally known as State Health Insurance Assistance Programs, or SHIPs); state and federal officials responsible for elder affairs or health care policy; managed care plans; large employers; labor unions; advocacy groups for seniors and/or minority communities; health care providers; and consumer groups. Our aim was to understand the experience of these knowledgeable stakeholders with M+C. We sought their insights on how beneficiaries are faring and asked them to identify new M+C policy initiatives that could foster more informed choices.

- This report focuses on several questions:

- What choices actually exist in the Medicare+Choice? We know that, nationwide, few of the new choice options authorized by the BBA legislation have materialized, even as some longstanding HMO plans have withdrawn from the program? Given these limitations, what options do most beneficiaries have to consider?

- Have Medicare beneficiaries embraced the idea of choice? How well do beneficiaries understand their choices?

- What information do beneficiaries actually want and need in order to make their choices?

- What information is being disseminated to help them make their decisions?

- How adequate is the infrastructure that provides the information to support these needs?

- How are vulnerable subpopulations of Medicare beneficiaries--the disabled, the low literate, and ethnic and racial minorities--faring under M+C?

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2When we began our visits in January 2000, there was only one operational PSO (in Albuquerque), no PPOs (other than those under demonstration authority for Medicare), and no private fee-for-service plans or MSAs. Starting July 1, 2000, a private fee-for-service option is being offered in all or a portion of 17 states, mostly in areas without other M+C options. In 1999, 97 Medicare managed care plans terminated contracts or reduced their service areas, affecting 407,000 enrollees. In 2000, 99 plans withdrew, affecting 327,000 enrollees (Kornfield and Gold 1999).

Executive Summary
CHOOSING AMONG MEDICARE OPTIONS IS DIFFICULT FOR MOST BENEFICIARIES

With some exceptions, most beneficiaries do not understand the basics of the Medicare program and Medicare+Choice. In every community, interviewees overwhelmingly reported that most beneficiaries do not understand the basics of the Medicare program. Educators, advocates, and some M+C managed care plans agree that beneficiaries understand very little about how original fee-for-service Medicare works or the differences between managed care and fee-for-service. Without such basic knowledge, most beneficiaries are unable to understand how the M+C program might affect them or how to obtain information necessary for making appropriate decisions. “They know so little about Medicare that they don’t know what questions to ask,” stated one educator in Albuquerque.

Not all beneficiaries are equally prepared to make choices. The six communities are home to various subgroups that seek information and make decisions in different ways. Nearly one-quarter of all Medicare beneficiaries have cognitive impairments (more than half of all beneficiaries younger than age 65 and over 85 years old have cognitive difficulties) (Kaiser Family Foundation 1999b). Two-thirds have multiple medical conditions that further complicate their ability to make decisions (Huffman et al. 1996). In addition, many beneficiaries confront literacy barriers. Of those older than 60, 39 to 47 percent score at the lowest levels of literacy (National Center for Education Statistics 1996).

Minorities often have different cultural and community values (and language barriers) that have consequences for how these subpopulations access and understand information. For example, in the sizable minority communities in Albuquerque, Baltimore, and Detroit, minorities generally do not actively seek information about public programs, including Medicare, until a trusted community member has had a successful experience learning about these programs or has received public benefits. Such communities are therefore more difficult to reach and thus less likely to receive information that can help them make appropriate decisions.

BENEFICIARIES FACE A COMPLEX SET OF CHOICES, MORE COMPLICATED THAN MANY NATIONAL POLICYMAKERS HAVE CONSIDERED

Even when beneficiaries acquire enough knowledge to want to make choices, they face a formidable task. Medicare beneficiaries, or new retirees, confront a very complicated array of options. Beneficiaries have to sort through a set of options that differ greatly based on their income, retiree benefits from prior employment, health status, and geographical location. They have to balance considerations of cost and coverage, while riding the changes in health status that inevitably emerge in old age. All this makes for a much more complicated picture than would first appear. The number and range of choices that beneficiaries face vary on the basis of personal and geographic considerations. Beneficiaries who qualify for group retiree benefits or Medicaid typically have access to more comprehensive benefits at lower cost than those in the individual market. They often have more limited or just different choices, but they may also benefit from the preliminary sorting and evaluation of options that employers or state governments undertake before offering choices. Only some individuals, however, have access to group benefits; eligibility depends on the history of their employment or that of their spouse.
Lower-income beneficiaries could qualify for coverage through Medicaid and related options like the Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) Programs. To qualify, however, beneficiaries must know the programs exist and must apply and be willing to assume the possible stigma of receiving benefits through a means-tested program.

Most beneficiaries who do not have access to either retiree insurance or Medicaid must decide if they want to purchase insurance to supplement their basic Medicare. Most beneficiaries want supplemental coverage because basic Medicare does not cover some major expenses, such as Medicare’s cost sharing (for example, physician coinsurance) and prescription drugs. Beneficiaries can obtain supplemental coverage by purchasing individual insurance (known as Medigap policies) or by enrolling in M+C managed care plans, which often cover expenses not covered by traditional Medicare. The choice of Medigap policies can be complicated because the options may not provide what beneficiaries want or can afford, and not all 10 standardized Medigap plans are available in all markets. Choice is also complicated when deciding among M+C MCOs. Almost all beneficiaries have multiple M+C MCO choices in the six markets we studied, ranging from 3 in Albuquerque to 10 in Orange County, California. Thus, Medicare beneficiaries face a complex array of choices beyond simply whether to choose an M+C plan (and if so, which one), but also must weigh their M+C plan options against other options for supplemental coverage.

**CHOICES ARE OFTEN UNSTABLE, AS MARKET VOLATILITY COMPlicates BENEFiciary DECISION MAKING AND INCREASES BENEFICIARY CONFUSION**

M+C options have not been stable during the period we studied (1998-2000); changes in both the number of MCOs offered and in the benefit design have occurred in most markets. From 1998 to 2000, all but one of the markets we studied (Detroit) experienced changes in M+C MCO choice, although each market had at least three M+C MCO choices. These changes included exits from and entries to the market, selective service area reductions and closed enrollments, as well as numerous changes in benefits coverage. Even beneficiaries in markets with an apparently stable number of M+C MCOs faced changes in options due to entries and exits that balanced each other out and were masked by comparisons using aggregate numbers.

Market volatility is not only a function of changes in MCO participation in the market. Provider networks also often change, as subgroups of providers or whole systems terminate their participation with specific health plans. This means that beneficiaries cannot just make a choice and put the decision behind them because their M+C MCO may lose providers with which they currently have relationships. As a result, beneficiaries may need to revisit their choices even if their M+C MCO stays in the market. Benefits, too, may represent a source of constant confusion because of annual alterations. M+C MCOs often alter the scope of supplemental benefits, such as prescription drug coverage. These benefit changes may be nuances, such as changes in formularies, but they are difficult for Medicare beneficiaries to comprehend, and they further complicate their choices.
BEFICIARY PREFERENCES FOR LEARNING CREATE CHALLENGES FOR MEDICARE EDUCATION

Since 1998, a varied set of information intermediaries has emerged in the six markets we visited. There is an evolving infrastructure that uses workshops, printed materials, mass media, telephone hotlines, and individual counseling to raise the level of knowledge about the Medicare program and the choices available to beneficiaries. The information preferences of beneficiaries, however, provide definite challenges to those trying to educate them about the Medicare program.

Information should be broad in scope, yet specific in details. Medicare beneficiaries who have come into contact with information intermediaries generally require that education about M+C issues begin with a broad explanation of the basic features of the entire Medicare programs. Beneficiaries need an explanation of both traditional Medicare as well as M+C in order to provide the context for choosing among the various options. At the same time, however, beneficiaries request specific, often fine, details about particular aspects of the Medicare program in order to tie the general information to their personal circumstances. Similarly, beneficiaries request information about specific local institutions as a way of grounding the abstract information about insurance options into their own understanding of the network of medical providers in their communities.

Beneficiaries are able to absorb only moderate amounts of information at a time. Information needs to be divided into small units that can be absorbed easily. Beneficiaries prefer to return to the information on subsequent occasions. Because beneficiaries often do not grasp all the information necessary at the initial encounter, they need to see the information several times.

Beneficiaries seem to prefer to receive Medicare information from personal contact with a Medicare educator rather than solely from written materials. They want information to be explained and tailored to their particular situation and regard written information as merely preliminary to learning.

Most beneficiaries seek information only when they have a problem. “Problems” include changes in circumstances due to both internal and external events, such as retirement, a change in health status, or external events such as MCO withdrawals. The information that beneficiaries seek during a crisis can differ from the beneficiary’s long-term needs (such as a comparison of out-of-pocket costs or prescription drug formularies), but beneficiaries are less likely to seek out information for these more important concerns.

TURNING BENEFICIARIES INTO INFORMED CONSUMERS REQUIRES THE DEVELOPMENT OF AN EDUCATIONAL INFRASTRUCTURE TO PROVIDE BENEFICIARIES WITH THE INFORMATION NECESSARY TO MAKE INFORMED CHOICES

Medicare education on the local level is not widespread. In contrast to the hopes and expectations expressed during the initial stages of the M+C program, Medicare education has
not become a major activity for most aging and health care organizations. Locally, Medicare education is carried out by a relatively small number of organizations in any one market. A core set of organizations plays active roles in each site, usually (although not uniformly) consisting of the local SHIP, the local Area Agency on Aging (if it was not the host to the SHIP), the M+C MCOs themselves, the Regional Office of HCFA, the Part B Carriers (that is, private insurance companies who administer claims for Part B services under original Medicare), and the state department of aging or elder affairs. Three markets had active state departments of insurance, while three markets saw Peer Review Organizations actively involved in Medicare education. This information infrastructure is marked by the gap between community-based and health plan information intermediaries. Cooperation between the two sides is relatively rare, with most education occurring along parallel, not intersecting, paths.

Many organizations thought to be likely “Medicare educators” do not actually provide much education. Only a few consumer or patient organizations are involved in Medicare education. Traditional health care providers—hospitals and physicians—are only minimally involved in Medicare education, though there are exceptions. Advocacy organizations that represent vulnerable beneficiaries, such as ethnic minorities, the disabled, or the low literate, are rarely actively involved in providing Medicare education (although they often host the efforts of others). Several reasons explain this lack of involvement. Most physicians and hospitals we spoke with pointed to the growing pressure for providing care within strict time limits and reduced or stationary reimbursements that limit their capacity to spend time educating their patients about insurance issues. Representatives from community-based organizations indicated that their organizations’ financial and political resources were too limited to spend much time educating their members about Medicare. Many of these groups focus on issues of interest to their members that are present across the entire life-span or, in the case of some organizations serving low-income ethnic communities, on their clients’ immediate financial and legal needs. They do not have the extensive resources to devote the needs of only part of their community.

**Despite increased need for Medicare education, most information intermediaries have received few additional resources to fulfill their responsibilities.** SHIPs, and to some extent PROs, are the exceptions to this statement, receiving additional federal and state funding (through funds for insurance counseling and aging services). This funding is relatively minimal, however. Local SHIPs report additional grants of only $5,000 to $10,000 for a year. In a few instances, local foundations have contributed funds for various types of Medicare education. In general, however, the local infrastructure has received few additional financial resources for Medicare education.

Probably because no additional funding has been forthcoming, most intermediaries have not made many staffing changes or reallocated large amounts of resources to handle Medicare education. This has limited the effort invested into Medicare education. Existing funds have simply been stretched to encompass the newer activities. For most, Medicare education is a sideline or just one of several activities. With the exception of the SHIPs, many intermediaries have simply added new modules to their standard informational presentations or produced an additional brochure or two.

*Executive Summary*
MEDICARE CAN BE MADE MORE COMPREHENSIBLE TO BENEFICIARIES

Many information intermediaries as well as policymakers have begun to grapple with the issues involved with the gap between the needs and preferences of beneficiaries and the resources and practices of Medicare educators. There are several strategies that could be implemented to begin to bridge those gaps.

Reduce reliance on the across-the-board approach that tries to reach all beneficiaries with large amounts of information. Policymakers and information intermediaries might consider investing in a strategy that separates outreach from education. This strategy would invest in a comprehensive effort to build as much awareness as possible about the availability of information on Medicare and M+C, while situating much of the actual educational materials in channels that beneficiaries can access at the times they find useful.

Adopt a more streamlined form of outreach to reach those not accessible by conventional methods. The relatively low level of contact between information intermediaries and organizations representing ethnic, disabled and other distinctive communities should be increased in order to develop new channels of information dissemination and education.

Create a new type of referral structure that can assist beneficiaries at teachable moments. Intermediaries and policymakers should develop ways to reach the beneficiaries undergoing the types of crises that force them to learn about their Medicare options. The professionals who assist beneficiaries during these teachable moments should be trained to refer them to the appropriate information intermediaries.

Use new educational techniques that more closely match beneficiary learning preferences. Information intermediaries should be encouraged, and funded, to take advantage of modern theories of adult education and the substantial expertise of public health educators. Greater investment should be made in studying how seniors learn new information and in identifying the best techniques for disseminating information to this specific audience.

CONCLUSIONS: FOUR KEY LESSONS ON THE CHALLENGES CONFRONTING THE IMPLEMENTATION OF M+C

We can draw several tentative lessons about the challenges involved in implementing the M+C model. The first lesson is that getting information across to consumers is hard; getting complicated insurance concepts across to the average American is even harder. Most information intermediaries report that beneficiaries have little prior knowledge of how Medicare works, and only those who have lived in areas where managed care has been in place for several years know much about managed care.

The second and related lesson is that education takes time and money. Educating Medicare beneficiaries takes many hours and lots of resources to explain the concepts and apply them to individual circumstances. Effective Medicare education requires teachers, counselors, website designers, graphic artists, editors, translators, and peers. This all costs money. Even unpaid volunteers require training. The educational agencies in our six markets tend to be small,
usually one or two part-time paid staff and assorted volunteers. Most have little or no funding for Medicare education. To improve the capacity of beneficiaries to make choices, more resources need to be generated. This could involve increased federal funding, larger contributions from state and local governments, foundation grants, or greater participation from the private sector (such as employers or unions); but no matter the source, to see more effective education increased resources will need to flow to those activities.

The third lesson is that national-level policymakers need to be more sensitive to the ways that theoretical systems play out at the local level. From the perspective of both beneficiaries and local educators, the Medicare market is hopelessly fragmented with many more complex choices than national policymakers have considered. The Medigap insurance market has 10 options and numerous insurance companies offering policies. The M+C market is volatile, with Medicare managed care plans withdrawing or reducing service areas yearly. The variety of choices means that individuals can find options that suit their needs, but the price of educating them about these many options is quite high. Moreover, the gap between national policy and local reality is growing, as the choices promised in the original legislation fail to appear and those that have appeared are now withdrawing. There is an inconsistency between the interest of Congress in promoting choice and what beneficiaries see and understand on the ground.

The fourth lesson is that education can solve only part of the problem. A small group of intermediaries with few resources are trying to educate a lot of beneficiaries with varying needs about an extremely complicated program. Improving education should help many beneficiaries make informed choices, but it is not enough. Policymakers need to have realistic expectations of what education can do and the limits of even the most successful education program. Education cannot make choices more stable or more simple.

Since 1998, a varied set of Medicare insurance choices has emerged in most of the six sites we visited, expanding in some places and contracting in others. The range of choices is much more complex than that envisioned by the BBA’s creators. Meanwhile, the campaigns to educate beneficiaries about all these considerations are still evolving. M+C MCOs, information intermediaries, and government officials alike, however, have only just begun to learn about the needs and preferences of beneficiaries, the most effective educational techniques, and the importance of differences within the general Medicare beneficiary population. They have only just begun to determine the best ways to transform “beneficiaries” into “consumers.”
CHAPTER I

INTRODUCTION

The Balanced Budget Act (BBA) of 1997 created the Medicare+Choice program, one of the most dramatic changes in Medicare policy implemented during the past 30 years. The aim of this new program (hereafter referred to as M+C) is to expand the number and types of plans that provide insurance to Medicare beneficiaries. The new plans represent innovations in financing and delivering care that have developed since Medicare was first designed. The authorized options include health maintenance organizations (HMOs) and preferred provider organizations (PPOs), as well as newer experiments, such as provider-sponsored organizations (PSOs), private fee-for-service plans, and medical savings accounts. The Medicare+Choice program, as its name implies, is designed to give the nation's senior and disabled population covered by Medicare more choice, allowing them to choose among this varied set of health insurance plans for their Medicare coverage. To facilitate the process of making decisions and to assist beneficiaries in making choices appropriate to their needs, the legislation included provisions for federal, state, and local activities to educate beneficiaries about the options they have and the implications of selecting from among those options.

THIS REPORT EXAMINES THE WAY LEGISLATED “CHOICE” TRANSLATES INTO ACTUAL CHOICES FOR MEDICARE BENEFICIARIES

What choices actually exist in the Medicare+Choice Program? We know that nationwide, few of the new choice options authorized by the BBA legislation, such as PPOs, PSOs, private fee-for-service insurance plans, and medical savings accounts, have materialized, while some longstanding HMO plans have withdrawn from the program.1 Have Medicare beneficiaries embraced the idea of choice? Do beneficiaries actively seek out the available options, or do they

1When we began our visits in January 2000, there was only one operational PSO (in Albuquerque), no PPOs (other than those under demonstration authority for Medicare), and no private insurance options or MSAs. Starting July 1, 2000, a private insurance option is being offered in all or a portion of 17 states, mostly in areas without other M+C options. In 1999, 97 Medicare managed care plans terminated contracts or reduced their service areas, affecting 407,000 enrollees. In 2000, 99 plans withdrew, affecting 327,000 enrollees (Kornfield and Gold 1999). In 2001, 65 M+C MCOs chose to not renew their M+C contracts and 53 plans reduced their service areas, affecting more than 934,000 Medicare beneficiaries (Health Care Financing Administration 2000b).
stick with the familiar? What information do beneficiaries actually need, and what information do they want, in order to make their choices? Is information on the price and content of each option enough? Or, do beneficiaries want information on the quality of care? Finally, what information is being disseminated to Medicare beneficiaries to help them make their decisions? How adequate is the infrastructure that provides the information to support these needs?

Implementation of the M+C program is a complex task; its success is not necessarily an automatic conclusion. The process that transforms Medicare options into beneficiary decisions has several stages and incorporates many factors (see Figure 1.1).

Choosing among a set of complicated insurance options requires that Medicare beneficiaries understand how original fee-for-service Medicare works, and how the new managed care options differ from the traditional program. Research shows, however, that even before the BBA, Medicare beneficiaries had only a poor understanding of the Medicare program (Blendon et al. 1995; Hibbard and Jewett 1998; and Murray and Shatto 1998). One-third reported knowing little about Medicare benefits and out-of-pocket payments, 40 percent knew little about private supplemental policies, and one-third did not understand the right to appeal a payment or a coverage decision (Hash 1998). Moreover, as many as 30 percent of Medicare beneficiaries knew almost nothing about HMOs, and only 11 percent had sufficient knowledge of the differences between fee-for-service and managed care to make an informed choice between the two options (Hibbard et al. 1998).

Furthermore, not all beneficiaries are equally prepared to participate in the M+C system. Medicare beneficiaries are a diverse group that includes particularly vulnerable subpopulations. Compared with Medicare beneficiaries as a whole, these subpopulations are more likely to have trouble choosing among complex options because their education or cognitive functioning are limited, English is not their primary language, their needs for insurance are complex, or simply because they lack access to information. Thirteen percent of Medicare beneficiaries are younger than age 65 and generally severely disabled (Olin et al. 1999) while about 12 percent are 85 or older (Kaiser Family Foundation 1999a). Nearly one-quarter of all Medicare beneficiaries have cognitive impairments (more than half of all beneficiaries both younger than age 65 and older than age 85 have cognitive difficulties (Kaiser Family Foundation 1999b). Two-thirds have multiple medical conditions that further complicate their ability to make decisions (Huffman et al. 1996). In addition, many beneficiaries confront language or literacy barriers. Of those older than age 60, 39 to 47 percent score at the lowest levels of literacy (National Center for Education Statistics 1996). Today, racial and ethnic minorities account for 16 percent of the Medicare population, a proportion that will double by 2025 (Kaiser Family Foundation 1999a). For these groups, language and cultural differences can create barriers to effective decision making.

Many Medicare beneficiaries have reason to be concerned about the options available to them. Nearly half have incomes below 200 percent of the year 2000 poverty level of $8,350 for a one-person family (Federal Register 2000). In particular, 63 percent of the under-65 disabled, 65 percent of African Americans, 66 percent of Hispanics, 59 percent of those 85 years of age or older, and 51 percent of women have incomes less than this near poverty level (Kaiser Family Foundation 1999b). Not all beneficiaries come to their decisions with equal

1: Introduction
FIGURE 1.1
THE PROCESS THAT TRANSFORMS
MEDICARE OPTIONS INTO DECISIONS

Medicare+Choice Options → Beneficiaries

External Events
  e.g. plan withdrawals

Media Reporting

Beneficiary Information Needs

Internal Events
  e.g. change in marital status

Salience of Medicare to beneficiary

Beneficiary Information Needs

Medicare Education
  - Advertising
  - Print Materials
  - Presentations
  - Counseling

Beneficiary Decision

Information Infrastructure

HCFA
SHIPs
Health Plans
Employers
Community-based Organizations
Family and Friends

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resources—cognitive, financial, or cultural—to make those decisions. Because beneficiaries are such a diverse group with numerous vulnerabilities, monitoring implementation of M+C and exploring its impact on beneficiaries is critical.

THE STUDY

This report offers one avenue to understanding the impact of the M+C program by focusing on implementation on the community level. Health care, like politics, is local. Medicare beneficiaries do not explore their options or make their choices in the abstract. Rather, they choose among the physicians, hospitals, and health plans that are available where they live and, generally who they might know. In other words, the plans and providers they consider are located and operate in the communities in which beneficiaries live and work. Therefore, a local “lens” must be used to study choice among Medicare options, because that is how beneficiaries see it. Only by understanding how M+C is being implemented and experienced on the local level is it possible to understand whether and why it is working or failing to meet its goals.

The study of the implementation of M+C on the local level is part of a larger research effort, “Monitoring of Medicare+Choice: Early Effects on the Insurance Decision Process of Medicare Beneficiaries” that the Robert Wood Johnson Foundation has sponsored since 1999. This effort includes several components: a national beneficiary survey of 6,500 Medicare beneficiaries in Spring 2000 (with oversampling of key “vulnerable” subgroups within the beneficiary population), targeted studies of M+C in six communities around the country (with a corresponding oversampling of 750 residents in those communities in the national survey), and several education and dissemination efforts. The study seeks to answer several questions:

• What options are open to Medicare beneficiaries, and are they changing? To what extent are the legislated insurance options available to beneficiaries in specific markets?

• How well do beneficiaries understand their choices?

• How do beneficiaries make their decisions? Who do they ask for assistance?

• Who provides information to beneficiaries?

• How adequate is the infrastructure of information intermediaries at providing beneficiaries with accurate and useful information?

• How are vulnerable subpopulations of Medicare beneficiaries—the disabled, the low literate, and ethnic and racial minorities—farin under M+C?

The national survey focuses on the impact of M+C on individual Medicare beneficiaries. It explores the sources of information beneficiaries used in making their M+C decisions and the factors that they take into account while making their decisions.²

²The survey took place in spring 2000, and the data are now being analyzed. One report on the impact of M+C MCO plan withdrawals has been released. See Gold and Justh (2000).
To begin to answer these questions, we visited the following six communities between January and March 2000: (1) Albuquerque, NM; (2) Baltimore, MD; (3) Detroit, MI; (4) New Orleans, LA; (5) Orange County, CA; and (6) Orlando, FL. The visits were designed to obtain detailed insights about the impact of the BBA changes from those on the “front lines” of communities across the nation. Project teams of two staffers spent four days in each community, holding discussions with a range of stakeholders, including organizations or agencies devoted to seniors, disabled insurance information counselors (formally known as State Health Insurance Assistance Programs, or SHIPs); state and federal officials responsible for elder affairs or health care delivery; managed care plans; large employers; labor unions; advocacy groups for seniors and/or minority communities; and consumer groups. Our aim was to understand the experience of these knowledgeable stakeholders with M+C. We sought their insights on how beneficiaries are faring under the programs, and their identification of which M+C policy initiatives can foster more informed choices.

OVERVIEW OF THE SIX COMMUNITIES

The following overview of the six markets highlights key characteristics that are important to understanding the implementation of M+C, its impact on beneficiaries, and the organizations that educate beneficiaries. The six study sites are a diverse mix of Medicare communities (Mittler and Gold 2000). They were selected because all had experience with Medicare managed care, as measured by the level and duration of Medicare managed care enrollment. The communities also were selected to reflect different levels of stability of the market (for example, the number of managed care plan withdrawals, mergers, or entries); different Medicare capitation payment rates; ethnic diversity; mix of employers and unions; and geographic representation (see Appendix A for summaries of each site). This variation was used to help us explore the range of community experiences with M+C and, especially, the experiences of vulnerable populations.

Each of the six communities is defined officially by its Metropolitan Statistical Area (MSA) (Table I.1). However, MSAs tend to be large and diverse, so our site visits focused on the core of the communities and on some important subareas, such as those with concentrations of vulnerable populations or that had experienced change (for example, in Medicare managed care plans). This narrowed focus is important because the MSAs often differ as much within themselves as they do across MSAs. The number of counties in each MSA ranges from one to eight. We found that the greater the number of counties included in the MSA, the higher the probability that demographics will differ within it, especially in the case of ethnic and low-income populations. For example, the population of the Baltimore MSA (consisting of seven counties) is about three-quarters white, but the center county (Baltimore City) is about 60 percent African American. In New Orleans (eight counties), Orleans and Jefferson parishes have larger and older beneficiary populations than do the other parishes in the MSA.

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TABLE I.1
METROPOLITAN STATISTICAL AREA DEFINITIONS
OF THE SIX COMMUNITIES

<table>
<thead>
<tr>
<th>Community</th>
<th>Number of Counties</th>
<th>County Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>3</td>
<td>Bernallilo, Sandoval, and Valencia</td>
</tr>
<tr>
<td>Baltimore</td>
<td>7</td>
<td>Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, Howard, and Queen Anne’s</td>
</tr>
<tr>
<td>Detroit</td>
<td>7</td>
<td>Lapeer, Livingston, Macomb, Monroe, Oakland, St. Clair, and Wayne</td>
</tr>
<tr>
<td>New Orleans</td>
<td>8</td>
<td>Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, and St. Tammany Parishes¹</td>
</tr>
<tr>
<td>Orange County</td>
<td>1</td>
<td>Orange County</td>
</tr>
<tr>
<td>Orlando</td>
<td>4</td>
<td>Lake, Orange, Osceola, and Seminole</td>
</tr>
</tbody>
</table>

¹In Louisiana, parishes are the equivalent of counties.

All the sites we selected are urban, reflecting the predominantly urban locations in which Medicare managed care operates. Nevertheless, we used the site visits to learn about the experiences of less-urban, sometimes quite rural areas, that are part of the various MSA definitions (such as St. Anne’s County in Baltimore, which is part of Maryland’s rural Eastern Shore) and the parishes outside the core New Orleans city.

Part of the reason we selected these sites was because collectively they enabled us to explore the different experiences of diverse vulnerable subpopulations. The age composition across all six sites is roughly the same; in each MSA, 11 to 13 percent of the population was Medicare eligible as of September 1999 (that is, was older than age 65) (HCFA 1999e). About nine percent of the elderly in each site were 85 years or older in 1990, a common benchmark for the age at which members of this population experience health changes that render them more likely to be frail (Table I.2). In contrast, there is considerable diversity in the racial mix of the six sites. Nationally, 80 percent of the entire population (i.e., both aged and younger) is white, 12 percent is African American, and 8 percent is from other racial/ethnic groups (Table I.2). In New Orleans and Orlando, in contrast, more than one-quarter of the population is African American. Twenty percent of beneficiaries in Orange County and Albuquerque are people of color, with large portions of that segment consisting respectively of Asians and Native Americans. (In Orange County, 10 percent of residents are Asian; in Albuquerque, 3 percent are Native American.) Hispanics make up 23 percent of the population of Orange County and 37 percent of Albuquerque, compared with 9 percent nationally. In Albuquerque, Detroit, and Orange County, at least 15 percent of the population speaks a language other than English in

1: Introduction
<table>
<thead>
<tr>
<th>National Average</th>
<th>Albuquerque</th>
<th>Baltimore</th>
<th>Detroit</th>
<th>New Orleans</th>
<th>Orange Co. (CA)</th>
<th>Orlando</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic location</td>
<td>--</td>
<td>Southwest</td>
<td>East</td>
<td>Midwest</td>
<td>South</td>
<td>West</td>
</tr>
<tr>
<td>Number of counties in MSA</td>
<td>--</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Population&lt;sup&gt;a&lt;/sup&gt;</td>
<td>270,248,000</td>
<td>678,633</td>
<td>2,483,952</td>
<td>4,473,853</td>
<td>1,309,445</td>
<td>2,721,701</td>
</tr>
<tr>
<td>Medicare eligible&lt;sup&gt;a&lt;/sup&gt; (Percent)</td>
<td>13%</td>
<td>13%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Seniors &gt; 85 Years (Percent)</td>
<td>8%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Race/Ethnicity (1990)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>80%</td>
<td>77%</td>
<td>72%</td>
<td>77%</td>
<td>62%</td>
<td>79%</td>
</tr>
<tr>
<td>Black</td>
<td>12%</td>
<td>3%</td>
<td>26%</td>
<td>21%</td>
<td>35%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
<td>20%</td>
<td>12%</td>
<td>2%</td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9%</td>
<td>37%</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
<td>23%</td>
</tr>
<tr>
<td>Language those 65 (1990)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speaks only English at home</td>
<td>88%</td>
<td>72%</td>
<td>93%</td>
<td>86%</td>
<td>90%</td>
<td>83%</td>
</tr>
<tr>
<td>Speaks English &quot;not well&quot; or &quot;not at all&quot;</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Disabled (Percent)</td>
<td>12%</td>
<td>13.8%</td>
<td>11.8%</td>
<td>13.6%</td>
<td>16.9%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Income, Those 65 (1990)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% below poverty</td>
<td>12%</td>
<td>10%</td>
<td>11%</td>
<td>10%</td>
<td>18%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<sup>a</sup> MSA population data are from Interstudy Competitive Edge Part III 9.2 (which uses July 1, 1998 estimates of population provided by the U.S. Census Bureau). Medicare eligible data are from HCFA September 1999. Data on the disabled are from the Medicare State and County Enrollment Data, 1998 (HCFA 1999b). The remaining data are from the 1990 U.S. Census.
the home, and 1 to 6 percent do not speak English well or at all. In addition to Spanish speakers, concentrations of other languages exist, such as Creole in New Orleans, Arabic in Detroit, and Vietnamese in Orange County. Studying these sites therefore, permits us to explore the impact of M+C on minority beneficiaries.

In four of the six communities, 10 to 11 percent of seniors are below the federal poverty level, about the national average (U.S. Census Bureau 1990). Orange County has the lowest proportion of seniors living in poverty (5 percent), whereas New Orleans has the highest (18 percent). These figures do not include the seniors and people with disabilities who have incomes that are above the poverty line, but who are still of relatively low income. For example, state personnel estimated that more than 30 percent of Medicare beneficiaries in Albuquerque would qualify on the basis of income for other programs, such as Medicaid.

The six selected communities have substantial numbers of under-65, disabled Medicare beneficiaries, ranging from a high of 16.9 percent of all Medicare beneficiaries in New Orleans to a low of 8.7 percent in Orange County (Health Care Financing Administration 1999b). Four of the sites have rates slightly higher than the national average of 12 percent disabled Medicare beneficiaries (Olin 1999).

counties. The number of participating M+C managed care plans range from 3 in Albuquerque to 10 in Orange County.

While no set of six communities can be representative of the multitude of communities across the United States, the characteristics of the communities chosen for this study can, when combined, present a varied portrait of the multifaceted Medicare beneficiary population and the variety of conditions in which they live. Together they can help us comprehend the ways in which M+C is being implemented on the local level and how beneficiaries are experiencing this dramatic change in the Medicare program.

ORGANIZATION OF THE REPORT

The remainder of this report is organized into four chapters. Chapter Two focuses on what choice looks like to beneficiaries at the local level. We discuss the numerous combinations of Medicare options available to beneficiaries, in particular, original Medicare, supplemental (or Medigap) insurance, employer-sponsored supplemental insurance, Medicaid, and M+C plans. In Chapter Three we discuss what we have learned about beneficiaries’ information needs and desires, what motivates beneficiaries to seek information, and whether there are any differences by subpopulation. In Chapter Four, we examine the “information infrastructure” (that is, the organizations and programs that provide information and education about Medicare and M+C to beneficiaries). We describe the different components of the information infrastructure, the kinds of Medicare education this infrastructure provides, and how beneficiary education is faring under M+C. Finally, in Chapter Five we draw from all that we have learned in this study to discuss the key policy and operational findings about whether and how communities can successfully facilitate beneficiaries’ informed and appropriate choice, a necessary element in making M+C actually work.

I: Introduction
We will argue that beneficiaries’ demands for information are complex. Beneficiaries want information to be broad yet detailed, consistent yet from a variety of independent sources, available continuously, and in small increments. Medicare educators report that it is difficult to provide information with these characteristics. Moreover, the information needed for decision-making is difficult to disseminate. Information about Medicare and M+C is filled with unfamiliar concepts, requires the ability to distinguish among numerous details, and features that are packaged into competing products. These products, in turn, are frequently changing in terms of their price and what they cover. Each year some choices may withdraw from the market, while other options never emerge as promised.

The information infrastructure, while trying valiantly to respond to these difficult conditions, is severely hampered by a lack of critical financial, technological, and organizational resources needed to educate beneficiaries. These limited resources restrict most information intermediaries to a limited number of educational techniques that disseminate information to only part of the beneficiary population. Moreover, much of that education is oriented to the “generic” beneficiary, rather than to beneficiaries with distinctive needs.

As a result, much of the current Medicare education falls short of creating an informed beneficiary population that can sort through their complicated choices in order to make appropriate decisions about their health care coverage. If Medicare beneficiaries are to make informed decisions, federal policymakers will have to develop additional resources to close the critical gaps in Medicare education. They also may need to consider how to make choice more easily managed for Medicare beneficiaries, such as by reducing the instability in the number and types of choices that beneficiaries must master.

I: Introduction
CHAPTER II

WHAT DOES BENEFICIARY CHOICE LOOK LIKE AT THE MARKET LEVEL?

Beneficiaries face a complex set of choices. How many choices and how different they are varies on the basis of personal and geographic considerations. No matter what the considerations are, however, the choices facing most Medicare beneficiaries are much more complex than most policymakers envision.

Most beneficiaries need and want some coverage to supplement basic Medicare since it does not cover some major expenses, such as Medicare’s cost sharing (e.g., physician co-insurance, hospital deductibles and skilled nursing facility coinsurance) and prescription drugs. Options for supplemental coverage depend on whether beneficiaries are part of the individual market, which is open to everyone, or can access subsidized coverage through the group market or through Medicaid. These basic divisions govern how individual beneficiaries interpret choice.

Two common circumstances also affect choice: (1) a prior relationship with a provider and (2) the timing of the choice and whether it is made voluntarily or because of the influence of external circumstances. The choices of beneficiaries who want to maintain relationships with their providers will be limited if one or more of their providers participate only in a subset of M+C managed care organizations (MCOs)—or do not participate at all. A beneficiary who turns 65 must make a choice within a certain period or lose rights to some coverage options (for example, Medigap) or pay a penalty to obtain others (such as Part B). Similarly, Medicare beneficiaries who retire might have to choose employer coverage by a certain date or lose some options. Beneficiaries in these situations must choose from the options available at the time. They cannot postpone their decision until a more attractive option becomes available. Otherwise, beneficiaries may decide voluntarily to review their choices, but they are not forced to make a choice unless their M+C MCO plan withdraws or their income changes.1

In this chapter, we describe what choice looks like to beneficiaries from the three subgroup perspectives: (1) the individual market, (2) the group market, and (3) Medicaid. We will argue that the range of factors that beneficiaries must consider in order to make their choice is much

1On January 1, 2002, “lock-in” provisions are scheduled to take effect, meaning that beneficiaries will be allowed to disenroll or switch once among M+C MCOs only during the first six months of the year. From 2003 on, beneficiaries can do so only during the first three months of the year. Limited exceptions are specified in the 1997 BBA legislation.
more complicated than most people realize. We begin with the individual market, which was most actively involved with the M+C program, and then describe how beneficiary choice changes when coverage is obtained through the group market or the Medicaid program. (Note that the group and Medicaid markets had weaker ties with the M+C program, with some exceptions, and therefore were more difficult to characterize during our site visits. Nevertheless, because they are important components of the market, we present what we learned. Concise market descriptions are also included as part of the site summaries in Appendix A.)

A key constraint on community studies on this topic rests in the very limited data on coverage in individual markets. We are fortunate that this study includes a companion survey that provides estimates for our six markets that can help place the community visits in context. Figure II.1 uses this data to break down types of coverage beneficiaries have in our six sites.

**INDIVIDUAL MARKET OPTIONS: MEDIGAP AND M+C MCOs**

Beneficiaries typically want coverage for benefits to supplement or complement basic fee-for-service Medicare, such as prescription drugs, vision care, or dental care. Many also want additional coverage to help reduce copayments and deductibles. In the individual market, beneficiaries have two options: (1) to buy a Medigap policy to supplement original Medicare, or (2) to enroll in an M+C option.

**Medigap Policies Are Available, but Options May Not Provide What Beneficiaries Want or Can Afford**

Medigap supplemental coverage, available in all markets, is a popular option with beneficiaries who want to choose among providers and get additional benefits, including some coverage of copayments, deductibles, more hospital days, emergency care in foreign countries, and prescription drugs. As shown in Appendix B, the 10 standard Medigap plans (A-J) provide different combinations of supplemental benefits, becoming more generous with the ascending plan letter. Thus, plans H, I and J provide some prescription drug coverage. H and I provide up to $1,250 of prescription drug coverage; plan J offers $3,000. Not all packages are available in all markets. In the six markets we studied, packages A, B, C, and F are the most widely available (all insurers offering Medigap policies must offer A), with C and F reportedly the most popular in terms of enrollment (Quotesmith 2000). Policies with some prescription drug coverage (H, I, and J) are offered by only a few companies in each of the six markets. In Albuquerque and Detroit, plans F and J are also available with a high-deductible option.

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2A report of our survey results will be forthcoming December 2000.
<table>
<thead>
<tr>
<th>Source of Coverage&lt;sup&gt;1&lt;/sup&gt;</th>
<th>U.S.</th>
<th>Albuquerque</th>
<th>Baltimore</th>
<th>Detroit</th>
<th>New Orleans</th>
<th>Orange County</th>
<th>Orlando</th>
</tr>
</thead>
<tbody>
<tr>
<td>None&lt;sup&gt;2&lt;/sup&gt;</td>
<td>17.3%</td>
<td>8%</td>
<td>17%</td>
<td>13%</td>
<td>14%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Medicare HMO</td>
<td>16.2</td>
<td>46</td>
<td>22</td>
<td>9</td>
<td>32</td>
<td>48</td>
<td>29</td>
</tr>
<tr>
<td>Group</td>
<td>33.8</td>
<td>38</td>
<td>36</td>
<td>50</td>
<td>36</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Medigap</td>
<td>20.6</td>
<td>13</td>
<td>22</td>
<td>19</td>
<td>17</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>Medicaid</td>
<td>14.3</td>
<td>11</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Military</td>
<td>5.8</td>
<td>8</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Other&lt;sup&gt;3&lt;/sup&gt;</td>
<td>14.1</td>
<td>9</td>
<td>15</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Population in 1000s</td>
<td>34,176</td>
<td>78</td>
<td>303</td>
<td>561</td>
<td>160</td>
<td>255</td>
<td>209</td>
</tr>
</tbody>
</table>


<sup>1</sup>Individuals may have more than one source of coverage so totals do not equal 100 percent. M+C MCO status is based on HCFA records as updated by respondents. Other coverages are based on self report.

<sup>2</sup>Calculated as a residual of those with none of the listed forms of coverage.

<sup>3</sup>Excludes, based on review of responses, coverage for long term care, life insurance; cancer/deadly disease, accident/worker’s compensation, sickness insurance/hospitalization; and single services (e.g., dental, behavioral health). In some cases, responses appear to duplicate other specified coverage.
Beneficiaries are guaranteed enrollment in all Medigap packages offered in their market during the six-month period after their initial enrollment in Medicare Part B. After that, they may be required to undergo a health screening or may be refused coverage (Consumer Reports 2000), though in some states (because of state law) there is no medical underwriting and previous condition limits can be no longer than a specified period. Beneficiaries are also guaranteed enrollment in specified Medigap policies (A, B, C, and F) when their health plan (M+C MCO, private fee-for-service, etc.) withdraws from the market, when they decide to leave the health plan within a year of joining and if they dropped their Medigap plan to join, or they enrolled in a plan at age 65 and left within one year. There are also other circumstances otherwise designated by state law that provide beneficiaries with Medigap protections. These “guarantees,” which are subject to market availability, are not necessarily affordable.

Under federal law, Medigap insurers are not required to sell policies to Medicare beneficiaries younger than age 65, so beneficiaries in this age range have less choice unless their state mandates coverage (Health Care Financing Administration 2000a; Demel et al. 1998). For example, the Maryland legislature mandated that insurers offering plans C and I must make them available to under-65 beneficiaries. In response to this requirement no insurer offered plan I at the time of our visit to Baltimore. Special provisions for the under-65 are not common (Health Care Financing Administration 2000a).

Medigap supplemental policies are costly and unaffordable for many beneficiaries, even though the standardized packages aim to encourage insurers to compete on cost. As shown in Figure II.2, the lowest quotes on the premium for the popular package F for a 65-year-old male across our sites ranged from $909 per year in Albuquerque to $1,602 per year in Orlando (Quotesmith 2000). The highest premium quoted for this package is 50 to 80 percent higher than the lowest quote in each market.

Plans with any prescription drug coverage are considerably more expensive than those that do not provide this benefit. Annual premium quotes for plan H (the Medigap plan with the least generous drug coverage) for a 65-year-old male ranged from a low of $1,368 in Baltimore to a high of $5,323 in Detroit. Within markets, the difference between the lowest and highest quoted premiums for plan H was 5 percent or less in New Orleans and Orange County but was between roughly 150 percent and roughly 270 percent in Albuquerque, Baltimore, and Detroit. (Figure II.2). Unless it is a guaranteed-issue policy, premiums can differ with health status, medical history, or claims experience (traditional underwriting) unless otherwise restricted by a

---

3 Beneficiaries have 63 calendar days after their health coverage ends to apply for a Medigap policy (HCFA 2000f).

4 All quotes for Medigap premiums are for the core county in the MSA. In the six sites, the core counties are Bernalillo County (NM), Wayne County (MI), Baltimore City County (MD), Orange County (CA), Orange County (FL), and Orleans Parish (LA). Quotesmith reports that the premium data quoted is collected directly from the insurance companies.

II: What Does Beneficiary Choice Look Like at the Market Level?
FIGURE II.2

MEDIGAP PRICES FOR A 65-YEAR-OLD MALE

<table>
<thead>
<tr>
<th>Market/County</th>
<th>Low</th>
<th>High</th>
<th>% Difference</th>
<th>Low</th>
<th>High</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque (Bernalillo)</td>
<td>$ 909</td>
<td>$ 1,408</td>
<td>55</td>
<td>$1,416</td>
<td>$3,989</td>
<td>181</td>
</tr>
<tr>
<td>Baltimore (Baltimore City)</td>
<td>1,040</td>
<td>1,662</td>
<td>60</td>
<td>1,368</td>
<td>3,471</td>
<td>153</td>
</tr>
<tr>
<td>Detroit (Wayne)</td>
<td>1,032</td>
<td>1,862</td>
<td>80</td>
<td>1,428</td>
<td>5,323</td>
<td>272</td>
</tr>
<tr>
<td>New Orleans (New Orleans)</td>
<td>1,224</td>
<td>2,245</td>
<td>83</td>
<td>1,707</td>
<td>1,800</td>
<td>5</td>
</tr>
<tr>
<td>Orange County</td>
<td>1,176</td>
<td>2,100</td>
<td>71</td>
<td>1,860</td>
<td>1,896</td>
<td>2</td>
</tr>
<tr>
<td>Orlando (Orange)</td>
<td>1,602</td>
<td>2,391</td>
<td>49</td>
<td>2,213</td>
<td>3,278</td>
<td>48</td>
</tr>
</tbody>
</table>

aData are from Quotesmith.com, July 18, 2000.

A Medigap policy is the only way that many beneficiaries can obtain supplemental benefit coverage if an M+C MCO is not available or after all M+C MCOs have left the market. According to interviewees in the six markets, beneficiaries have expressed real fear that they will be unable to regain access to or afford their Medigap coverage if M+C MCOs leave the market. Although protections guarantee that beneficiaries would be able to obtain Medigap policies A, B, C, or F, these protections do not extend to packages that include prescription drug benefits. Even if they qualify for coverage that includes drugs, the cost may be prohibitive. When M+C MCOs withdrew from the Eastern Shore counties of Maryland at the end of 1998, more than 15,000 beneficiaries were left without prescription drug coverage (American HealthLine 2000). A backlash occurred when many of these beneficiaries could not afford supplemental coverage for prescription drugs, leading the Maryland state legislature to establish a program to temporarily restore the prescription benefits that rural seniors recently lost.

M+C Plan Choices Vary by Where a Beneficiary Lives. While the Set of Choices Is Often Unstable, M+C Plans Have Been an Important Source of Supplemental Benefits at No or Little Cost

M+C MCOs that have entered a market often are a good option to help beneficiaries save money and obtain supplemental benefits because they typically have offered extra benefits as

5Often the value of the increased prescription benefits is less than the higher premiums needed to pay for it because of these selection issues.

6Under this program, seniors pay a $40 monthly premium and a $50 deductible for a $1,000 annual benefit. That is, $530 a year for a $1,000 benefit not including copayments. Copayments per prescription are $10 for generic drugs, $20 for “preferred” brand-name drugs, and $35 for all others. Insurance companies that left the market pay for a bulk of the program, although state money is also used. The program, which is capped at 15,000 members, became effective June 22, 2000 (Salganik 2000).
part of their basic coverage at little or no beneficiary cost. This is true for beneficiaries with no supplemental coverage as well as for those facing supplemental Medigap policies that are unaffordable or that offer insufficient financial protection. Almost all beneficiaries have multiple M+C MCO choices in all six of the markets we studied (Figure II.3). In 2000 the number of participating M+C MCOs ranged from 3 in Albuquerque to 10 in Orange County. All the MCOs are M+C health maintenance organizations (HMOs), with one exception: St. Joseph, in Albuquerque, is the nation’s only M+C provider-sponsored organization (PSO).\(^7\) Albuquerque, Detroit, and New Orleans are dominated by local plans; Baltimore and Orlando are dominated by national firms; and Orange County is dominated by national firms that began in California and therefore are perceived as local MCOs (see Table II.1). The M+C medical savings account option is not offered anywhere in the United States, and the first M+C private fee-for-service plan became operational only in July 2000.\(^8\) (Of the six markets, only Albuquerque will definitely be offered this option (Health Care Financing Administration 2000).

**FIGURE II.3**

PERCENTAGE OF BENEFICIARIES IN THE MARKET WITH CHOICE IN 2000\(^a\)

<table>
<thead>
<tr>
<th>Choice of all MCOs in the MSA</th>
<th>Choice of Four or More MCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>100%</td>
</tr>
<tr>
<td>Baltimore</td>
<td>80</td>
</tr>
<tr>
<td>Detroit</td>
<td>0</td>
</tr>
<tr>
<td>New Orleans</td>
<td>73</td>
</tr>
<tr>
<td>Orange County</td>
<td>100</td>
</tr>
<tr>
<td>Orlando</td>
<td>56</td>
</tr>
</tbody>
</table>

\(^a\)Data are from the Health Care Financing Administration and are weighted by March 2000 eligibles.

A beneficiary’s choice of M+C MCO varies by where in a market a beneficiary lives. Some beneficiaries do not have all the choices, but most have some choice (Figure II.3). In Albuquerque and Orange County, all the choices are available marketwide. In Baltimore, Detroit, and New Orleans, only a subset of beneficiaries has a choice of all the participating M+C MCOs because the M+C MCOs in these markets do not necessarily serve all the markets’

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\(^7\)In a key difference from other MCOs, PSOs may request a one-time three-year waiver of state fiscal solvency standards in favor of federal ones. St. Joseph has informed HCFA that it will stop participating as an M+C PSO in January 2001.

\(^8\)A medical savings account plan has a specified high deductible that applies before Medicare pays for benefits. Medicare deposits the difference between the individual’s capitation rate and the policy’s premium to be used for qualified medical expenses. Residuals can be used for other purposes but are subject to taxes and other withdrawal penalties. A private-fee-for-service plan pays providers on a fee-for-service based without financial risk, and providers can balance bill all beneficiaries up to 15 percent above the plan fee schedule.

**II: What Does Beneficiary Choice Look Like at the Market Level?**
### TABLE II.1
M+C MCOs PARTICIPATING AS OF JANUARY 1, 2000

<table>
<thead>
<tr>
<th>Community/MCO</th>
<th>Number of Counties</th>
<th>Local vs. National Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albuquerque</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presbyterian</td>
<td>3</td>
<td>Local</td>
</tr>
<tr>
<td>St. Joseph</td>
<td>3</td>
<td>Local</td>
</tr>
<tr>
<td>Lovelace</td>
<td>3</td>
<td>National (owned by CIGNA)^a</td>
</tr>
<tr>
<td><strong>Baltimore</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIGNA</td>
<td>6</td>
<td>National</td>
</tr>
<tr>
<td>CareFirst</td>
<td>4</td>
<td>Local (Blue Cross/Blue Shield)</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>4</td>
<td>National</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>6</td>
<td>National</td>
</tr>
<tr>
<td><strong>Detroit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Care</td>
<td>4</td>
<td>Local (Blue Cross/Blue Shield)</td>
</tr>
<tr>
<td>Care Choices</td>
<td>3</td>
<td>Local</td>
</tr>
<tr>
<td>Health Alliance Plan</td>
<td>5</td>
<td>Localb</td>
</tr>
<tr>
<td>Micare</td>
<td>3</td>
<td>Local</td>
</tr>
<tr>
<td>Paramount Care</td>
<td>1</td>
<td>Local</td>
</tr>
<tr>
<td>SelectCare</td>
<td>3</td>
<td>Local</td>
</tr>
<tr>
<td><strong>New Orleans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna U.S. Healthcare</td>
<td>7</td>
<td>National</td>
</tr>
<tr>
<td>Gulf South</td>
<td>7</td>
<td>Local</td>
</tr>
<tr>
<td>Ochsner</td>
<td>7</td>
<td>Local</td>
</tr>
<tr>
<td>SMA</td>
<td>8</td>
<td>Local</td>
</tr>
<tr>
<td>Maxicare</td>
<td>3</td>
<td>National</td>
</tr>
<tr>
<td>HMO Louisiana</td>
<td>5</td>
<td>Local (Blue Cross/Blue Shield)</td>
</tr>
<tr>
<td>Tenet (Choices Demonstration)</td>
<td>4</td>
<td>Local</td>
</tr>
<tr>
<td><strong>Orange County</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna U.S. Healthcare</td>
<td>1</td>
<td>National</td>
</tr>
<tr>
<td>Blue Cross of California</td>
<td>1</td>
<td>Local</td>
</tr>
<tr>
<td>California Physicians' Services</td>
<td>1</td>
<td>Local</td>
</tr>
<tr>
<td>Care America</td>
<td>1</td>
<td>Local</td>
</tr>
<tr>
<td>CIGNA</td>
<td>1</td>
<td>National</td>
</tr>
<tr>
<td>Health Net</td>
<td>1</td>
<td>National (but originated in California)^a</td>
</tr>
<tr>
<td>InterValley</td>
<td>1</td>
<td>Local</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>1</td>
<td>National (but originated in California)^a</td>
</tr>
<tr>
<td>Maxicare</td>
<td>1</td>
<td>National (but originated in California)^a</td>
</tr>
<tr>
<td>Pacicare</td>
<td>1</td>
<td>National (but originated in California)^a</td>
</tr>
<tr>
<td>Prudential</td>
<td>1</td>
<td>National</td>
</tr>
<tr>
<td>UHP</td>
<td>1</td>
<td>Local</td>
</tr>
<tr>
<td><strong>Orlando</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna U.S. Healthcare</td>
<td>3</td>
<td>National</td>
</tr>
<tr>
<td>AvMed</td>
<td>3</td>
<td>Local</td>
</tr>
<tr>
<td>CIGNA</td>
<td>3</td>
<td>National</td>
</tr>
<tr>
<td>Health Options</td>
<td>3</td>
<td>Local (Blue Cross/Blue Shield)</td>
</tr>
<tr>
<td>Humana</td>
<td>4</td>
<td>National</td>
</tr>
<tr>
<td>Prudential</td>
<td>3</td>
<td>National</td>
</tr>
<tr>
<td>Wellcare</td>
<td>3</td>
<td>National</td>
</tr>
</tbody>
</table>

**SOURCE:** Interstudy Competitive Edge 9.2 and MPR database.

^aIn the market, it is perceived as a local plan.

^bHealth Alliance Plan is identified as a national plan in Interstudy 9.2 because its parent system has a plan in one other state.
counties (as defined by the metropolitan statistical area, or MSA). For example, in Detroit, no beneficiary can choose from all MCOs because one of the MCOs serves only one county (and it is not served by all the other market M+C MCOs) (Table II.1). Nevertheless, more than 90 percent of the beneficiaries in Detroit have a choice of the five remaining M+C MCOs.

*Experience with managed care affects how "inviting" a market is to M+C MCOs.* From other perspectives, M+C options are more “comfortable” in some markets and for some beneficiaries than others because of previous experience with managed care. Commercial managed care was first to emerge in the six markets (as early as 1940s in Orange County), and its general success paved the way for other populations to be initiated into managed care. In addition, Medicaid managed care programs operate in all of the markets except New Orleans.

Of the six markets, Albuquerque and Orange County are the most mature managed care markets with total managed care penetration of 52 percent and 48 percent in January 1999, respectively (*The Interstudy Competitive Edge 9.2 1999*). As expected, these two markets also are the most advanced Medicare markets with Medicare managed care penetration (as of March 2000) reaching highs of 39 percent (see Figure II.4). Beneficiaries in these markets therefore have had more opportunity to become familiar with managed care and to experience it while working, increasing interest in managed care options and decreasing confusion about them. Providers and MCOs also have had experience with managed care, increasing both the possibility that they will participate in the Medicare managed care market and options available to beneficiaries.

**FIGURE II.4**

<table>
<thead>
<tr>
<th>Managed Care Penetration</th>
<th>Total Penetration</th>
<th>Medicare Penetration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>52%</td>
<td>39%</td>
</tr>
<tr>
<td>Orange County</td>
<td>48</td>
<td>39</td>
</tr>
<tr>
<td>Orlando</td>
<td>45</td>
<td>27</td>
</tr>
<tr>
<td>Baltimore</td>
<td>39</td>
<td>15</td>
</tr>
<tr>
<td>Detroit</td>
<td>28</td>
<td>9</td>
</tr>
<tr>
<td>New Orleans</td>
<td>27</td>
<td>32</td>
</tr>
</tbody>
</table>

*Total managed care penetration is from January 1, 1999 (*The Interstudy Competitive Edge 9.2*)

Medicare managed care penetration is from the Health Care Financing Administration for March 2000.

*Experience with managed care and the degree of provider organization in an MSA affects beneficiary choice.* The way physicians and hospitals are aligned is important because the alignment affects beneficiaries’ choice. In markets in which providers contract with a limited number of M+C MCOs, a beneficiary who prefers a particular provider or who wants to maintain an established relationship with a provider will have a more limited set of M+C MCO choices, though from the beneficiary's perspective this may mean that the choices will be clearer.

*II: What Does Beneficiary Choice Look Like at the Market Level?*
A range of M+C MCO network exclusivity was evident in the six markets. In Orange County, physicians are highly organized, and almost all practice in large medical groups. The MCOs' network models typically have specialty groups that are affiliated exclusively with particular primary care groups. Consequently, beneficiary access to a specialist varies with the primary care group. In New Orleans, physicians are organized (that is, into many independent practice associations and some physician hospital organizations) and contract with most plans. The exception is one medical group, the Ochsner Foundation, which only participates in the Ochsner M+C MCO. If a beneficiary wants to see an Ochsner Foundation physician, he or she must either sign up with this M+C MCO or remain in fee-for-service. Similar exclusivity exists in Albuquerque, where three of the four hospital systems participate with their own M+C MCOs. In contrast, Baltimore and Orlando are markets with relatively unorganized physicians who engage in considerable cross-MCO contracting. In these markets, therefore, beneficiaries who have provider preferences have a relatively greater amount of M+C MCO choice. Detroit is reportedly moving toward more cross-plan provider contracting. Historically, however, we were told that most provider networks have been exclusive.

**M+C options are unstable, leading to changes in available choices and increased beneficiary confusion.** M+C options have not been stable during the period we studied (1998-2000); changes in both the number of MCOs offered and in the benefit design have occurred in most markets. From 1998 to 2000, all but one of the markets (Detroit) experienced changes in M+C MCO choice, although each market had at least three M+C MCO choices (see Figure II.5). These changes included exits from and entries to the market, selective service area reductions and closed enrollments, as well as numerous changes in benefits coverage. The largest one-year change occurred in Baltimore, which had eight M+C MCOs serving Medicare beneficiaries in the core urban counties in 1998, but only four doing so in 1999.

The choices beneficiaries will have in 2001 in the six markets continue to change (and to confuse), as the number of M+C MCOs shrink in all but one market (Detroit). In Baltimore, all M+C MCOs with the exception of Kaiser Permanente (Kaiser) have withdrawn from the market. Beneficiaries now have only one MCO choice, and it has been affected by recent actions of Kaiser. Kaiser tightened its Medicare network for new enrollees (limiting it to its core providers) and closed enrollment effective in August 2000. In Albuquerque, at the time of our visit there, two of the three M+C MCOs had closed enrollment. As a result, beneficiaries who

---

9However, Orlando's three hospital systems seem to be becoming more selective in their contracting.

10Under closed enrollment, a plan accepts new enrollees only during November and only under certain circumstances (such as those newly enrolling in Medicare).
FIGURE II.5

M+C MCOs IN THE MARKET*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Baltimore</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Detroit</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>New Orleans</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Orange County</td>
<td>12</td>
<td>9</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Orlando</td>
<td>10</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

*Analysis of data from HCFA’s quarterly State/County/Plan Files, Geographic Service Area Files, and Plan Withdrawal Files.

wanted to switch to another M+C MCO could only choose St. Joseph, which had open enrollment enrollment at the time. However, St. Joseph has since announced that it will leave the market in January 2001 and that option will no longer be available. Closed enrollment in Orlando has greatly reduced the number of M+C MCO choices available to current beneficiaries as well.

Even beneficiaries in markets with an apparently stable choice of M+C MCOs may actually face changes in options that are masked by comparisons of the aggregate number of M+C MCOs in the market. For example, Baltimore and Orlando experienced no net change in M+C MCOs in the numbers of 2000: (four and six M+C MCOs available in both 1999 and 2000, respectively). However, in Orlando (effective in 2000), the market experienced one M+C MCO exit, one M+C MCO entry, one M+C MCO reduction in service area, and two M+C MCO closed enrollments. Of the four M+C MCOs in Baltimore, only one had open enrollment.

In addition, even if an M+C MCO stays in a market, its provider networks can change with subgroups of providers to whole systems leaving. This means that beneficiaries cannot just make a choice and “forget about it,” because their M+C MCO may lose providers that they currently have relationships with or want to be able to access. As a result, beneficiaries may need to revisit their choices and decision making as networks change even though their M+C MCO stays in the market.

There are many factors that influence M+C MCO participation in any particular market, including payment, practice patterns, provider organization, beneficiary characteristics, historic managed care patterns and trends in other lines of business (commercial, Medicaid) among others (Brown and Gold 1999). Even if payment were the same in a county or market, the number of M+C MCOs would still vary because of the other factors that influence participation. Still, payment does affect whether MCOs can afford to participate in M+C and also influences the benefit package an M+C MCO can create. Because payment is set at the county level and is still related to fee-for-service payments, it can vary substantially within an MSA, influencing the number and type of MCO choices that beneficiaries in the MSA have

II: What Does Beneficiary Choice Look Like at the Market Level?
depending on their county of residence. Among Baltimore's seven counties, the highest payment in 2000 is $671; the lowest is $469—a difference of 30 percent. The average payment in 2000 ranged from 84 percent of the national average in Albuquerque to 133 percent above the national average in New Orleans (see Figure II.6).

**FIGURE II.6**

**M+C PAYMENT IN 2000**

<table>
<thead>
<tr>
<th>Average 2000 Payment</th>
<th>Percentage of National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>$505</td>
</tr>
<tr>
<td>Albuquerque</td>
<td>425</td>
</tr>
<tr>
<td>Baltimore</td>
<td>603</td>
</tr>
<tr>
<td>Detroit</td>
<td>648</td>
</tr>
<tr>
<td>New Orleans</td>
<td>671</td>
</tr>
<tr>
<td>Orange County</td>
<td>610</td>
</tr>
<tr>
<td>Orlando</td>
<td>538</td>
</tr>
</tbody>
</table>

*This payment is weighted by September 1999 enrollment data from the Health Care Financing Administration.*

In our six markets, counties with lower payments have less managed care penetration and less MCO choice than do other counties in the MSA. Often these counties are rural, have relatively small numbers of beneficiaries, or may have provider monopolies, all of which make a county less attractive to M+C MCOs. Not surprisingly, these counties were the first to experience withdrawals or closed enrollment by participating MCOs. For example, Queen Anne’s county (in the Baltimore MSA) had three Medicare managed care options in 1997, but all withdrew in 1998, reportedly in a large part due to the low payment of $433 and provider contracting issues. (This payment is 93% of the national average but also pales in comparison to Baltimore City, which received $633 in 1997.) Subsequently, in our markets and others, higher payment counties also began experiencing notable withdrawals in 2001.

Historically, Medicare MCOs were paid 95 percent of the expected fee-for-service costs for demographically similar beneficiaries in the same county. This meant that Medicare paid lower rates to counties where patterns of healthcare provision resulted in lower fee-for-service costs. To reduce payment the disparity over time, the payment method was changed under M+C. M+C MCOs receive the greatest of three possible increases over the rate from the previous year: (1) a phased-in blend of a national payment rate and the county rate, (2) a national "floor" or minimum, or (3) a minimum increase of two percent over the previous year's county rate. Because of budget neutrality provisions for the program, no blending of rate occurred in 1998, 1999 or in 2001. Starting in 2000, the Health Care Financing Administration also has begun phasing-in risk-adjusted payments, which will account for enrollees' health status by paying more for sicker beneficiaries. In addition the BBA eliminates medical education payments from the capitation rates on a phased-in basis. This means increases in rates in areas could be below the 2 percent minimum (Cassidy and Gold 2000).
From a cost perspective, M+C options typically are more attractive to beneficiaries than are Medigap options, but how much so varies by county.\textsuperscript{12} A zero premium plan offers beneficiaries who are willing to limit their choice of provider and to live within the plan rules access to additional supplemental benefits at no additional cost. This incentive is highly attractive to beneficiaries who are considering enrolling in an M+C MCO, especially to those with limited or low incomes who might otherwise have to forgo the extra benefits. In 1999, virtually all basic benefit packages offered in the six markets did not charge an additional premium beyond the standard Medicare Part B premium.

In 2000, beneficiaries in four of the markets faced higher premiums, with the most significant changes occurring in Baltimore and Orlando (see Table II.2). Fifty-four percent of enrollees in Baltimore were in M+C MCOs (and counties) that increased the premium for their basic benefit plan from $0 in 1999 to between $50 and $75 in 2000. In Orlando, 40 percent of enrollees who had $0 premiums in 1999 were in plans with year 2000 premiums ranging from $50 to $75. These MSAs had lower payment than did other markets, a clear factor in the introduction of premiums. Beneficiaries therefore have fewer options at no additional cost and no guarantee that the premiums will not increase from year to year.

At the same time M+C MCOs are altering the scope of supplemental benefits, such as prescription drug coverage, in the interest of cost control. The changes may be “nuances” (for example, changes in formulary or conversion to three tiers of copayments), but they are hard for beneficiaries to comprehend and assess, making the decision process more difficult. From 1999 to 2000, cost sharing for prescription drugs increased in three of the six markets: Albuquerque, Detroit, and Orlando. For example, M+C MCOs in Albuquerque and Orlando increased the copayment for brand name drugs. M+C MCOs in Orlando lowered the pharmacy cap, as did M+C MCOs in Baltimore, where nearly 40 percent of enrollees were enrolled in benefit plans with lower pharmacy caps in 2000 than in 1999. In the three other markets, some pharmacy benefits became more generous and others less generous (Table II.2).\textsuperscript{13}

Clearly, where a beneficiary lives affects the generosity of the prescription drug benefit available through MCOs. In Albuquerque, all benefit plans have an annual cap of $500 or less, and in Orange County, almost all benefit plans have an annual cap of more than $1,500. Regardless of where beneficiaries live, however, the benefit is likely to change in some way from year to year, making cross-MCO comparisons difficult and requiring ongoing decision-making by beneficiaries.

\textsuperscript{12}This benefit and premium analysis was supported by The Commonwealth Fund.

\textsuperscript{13}Detroit is the sole market with less prevalent coverage of prescriptions drugs, which may be an artifact of the extensive role of employers’ retiree coverage. Beneficiaries with certain retiree coverage can add wrap-around supplemental benefits including prescription drugs to their MCO coverage. The role of the group market in Detroit is addressed in the next section.

II: What Does Beneficiary Choice Look Like at the Market Level?
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SOURCE: MPR analysis from HCFA's Medicare Compare Database release of October 1999 for the year 2000 and release of August 1999 for year 1999. Enrollment data are from HCFA for September 1999 and March 2000. For Orlando and New Orleans, one or more contracts were missing from the database. This analysis was supported by the Commonwealth Fund.

*The column does not add up to 100% because data for one or more contract areas are missing.
In summary, the individual market for Medicare beneficiaries is quite complex. The choices vary by a large set of considerations that differ due to market conditions and individual preferences and circumstances.

**SUBSIDIZED SUPPLEMENTAL COVERAGE: EMPLOYER-SPONSORED GROUP COVERAGE AND MEDICAID**

Employer-Sponsored Group Retiree Coverage Is a Good Way for Beneficiaries to Obtain Subsidized Supplemental Coverage, but Eligibility for Such Coverage Is Limited and Alters Choice

Beneficiaries in the *group market* have different choices than do those in the individual market because they are eligible for retiree health benefits from their (or a family member’s) former employer (or affiliated union or professional group). Group retiree options with supplemental benefits can be less costly to the beneficiary because the employer contributes to the cost or is able to negotiate reduced rates through group-based purchasing. To take advantage of the employer subsidy, however, beneficiaries must select one of the options offered by their employer. This set of options is employer-negotiated, so it may not include an M+C MCO and the supplemental benefits offered do not necessarily follow one of the standardized Medigap packages. This disparity can benefit a beneficiary because it may allow more generous coverage, but it also can create confusion because options may be more complicated to understand.

In five of the six markets, employers offering retiree coverage were relatively indifferent to the M+C program. The employers either did not have an M+C option for retirees or did not offer retirees incentives to select an M+C choice. In many cases, the employers lack sizable populations of retirees in these markets. Retirees of national employers often are scattered geographically, hampering incentives to become active in a local market. In addition, decisions often are made at national headquarters located outside the six markets. Of employers with retirees, public employers appeared to be the most involved: they are geographically concentrated and have or can coordinate a sizable retiree population. For example, in Albuquerque, the state created the New Mexico Retiree Health Care Authority to actively purchase and administer retiree benefits for 30,000 retirees and their dependents from across state agencies.

Detroit is different from the other markets because it has a concentrated number of large employers that are unionized (the “Big Three” Automakers and the United Autoworkers) who actively purchase healthcare in the market for both active and retiree employees under both unionized and nonunionized arrangements. The size of its covered retiree population is large enough that these employers have influenced the design and number of options available, as well as dedicate substantial resources to educating retirees about Medicare and M+C. Reportedly, more than half of the Medicare beneficiaries in this market have employer-sponsored retiree coverage in a large part due to the negotiation power of the unions, which have been able to bargain for generous retiree benefits for hourly (unionized) workers. These arrangements have influenced retiree benefits for nonunionized (salaried) employees, although
there are still large coverage differences between the two groups (unionized employees receive more generous benefits).

**Medicaid Provides at Least Some Supplemental Benefits to Beneficiaries with Low Incomes, but Except for Those Who Are Dually Eligible for Full Medicaid and Medicare Benefits, Choice Is Similar to That Faced by Those in the Individual Market**

Four options available through Medicaid offer Medicare beneficiaries supplemental benefits in the form of reduced premiums or cost sharing. The least comprehensive option (QI-2) pays for a part of the monthly Part B premium, and the most comprehensive option (QMB) covers all Medicare premiums, deductibles, and coinsurance (see Appendix C). The two other options (QI-1 and SLMB) cover the monthly Part B premiums. In addition, some beneficiaries are also eligible for coverage of full Medicaid and monthly Part B premiums (SLMB Plus), or full Medicaid and full Medicare benefits (QMB Plus). In addition to having costs associated with Medicare covered services, these beneficiaries are entitled to the other Medicaid benefits, such as prescription drug coverage and long-term-care coverage. Beneficiaries receiving benefits from any of these options are often called “dual eligibles” (Health Care Financing Administration 1999a). (Appendix C provides additional details.)

Significant barriers continue to limit the reach and effectiveness of the programs’ enrollment efforts. We were told that some beneficiaries are reluctant to accept government benefits that are income related, although the degree of reluctance varies among the six markets. Interviewees suggested that the more fundamental barrier seemed to be distaste for the enrollment process. To enroll, beneficiaries often must complete long, complex forms at the welfare office. Some beneficiaries reportedly find in-person enrollment requirements extremely burdensome. For example, interviewees in Baltimore noted that some eligible beneficiaries are homebound. In addition, with the exception of QMB and SLMB Plus, Medicaid supplemental benefits are limited to subsidization of the Part B premium only (see Appendix C).

Medicaid supplemental coverage conveys different benefits and choices depending on the category of eligibility for Medicaid. Those qualifying only for Medicaid supplemental benefits (not the full set of Medicaid benefits) have some or all of the Medicare premium and cost sharing covered. Nevertheless, because Medicare does not cover prescription drugs, and low incomes of Medicaid-eligible beneficiaries probably place supplemental plans out of financial reach, these beneficiaries still must confront the challenge of obtaining coverage for prescription drugs. If a plan is offered with such coverage, especially at no cost, they may enroll in a M+C MCO to obtain the benefit. Otherwise, unless they qualify for a state-sponsored prescription drug plan, they will not be able to obtain prescription drug coverage. From this perspective, these beneficiaries are similar to beneficiaries in the individual market, although they have the added benefits and/or financial subsidies available through Medicaid’s supplemental coverage.

Those dually eligible for full Medicare and Medicaid coverage are in a different situation. Medicaid covers their prescription drugs, although there may be limits, as well as the cost sharing Medicare requires and other noncovered benefits that Medicare may exclude (such as long-term care). These beneficiaries may voluntarily choose to enroll in a M+C MCO, but they have little incentive to do so. State Medicaid programs cannot compel individuals dually eligible

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*II: What Does Beneficiary Choice Look Like at the Market Level?*
for Medicare and Medicaid to join. (This choice remains voluntary under Medicare law which remains primary.) States could require beneficiaries to join a Medicaid HMO to obtain coverage for the benefits only offered by Medicaid, but few states do so and many do not allow it because of the complexities of coordinating coverage with Medicare. Five of the six markets we studied have Medicaid managed care (Louisiana has only a primary care case management program). All, except Florida, exclude the dually eligible from the program.\footnote{In Florida, the dually eligible may voluntarily enroll, and the program includes both a primary care case management option and a Medicaid HMO option (National Academy for State Health Policy 1999).}

In sum, the choices beneficiaries face depend on “where they sit” as a member of the individual, group or Medicaid market, and the nature and number of market offerings. Choice outside of the individual market may be constrained by employer or state (Medicaid) rules and options. Further, the six markets produce a variety of M+C MCO benefits, premiums, and provider structures, but these features are not static as M+C MCOs and insurers respond to changing market conditions. This can translate into an unstable array of options that make decision making quite difficult for Medicare beneficiaries.
CHAPTER III

WHAT INFORMATION ABOUT THEIR CHOICES DO BENEFICIARIES WANT, AND WHEN DO THEY WANT IT?

Any assessment of how beneficiaries are faring under the M+C program must be based on a good understanding of how well they comprehend the program. In particular, we must understand their demand for information, the decision process they go through, and their perceptions of the adequacy and accuracy of information available to them. To gain insight into these issues, we asked plans, advocates, and educators for their perceptions about what beneficiaries know, what questions they ask, when they ask for information, and what considerations they use to make their health care coverage decisions.

The information we obtained during our visits suggests that most beneficiaries do not understand the basics of Medicare and M+C and are confused, regardless of whether they have choices. Beneficiaries seek information only when an event or crisis pushes them to do so, and they want individual counseling with their education. We also learned that beneficiaries make decisions almost exclusively on the basis of cost, availability of prescription drug coverage, and inclusion of their own providers. They do not consider information about quality, at least as policymakers have defined it.1

WITH SOME EXCEPTIONS, MOST BENEFICIARIES DO NOT UNDERSTAND THE BASICS OF THE MEDICARE PROGRAM AND MEDICARE+C

In every community, interviewees overwhelmingly reported that most beneficiaries do not understand the basics of the Medicare program. Anecdotal evidence from educators, advocates, and some plans reveals quite clearly that beneficiaries understand very little about how original fee-for-service Medicare works, including such basic program information as the differences between Medicare Part A and Part B, or between managed care and fee-for-service. One educator in Orlando expressed the sentiment we heard from interviewees in all six markets, “So many people don’t know what Medicare is.” Another respondent ruefully noted, “They don’t know what they don’t know.” A third educator described MCO beneficiaries who continue to carry both their Medicare card and their M+C MCO card. When providers do not accept one of the cards, these beneficiaries will present the other, because they do not understand that the

1These conclusions are consistent with findings of other studies reviewed in Sofaer and Fox 1998.
M+C MCO replaces original Medicare. Anecdotal testimony about beneficiaries’ lack of knowledge and understanding about Medicare was pervasive in our sites. Several studies confirm these realizations (see for example, Hibbard et al. 1998; Murray and Shatto 1998; and Sofaer and Fox 1998).

Without basic program knowledge, most beneficiaries cannot understand how the M+C program might affect them. They do not know how to obtain information necessary for making appropriate decisions. “They know so little about Medicare that they don’t know what questions to ask,” stated one educator working with beneficiaries with retiree coverage in Albuquerque. “They don’t know about parts A and B. They confuse Social Security with Medicare. They think that Medicare will replace their retiree benefits. This is an educational challenge.” In response, educators have expanded their M+C efforts to educate beneficiaries about basic information, such as the concepts of deductibles and coinsurance, networks, the differences between Part A and B, how to read HCFA forms, and the services covered by the Medicare Program.

Furthermore, the M+C program adds new terminology and concepts, such as private fee-for-service plans and medical savings accounts, in addition to other program changes in the enrollment time line, such as the phase-in of lock-in provisions, that increase the complexity of understanding the Medicare program. A director of a senior center and meals site in Orlando made this assessment:

The ones that are even aware that Medicare+Choice exists are much more confused, but many don’t even know what the program is. A lot hear about choices and that there is something out there but don’t know what it is. But they need someone to know what they are talking about when they call up.

One community information counselor summed it up, “…[beneficiaries] don’t understand the maze of insurance… a lot of people don’t fight it, [they] take it whichever way it comes.”

The extent of beneficiaries’ understanding of the Medicare program varies across and within sites. Where managed care has been a major part of the health care system for several decades (as in Albuquerque and Orange County), relatively large portions of the Medicare population understand Medicare managed care much more than in areas where managed care is relatively minor (such as Detroit). Still, in Albuquerque and Orange County, interviewees reported that the new M+C terminology and “choices” confused beneficiaries, especially since initially M+C meant the same choices as before the program was implemented—not more.3

3When a lock-in is in effect, a beneficiary can change M+C plans only during a designated period in a year. See Chapter II for a description of private fee-for-service plans and medical savings accounts.

3An M+C provider-sponsored organization (PSO) entered the Albuquerque market, but over time, five of our six markets actually have less choice.

III: What Information about Their Choices Do Beneficiaries Want, and When Do They Want It?
An educator in Orange County observed, “There’s a real divide in the knowledge of Medicare versus HMOs by age and previous employment. Those in their 60s are very savvy whereas those in their 80s are less savvy.” This educator also told us, “The very ill seniors are quite savvy. Some know to the day when they reach their prescription drug cap, so they can make changes to another health plan to begin a new prescription drug cap. But the newer and the healthier are confused.” In general, however, beneficiaries have only a poor understanding of Medicare, and for some subgroups it is more limited. Focus-group research by Davanzo et al. (1998) revealed that Hispanic, African-American, dually eligible, and poorly educated beneficiaries know little about basic Medicare benefits. Every community has its small segment of sophisticated beneficiaries who are likely to seek information by attending multiple presentations, calling M+C MCOs, attending health fairs, asking questions, and comparing information across sources. All interviewees mentioned this group of seniors but noted that this educated minority is small relative to the large group of uninformed beneficiaries. According to our respondents, sophisticated beneficiaries are more likely to ask detailed questions and tend to be younger, educated seniors who may have had previous experience with commercial managed care or are ill seniors who have experience using the health system. M+C MCOs in all our sites were more likely than other interviewees, such as senior organizations or state health insurance assistance programs (SHIPs), to report encountering seniors who were sophisticated and educated, and who asked detailed questions, indicating that those thinking of joining plans know more and are motivated to learn.

**BENEFICIARIES GENERALLY DO NOT ASK FOR INFORMATION UNTIL THEY HAVE A PROBLEM OR CRISIS. THESE “TRIGGER” EVENTS CAN BE INTERNAL (E.G., CHANGE IN HEALTH STATUS) OR EXTERNAL (E.G., A WITHDRAWAL OF AN M+C MCO)**

Most beneficiaries seek information only when they have a problem or a crisis. In other words, they operate on a need-to-know basis. In Albuquerque, according to one educator:

> [Beneficiaries] are looking at all the materials and saying, “‘You’ve got to be kidding! You want me to learn all of this?’ They can’t deal with it. They feel like it is constantly changing and so they’ll wait until ‘[they’ll] need to know.’”

The materials and information can seem overwhelming, especially for seniors, many of whom are averse to change and easily confused. In Orlando, an interviewee from one senior organization told us about following a group of beneficiaries at a health fair from one table to another as they asked questions, compared information across booths, and probed inconsistencies. Normally, this interviewee deals with relatively unmotivated seniors who do not seek information. He felt that this active, motivated group were a minority and was intrigued that even they were clearly struggling with the information.

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4Hibbard and Weeks (1987) also found that beneficiaries who are white, more educated, or have experience using health care services have greater knowledge about Medicare.

**III: What Information about Their Choices Do Beneficiaries Want, and When Do They Want It?**
Those with low literacy levels or who speak English as a second language face additional obstacles. One Orange County educator stated, “The materials are daunting—you really have to work to understand them. . . . We count now on [beneficiaries] that learn by reading, and we’re not addressing those who [don’t or can’t].” Other educators working with minority communities noted that non-English monolingual beneficiaries even have trouble understanding translated materials because program concepts and nuances do not necessarily translate well.

Both internal events and external events influence demand for information. Internal events are things that happen to a beneficiary that change the beneficiary’s status or situation. These events are personal and often require immediate attention and specific information about a particular situation. Key internal events include:

- Enrollment in Medicare
- A change in health status, such as getting sick and being admitted to a hospital or nursing home
- Receiving a bill from a provider or a coverage-of-benefits notice from HCFA
- Receiving a discharge notification in the hospital
- Exhausting their M+C MCOs’ pharmacy cap
- Receiving a bill with an increase in the Medigap premium
- A change in personal circumstances that affects the beneficiary’s income or supplemental coverage (for example, divorce or death of a spouse)

Of the internal factors identified across the six communities, we were told that billing issues and hospital discharge were the main reasons why a beneficiary or a family member contacts an information source. All SHIPs that educate beneficiaries and Part B carriers (claims payers for Medicare) reported that many of their clients arrive at their offices with a bill or notification about payment—sometimes with bags of them—and ask for help in sorting it out. A Medicare educator in New Orleans reported that beneficiaries will bring a stack of bills or “explanations of benefits (EOBs)” and say, “Honey, I got a problem.” These beneficiaries know they need help but they do not know what kind. They frequently do not understand what the bills or EOBs mean or what to do with them, but they know they do not have the money to pay them. Family members or friends often became involved, either in person or by telephone, when the precipitating internal event is a hospital discharge. They will contact SHIPs or peer review organizations (PROs) to find out what is covered and what options the beneficiary has. In Orange County, for example, the SHIP reported that children call on behalf of their parents, who they believe are not receiving benefits to which they are entitled, particularly concerning hospital discharge, skilled nursing care coverage and home health.

III: What Information about Their Choices Do Beneficiaries Want, and When Do They Want It?
As these examples illustrate, much of the information the beneficiaries want is specific to an immediate problem or situation. This information sometimes differs from the beneficiary’s long-term information needs (for example, information on their out-of-pocket plan costs or on whether their plan is a good fit for their needs), but beneficiaries are less likely to seek out information for these latter concerns.

*External events* affect multiple beneficiaries, such as those in an MCO, a county, or even the country as a whole. They include:

- MCO withdrawals
- Provider contract termination and changes in provider networks
- Changes in premiums or benefits (for example, M+C MCO or Medigap premiums and, especially, pharmacy coverage)
- Organized education from HCFA about the Medicare and M+C program (provided each fall)

M+C MCO withdrawals and benefit changes are key events that create a huge demand for information. Baltimore, New Orleans, Orange County, and Orlando had M+C MCO withdrawals and benefit changes from 1998 to 2000, including the introduction of a premium for most beneficiaries in Baltimore and Orlando. From 1998 to 1999 Baltimore lost about half its M+C MCOs so that, according to one educator, “… People called in left and right asking: ‘What should I do? How does this affect me?’” After M+C MCOs left rural areas in the New Orleans area with no other managed care options, educators received a flood of calls from beneficiaries who had such questions as, “My HMO went out of business. What do I do now?” The confusion and panic are often intensified for beneficiaries who lack other managed care options in their county and who cannot afford a supplemental policy.

**THE MEDIA HELPS RAISE AWARENESS AND TRIGGER CALLS BY PUBLICIZING M+C MCO WITHDRAWALS OR OTHER ISSUES, BUT IS NOT TYPICALLY CONSIDERED A SOURCE OF INFORMATION ON HOW TO RESPOND**

The national and local media plays a crucial role in raising awareness about issues, but may also confuse and frighten seniors. In all six communities, we learned that stories in local newspapers about local M+C MCOs and benefits typically result in an increase in calls to information brokers, particularly SHIPs, about the story topics. Although local stories are often more relevant than national news reports, interviewees say that beneficiaries often become panicked when they are unable to understand the context surrounding the reports. For example, the main newspaper in New Orleans covered the Ochsner M+C MCO withdrawal from rural parts of the state but did not report that Ochsner would continue to operate in New Orleans. Some beneficiaries, alarmed, called the plan or the SHIP to obtain the “real” information. In Orlando, according to information counselors, local media stories about

**III: What Information about Their Choices Do Beneficiaries Want, and When Do They Want It?**
withdrawals or benefit and premium changes often became public before official information is released. The Orlando SHIP described how beneficiaries called and wanted to join another M+C MCO immediately even though they did not have to disenroll until December of that year. They also observed that beneficiaries often asked about “scary” media stories on fraud, abuse, and M+C MCO dropouts. Many interviewees felt that these stories create feelings of distrust and skepticism among beneficiaries about managed care, even if they are infrequent events. In short, local media is an important source of information and is instrumental in raising awareness about M+C issues, but due to a general lack of knowledge and the complexity of the program, beneficiaries easily are confused by such stories.

National news also raises awareness of issues. In Detroit and Orange County, beneficiaries began asking more questions about the financial stability of MCOs and providers after stories about medical groups’ bankruptcy pervaded the national and local media. In contrast, educators in Albuquerque believe that beneficiaries pay little heed to the national news, as they generally do not receive questions about national news topics.

HCFA’s media and education about the M+C program (National Medicare Education Program), which includes the annual fall education campaign, has also created demand for information. A small portion of the Medicare population calls for more information after mailings form HCFA. Interviewees report that available program materials are often good general resources but are lengthy and overwhelming for most beneficiaries who have trouble “seeing themselves in it.” Furthermore, most educators are under the impression that beneficiaries do not closely examine substantive materials, such as HCFA’s Medicare’s You handbook. A respondent from a senior center that provides outreach and such services as home assessments, housekeeping, and meals, stated:

The number one thing is that it’s just too much for them to even look at this stuff. It’s overwhelming for our clients. Those who do get medical bills just toss it all in a pile or in a bag. If [materials] are too much, they just don’t look at them.

Educators believe that beneficiaries have difficulty sorting through the information for options and information that are personally relevant, especially because the full spectrum of “choices” may not be available in all areas. In New Mexico, for example, managed care is available only in the Rio Grande Corridor (that includes Albuquerque) and in Las Cruces (at the time of our visit). Consequently, beneficiaries in other parts of the state frequently call the SHIP or the State Agency on Aging to ask when they will have access to prescription drug coverage and managed care.

**ETHNICITY, LITERACY, DISABILITY, AND AGE AFFECT HOW INFORMATION IS SOUGHT, WHICH HAS IMPORTANT IMPLICATIONS FOR EDUCATION**

The six communities are home to various subgroups that seek information and make decisions in different ways. Minorities may have different cultural and community values (and language barriers) that have implications for how these subpopulations access information,
understand program information, and make decisions. In the relatively sizable minority communities in Albuquerque, Baltimore, and Detroit, minorities generally do not actively seek information about public programs, including Medicare, until a trusted community member has had a successful experience learning about these programs or has received public benefits. In Orange County, radio and television have been successful mediums for communicating information to women in the Latino community. In other heavily ethnic communities, such as the Arab-American and Chaldean community in Detroit, or the Italian, Greek, and Polish enclaves in Baltimore, an extensive set of community organizations may exist that community members turn to first for information. In contrast, although non-ethnic beneficiaries also ask friends and families for advice and information, they also are more likely to access formal information channels independently. One educator in Orlando conveyed her impression that outside of minority or ethnic communities most Medicare beneficiaries will select senior organization names from the telephone book when they need to obtain information from someone.

Educators in New Orleans pointed out that trust is an important issue for minority communities, especially communities that have experienced a history of formal and informal discrimination and segregation. As a result, word-of-mouth and informal communication at community institutions are key paths to education in these communities, more so than for the “average” Medicare beneficiary. For example, we were told that minorities in New Orleans are hesitant to seek information from largely white or official organizations. Rather, they typically access information through their churches and pastors. In fact, to reach minority populations in their African American, Hispanic, Arabic, and Chaldean communities, educators in five of the six sites work through religious institutions, such as churches or mosques. Others acknowledge the need to take this step. Some senior centers provide services specifically to Baltimore’s African American community. Similar centers operate in Detroit, where they target members of the city’s Arab community. In Albuquerque, in contrast, minorities reportedly are less likely to frequent senior centers and consequently are unaware of the educational activities available there. For example, one Area Agency on Aging educator based in an Albuquerque senior center reportedly told a Hispanic member of the kitchen staff that she was at the center to help people learn about the program possibilities. After one referred community member successfully met with the educator, many other community members followed.

We found that beneficiaries under 65 with disabilities are somewhat “invisible” members of the Medicare population, and that the organizations that serve disabled communities in all six sites operate largely separately from the senior network. Chapter IV discusses this issue in greater detail. Interestingly, we learned that the overriding concern of many people with disabilities is “how to survive” the two-year wait between their eligibility for Social Security Disability Insurance (SSDI) and eligibility for Medicare. “Disabled are holding their breath waiting for Medicare,” one New Orleans educator noted, adding that they have pressing needs for home health, personal care assistance, case management and pharmacy coverage, in particular.

Furthermore, people with disabilities do not feel that Medicare “works” for them, in part because education and marketing are directed primarily to seniors and because the names of
Medicare managed care products commonly contain the words “senior” and “65” in them. Advocates for the disabled and M+C MCOs noted that most mainstream Medicare educators and most M+C MCOs make only minimal efforts to reach out to people with disabilities. Advocates in the disabled community distinguished between beneficiaries with long-term disabilities, who tend to be more sophisticated about ensuring their needs are met, and beneficiaries with recent disabilities, who have relatively more difficulty navigating programs. However, education about Medicare choices and managed care is not tailored to address either group’s concerns, nor does it seem to be reaching the disabled through traditional routes. Nevertheless, in the six sites, M+C MCO respondents suggested that the under-65 population is enrolling in M+C MCOs. It seems that the financial support and access to providers is sufficient to attract some of the under-65 despite the lack of targeted education and/or marketing.

Interviewees in all six communities reported that age affects both comprehension about Medicare choices and the sources beneficiaries access for information. They told us that older beneficiaries, whose managed care experience is relatively limited, are likely to be confused by the new concepts. Adding to the problem is that memory and comprehension change with age (Craik 2000, Parks 2000, Sanfey et al. 2000) making the decision-making process more difficult. Those who are older (80+), have less education, and have poorer health are least able to use comparative information for making choices (Hibbard 2000). Furthermore, relative to younger beneficiaries, older beneficiaries are more likely to be frail and less mobile, which constrains the sources of information they can access. Most education, such as presentations at senior centers, is geared toward mobile beneficiaries. Efforts to reach homebound seniors through meals-on-wheels are limited. Finally, interviewees told us that older seniors are less likely to use the Internet to access information because they are not comfortable or familiar with computers.

THE THREE MOST IMPORTANT QUESTIONS BENEFICIARIES ASK ARE ABOUT COST, COVERAGE OF PHARMACY BENEFITS, AND INCLUSION OF THE BENEFICIARY’S PHYSICIAN OF CHOICE

Across the communities, educators, advocates and plans agree that beneficiaries want to know (1) how much things cost; (2) whether pharmacy benefits are covered; and (3) whether their physician is in the M+C MCO. Often, beneficiaries who ask educators these questions also ask, “Which plan is the best one?”

“They look at what it costs to go to [their] doctor and get drugs and are not interested in the details.” Information Counselor (Baltimore 1999)

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5Nationally, only 4 percent of the under-65 population is enrolled in an M+C MCO compared with 10 percent of those over 65 (Kaiser Family Foundation 1999a).

III: What Information about Their Choices Do Beneficiaries Want, and When Do They Want It?
Drug coverage and cost (that is, the premium) were clearly the most important of the three factors that go into beneficiary choice. The importance to beneficiaries of having their physician or hospital in the plan came next, but its importance varied, depending on the region. In Baltimore and Orange County, interviewees said that physician participation is highly important because of beneficiary loyalty and contracting exclusivity, respectively. In Orlando, a site with individual and small physician groups, physicians are more likely to contract across plans, so the issue is relatively less important. In Detroit, we heard that the history of rich fee-for-service benefits and provider choice, supported by union activity, has conditioned retirees to expect a wide choice of providers. If physician contracting does differ across plans, it could influence choice. For example, according to interviewees, beneficiaries in Detroit are more likely than beneficiaries in other markets to pay more to have choice. Unlike those in the other sites, we were told that beneficiaries in Albuquerque do not ask about physicians. Many beneficiaries in this site reportedly choose a plan on the basis of the sponsoring hospital system, and most of these systems exclusively serve their own M+C MCO (though in most cases beneficiaries are already using their preferred hospital system and an appropriately affiliated physician when they enroll in Medicare.) Similarly, in New Orleans, where the physician market is dominated by IPAs, beneficiaries reportedly have strong loyalties to particular hospitals—which are segmented into for-profit, not-for-profit, public and private. Most physicians are in multiple-plan networks, so loyalty to a hospital tends to be the deciding factor.

Counselors assert that most beneficiaries fail to understand managed care and its restrictions. For example, beneficiaries frequently ask why they have received bills after seeing a non-network provider. More sophisticated seniors do ask pointed, detailed questions about benefit coverage (such as formulary) and network restrictions. It appears that this more knowledgeable population was larger in Orange County and Albuquerque, where managed care penetration is high, than in the four other sites. Interviewees from MCOs believe that many “sophisticated” beneficiaries attend education sessions and actively ask questions. In contrast, interviewees from SHIPs reported that most of their clients are bewildered and unsophisticated.

**MOST BENEFICIARIES DO NOT USE INFORMATION ON QUALITY OF CARE**

Information from the Consumer Assessment for Health Plans Study (CAHPS) and the health plan employer data and information set (HEDIS) measures are available from HCFA, by calling 1-800-Medicare (HCFA 2000d) or accessing www.medicare.gov. Still educators conveyed clearly that most beneficiaries focus on the basics. It is unclear if beneficiaries are even aware of the CAHPS and HEDIS measures or how to use them. Although information counselors report that beneficiaries ask which plan is “the best,” the question, which combines general issues of quality, value, and appropriateness of the plan, is ambiguous and likely reflects general ignorance about how to judge quality. In Albuquerque and Baltimore, state commissions produce MCO report cards on quality, that include breakouts for the Medicare

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6Physicians in Orange County are highly organized and often contract exclusively with plans. Physicians in Baltimore are not particularly organized, with the exception of some large groups associated with university systems.

III: What Information about Their Choices Do Beneficiaries Want, and When Do They Want It?
population. It was unclear how many beneficiaries use this information. (This effort is only in its second year in Albuquerque and the state is still refining accessible formats and distribution).

In most cases, as one educator noted, the presence of a personal physician in a plan is the beneficiary’s proxy for quality. In others, a hospital may serve this function. Everything we have learned indicated that quality information is not central to the decision-making process of most beneficiaries. Orange County was the exception. An interviewee from one M+C MCO mentioned that some sophisticated, well-educated beneficiaries from high income brackets are interested in report cards and quality measures. However, the other interviewees made it clear that few beneficiaries are even aware that information about quality of care is available. Most beneficiaries are still struggling to understand more basic information.

In sum, beneficiary demands for information are limited by the knowledge of beneficiaries have and their ability to form questions. Many beneficiaries have so little information, according to our informants, that they do not know how to collect appropriate information. Moreover, large numbers of beneficiaries have significant language, literacy, or cultural barriers to effective information collection. Most beneficiaries feel the need for information about Medicare when they are in a crisis. All of these considerations create distinct challenges for those organizations that are attempting to educate beneficiaries about informed choices.

CONCLUSION

Medicare beneficiaries find it difficult to understand the complicated program that pays for much of their health care. They try to understand only as much as is directly relevant to their circumstances and rarely seek information unless there is some kind of change in circumstance or crisis, whether internally or externally induced. They make decisions on the basis of the most basic information about the cost of the coverage, whether their physician is in the health plan and whether there is coverage for prescription drug needs. They do not generally use formal information on the quality of care provided by health plans or specific providers. All of these findings have implications for the design and implementation of effective education initiatives, as well as for the ultimate goal of using beneficiary decisions to drive the market for health insurance for Medicare beneficiaries.

III: What Information about Their Choices Do Beneficiaries Want, and When Do They Want It?
CHAPTER IV

THE INFORMATION INFRASTRUCTURE: WHAT EFFORTS ARE BEING MADE TO EDUCATE MEDICARE BENEFICIARIES?

Organizations with diverse missions and varied approaches to Medicare information provide education to Medicare beneficiaries about how the Medicare program works. Federal, state, and local government entities provide information as part of their responsibilities to administer health and aging benefits. Market-based organizations, such as health plans, hospitals, and medical groups, provide information as part of their marketing or patient education efforts. And finally, nonprofit organizations in the health and aging sectors provide information as part of their efforts to improve the lives of their clients.

During our site visits, we focused on educational efforts at the local level, exploring the activities of community-based organizations, local governments, and local providers, as well as the local representatives of the federal or state governments and the local operations of national managed care plans. We documented a broad set of activities that can be defined as “Medicare education,” including the distribution of written materials developed by HCFA or other sources, intensive counseling of individual beneficiaries, and the many types of education falling in between. This “infrastructure” of “information intermediaries” that undertake Medicare educational efforts varies from site to site. In most sites, a core set of organizations dominates Medicare education. However, which organizations participate, what they do, and how well they meet the demands and needs of beneficiaries depends on the particular economic, social, and political conditions of each community.

THE MEDICARE PROGRAM HAS ALWAYS BEEN SUFFICIENTLY COMPLICATED TO WARRANT BENEFICIARY EDUCATION

From its beginning in 1965, Medicare has been a complicated system for beneficiaries to understand and to navigate. It is a public program with claims administered by private carriers;
it has been divided into two “Parts” (A and B), each covering different types of health care providers and relying on different financing; and it has been supplemented by optional private insurance covering some of the medical services that Medicare does not. In response to these complex program features, the Health Care Financing Administration (HCFA), the Social Security Administration, and the private-sector intermediaries have long made efforts to teach Medicare beneficiaries about the program, publishing scores of explanatory brochures and, during the previous decade undertaking more active outreach to beneficiaries. In 1991, Congress took an additional step by creating the Insurance Counseling and Assistance (ICA) Program to offer insurance counseling to beneficiaries, thereby expanding the scope of Medicare education.

These small-scale efforts were given a boost with the establishment of the Medicare+Choice (M+C) program in 1998. The ICA Program was renamed the State Health Insurance Assistance Program (SHIP) and given expanded responsibilities and increased funding. At the same time, HCFA created the National Medicare Education Program (NMEP), a multifaceted campaign that encompasses toll-free hotlines; a detailed handbook, Medicare & You, which is distributed to every Medicare beneficiary; the establishment of a website containing information on the availability of health plans in each ZIP code, their prices, benefits, and measures of the quality of care they provide; and the creation of partnerships with national and local organizations of all stripes to undertake a variety of educational efforts, including the dissemination of HCFA materials, the sponsorship of health fairs, and the development of media campaigns.

**NATIONAL LEVEL MEDICARE BENEFICIARY EDUCATION IS INSUFFICIENT. MEDICARE EDUCATION MUST INCLUDE A LOCAL COMPONENT**

Most of the education efforts described in the preceding section are national in scope and are insufficient by themselves because health care is ultimately a local matter. Hospitals, physicians, and patients operate in response to local market conditions, whether economic (as in the local reimbursement rates), social (as in the demographic characteristics of the local patient population), or geographic (as in the accessibility of facilities). Given that beneficiaries make decisions after considering such local conditions, Medicare education must include a local component. Both the SHIP program and HCFA have recognized this necessity. The SHIPs often establish offices in localities or subcontract to existing organizations, such as Area Agencies on Aging (AAAs) to carry out local efforts. HCFA, which does not have a presence at the local level, has directed its regional offices to form partnerships with local organizations to engage in Medicare education.²

²Although we did not find these partnerships to be highly developed in most sites, they represent a potentially important source of financial support and technical assistance to local information intermediaries and could be one of the most effective means of addressing gaps among different local areas.

*IV: The Information Infrastructure: What Efforts Are Being Made to Educate Medicare Beneficiaries?*
A SMALL CORE OF ORGANIZATIONS HAS UNDERTAKEN MEDICARE EDUCATION. IT IS NOT A MAJOR ACTIVITY FOR MOST AGING AND HEALTH CARE ORGANIZATIONS ON THE LOCAL LEVEL.

In contrast to the hopes and expectations expressed during the initial stages of the M+C program, Medicare education has not become a major activity for most aging and health care organizations on the local level. As we will discuss later, educating Medicare beneficiaries takes substantial effort. Very few additional resources have been granted to local information intermediaries so far. This is perhaps the reason for the dearth of widespread activity by local aging and health care organizations. Local provision of Medicare education is carried out by a relatively small number of organizations in any one market. In the six markets that we visited, a core set of organizations played active roles, usually (although not uniformly) consisting of the local SHIP, the local AAA (if it was not the host to the SHIP), the M+C MCOs themselves, the Regional Office of HCFA, the Part B Carriers (that is, private insurance companies who administer claims for Part B services under original Medicare), and the State Department of Aging or Elder Affairs. Three markets (Florida, California, Louisiana) had an active State Department of Insurance (DOI). The DOI in Albuquerque is in the process of establishing a unit to provide education and oversight. The local peer review organizations (PROs) were substantial participants in three of the six sites—Detroit, New Orleans, and Orlando. In Orlando, the PRO is sponsoring the VOICE (Volunteers Outreach Interagency Communication for the Elderly) Coalition, a coalition of health care and aging organizations that educate Medicare beneficiaries. VOICE’s purpose is to share information, avoid duplication, and close gaps among the efforts of the member organizations to present a more coherent curriculum.

In several markets, agencies or organizations not involved in a majority of our sites play substantial roles in providing education when they do participate. In Albuquerque, the American Association of Retired Persons (AARP) is very active in both statewide and local Medicare education activities. It supplies many of the volunteer counselors for the SHIP program and conducts many of the Medicare education workshops in cooperation with the state government’s Administration on Aging. In the Baltimore area, the local office of the congressional representative is quite involved in Medicare education; in the Detroit area, the United Auto Workers and the “Big Three” automakers are conspicuous players in educating about Medicare.

Most sites also have specialized educational efforts that are carried out by organizations to address particular aspects of the Medicare program. In several sites, organizations for the disabled educated clients about their distinctive Medicare rights; in three other sites, there were active Legal Services organizations representing Medicare beneficiaries in legal proceedings. Neither type of organization, however, provided the more general education that helps beneficiaries to make choices among their Medicare insurance options.

In all six sites, the Medicare managed care plans provided Medicare-related education as part of their marketing and patient education efforts. This education often consists of information not only on the health plan’s specific benefits, but on how managed care works (for example, rules on referrals, pre-admission procedures and so on). Health plans use their patient

IV: The Information Infrastructure: What Efforts Are Being Made to Educate Medicare Beneficiaries?
education and member retention activities to reinforce those lessons. This education takes place through sales presentations and alongside other information intermediaries at health fairs and in workshops sponsored by senior centers, churches, fraternal organizations, and other groups (see Table IV.1).

This list of information intermediaries is notable for those that it does not contain. Many organizations thought to be likely “Medicare educators” do not actually provide much education. Few consumer or patient organizations are involved in Medicare education (with the exception of independent consumer groups in New Orleans and Orange County). Traditional health care providers—hospitals and physicians—are only minimally involved in any organized way.3 Moreover, advocacy organizations that represent vulnerable beneficiaries, such as ethnic minorities, the disabled, or the low literate, are rarely actively involved in providing Medicare education (although they often host the efforts of others). Several reasons explain this lack of involvement. Most providers (physicians and hospitals) explained their lack of involvement in Medicare education by pointing to the growing pressure for providing care within strict time limits and reduced or stationary reimbursements limiting their capacity to spend time educating their patients about insurance issues. Representatives from community-based organizations indicated that their organizations’ financial and political resources were too limited to spend much time educating their members about Medicare. Many of these groups focus on issues of interest to their members that are present across the entire life span or, in the case of some organizations serving low-income ethnic communities, on their clients’ immediate financial and legal needs. They do not have the extensive resources to devote the needs of only part of their community.

This picture of the information infrastructure becomes more complex when we analyze what we mean by “Medicare education.” Educating beneficiaries about the Medicare system and their choices can be viewed as a set of activities that range from passively distributing printed materials developed and provided by others (primarily HCFA and the AARP), to preparing one’s own materials, to running workshops or speaking at community forums on Medicare, to providing counseling that supports individual decision making (through telephone hotlines

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3There are exceptions. Some individual hospitals in Orlando, Orange County, and New Orleans provide Medicare education as part of general health education efforts to serve their patients and secure patient loyalty to the hospital.
TABLE IV.1
KEY MEDICARE EDUCATORS IN EACH COMMUNITY

<table>
<thead>
<tr>
<th>ALBUQUERQUE</th>
<th>BALTIMORE</th>
</tr>
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<tbody>
<tr>
<td>State Administration on Aging</td>
<td>Lead agency in Medicare education: trains volunteers; funds local SHIPS; conducts statewide education</td>
</tr>
<tr>
<td>SHIP (State Health Insurance Assistance Program)</td>
<td>Leading educators. Both statewide and citywide SHIPS. (Called HIBAC in New Mexico). Conduct one-on-one counseling; run hotlines; disseminate information; make presentations</td>
</tr>
<tr>
<td>Department of Insurance (DOI)</td>
<td>Educates about Supplemental Medicare; in process of forming educational and regulatory unit for Medicare HMOs</td>
</tr>
<tr>
<td>Peer Review Organization (PRO)</td>
<td>Specialized educator: focuses on choice and quality; rights to benefits and appeals</td>
</tr>
<tr>
<td>Social Security Administration</td>
<td>Specialized educator: focuses on traditional Medicare</td>
</tr>
<tr>
<td>Part B Carrier</td>
<td>Specialized educator: focuses on Part B, traditional Medicare</td>
</tr>
<tr>
<td>AARP</td>
<td>Leader in Medicare education: develops materials; recruits volunteers for SHIPS; makes statewide presentations; lobbies for state funds for education</td>
</tr>
<tr>
<td>Medicare Managed Care Plans</td>
<td>Makes presentations at health fairs; makes marketing presentations; provides member education to increase retention.</td>
</tr>
<tr>
<td>Protection and Advocacy Organization</td>
<td>Specialized educator: focuses on disabled population; partners with State Administration on Aging</td>
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IV: The Information Infrastructure: What Efforts Are Being Made to Educate Medicare Beneficiaries?
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<th><strong>TABLE IV.1 (continued)</strong></th>
<th><strong>Baltimore (continued)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Area Agencies on Aging</td>
<td>Eastern Shore aging agencies. Serves as lead educators in their counties; provide counseling; disseminate materials; make oral presentations</td>
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<tr>
<td><strong>Detroit</strong></td>
<td><strong>SHIP</strong></td>
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<tr>
<td></td>
<td>Statewide SHIP is hosted by Area Agencies on Aging Association (AAAA). Called Michigan Medicare/Medicaid Assistance Program (MMMAP) in the state. Statewide MMMAP is a leading Medicare educator: trains and coordinates volunteers, distributes funds to all 16 local MMMAPs. Local MMMAPs are usually hosted by local Area Agency on Aging. Provide direct counseling, disseminates materials, runs hotlines; makes oral presentations.</td>
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<td></td>
<td>Department of Insurance</td>
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<tr>
<td></td>
<td>Communications Office responds to telephone inquiries but there is no official hotline. In partnership with statewide MMAP, developing website that will provide comparative information on health plans under Medicare</td>
</tr>
<tr>
<td></td>
<td>Legal Services</td>
</tr>
<tr>
<td></td>
<td>Specialized educator: educates on dual eligibility (QMB/SLMB) as well as provides general Medicare education; provides individual counseling, but only to those under certain income limits.</td>
</tr>
<tr>
<td></td>
<td>Part B Carrier</td>
</tr>
<tr>
<td></td>
<td>Specialized educator: focuses on Part B of traditional Medicare</td>
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<tr>
<td></td>
<td>Coalition of Medicare Educators</td>
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<tr>
<td></td>
<td>Coalition to coordinate Medicare education. Members: MMMAPs, Social Security Administration, Part B carrier, PRO, Michigan Hispanic Senior Citizen’s Coalition</td>
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<td></td>
<td>Employers and Labor Union</td>
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<tr>
<td></td>
<td>“Big Three” automakers and United Auto Workers engage in Medicare education: disseminate materials, make presentations, provide individual counseling to current and retired employees/members</td>
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<td></td>
<td>Medicare Managed Care Plans</td>
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<td></td>
<td>Makes presentations at health fairs; makes marketing presentations</td>
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<td></td>
<td>Michigan Protection and Advocacy Service</td>
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<tr>
<td></td>
<td>Specialized educator: focuses on disabled population. Recently won HCFA grant to enroll all those eligible for Medicaid QMB/SLMB benefits</td>
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<tr>
<td><strong>NEW ORLEANS</strong></td>
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<tr>
<td><strong>SHIP/ Department of Insurance</strong></td>
<td>Statewide SHIP program located in Department of Insurance. Called SHIIP in Louisiana. It is the lead educator in state. Develops own materials, runs hotline, distributes funds to local SHIIPs, runs cable TV educational show. State SHIIP workers are hosted by local Councils on Aging in parishes. The active local SHIIPs are in the New Orleans and Jefferson parishes. Provides counseling, makes presentations, disseminate materials.</td>
</tr>
<tr>
<td><strong>Medicare Beneficiary Council</strong></td>
<td>Coalition of Medicare educators. Members: Social Security Administration; Part B carrier, PRO State SHIIP. Is lead by PRO. Provides means to coordinate common presentations.</td>
</tr>
<tr>
<td><strong>PRO</strong></td>
<td>Specialized educator: focuses on quality education for choice</td>
</tr>
<tr>
<td><strong>Part B Carrier</strong></td>
<td>Specialized educator: focuses on traditional Part B Medicare</td>
</tr>
<tr>
<td><strong>Medicare Managed Care Plans</strong></td>
<td>Makes presentations at health fairs; makes marketing presentations</td>
</tr>
<tr>
<td><strong>Social Security Administration</strong></td>
<td>Specialized educator: focuses on traditional Medicare</td>
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<th><strong>ORANGE COUNTY</strong></th>
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<tr>
<td><strong>SHIP</strong></td>
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<tr>
<td><strong>Department of Insurance</strong></td>
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<td><strong>Department of Corporations</strong></td>
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<tr>
<td><strong>Medicare Managed Care Plans</strong></td>
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*IV: The Information Infrastructure: What Efforts Are Being Made to Educate Medicare Beneficiaries?*
TABLE IV (continued)

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<th>ORANGE COUNTY (continued)</th>
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<tr>
<td>Senior Citizens Legal Advocacy Program</td>
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<tr>
<td><strong>ORLANDO</strong></td>
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<td>SHIP</td>
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<tr>
<td>Part B Carrier</td>
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<tr>
<td>PRO</td>
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<tr>
<td>VOICES</td>
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<tr>
<td>Philanthropic Foundation</td>
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<tr>
<td>Medicare Managed Care Plans</td>
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<tr>
<td>Department of Insurance</td>
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</table>
or in person). These efforts are joined by the education that the Medicare managed care plans themselves provide, which makes use of printed materials, videos, contacts with caregivers, and senior volunteers or “ambassadors” to spread Medicare education.

THE INFORMATION INFRASTRUCTURE HAS TWO TIERS: ORGANIZATIONS THAT ACTIVELY DEVELOP AND PRESENT MATERIALS AND ORGANIZATIONS THAT HOST THE FIRST-TIER GROUPS

The first tier of information intermediaries consists of organizations that develop, distribute, and actively present information. They usually are publicly funded groups, such as AAAs, the SHIPs, PROs, DOI, and the Part B carriers, as well as the (private) managed care organizations. The second tier is composed of organizations that host the active educational organizations, including senior centers, ethnic churches, advocacy groups for immigrants, fraternal organizations, Meals on Wheels programs, unions, hospitals, and clinics, among others. This tier invites Medicare educators to assist their members or clients on site. Second-tier organizations undertake outreach (for example, advertising the availability of materials, workshops, and advice), may provide advice on community needs, but rarely undertake direct education on their own.

The information infrastructure is marked by the gap between community-based and health plan information intermediaries. Cooperation between the two sides is relatively rare, with most education occurring along parallel, not intersecting, paths. Health plan efforts to educate beneficiaries are viewed with some suspicion by public and non-profit intermediaries (who have to deal with the results of occasional zealous or fraudulent marketing), whereas many health plans are unaware of any activities (or, sometimes, the very existence) of the SHIPs or other non-profit educational efforts. Typically, health plans devote substantially more resources to marketing and enrollment than do the public or non-profit sectors. Thus, they are likely to reach many more people.

4S. Sofaer has developed a similar typology. See S. Sofaer. “Classification Scheme of Individuals and Agencies Who Serve As Information Intermediaries for People on Medicare.” Unpublished paper, Baruch College, May 15, 2000.

5Again, there are exceptions, with private-sector organizations such as the AARP in Albuquerque and Orange County playing active roles in materials development. In various sites health plans and non-profit intermediaries share presentations.

6There are always exceptions. In Louisiana, the local SHIIP invites the health plans to help explain to beneficiaries why plans were withdrawing from the market. In Orange County, health plans refer their members to the SHIP (HICAP) for assistance in making decisions.

IV: The Information Infrastructure: What Efforts Are Being Made to Educate Medicare Beneficiaries?
DESPITE INCREASED PROVISION OF MEDICARE EDUCATION, MOST INFORMATION INTERMEDIARIES HAVE RECEIVED FEW ADDITIONAL RESOURCES TO FULFILL THEIR RESPONSIBILITIES

The introduction of M+C has given regional and local organizations new opportunities and responsibilities to help beneficiaries make critical choices about health insurance coverage. Where have they found the resources to address the new demands imposed on them?

M+C has changed the way aging and health care organizations approach the process of informing beneficiaries. Before M+C, notices would be sent and information on rights and appeals could be distributed, but with little emphasis on explaining concepts and providing knowledge that should be used for action. Because beneficiaries were not expected to actively use information to make decisions, the organizations seldom expected to receive information requests. Local information intermediaries mostly distributed materials from federal agencies, did a small set of presentations, and could handle the small number of phone calls with relatively small staffs.7

The newly enhanced emphasis on education has resulted in distinct changes and the addition of many more activities. Most local intermediaries report increased contacts from beneficiaries, especially after major events such as M+C MCOs withdrawals. They also report increased efforts on their part to distribute materials, undertake presentations, and provide information and assistance to help their clients to cope with these changes. Many of the organizations in the first tier of Medicare education (the core set of active educators) have increased the number of volunteers they use to carry out the expanded educational and counseling functions. The SHIPs (on both the local and state levels) and the AAAs have been particularly active in this area. These organizations typically use these volunteers to provide counseling and make presentations.

All of these increased activities generate increased costs. Volunteers do not require salaries but do require additional expenditures of resources to recruit and continuously train. Adapting brochures, traveling to health fairs and other educational activities also demand additional resources.

Most local level intermediaries have not received or generated the additional resources to cover these intensified educational activities. SHIPs, and to some extent PROs, are the major exceptions, receiving additional federal and state funding (through funds for insurance counseling and aging services). This funding is relatively minimal, however, particularly when spread across an entire state. Local SHIPs report additional grants of only $5,000 to $10,000 for a year. In a few instances, local foundations (such as the Winter Park Health Foundation, in

7This depiction of the activities involved with medicare education does not include the time and resources spent helping Medicare beneficiaries under fee-for-service Medicare understand their claims and the Explanation of Benefits forms.
Orlando, and the Frost Foundation, in Albuquerque) have contributed funds for various types of Medicare education. In general, however, few additional financial resources have been infused into the local infrastructure for Medicare education.

Probably because no additional funding has been forthcoming, most information intermediaries have not made many staffing changes or reallocated large amounts of resources to handle Medicare education. This has limited the effort invested into Medicare education. Existing funds have simply been stretched to encompass the newer activities. For most, Medicare education is a sideline or just one of several equal activities. With the exception of the SHIPs, many intermediaries have simply added new modules to their standard informational presentations or produced an additional brochure or two. Most organizations that serve as intermediaries operate with limited budgets; they have experience doubling up staff to work on related activities and stretching existing funds to cover new and relevant activities. But the lack of resources takes a toll. Several agencies in each of our sites, particularly the agencies for the aged and agencies that serve the disabled, indicated that Medicare education efforts limited their ability to mount activities to address other client problems (5 out of the 13 intermediaries in these categories).

INFORMATION INTERMEDIARIES HAVE GRADUALLY DEVELOPED A CURRICULUM THAT IS BROADER THAN M+C—ONE THAT IS ORIENTED TO THE AVERAGE MEDICARE BENEFICIARY

Providing information about the intricacies of the Medicare program in sufficient clarity and detail to enable beneficiaries to make appropriate choices is not an easy task. Large segments of the beneficiary population have low levels of literacy and chronic health conditions that detract from their capacity to learn about the program. Beneficiaries from immigrant or minority communities and those with little education find standard sources of information inadequate. Information intermediaries have grappled with these complexities with mixed success. It has taken time to gauge the considerable educational needs of beneficiaries. The scope of the material necessary for effective education is quite broad. One educator in Orlando expressed the sentiment heard from all six markets: “So many people don't know what Medicare is.” Thus, in order for beneficiaries to understand their choices under M+C, intermediaries have found that they have had to increase beneficiaries’ knowledge about the major alternative to Medicare managed care, namely the original (fee-for-service) Medicare program. Many beneficiaries were not able to grasp the significance or relevance of M+C choices without a better understanding of what they would be leaving. Information intermediaries therefore have expanded their efforts to include education on how the health care system as a whole actually works; teaching about deductibles, networks, referrals to specialists and so on.

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*See the discussion in Chapter III for greater detail on these issues.*

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The result of this expansion in the content of the education as well as the natural evolution of teaching practices are six information infrastructures that are organized around a common core of basic concepts, but that differ widely in the information surrounding that core and in the quality of execution. Most information intermediaries are confronted with a tricky challenge: They must condense and simplify a large amount of complicated information into manageable pieces. For example, Medicare educators must provide information on the differences between fee-for-service and managed care, the concepts of deductibles and co-insurance, the differences between Part A and B, how to read HCFA forms, the services covered and not covered, and various combinations of Medicare and supplemental insurance or Medicare and managed care. According to several information intermediaries, most seniors are not willing to attend presentations that last for more than 30 minutes, but the concepts, several respondents assured us, generally require much more time to explain.

Most of the key intermediaries, the SHIPs, and the AAAs (as well as the AARP, employers, and unions) generally attempt to present the gamut of what they consider information necessary to understand Medicare, sacrificing in depth what they make up for in comprehensiveness. Other intermediaries cope by specializing in specific aspects of Medicare. Indeed, in most of our markets, there appeared to be semi-explicit agreements among intermediaries to divide the turf. For example, Part B carriers, concentrate on education about traditional Medicare and refer questions about M+C options to the SHIPs or others. The DOIs emphasize information on supplemental (Medigap) insurance. Health plans offer education about managed care practices and provide detailed information on the workings of the M+C products, whereas the PROs focus on beneficiaries’ rights to quality care. In Orlando, New Orleans, and Detroit, intermediaries have formed formal coalitions to exchange information and coordinate their diverse educational efforts.

Medicare education was set back a few paces by an initial serious misstep. Most intermediaries in five of the six markets initially geared up to educate beneficiaries about their choices among different types of health care coverage offered under the M+C legislation. HCFA encouraged this approach in its training of intermediaries in fall 1998. This educational tactic was a mistake, however, because many of the various “choices” (such as MSAs or private fee-for-service plans) never materialized. As reported in five of the six sites, Medicare education during that first fall campaign made laborious efforts to explain these rare or nonexistent options to beneficiaries. This education initiative had negative consequences for the intermediaries and the beneficiaries they serve. Both sides felt misled. Intermediaries had to make tremendous efforts to explain complicated concepts, which beneficiaries tried to comprehend. Intermediaries reported frustrated and hostile receptions by beneficiaries, who complained about struggling to understand the options only to be told that they were unavailable. Many of our respondents also reported that for a time, both intermediaries and beneficiaries became less interested in education because of this initial error in emphasis.

The ultimate effectiveness of all these Medicare education activities depends not only on what is said, but on how it is presented. The educational approaches that the majority of information intermediaries use fall into a relatively narrow range and appear to be relatively
limited in reaching the bulk of the Medicare population. Medicare education mostly consists of three approaches:

1. The distribution of printed materials

2. Oral presentations to community groups and at health fairs

3. Individual counseling, generally through telephone hotlines

M+C MCOs, with greater financial resources than the other intermediaries, have produced a wider variety of materials.

Despite its limitations with many types of beneficiaries who have problems with literacy or sight, print is a favorite medium of most information intermediaries. Materials are distributed through the mail; at health fairs; or through churches, banks, and other community venues. The materials are often those produced by HCFA (or based on HCFA templates), with customized information intended to provide specific local details, such as the names and features of local market health plan offerings, or to fit local population needs, such as materials in Spanish (Albuquerque) or Arabic (Detroit). Many local intermediaries have developed their own materials, including worksheets to help beneficiaries work through the decision-making process (Albuquerque and New Orleans), comparison charts providing information on the features of available managed care plans (Baltimore, Detroit, New Orleans, and Orange County), and lists of resources (Albuquerque and Orange County), to name a few. All intermediaries emphasize that they are simplifying and improving the readability of HCFA materials, as well as increasing the comprehensibility of the information by incorporating references to local institutions and M+C MCOs.

Much of the intermediaries' energy and time is taken up by the second educational approach, presentations to community groups. Almost every intermediary in our six sites used oral presentations to educate beneficiaries. There were no systematic differences among the sites in terms of where the presentations were made. The core set of information intermediaries (the SHIPS, AAAs, State Departments on Aging, PROs, and Part B carriers) and Medicare health plans spoke to church groups, hospital personnel, fraternal organizations, retiree clubs and made presentations at senior centers, nutrition programs, and libraries, among many other venues. Some intermediaries organized yearly conferences (Albuquerque and Baltimore). All made regular rounds of all their area’s health fairs. Presentations ranged from one to three or four per month, and the audiences ranged from 10 to 100 beneficiaries at each meeting. Although widely used, presentations are relatively inefficient, reaching only a small fraction of Medicare beneficiaries despite considerable expenditure of time and effort.

The third major format for Medicare education is individual decision support (or counseling). In every market, the SHIP programs provide counseling as part of their basic mission and philosophy. Some SHIPs (Albuquerque, Baltimore, and Orlando) even make house calls. Other organizations that provide counseling (either face to face or via hotlines) include
AAAs, PROs, large employers, unions, the DOIs (in four sites), organizations for the disabled, and Legal Service organizations. Many Medicare managed care plans provide individual counseling during sales calls.9

Most intermediaries reported that they believed individual counseling was the most effective technique because it could be tailored to individual levels of knowledge and specific circumstances. As one Baltimore informant observed, “HCFA is putting out good information. Still you need to have someone to explain the information.” However, most intermediaries, with the exception of the federally funded SHIPs, cannot undertake much counseling because it is too labor intensive and costly. Nevertheless, many undertake information and referral tasks, such as providing basic explanations and then referring beneficiaries who need more assistance to the one or two intermediaries in each market that provide more intensive individual counseling.

Some agencies provide counseling, but the length of time devoted to each beneficiary case varies tremendously according to the resources of the organization. Most intermediaries use volunteer counselors who are trained and supervised by one or two paid staff. Turnover can be high, and each counselor can volunteer anywhere from 2 to 40 hours per week. (Most volunteers are retirees who provide much less than 40 hours.) Thus, although counseling is seen as most effective for an individual beneficiary, it, too, appears to have limited effectiveness across the total number of beneficiaries in the market due to the constricted resources of most information intermediaries.

Information intermediaries have been slow to adopt innovations in information dissemination or in teaching techniques. Most intermediaries do not yet use video or audio tapes as educational tools to reach those who prefer (or require) this type of educational format (for example, the visually impaired or the low literate). In four sites, information intermediaries produced cable television programs (Albuquerque, New Orleans, Orange County, and Orlando). Only two intermediaries in the sample have adopted computer-based educational tools (the AAAs in Baltimore and soon in Orlando). Although four of the six sites now have intermediaries that have developed websites. Few intermediaries appear to use innovative learning activities in their oral presentations (such as forced-choice exercises). Most oral presentations appeared to be standard slide shows. None of the information intermediaries we interviewed discussed teaching techniques or mentioned plans to alter their presentations to include newer technologies. We hypothesize that lack of time and experience in teaching limit the capacity of local intermediaries to innovate.

Several market and community factors appear to affect the utilization and effectiveness of the three main educational activities used by most information intermediaries. First, several of the markets had greater numbers of community organizations than others and so offered larger

9Some states prohibit health plans from including marketing activities in their general educational presentations, but states do not prohibit the plans from providing educational counseling during formal sales calls.
numbers of venues and easier access to beneficiaries. For example Detroit, New Orleans, and Orlando have dense organizational networks (particularly among many of the vulnerable communities), whereas Albuquerque, Baltimore, and Orange County did not. Beneficiaries in those sites had fewer places to go for help. Where there were fewer community organizations, managed care plans took a more prominent role in Medicare education (for example, Orange County, where health plans are quite sophisticated). However, this reliance on plan-based education does present potential challenges. To the extent that health plans tend to provide information relating to their own offerings, education in the communities is less comprehensive. Some beneficiaries prefer information from independent sources (Gibbs et al. 1996), and this lack of education based in community organizations reduces the number of sources of trusted information.

The second environmental factor to affect educational activities is the presence of large employers in a market. In the sites we visited, large employers became major allies of smaller community-based intermediaries. In Detroit, for example, the efforts of the Big Three automakers and the UAW produced much of the Medicare education of the group market, enabling the SHIP and others to focus on the problems and concerns of individual beneficiaries. Similarly, the Baltimore information infrastructure found its job slightly easier because the educational activities of the Federal employees benefits system addressed the concerns of the large numbers of Baltimore residents who are federal retirees. As we have noted in Chapter II, however, rates of employer-based retiree coverage are decreasing, and few large employers are as concentrated in Detroit, so they often do not play a major role in any one community.

**THE INFORMATION INFRASTRUCTURE OFTEN MEETS THE NEEDS OF ACTIVE BENEFICIARIES WHO SEEK INFORMATION, BUT IT DOES NOT REACH THOSE WHO DO NOT KNOW TO LOOK FOR INFORMATION**

Most of the information intermediaries we interviewed believe that they are doing a reasonable job under the circumstances. Materials are being written, designed and distributed; outreach activities are inducing many beneficiaries to call; and people are requesting and attending informational meetings. When asked about the quality of the information they are disseminating, most felt that it was of high quality given the fact that Medicare and insurance are difficult matters to explain. When asked about the availability of information, many felt that the information was available in the community, but that beneficiaries were slow to become aware of its existence. One educator summed up the attitude of most intermediaries in this way:

“There are 700,000 beneficiaries in the state. Are we reaching all of them? No. Do we need to reach all of them? No. Are we reaching everyone we need to reach? No.”

The intermediaries acknowledge that there is need for improvement, but they also recognize the accomplishments made in the few short years of M+C.

However, do these myriad activities actually match the needs of the beneficiaries, as the intermediaries understand them? Is the information the intermediaries provide an improvement over the more informal sources of information that beneficiaries obtain from their peers, their

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children, the library, or the Internet? As we have discussed in Chapter III, Medicare beneficiaries have complicated informational needs.

1. Information must be understandable and available in small increments, so that it can be easily absorbed.
2. Information must be broad enough to provide a clear understanding of how the Medicare program works, but detailed enough to help explain specific bills or denials of care.
3. Information must be available in a crisis, when beneficiaries are motivated to learn.
4. Information must be relevant to the different characteristics of the various types of beneficiaries (taking into account different levels of literacy, education, income and cultural differences).

Are the local information infrastructures organized in such a way that they are able to provide education that meets these needs? We can assess the adequacy of the information and the infrastructures in our six sites according to several criteria:

- Comprehensiveness of information
- Understandability of information
- Capacity to reach the local beneficiary population
- Coordination of efforts among the intermediaries
- Flexibility in responding to needs

**Comprehensiveness of Information**

Does the education provided cover the broad scope of topics necessary to understand how the Medicare program works and the choices that are appropriate for beneficiaries? The answer to this is yes. Most educational efforts, called “Medicare 101” by respondents in several sites (for example, Detroit, New Orleans, and Orlando), cover such topics as the differences between fee-for-service and managed care; the different types of managed care (where available); the common health care services that are covered by the different “parts” of Medicare; beneficiary rights to appeal; pharmaceutical formularies, and how they work; the differences between Medicare and supplemental (Medigap) insurance; participating and nonparticipating providers;
premiums; deductibles; and more. Critical information is presented to beneficiaries who want or are able to use it.

**Understandability**

Can most beneficiaries understand the information? The answer, not surprisingly, varies with the specific materials and their format. Respondents at all six sites were fairly consistent in their opinion that the materials provided by HCFA (particularly the handbook, *Medicare & You*) are too complicated and in need of simplification (which many intermediaries indeed do). The intermediaries themselves use the handbook as a resource. Typical respondent assessments of the materials HCFA provides include the following:

- “*Medicare & You*—you can’t see yourself in it.” (Baltimore)

- “[We need to] take the information to a level that everyone can comprehend.” (Orlando)

- “I hear ‘I’ve given this [the handbook] to my son or daughter to translate.’” (Orange County)

- “Drop the handbook.” (Albuquerque)

Most respondents are confident that their own materials are understandable. When asked to rate the quality of the materials available in their community on a 10-point scale (where 10 is the highest quality), most respondents gave their materials a quality score of 7 or higher. As the information intermediaries acknowledge, however, the degree to which beneficiaries understand the education varies considerably. Understandability is highly dependent on such factors as the skills of the presenter (or writer), the pace or length of the presentations, and so on. We have few measures of such factors, although several respondents gave estimates of the time it takes to deliver their basic “Medicare 101” talk. The estimates ranged from 30 minutes (Orange County) to 2 hours (Orlando). The optimal time the talk should take is unknown, but it is likely that some beneficiaries who hear the talks are receiving too little or too much information. The perception of the quality of the materials also varies by perspective. Several of the second-tier organizations that sponsored direct Medicare educators had a more disappointed opinion of local Medicare education. For example, one front-line service delivery organization told us that, “the material is too complicated and they [the beneficiaries] can’t figure it out” (Orlando).

Understandability also varies with the type of educational approach used and the characteristics of the individual beneficiary. Written materials and telephone hotlines enable beneficiaries to refer to the information again and again (as they prefer). Appearances on cable television talk shows or oral presentations do not offer this advantage. Beneficiaries are better able to understand material if it has been tailored to their personal circumstances. Oral presentations and individual counseling are therefore more understandable (in this way) than mass-produced educational materials. Because they are not continuously available, however, beneficiaries cannot refer to them as needed in order to increase their comprehension.
Capacity to Reach the Local Beneficiary Population

Many information intermediaries recognized that their activities do not reach most beneficiaries. The following sample of quotes from the respondents indicates that the intermediaries are well aware of the problem.

- “Pockets, such as the disabled, are not being reached and we need to” (Orlando).
- “The question is, are we reaching those who aren't interested or in the aging network? Those people that we readily access are those that are accessing the aging network, which has developed over 25 years. It's hard to reach the others, truthfully” (Albuquerque).
- “[The information] is out there, but still a segment of the population is not reached. For example, the nonparticipating beneficiaries who don’t go to the senior centers or don’t have a computer” (Orlando).
- “[The information] is not easy to find. You must know what you are doing” (Detroit). “Our callers are medium to high educated and call after they’ve done their research. If the people are low literate, low income etc., they may be getting their information from other sources but it’s not from us” (Detroit).

Some of the more reflective information intermediaries proposed a variety of explanations for the limited reach of their activities. Some point to inertia or tradition. “I guess Baltimore consumers have not needed much consumer education. . . . In Baltimore, they stick with what they first have” (Baltimore). Others tie the shortfall to the characteristics of the elderly. “Information has never been all that good and because of the age of the people and [the lack of] willingness, and ability to comprehend, it’s hard” (Albuquerque). “Seniors accept things as they are. More so with the minority populations, they don’t ask for help even if they are suffering; they think of health care as a luxury” (Albuquerque). Still others assert that it is a problem with information distribution, not with comprehension. “The availability of information is good but seniors don’t know where to get it” (Orange County). Other intermediaries point out that the traditional educational mechanisms they use limit who receives the information. “Very good information, but not everybody reads. They mostly watch TV that tells them the things they need” (Detroit).

Most of the information intermediaries’ efforts depend heavily on beneficiary self-selection. Beneficiaries usually must seek out the community forums; similarly, they must locate a hotline number and make the telephone call. The only mechanism that does not rely on beneficiary initiative is the distribution of printed materials. Nevertheless, the effectiveness of these materials is highly dependent on both the beneficiary’s comfort level with reading and the creativity and persistence of the intermediary’s outreach efforts.
Coordination of Efforts

The fourth way to assess the information infrastructure is to examine whether the information intermediaries coordinate their efforts. We observed varying degrees of coordination across the six sites. Three of the sites (Detroit, New Orleans, and Orlando) have seen the development of coalitions of educators. The coalitions have been designed to reduce the duplication of information and to obtain "the real information on what is going on out there with beneficiaries" (Orlando). (Duplication is not necessarily inefficient if it helps beneficiaries who have difficulty in understanding the material.)

Flexibility in Responding to Needs

Information intermediaries need to adapt to variations in both the needs of beneficiaries and the demand for information. Beneficiaries with different characteristics will require different educational approaches. Secondly, beneficiary demand surges every time an M+C MCO changes its participation in the Medicare program or when a new “horror” story about managed care hits the media creating additional pressure on the information infrastructure.

Unfortunately, most of the information infrastructures are still relatively inflexible in terms of their capacity to adjust to different types of Medicare beneficiaries. The “curriculum” that has evolved is oriented toward the “generic” beneficiary. Few intermediaries make specific attempts to tailor their messages to specialized audiences, particularly those from vulnerable populations, such as low-income or ethnic communities. Little thought has been given to different preferences for learning or the cultural concepts that might contradict the more “generic” messages. When asked if they were aware of differences in the information needs of vulnerable populations, most respondents (with a few exceptions), admitted that they were not particularly oriented toward those issues. The intermediaries have made efforts to adjust education materials to special populations in only one area—language differences. For example, they have translated materials into Spanish, Arabic, and/or Chaldean in Albuquerque, Baltimore, Detroit, and Orange County. In addition, various hotlines have used counselors who speak other languages. Thus far, however, little has been done to write materials containing illustrative examples that would be relevant to various ethnic cultures, for example, or to ensure that graphic design reflects cultural practices or does not violate cultural taboos.

Rather than changing the curriculum itself, intermediaries have dealt with differences among Medicare beneficiaries by varying their outreach strategies. They have conducted outreach to ethnic institutions, such as the black churches (Baltimore and Detroit); immigrant churches (New Orleans); or social service organizations that serve particular ethnic communities (Baltimore, Detroit, and Orlando). Only two components of the information infrastructure have evolved beyond education for the generic beneficiary: (1) the M+C health plans, and (2) groups for the disabled. The health plans have identified various ethnic communities as potential markets and have developed the cultural competence to design educational and marketing campaigns that are appropriate to specific communities (for example, Orange County). In another site (Albuquerque), information intermediaries for the aging cooperated

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with their counterparts in the disability community to reach the under-65 disabled Medicare beneficiaries through outreach to meetings that the disabled attend.

Intermediaries recognize the need to alter their information and format to fit the information preferences of different beneficiary groups, but few have been able to make extensive efforts to do so. Resource limitations play a role in this omission.

- “We need, as a community [of educators], a multimedia approach because print won't work for everyone. We need video and other means” (Detroit).

- “Do one-on-one counseling because the educational materials don't make the difference . . . [but] we need money and resources in the community to . . . assist and do hand holding” (Albuquerque).

- “Written material is wasted . . . People don’t or can't read—either they never learned or they can't see. . . Written material is really used by agencies not clients—what a waste” (New Orleans).

Intermediaries make a few special efforts to address the information needs of beneficiaries with sight or hearing impairments. Some intermediaries have dedicated telephone lines for the hearing impaired; a few have sought to work with the disabled. But broad scale adjustments to fit special information preferences are yet to be done.

Few information intermediaries are able to cope with the extra demands placed on any agency that works with low-income ethnic communities. Clients in these communities have greater needs than do those in wealthier communities. When information intermediaries do work with many of their low-income and/or ethnic communities, they find that they must integrate their Medicare activities with efforts to help beneficiaries deal with utility bills, housing crises, and family matters—all part and parcel of the living experiences of those of limited means and/or frail health. Many information intermediaries do not have the staff or the expertise to take on these additional challenges.

Most information intermediaries have too few resources to make these adjustments to learning differences among beneficiary subpopulations. Almost all government and non-profit intermediaries are in agencies or organizational units with few staff (usually fewer than 10 paid staff, of whom only one or two are involved in Medicare education and often only part time), so they rely on volunteers to undertake most of the activities. This lack of resources contributes to the lack of flexibility. The active educators are forced to rely on adapting materials given to them by national-level organizations (such as HCFA, the national AARP, or the National Association of Area Agencies on Aging), because few have the staff or time to devote to the preparation of materials from scratch. There are few resources available to undertake research on different formats for education or the needs of special groups. In the sites that were able to conduct this research, such as in Albuquerque and Orange County, where the local AARP organization created new materials explaining basic Medicare principles, volunteers did the work.

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Furthermore, the intermediaries have little flexibility to cope with surges in demand for information. With the withdrawal of M+C health plans from several markets in the summers of 1998 and 1999, many information intermediaries encountered very high levels of demand for information from beneficiaries, providers, and elected officials. SHIPs in Baltimore and Louisiana had to bring in large numbers of volunteers to staff telephone hotlines. In addition, staff were pulled in from other areas of activity to handle the increased demand, and various outreach or other educational activities were postponed in order to cope with the confusion (both bureaucratic and among beneficiaries).

There are solutions to the gaps and the challenges to providing better education about Medicare. The concluding chapter explores the possible policies and steps that might be taken to bring the activities of the information infrastructure in line with the needs and demands of Medicare beneficiaries.
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CHAPTER V

CONCLUSIONS

The passage of Medicare+Choice legislation sought to do more than merely introduce managed care to the Medicare program. It was designed to create a market-based insurance system for Medicare that would enable beneficiaries to choose among a variety of competing public and private insurance products rather than simply receive a government-designed package of benefits. Such a system would generate the need for educated “consumers,” not just “beneficiaries,” and would require the development of educational efforts to provide beneficiaries with the information needed to make informed choices.

Has the M+C program realized its ambitions? Has it generated a market with choices? Has it led to the development of educated consumers who no longer are passive beneficiaries? Our study of the implementation of M+C on the local level—where the individual beneficiary actually experiences the program—suggests that the answers to these questions are complicated. Since 1998, a varied set of Medicare insurance choices has emerged in most of the six sites we visited, expanding in some places and contracting in others. Beneficiaries must sort through a set of options that differ greatly based on their income, retiree benefits from prior employment, health status, and geographical location. They have to balance considerations of cost and coverage, while riding the wave of changes in health status that inevitably emerge in old age. All this makes for a much more complicated picture than would first appear. Meanwhile, the campaigns to educate beneficiaries about all these considerations have become an evolving infrastructure of information efforts that are trying to raise the overall level of knowledge about the Medicare program and the choices available to beneficiaries. Health plans, information intermediaries, and government officials alike, however, have only just begun to learn about the needs and preferences of beneficiaries, the most effective educational techniques, and the importance of differences within the general Medicare beneficiary population. They have only just begun to determine the best ways to transform “beneficiaries” into “consumers.”

THERE ARE CONCRETE STEPS THAT CAN BE TAKEN TO MAKE MEDICARE MORE COMPREHENSIBLE TO BENEFICIARIES

After two years of conceptualizing, designing, and organizing educational activities for Medicare beneficiaries, information intermediaries have identified a constellation of beneficiary educational needs and preferences. The preferences that Medicare educators have identified can
guide the development of improved strategies for consumer education (Figure V.1). Let us first briefly recap these preferences and then explore possible actions that local-level intermediaries and national and state policymakers might take to more closely match needs and information, thereby moving beneficiaries closer to effectively choosing among Medicare insurance options.

**FIGURE V.1**

**MEDICARE BENEFICIARY INFORMATION PREFERENCES**

1. Broad scope yet specific detail
2. Local content
3. Divided into small units
4. Available on a continuous basis
5. Delivered via personal contact
6. Accessible in moments of crisis

Medicare beneficiaries who have come into contact with information intermediaries generally request or require that education about M+C issues begin with a broad and basic explanation of the features of the entire Medicare program. It is clear to most Medicare educators that beneficiaries need a basic explanation to provide the context for choosing among the various options. At the same time, however, beneficiaries request specific, often fine, details about aspects of the Medicare program in order to tie the general information to their personal circumstances. Similarly, beneficiaries request information about specific local institutions (such as participating hospitals) as a way of grounding the abstract information about insurance options in their own understanding of the network of medical providers in their communities.

The sheer scope of information that these multiple demands produce has led to preferences (and constrictions) about how the information is packaged and made available, according to the information intermediaries we spoke to. First, beneficiaries are able to absorb only moderate amounts of information at a time, so intermediaries have learned that they need to divide their information into small units. Second, many beneficiaries prefer to return to the information later because they have not grasped all the information necessary at the initial encounter. Finally, many beneficiaries seem to prefer to receive Medicare information from personal contact with a Medicare educator rather than solely from written materials. They want information to be explained, not just disseminated.

**V: Conclusions**
In addition to these preferences for specific kinds of content and packaging, beneficiaries have revealed a strong preference for the timing of their education. Experienced Medicare educators were clear that beneficiaries most often seek information about Medicare at times of personal crisis or after program changes have been reported in the media. Beneficiaries first demand and then learn the information during these occasions, rather than when they receive printed materials or attend a workshop. This has tremendous implications for the timing and design of information campaigns.

**CURRENT OUTREACH STRATEGIES NEED TO BE AUGMENTED IN ORDER TO BE MORE EFFECTIVE IN MEETING THESE BENEFICIARY PREFERENCES**

Most of the education efforts at the local level, when taken as a whole, consist of a campaign to provide a tremendous amount of information about the operations of the Medicare program to as many beneficiaries as can possibly be reached. This "across-the-board," approach is not succeeding in the ways one might hope. First, the strategy tries to teach too much to too many beneficiaries. It often overloads beneficiaries with details. It reaches beneficiaries who self-select, but does not find those who are isolated from traditional dissemination channels or traditional dissemination channels, or who do not realize that greater knowledge about their Medicare options could help them resolve problems in obtaining health care. In its efforts to appeal to as many beneficiaries as possible, moreover, the across-the-board approach cannot cope with different learning styles, levels of literacy and/or education, and life circumstances.

The most forward-thinking members of the information infrastructure have begun to grapple with this mismatch between beneficiary information needs and preferences and the current activities of an information infrastructure that is trying to educate these beneficiaries.

**FOUR NEW TACTICS MIGHT EXPAND THE EFFECTIVENESS OF MEDICARE EDUCATION**

Local-level Medicare educators and national, state, and local policymakers might want to reformulate the current approach to transforming beneficiaries into consumers. This reformulation might be divided into four shifts in strategy:

1. Reduce reliance on the across-the-board approach that tries to reach all beneficiaries with large amounts of information.

2. Adopt a more streamlined form of outreach to reach those not accessible by current methods.

3. Create a new type of referral structure that can assist beneficiaries at "teachable moments."

4. Use new educational techniques that more closely match beneficiary learning preferences.

V: Conclusions
The first major shift in strategy might consist of changing the current outreach tactic, which tries to convey as much information as possible to as many people as will listen. This strategy requires extensive resources to be successful. It generates a need for resources to convince the bulk of beneficiaries that it is in their interest to master information about their Medicare benefits and then uses substantial resources to try to teach these large numbers of people to understand this complicated information. Policymakers and information intermediaries therefore might consider investing in a strategy that separates outreach from education. By this we mean, investing in a comprehensive effort to build as much awareness as possible about the availability of information on Medicare and M+C, but situating much of the actual educational materials in channels that beneficiaries can access at the times they find useful. (For more details on the channels, see discussion below). This separation of outreach from education could reduce the amount of money devoted to trying to entice beneficiaries who do not currently need detailed information and would allow for greater investment in devising repetitive yet creative ways to convey messages about the availability of information to a broader set of people.

The second, and related, strategy would be to adopt outreach methods that target the wide range of Medicare beneficiaries who remain untouched by conventional methods. The relatively low level of contact between local information intermediaries and organizations representing ethnic and minority communities should be increased in order to develop new channels of information dissemination. Resources, especially staff, would need to make contact, build trust (where necessary), and plan joint educational activities more appropriate to those cultures. HCFA or other national organizations could disseminate research on information preferences among culturally distinct, low-literate or disabled populations to intermediaries who can then use it to develop more appropriate educational activities. Local Medicare educators could redouble their efforts to join with ethnic organizations to identify ethnic community residents who could be recruited into volunteer roles in Medicare counseling. Similarly, outreach methods, now relatively conventional in terms of format, could be augmented by mechanisms more attuned to the low literate and hearing-impaired beneficiary populations. These mechanisms might include increased efforts to place public service announcements on radio and television or on the Internet, where the disabled get their information.

A third shift in strategy could be used to cope with the predilection for learning about Medicare only in times of crisis. Policymakers and intermediaries could develop new ways to attract the attention of beneficiaries who are experiencing the types of crises that force them to learn more about their Medicare options. One new channel might be to teach the professionals who assist beneficiaries during these teachable moments, to make referrals to appropriate sources of information. For example, hospital discharge planners, retirement counselors, staff in public housing complexes or in assisted living centers, and Social Security claims representatives could be trained to know enough about Medicare to refer beneficiaries to appropriate information intermediaries. Information intermediaries could also develop sequential publications, divided into clusters, that could be more readily and slowly absorbed. That would be one educational technique that might match beneficiaries’ preferences for information in small segments, as well as information that can be accessed repeatedly. Placed in libraries, senior centers, religious institutions, or patient education centers at hospitals or health plans,

V: Conclusions
these publications could serve as a continuous resource that beneficiaries would be able to access at will and return to as circumstances change.

Finally, local-level information intermediaries must develop new approaches that use educational techniques more closely matched to beneficiaries’ learning preferences. The education efforts that we identified in our six sites have not yet been able to take advantage of modern theories of adult education or of the substantial expertise of public health educators. Greater investment needs to be made in studying how seniors learn new information and in identifying the best techniques for disseminating information to this specific audience.

Similarly, Medicare information can be put onto the web to better match beneficiary information preferences. Web-based information can be organized into layers, with the more general information accessed first, and the more advanced or more specialized information embedded in files that are layered underneath. It can also allow for national information to be tailored to reflect local conditions. A system of community-based computers (and ongoing programs to reduce the so-called “digital divide”) would help a broad range of seniors access Medicare information in a way that matches their preferences. Volunteers could be trained to access data as they educate beneficiaries, thereby ensuring greater standardization of information. HCFA currently maintains a national-level, web-based database, Medicare Healthplan Compare, consisting primarily of comparative information on M+C plans. This database does provide links to general information on how the Medicare program operates in both its traditional and M+C forms, but could also more closely be linked to local Medicare education efforts.

And finally, one of the key preferences that beneficiaries expressed was to receive information from in-person counselors. Personal counseling may help beneficiaries relate the general information to their personal circumstances, and it allows counselors to tailor information more precisely. The SHIPs who provide such counseling, already are perceived by the rest of the information infrastructure as the heart of Medicare education in each community. Policymakers could build on this implicit leadership and to use the SHIPS as centers to train volunteers for community-based organizations and to coordinate the educational efforts of the information infrastructure.¹

The Balanced Budget Act of 1997 broke new ground as one of the first pieces of federal health legislation that explicitly required program beneficiaries to make decisions among a variety of program alternatives. We have described the efforts of those who have taken up the challenge of teaching the beneficiaries of a social program how the program works in six markets around the country, and have described their successes and limitations. Most Medicare beneficiaries, however, are still unsure of how their Medicare benefits work and how to choose among the both complex and volatile set of traditional and new options that confront them. The view from ground level is far more daunting than the optimistic vision that inspired the original policymakers that designed Medicare+Choice.

¹SHIPs in California have already begun to play this role.

V: Conclusions
FOUR KEY LESSONS ON THE CHALLENGES CONFRONTING THE IMPLEMENTATION OF M+C

We can draw several tentative lessons about the challenges involved in implementing the M+C model. The first lesson is that *getting information across to consumers is hard;* getting complicated insurance concepts across to the average American is even harder. Most information intermediaries report that beneficiaries have little prior knowledge of how Medicare works and only those who have lived in areas where managed care has been in place for several years know much about managed care. Most Medicare beneficiaries, therefore, have to learn a large set of complicated concepts almost from scratch.

The second, and related, lesson is that *education takes time and money.* Educating Medicare beneficiaries takes many hours and lots of resources, *per beneficiary,* to explain the concepts and apply them to individual circumstances. Effective Medicare education requires teachers, counselors, website designers, graphic artists, editors, translators, and peers. This all costs money. Even unpaid volunteers require resources to train. The educational agencies we have seen in our six markets are small, usually one or two part-time paid staff and assorted volunteers. Most have little or no funding for Medicare education. Most information intermediaries have not been able to invest much time or money into developing precise and varied educational activities. If we want effective education to improve the capacity of beneficiaries to make choices, we need to generate more resources to do the job. This could involve increased federal funding, larger contributions from state and local governments, foundation grants, or greater participation from the private sector (such as employers or unions). But no matter the source, if we are to see more effective education we will need to increase the resources flowing to those activities.

The third lesson is that *national-level policymakers need to be more sensitive to the ways that theoretical systems play out on the local level.* From the perspective of both beneficiaries and local educators, the Medicare market is hopelessly fragmented with many more complex choices than national policymakers had considered. The individual supplemental insurance market (Medigap insurance) has 10 options and many insurance companies offering polices. The M+C market is volatile, with Medicare managed care plans withdrawing or reducing service areas yearly, and employer retiree coverage constantly changing. Few national policymakers think about Medicaid in the context of M+C, but it too, as well as state pharmacy assistance programs, also factor into beneficiary choices. The variety of choices means that individuals could find options that suit their needs, but the price of educating them about these many options is quite high. Moreover, the gap between national policy and local reality is growing, as the choices promised in the original legislation fail to appear and those that have appeared are now withdrawing. There is an inconsistency between the interest of Congress in promoting choice and what beneficiaries see and understand on the ground.

The fourth lesson is that *education only takes you so far.* A small group of intermediaries with few resources are trying to educate a lot of beneficiaries with varying needs about an extremely complicated program. Improving education should help many beneficiaries make informed choices, but is not enough. Policymakers need to have realistic expectations of

V: Conclusions
what education can do and the limits of even the most successful education program. Education
can not make choices more stable or more simpler. These are just two of the program issues
that policymakers need to address in addition to education in order to make Medicare+Choice
successful.

Federal, state and local policymakers need to create a better match between congressional
intention and what beneficiaries see, understand, and want if the Medicare+Choice program is
to flourish.
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REFERENCES


References


References
APPENDIX A

PROFILES OF EACH OF
THE SIX COMMUNITIES
**ALBUQUERQUE, NEW MEXICO**

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<td>The Albuquerque MSA includes Bernalillo, Sandoval, and Valencia counties. The city of Albuquerque makes up most of Bernalillo County. Medicare education varies across the MSA because Bernalillo County is a separate service area for both state and city efforts. Although we focus primarily on Bernalillo County, the managed care market is commonly thought of as the “Rio Grande Valley” or “Rio Grande Corridor”—the contiguous area stretching from Bosque to Espanola (just beyond Sante Fe). This area is the only one in the state (aside from Las Cruces) that has Medicare managed care.</td>
<td>The Albuquerque MSA has 679,000 people, 13 percent of whom are Medicare eligibles and 14 percent of whom are enrolled in Medicaid (1999 data). In 1997, 52 percent of the MSA population were white non-Hispanic, and 48 percent were minorities, of whom 39 percent were Hispanic. In 1990, 10 percent of seniors were below the poverty line.</td>
<td>The Albuquerque market tends to have relatively small employers; the largest employers are in the public sector. Most public employers, including state agencies, public school districts, colleges and universities, and state and local governments, are part of the New Mexico Retiree Health Care Authority (NMRHCA), a state agency that administers retiree benefits for public retirees. It currently has 20,000 retirees and 10,000 dependents. No single employer has leverage in the Medicare market or commercial market. Only NMRHCA and the local public schools have teamed up to solicit contractors to provide health care coverage to a collective 120,000 lives (roughly 12 percent of the state population). NMRHCA already practices some value purchasing activities and continues to build these efforts. Unionization is not a factor in this market.</td>
<td>The State Agency on Aging is a strong leader across the state and in Albuquerque. It is unique in that it plays a direct role in senior education and services, operating one of the area Health Insurance and Benefits Assistance Corps (HIBACs). The State Agency on Aging has formed a strong alliance with the AARP. Together, they are powerful advocates for aging issues with the state legislature and governor. This relationship is unique with respect to other markets we visited. Albuquerque is active in senior affairs and senior education through its Department of Senior Affairs (the city defines seniors as age 55+). The city provides funds and services for seniors through coordinated programs and houses the local HIBAC. (The HIBAC will provide assistance to any Medicare beneficiary regardless of age.) Once a year the city hosts the Albuquerque Conference on Aging, which brings community senior organizations together. Finally, we were told that state funding for senior programs is generous relative to amounts in many other states, but is still felt to be underfunded.</td>
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<td>Each system has a large hospital anchor, and each employs a significant number of physicians. The systems have long been established in Albuquerque and have recognizable “brand” names. St. Joseph, Presbyterian, and Lovelace have their own M+C MCOs, and at the time of our visits, the University of New Mexico System contracted with at least two of the plans.</td>
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**Provider Organization**

**Delivery Systems.** Albuquerque's health system is based in the St. Joseph, Presbyterian, Lovelace, and University of New Mexico delivery systems. Each system has a large hospital anchor, and each employs a significant number of physicians. The systems have long been established in Albuquerque and have recognizable "brand" names. St. Joseph, Presbyterian, and Lovelace have their own M+C MCOs, and at the time of our visits, the University of New Mexico System contracted with at least two of the plans.
## ALBUQUERQUE, NEW MEXICO

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<thead>
<tr>
<th>Provider Organization (cont’d)</th>
<th>Hospitals.</th>
<th>Physicians.</th>
<th>Managed Care.</th>
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<td>The only notable change in hospital systems has been development of the New Mexico Heart Hospital in the late 1990s. Originally, both Presbyterian and St. Joseph were part of this venture, but ultimately Presbyterian did not participate. Competition among the hospital systems is extensive and is partly fueled by the overlapping service areas.</td>
<td>New Mexico, including the Rio Grande Valley, suffers from a general shortage of physicians. Each delivery system has a large of group primary care practices, but the market also contains individual and small groups. Lovelace and University of New Mexico are staff models. There is some IPA activity. Physician contracting across MCOs is extremely limited.</td>
<td>Albuquerque is a highly penetrated market. Total managed care penetration reached 53 percent in January 1999, and Medicare managed care penetration was 39 percent in March 2000. Commercial managed care was the first to enter the market, in the 1970s; Medicare risk entered in 1986. Provider-system-based MCOs dominate the market, even if they have HMO licenses. Some national managed care firms had operated previously, but most left by 2000. Each MCO is associated with distinct provider hospital systems and compete on system “brand name.”</td>
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<th>Medicare Insurance Options</th>
<th>M+C MCOs.</th>
<th>M+C Products.</th>
<th>M+C Capitation.</th>
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<td>In 2000, three M+C MCOs (based in the Lovelace, Presbyterian, and St. Joseph health systems) served the entire three-county MSA and covered a total of 36,044 enrollees in March 2000. Both Lovelace and Presbyterian had closed enrollment when we visited. St. Joseph is the only PSO participating in the M+C program, but will exit the market in 2001. However, the other two MCOs are also provider-based. In 1998 and 1999, four MCOs had a presence in the market, but the market has experienced consolidation. St. Joseph has absorbed QualMed’s membership after the latter left the market in 2000, and Presbyterian bought FHP (a PacifiCare plan) and accommodated its membership in 1999. As in other communities, market concentration is high, with Presbyterian accounting for 48 percent of the Medicare managed care market and the top two (Lovelace and Presbyterian) for 87 percent (March 2000).</td>
<td>Each M+C MCO offers more than one product. The number of products that Presbyterian and St. Joseph offer is currently related to the MCOs’ Medicare acquisition activities. Each believed that it should initially retain all the products offered by the MCOs from which they acquired the Medicare business. The products offered are a gatekeeper, HMO model and offer some supplemental benefits. However, because of the MSA’s very low payment rate, these benefits are “low” relative to other markets.</td>
<td>The capitation for Medicare in the MSA is low, averaging $424 in 2000 (compared with the floor payment of $402). The average payment rate in Albuquerque is 89 percent of the national average. Individual payment to the plans will vary based on demographic factors and assessment of other fees (for example, a user fee). The difference across counties in this MSA is minimal, with the highest and lowest payment of only $29.</td>
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Medigap. In New Mexico, 77 Medigap carriers operate, covering about 24,120 beneficiaries (1998). After plan A (which is a state-required offering), the plans offered most often are F, C, and B (in that order).
Appendix A: Profiles of Each of the Six Communities

ALBUQUERQUE, NEW MEXICO

|----------------------------|--------------------|---------------|----------------------|----------|---------------------|

In Albuquerque, the key players include the State Agency on Aging, local HIBAC, city Department of Senior Affairs, and the AARP. The State Agency on Aging operates its own HIBAC for the Santa Fe region, and senior organizations often consider it the “home base” organization to answer questions. The aging network is quite large, and the state makes many targeted grants to organizations to reach seniors, such as legal service providers or advocates for persons with disabilities, but the scope of educational activities varies among them. MCOs also are becoming more involved in educating their seniors. Some MCOs conducted less marketing than in previous years (because of closed enrollments), but education through member retention programs is growing.

A substantial amount of Medicare education focuses on basic program information such as benefits and beneficiary rights. Both senior organizations and many M+C MCOs address managed care topics mainly as part of a larger discussion of Medicare. Because of its presence in the marketplace, managed care is not a totally new concept to beneficiaries, however, most of the Medicare population still does not understand it.

One-to-one counseling, presentations and materials distribution are the dominant education activities. Some health fairs are held in Albuquerque, but they are not as pervasive or popular as in some other sites. The Agency on Aging has a 1-800 number that is a central component of its operations. Much of the Medicare education activity of the State Agency on Aging and the AARP consists of education in rural areas of the state.

Senior organizations use presentations, posters, newsletters, health fairs and newspapers to reach beneficiaries. Some newspapers are targeted solely to seniors and provide coverage of senior events, activities, and issues. Some of the more established staff at senior organizations use their personal connections to the community to raise awareness. A substantial amount of outreach is conducted at senior centers, although some organizations and M+C MCOs reported that they worked with churches. In addition, the New Mexico Medical Review Association (the PRO) hosts a small beneficiary outreach committee consisting of senior organizations and employers that organizes an annual educational fair on Medicare and M+C.

Most questions are about the Medicare program in general, focusing on program eligibility and benefit questions, including services covered and billing issues. The majority of beneficiaries are not sophisticated enough to ask questions comparing Medicare and managed care. Most do not know enough to even know what to ask. Senior organizations felt that beneficiary questions have not changed, especially as managed care has been in the market for some time.
## ALBUQUERQUE, NEW MEXICO

### Information Infrastructure (cont’d)

**Availability and Quality of Medicare Information.** Senior organizations consistently indicated that availability of information was high in Albuquerque and the Rio Grande Corridor, but that seniors may not be accessing or understanding it. In particular, they were concerned that certain subgroups of seniors, such as Hispanics, Native Americans, or people with disabilities, are not receiving this information because they access information from sites and sources other than those used to provide Medicare information. The quality of the information received mixed reviews. Many felt it was good, but most believed it could be improved to be more targeted, shorter, and simpler.

**Resource Adequacy.** Some feel that many agencies provide education, but that seniors simply do not know about them. Others believe resources are too limited to provide all the outreach and education they should be offering, especially to special subgroups, such as the disabled or ethnic groups. There is consensus that some sets of seniors are not being reached, but also the belief that, in addition to resource adequacy, the seniors' motivation to learn is a factor.

### Unique Efforts

**Alliance Between State and Advocate Group.** The alliance of the State Agency on Aging and the AARP is unlike any other in the six communities we visited. The two organizations work to present a unified agenda, which they believe will expand their reach into the senior community and increase their effectiveness with the legislature and governor. For example, AARP provides the bulk of the volunteer force, funds volunteer training, and supports programs by providing consumer alerts. In turn, the State Agency on Aging gives presentations to AARP chapters and helps train AARP volunteers. This alliance is the result of a concerted effort to build a relationship that would be successful in advocating for seniors.

**State Agency on Aging.** Unlike other states, the State Agency on Aging is a stand-alone agency reporting directly to the governor. However, it is not a cabinet-level agency. The agency's authority can, therefore, change. The agency is also unique in that it not only brokers federal and state dollars to aging organizations, but also does direct service delivery including the local HIBAC.

### Recommendations from the Field

**Promote awareness and coordination among senior organizations, especially those in the “second tier” of service providers.** Organizations in the “top tier” of senior services and education felt that their efforts were coordinated. However, in organizations farther away from the center, staff felt less connected and less aware of what other organizations were doing. Some organizations felt that many senior were referred incorrectly, and that both seniors and the organizations themselves benefit from an increased awareness of where to go for help.

**Make education sensitive to cultural diversity and understand what that means.** Information should be developed that gives attention to the different value systems, perspectives, and techniques that best reach a community. Translation alone is not enough. Some communities may prefer one-to-one interactions or may be receptive to activities only after a key community member has deemed it acceptable.
ALBUQUERQUE, NEW MEXICO

Recommendations from the Field
(cont’d)

Make education sensitive to cultural diversity and understand what that means. Information should be developed that gives attention to the different value systems, perspectives, and techniques that best reach a community. Translation alone is not enough. Some communities may prefer one-to-one interactions or may be receptive to activities only after a key community member has deemed it acceptable.

Educate beneficiaries before they enroll in Medicare and teach them the basics, including how to make a decision and how to navigate. Seniors need to know up front what Medicare provides and what types of criteria they should use to make decisions. Because they know so little about Medicare many seniors do not know what criteria to base decisions on or what questions to ask. Beneficiaries also need to understand the basic benefits and rights afforded them. Finally, they need to know whom to contact when they have questions.

Increase awareness of materials available and make these materials accessible to diverse populations. Consistently, we were told that information was plentiful in Albuquerque but that seniors were not accessing it. One particular concern was that subgroups, such as the Hispanic community and the disabled, had to be able to access information in the places they frequent, not just senior centers.

Simplify and shorten materials. Educators felt that information was often presented in overly complicated and difficult-to-understand forms. They recommended lowering the reading level, sticking to basic information, and keeping it short.

Customized efforts and one-to-one counseling are optimal. Seniors have individual needs that need individual attention. One-to-one counseling fulfills this need. Philosophically, many organizations felt they would rather see an individual all the way through the problem-solving process, than conduct more mass efforts. Mass education, including the Medicare&You handbook, were often cited as confusing and too general. Too many materials were overwhelming.

Lessons

Cooperation among educators facilitates consistency among educational messages. Largely as a result of cooperation among the primary educators, Albuquerque has not experienced a notable problem with community educators delivering contradictory or inconsistent information.
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Appendix A: Profiles of Each of the Six Communities

Baltimore, Maryland

Community Characteristics

Community Definition. The Baltimore MSA is composed of Baltimore City and County and the surrounding counties of Anne Arundel, Carroll, Harford, Howard, and Queen Anne's. Although considered part of the MSA, Queen Anne's County lies across the Chesapeake Bay from Baltimore on the Eastern Shore. During our visit, we focused mainly on Baltimore City and on plans withdrawals on the Eastern Shore. The Eastern Shore consists of nine counties, and we talked with Area Agency on Aging (AAA) staff serving four of them: Caroline, Kent, Queen Anne's, and Talbot.

Demographics. The Baltimore MSA has 2.4 million people, 1.4 million of whom are divided about equally between Baltimore city and Baltimore County. Fourteen percent of the MSA population receives Medicare and 9 percent receive Medicaid (The Interstudy Competitive Edge 9.2 1999). The MSA is predominantly white (72 percent), whereas Baltimore city is 59 percent African American. Both Baltimore city and the greater MSA have small Hispanic and Asian populations (one percent and one to two percent respectively). The residents of the city are older and considerably poorer and less well educated than their counterparts elsewhere in the MSA. Fourteen percent of Baltimore city's residents are older than age 65, compared with 12 percent in the MSA as a whole. Nineteen percent of seniors in Baltimore city are below the poverty line.

The four Eastern Shore counties we visited have between 18,000 and 34,000 residents each, for a total of 109,000 people. All the counties are predominantly white with the remainder of the population African American. Twelve percent of the population is 65 years or older. Between 13 and 20 percent of seniors live below the poverty line.

Labor Market. According to the Baltimore Metropolitan Council, the 25 largest employers in Baltimore city are hospitals/medical centers and colleges/universities. Public-sector employers at the federal, state, and local levels are important throughout the MSA. Many of the large employers are self-insured and do not offer retiree coverage, whereas others do not give employees incentives to enroll in M+C plans. For example, the Federal Employee Health Benefits Program (FEHBP) offers retirees the same options and benefit coverage that are available to active federal employees, including HMOs. However, FEHBP contracts directly with HMOs for coverage of their entire population (including retirees) and does not go through the M+C program. Several large national firms are in the market that offer retiree health benefits. We were informed that roughly 20 percent of the enrollment in the largest M+C MCO consists of group retirees.

Political Infrastructure. Substantial regional tensions are apparent in the state, which are exacerbated when programs appear to differ geographically (as do the benefits for M+C). On the Eastern Shore, the congressional district staff were deeply involved in negotiations with state and M+C MCO officials attempting to retain an M+C option on the Eastern Shore. State funds and MCO contributions are being used to fund a stand-alone prescription drug program for MCO members who lost coverage in rural areas. (This program began operating June 22, 2000).
BALTIMORE, MARYLAND

**Provider Organization**

**Hospitals.** Maryland is the only state that still has an all-payer rate setting commission. This system greatly limits the ability of HMOs to negotiate lower rates with hospitals. In 1999, the state's largest insurer, CareFirst Blue Cross/Blue Shield, sought controversial alternative-rate arrangements with all Maryland hospitals that would give CareFirst significant discounts off the commission-approved rates.

There are 23 hospitals in the Baltimore MSA (NIHCM 1999) but no dominant hospital system. The facilities range from hospitals affiliated with private or public universities to nonprofit, religiously affiliated institutions. No one facility dominates the Medicare market. Generally, seniors do not like to travel to receive medical care and are likely to use the closest hospital.

**Physicians.** In Baltimore, MCOs compete on the basis of network (among other features), and beneficiaries hesitate to change their providers to enroll in a managed care plan. CareFirst has the broadest provider network. In many areas of the Eastern Shore, the number of physicians is limited, and it is often difficult for new residents to find a physician regardless of their insurance coverage. Most Eastern Shore physicians participated in CareFirst's Medicare network, and enrolling in the MCO did not disrupt long-standing provider-patient relationships there.

**Managed Care.** Total managed care penetration in the Baltimore MSA reached 39 percent in January 1999. Medicare managed care penetration was 15 percent (52,240 enrollees) in the MSA and 16 percent in Baltimore City in March 2000. The four Eastern Shore counties we visited have no M+C plans in 2000. Since 1997, Maryland has had a mandatory Medicaid managed care program, HealthChoice.

**Medicare Insurance Options**

**M+C MCOs.** In 2000, the Baltimore market has four M+C MCOs that offer M+C plans. (In 2001, only one MCO—Kaiser Permanente—will participate in M+C.) CareFirst has 56 percent of the Medicare managed care enrollees; its next-closest competitor, United Healthcare, has 27 percent. The remainder of the market is divided between Kaiser Permanente and CIGNA. Competition is based on premium, pharmacy benefits, and provider network. As of April 15, 2000, only CareFirst was accepting new enrollment. Baltimore was heavily affected by M+C withdrawals at the end of 1998, with four of the eight M+C MCOs in the market choosing not to renew their M+C contracts in 1999. Roughly 17,500 enrollees were affected by the withdrawals, and an additional 800 enrollees were affected by withdrawals in the four Eastern Shore counties. The sole M+C MCO serving the Eastern Shore in 1999 (CareFirst) withdrew at the end of the year, affecting about 3,700 enrollees in the four counties we visited. No M+C MCO serves the Eastern Shore in 2000.

**M+C Products.** The four M+C products offered in the Baltimore area are a gatekeeper, HMO model with some supplemental benefits, including prescription drugs. In 2000, MCOs increased premiums for their M+C products or reduced prescription drug coverage. Two of them reduced the limit on prescription drugs by $200 to $500, and two implemented a premium of $19 (Kaiser) and $50 (CareFirst). At the time of the visit, it was too soon to tell what effect the premiums and changes in benefits would have on enrollment levels. The employer/group product has the same basic design.
### Baltimore, Maryland

**Medicare Insurance Options (cont’d)**

but the employer may purchase additional benefits, such as more generous drug coverage, or may choose to pay a member's premium. The M+C product available on the Eastern Shore in 1999 was the same as elsewhere in Maryland, but CareFirst added a $75 premium for a policy with $1,000 in prescription drug coverage. The premium was controversial because Eastern Shore residents were aware that beneficiaries in other parts of the state were not charged a premium for the same product.

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<th><strong>M+C Capitation.</strong> The capitation for Medicare in the Baltimore MSA, at an average of $603 in 2000, is 19 percent higher than the national average payment. Baltimore City has the highest capitation rate in the MSA ($671). The rate on the Eastern Shore is less than the national average. Rates in 2000 in the four Eastern Shore counties with no M+C plans ranged from $440 to $483, which is between 87 percent and 96 percent of the national average and between 110 percent and 120 percent of the floor payment rate in 2000.</th>
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<td><strong>Medigap.</strong> The primary Medigap carriers in the Baltimore market are United Healthcare Insurance Company, which sells the AARP supplement, and CareFirst of Maryland, Inc. Premiums have increased in recent years, and, beginning in 1999, the Maryland Insurance Administration (MIA) ceased approving premium rate increases of more than 20 percent even if the experience would justify a higher increase. Some Medigap carriers do not file annually for premium rate increases with the MIA, an action designed to limit the one-time increase beneficiaries could face. Also, the MIA has recently promulgated regulations that provide protections against more than one premium increase per year for Medigap policyholders. Maryland also has guarantee issue requirements for Medicare disabled beneficiaries who are under age 65. This legislation guarantees that these beneficiaries can purchase plans C and I, if the plans are offered to Medicare-eligible seniors. Several carriers have responded to this legislation by withdrawing plan I in Maryland. (Plan I is one of the three standardized Medigap plans that includes prescription drug coverage. The others are plans H and J.) The most popular Medigap plans are C and F.</td>
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| **Information Infrastructure** | **Key Organizations.** The key education groups are the AAAs, which are familiar with each other's activities and staff but are not formally linked. The Baltimore City AAA is the Commission on Aging and Retirement Education (CARE), which provides services to the city's senior population as well as educates the city's retirees about their insurance options. The primary educators on the Eastern Shore are the county AAAs which worked extensively with staff in the local congressman's office to respond to the withdrawal of the area's final managed care option at the end of 1999. Also active is the Maryland State Health Insurance Assistance Program, one of the oldest SHIP programs in the country. It is located in the Maryland Department of Aging. The SHIP provides training and funding to the AAAs to perform counseling and outreach. The Department of Aging has been assigned special responsibility for educating Medicare beneficiaries about their health insurance options. As a result, although the MIA responds to all inquiries about health insurance issues, it does not conduct most of the Medicare education efforts. |
BALTIMORE, MARYLAND

**Information Infrastructure (cont’d)**

**Topical Focus.** Education focuses on the Medicare program as a whole, one part of which is M+C. Education efforts often focus on programs available to low-income beneficiaries. On the Eastern Shore, education focuses on guaranteed issue rights for Medigap policies because of the withdrawals, and medical and pharmacy assistance programs available to low-income beneficiaries.

**Education Activities.** The dominant activities in Baltimore are one-on-one counseling and group presentations by AAA staff. On the Eastern Shore, the emphasis is on group presentations to beneficiaries who have been affected by the withdrawals.

**Outreach.** CARE works with local groups to reach beneficiaries neighborhood by neighborhood. Depending on the dynamics of a particular neighborhood, these groups could be churches, faith-based social service organizations, or retired professional groups. CARE also conducts outreach through the senior centers and meal sites it operates. Educators publicize their activities in small local newspapers, via direct mail, and through health fairs and senior centers. The minority population does not currently have large demands for service, as these populations are young. CARE is conducting outreach to Hispanic and Asian communities to strengthen its role with those residents. The aging groups say disabled beneficiaries have similar concerns and needs for information as senior beneficiaries do and consider them part of their client base. However, they say that it is unusual for disabled beneficiaries to look to aging groups as a resource, and that the disabled community view the groups as insensitive to their needs. Disabled advocacy groups focus on systems issues and access to services, rather than on insurance coverage concerns.

**Essential Questions.** In Baltimore and on the Eastern Shore, the withdrawal of the M+C MCOs has caused beneficiaries, educators, and providers to question the stability and viability of the program. Educators are concerned that beneficiaries are not fully aware of managed care's restrictions and of limitations on the supplemental benefits offered in M+C MCOs, but they also believe that M+C coverage is a valuable option for low-income beneficiaries. Beneficiaries often request help in choosing an M+C MCO, and they are most concerned about whether their physician participates in the plan and what the plan costs. Educators are asked about enrolling in original Medicare, coverage issues, skilled nursing facilities, and Medigap. Educators perceive that seniors do not enroll in programs for low-income beneficiaries partly because many of the programs require a burdensome application, which must be completed in a state Medical Assistance office. Maryland currently is testing a pilot program that greatly reduces the length of the application and that allows applications to be submitted without a face-to-face interview.

**Availability and Quality of Medicare Information.** Educators feel that reliable resources are available to people who seek information, but that many beneficiaries are either unaware of the resources or believe they do not apply to them. Beneficiaries categorized in this way include both inner-city residents, who are isolated from others and may not read newsletters and
BALTIMORE, MARYLAND

Information Infrastructure (cont’d)

Mailings, and more affluent beneficiaries, who may qualify for services or assistance programs but are not aware of the opportunities or do not consider themselves part of the program’s target audience. Some means of communication, such as television, are not being used to their full potential in educating beneficiaries, especially those with low literacy levels or physical impairments that make reading difficult.

Resource Adequacy. Health insurance information is a small part of the missions of most groups with whom we talked. Including the state SHIP program, most groups had only one full-time or part-time staff member devoted to education activities and handled many insurance-related queries through information and assistance programs. The state SHIP program relied on volunteers from county AAA programs to meet increased demand for information occurring after the withdrawals were announced.

Unique Efforts

The AAAs on the Eastern Shore partnered heavily with staff in the office of the local congressman to reach out to beneficiaries affected by M+C withdrawals.

Maryland passed guaranteed-issue requirements to give disabled beneficiaries access to Medigap plans C and I. Federal regulations provide beneficiaries older than 65 guaranteed access to certain Medigap plans (A, B, C, and F) when M+C plans withdraw but do not guarantee issue of any Medigap plans to disabled beneficiaries.

Recommendations from the Field

Beneficiaries need early and broad education about Medicare. Education should begin well before beneficiaries are enrolled in the program and should cover the array of options available.

Publications should be targeted to beneficiaries at a local level. Educators warned about confusion and perceived irrelevance when publications and brochures are produced on a national level. One educator described the difficulty in “seeing yourself” in a publication that is designed to be sent to beneficiaries across the country. Educators stressed the need for local information and resources to address the specific situation of beneficiaries in the area and the specific options available to them.

Beneficiaries differ in their preferences for receiving information. Education and outreach efforts should use a variety of communication methods, such as age, education levels, and income, to influence how beneficiaries obtain and use information. For example, although younger, more educated beneficiaries respond well to newsletters and direct mail, the poorest and least educated seniors rely on the radio for news and information.

One-on-one communication is still the most effective. Educators often use mailings and other forms of outreach to try to increase awareness of resources and options. Nevertheless, face-to-face communication remains the most effective method.
### BALTIMORE, MARYLAND

| Lessons | M+C withdrawals have made educators and providers wary of the program and they perceive a similar uneasiness among beneficiaries. Beneficiaries are concerned about the stability of their M+C plan even as they value the additional benefits and lower costs that it offers. Both in Baltimore and on the Eastern Shore, low-income beneficiaries who cannot afford a supplemental plan are the most dependent on M+C. |
DETROIT, MICHIGAN

Community Characteristics

**Community Definition.** Detroit is located in southeast Michigan. The MSA includes Wayne, Lapeer, Livingston, Macomb, Monroe, Oakland, and St. Clair counties. Detroit is in Wayne County. Ann Arbor, in Washtenaw, is outside the MSA to the west and a small but increasing factor in market development. We focused primarily on Wayne County, with some attention to the evolving influence of the Ann Arbor HMO, MCARE.

**Demographics.** The Detroit MSA has 4.5 million people, or 47 percent of Michigan's population. Fourteen percent receive Medicare benefits and 11.4 percent receive Medicaid (1999). Fourteen percent are seniors who are below the poverty line (1990). Roughly 73 percent of the total population is white, 23 percent African-American, 1.8 percent Asian, and 2.3 percent Hispanic (1998). In addition, a major Arabic/Chaldean population is in Dearborn. A disproportionate share of African Americans reside in the city of Detroit.

**Labor Market.** Detroit's industry is dominated by the “Big Three” automakers and their suppliers. The United Auto Workers (UAW) is a key influence, with separately negotiated and generally comprehensive health benefits for unionized (hourly) workers distinct from nonunionized (salaried) workers. Health benefits are a top negotiating priority for the union. It has opposed efforts to create strong financial incentives to encourage M+C enrollment, which it views as "privatization." The other major employers are the public sector (schools) and the health care sector. More than half the Medicare beneficiaries in the MSA reportedly have employer-sponsored coverage—a unique feature of this market.

**Political Context.** State Medicaid policy is fiscally conservative under Governor Engler, a Republican. Detroit's population has been shrinking since the late 1960s, when riots occurred and racial tension was high. However, with a new city government and the renovation of Renaissance Center as the General Motors (GM) headquarters, more optimism is evident. The county and some city governments are responsible for managing the state's public health and social service programs. Closures of private hospitals located in predominately minority communities in Detroit, most recently Mercy Hospital, have been controversial.

Provider Organization

**Hospitals.** The Henry Ford System (HFS) and the Detroit Medical Center (DMC) are the city's tertiary care centers and the largest Medicaid and Medicare safety net hospitals. Both have experienced recent financial losses and cuts in services and staff. Suburban hospitals have better payer mixes and have avoided financial downturns.

**Physicians.** The physician market is not organized; most physicians practice individually or in small groups and contract with multiple MCOs. MCOs appear to have distinct networks, a feature that is largely the effect of Health Alliance Plan's network. MCARE is expanding into Detroit. There is more competition among MCOs with overlapping.

**Managed Care.** The Detroit managed care market is dominated by local firms that offer products primarily in southeast Michigan. As a result of the limited incentive to join HMOs in many large employer groups, overall MSA-wide penetration is 28 percent. However, this is becoming less true.

Appendix A: Profiles of Each of the Six Communities
DETROIT, MICHIGAN

| Provider Organization (cont’d) | particularly in the non-unionized sector of the industry. Plans include HAP, s owned by HFS and the dominant M+C MCO, and Blue Cross Blue Shield Michigan (BCBSM), which has the dominant fee-for-service business. Since 1993, employers and unions have collaborated on health care quality initiatives and some purchasing initiatives through the Greater Detroit Area Health Council’s Health Information Action Group (HIAG). HIAG evaluates MCOs on negotiated quality standards and purchases carve-out benefits such as prescription drugs and dental benefits. Until recently, these efforts did not involved the Big Three, but GM is now involved. In 1999, Detroit-area MCOs ranked high on HEDIS and consumer satisfaction ratings. |
| Medicare Insurance Options | M+C MCOs. The M+C market, which first began operating in the Detroit MSA in the mid-1990s, has been relatively stable. In 2000, six M+C MCOs serve the Detroit metropolitan area, covering 55,577 enrollees as of March 2000. The largest plans are Blue Care Network, HAP, MCARE, and SelectCare; together HAP and MCARE account for 75 percent of M+C enrollment (March 2000). The high rate of employer-sponsored retiree coverage has led to fierce competition between HAP and MCARE, as the remaining pool of prospective enrollees in the individual market is small. HAP introduced a Medicare risk product briefly in 1986 but closed it after suffering losses. This product has grown steadily since 1995 when it was reintroduced. MCARE, owned by the University of Michigan, serves the western portion of the Detroit metropolitan area. Blue Care Network, a division of BCBSM, has not aggressively marketed its M+C products. At the time of our visit, SelectCare was for sale and had two prospective buyers, HAP and WellPoint, a California-based MCO. M+C Products. More so than in other areas, plans market their Medicare products in different ways to individuals and groups. In the individual M+C market, the major barrier to enrollment is the desire to retain choice of providers. Choice is so important in the Detroit market than even some lower-income beneficiaries who cannot afford a Medigap plan would rather remain without coverage than enroll in an M+C MCO that restricts choice. MCO marketing is careful to emphasize administrative simplicity and quality, stable health care. Industry representatives note that they offer “financially stable” but “not rich” benefits despite the area’s high payment from HCFA. Careful benefit design has enabled HAP and MCARE to be profitable with relatively small enrollments. The typical M+C individual offering is either a zero-premium plan with a $1,000 to $1,200 prescription drug benefit or a $68 per month premium plan that gives access to a broader network, dental benefits, and a slightly higher prescription drug cap ($1,600). The majority of beneficiaries choose the low-cost plan. In the group market, the M+C MCOs work through group sponsors that may offer two types of products. The M+C product involves enrollment in one of the M+C options, with the employers purchasing a rider to cover the additional benefits included in their plans. In some cases, the M+C option is the basic plan, with the rider covering most supplemental options. The alternative--based on traditional arrangements--involves direct enrollment in an employer group's HMO. Unionized UAW retirees can join the commercial HMO offering sponsored by the automobile company. They are given strong incentives to purchase |
### DETROIT, MICHIGAN

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<th>Medicare Insurance Options (cont’d)</th>
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<td>Medicare Part B. With this coverage, they can see any provider, but their supplemental benefits only are covered in the HMO. These products act like a supplemental policy: MCOs are at risk for what Medicare does not pay, including copays and deductibles, and they bill Medicare as a fee-for-service provider. Some companies have eliminated the non-M+C option, especially for salaried workers.</td>
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<td><strong>M+C Capitation.</strong> In 2000, the average payment capitation for Medicare in the Detroit MSA (weighted by county eligibles) was $647, about 28 percent higher than the national average. Payment drops considerably outside southeast Michigan, with a dearth of M+C offerings throughout the rest of the state.</td>
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<td><strong>Medigap.</strong> BCBSM is the dominant Medigap insurer, and 90 percent of its Medigap policies are plan C, which is guarantee issue, followed by plan F. In 1999, BCBSM introduced a blended product with features of A and C. BCBSM has a strong, historical relationship with the UAW and has a strong Medicare supplemental business through the automakers.</td>
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### Information Infrastructure

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<th>Key Organizations.</th>
<th>A core group led by the Medicare Medicaid Advisory Program (MMAP) conducts Medicare education outside the group accounts. The Detroit MMAP, Part B carrier, and Michigan Peer Review Organization (MPRO) coordinate their education efforts, share volunteers, and collaborate frequently on group education activities. MMAP provides on-site education services, including staff training to senior centers, meal sites, senior groups, and churches. The state Bureau of Insurance regulates both M+C and Medigap policies and provides some consumer information by telephone and mail. The Bureau is developing a consumer website with information on Medicare supplemental products.</th>
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<td>The state MMAP contracts with local groups. Two Area Agencies on Aging serve the metropolitan area: (1) the Detroit AAA, which serves the city of Detroit and eastern Wayne County communities; and (2) the Detroit Senior Alliance, which serves western and southern Wayne County. The state MMAP association has contracts with the Native American center in Saginaw to provide MMAP services for the population throughout the state. The Detroit-based Arabic/Chaldean community center provides translation services to seniors applying for Medicare and refers prospective Medigap buyers to an insurance agent in the community. This center is exploring the idea of forming a M+C educational alliance with MMAP.</td>
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<td>No one organization addresses the needs of the elderly disabled, although the Michigan Protection and Advocacy Service, Inc., which serves the under-65 disabled, will implement a HCFA demonstration project to increase the number of seniors enrolled in the Qualified Medicare Beneficiary (QMB)/Specified Low-Income Beneficiary (SLMB) programs in mid-2000. The QMB and SLMB programs provide subsidized Medicare coverage and, in some cases, full Medicaid benefits.</td>
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DETROIT, MICHIGAN

Information Infrastructure (cont’d)

The community has limited resources, so MCOs are a key source of M+C information. HAP and MCARE have active marketing efforts. HAP (but not MCARE) also collaborates with the Wayne County MMAPs and Detroit-area community/senior centers. BCBSM has not aggressively marketed either its Medigap or M+C products and has focused on lower-cost strategies, such as sponsoring community events.

More than in other markets, education is heavily influenced by the resources and associated demands of the automobile industry and group accounts. Each of the auto makers has its own National Benefits Service Center (NBSCs) to respond to the benefits questions of active and retired employees. Firms work cooperatively with unions on benefits, hiring union representatives to respond to members’ benefit concerns. GM has been the most open among the automakers in collaborating with local MMAPs to make Medicare and M+C presentations to its retirees around the country. Group accounts also often generate demands for MMAP activity, such as presentations to retiree groups.

Topical Focus. Education focuses on the basic differences between original Medicare and M+C. Educators must tailor their presentations according to whether beneficiaries have employer-sponsored or individual coverage. If beneficiaries have employer-sponsored coverage, educators discuss what benefits they have and how they compare with those of a commercial M+C plan. Educators also redirect beneficiaries to their employers for further assistance.

If beneficiaries have individual coverage, educators emphasize the difference between Medigap plans and M+C coverage, and how to evaluate both types of coverage based on individual need. Educators emphasize that beneficiaries with individual coverage do not have to change their current coverage choice.

The limited availability of M+C options in southeast Michigan has been a source of confusion to both “snow-birds” accustomed to greater MCO choice in the Sun Belt states and to retirees returning to Detroit to live near their families. Educators must ensure that members of these groups understand which areas of the state have “real choice,” as well as the types of choices that are available.

Education Activities. Group presentations by the MMAP, MPRO, and the Part B carrier are the dominant education activities in Detroit. One-to-one counseling is provided almost exclusively by the MMAP program. Each automaker has its own National Benefits Service Center to respond to benefit questions by telephone and mail.

Outreach. Outreach is active along traditional and nontraditional lines. Educators have found that word-of-mouth is a strong method of outreach. The Detroit MMAP has made efforts to reach traditional aging groups, senior organizations, including senior housing, and churches (primarily African American). Outreach to the Arabic/Chaldean and Hispanic communities has been only somewhat successful. These communities are tight-knit and closed, so that it is difficult for outsiders to be effective.
Appendix A: Profiles of Each of the Six Communities

### DETROIT, MICHIGAN

#### Information Infrastructure (cont’d)

**Essential Questions.** Questions vary by type of coverage. All beneficiaries have questions about differences between Medicare Parts A and B, and also between Medicare and M+C. Beneficiaries in the individual market who understand program differences want to know which Medigap policy or M+C plan is best for them. Prescription drug coverage and the ability to see their own physician are important factors.

Retirees with employer-sponsored benefits ask about covered benefits, how to enroll, and what to do with their Medicare card. Counselors report that these beneficiaries do not have a deep understanding about benefits, so they ask about claims rejections and travel coverage. Employers find they must explain the coordination of benefits between Medicare and the employer.

**Availability and Quality of Medicare Information.** The key actors believe they have done well, but that the quality of printed information provided by HCFA should be easier to understand. Interviewees reported that many seniors were not aware of the resources that were available. Sometimes, beneficiaries considered letters from HCFA alarming, rather than informative.

**Resource Adequacy.** Resources for education are relatively limited, especially outside the group accounts. The intermediaries we interviewed also expressed concern about the lack of any real effort or resources to use mass media (especially television) to provide unbiased information to beneficiaries.

#### Unique Efforts

MMAPs and other organizations have made extensive efforts to coordinate their education activities; cross train and share volunteers; and refer beneficiaries, as appropriate.

Detroit has an extensive infrastructure for education built to support needs of group retirees affiliated with the programs of the three auto makers and the UAW unions.

The Greater Detroit Area Health Council (GDHAC) represents a unique, broad-based program to assess health delivery quality though a collaborative private-public sector effort.

#### Recommendations from the Field

**Educate One-on-One about the Basics.** Group presentations are useful for orienting beneficiaries about differences between traditional and managed care Medicare, but beneficiaries want one-on-one counseling for individual decision making.

**Educate beneficiaries before they enroll in Medicare.** Seniors need to know before they retire what Medicare covers and the criteria they should use to compare supplemental and M+C coverage.

**Increase the coordination and communication between HCFA and large employers.** Employers want a single HCFA staff member to serve as point of contact, who would answer their questions about imminent program changes in a timely way.
**Recommendations from the Field (cont’d)**

| **Use multiple media to educate beneficiaries about Medicare.** Educators recommended that multiple approaches be used to reach seniors. Radio and television can reach a broad number and range of beneficiaries, particularly the homebound. |
| **Simplify materials to convey a clear, consistent message.** Educators felt that information should be at the fifth- to eighth-grade reading level; it should be concise, easy to understand, and convey a few important messages consistently. Messages should be consistent and repeated across other mediums that HCFA and educators use. |
| **Promote stability in the market.** Educators felt that national media “horror” stories about managed care and M+C plan withdrawals elsewhere had made seniors wary about M+C. |
| **Increase awareness of available materials.** Most felt that information was available, but that beneficiaries did not know how to access it. |

**Lessons**

- Detroit highlights the dominant role employers can play in shaping market demand if they are active in health issues, as well as the complex impacts of a new M+C program on existing employer-based coverage. These purchasers are leading sophisticated quality initiatives with health plans.

- In Detroit, we learned that an extensive need for basic education on the Medicare and M+C program exists, not just among lower-income beneficiaries, but among Medicare beneficiaries overall.

- Finally, Detroit's experience with closely knit ethnic communities shows that these communities require specifically tailored strategies for education, and that trust is the key issue.
### NEW ORLEANS, LOUISIANA

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<td>The New Orleans MSA is composed of eight parishes: Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, and St. Tammany. Jefferson and Orleans Parishes, the two core urban parishes, were the focus of our site visit. The boundaries of Orleans parish are also the boundaries of the city of New Orleans. Both Jefferson and Orleans parishes are divided into East and West Banks by the Mississippi River.</td>
<td>The New Orleans MSA contains 1.3 million people, of whom 14 percent receive Medicare benefits and 17 percent receive Medicaid (1999). Compared with the other parishes, Orleans and Jefferson parishes have larger and older populations, and Orleans Parish has more low-income households. These two parishes account for 74 percent of the MSA population. Thirteen percent of the residents of Orleans Parish are age 65 or older, as are 10 percent of Jefferson Parish residents. Between five and seven percent of the residents of the six other parishes are age 65 or older. Twenty percent of the Orleans and Jefferson seniors are below the poverty line. Orleans Parish is mostly African American (62 percent), and Jefferson Parish is primarily white (78 percent). Less than six percent of the residents of either parish are Hispanic (1990).</td>
<td>According to the Louisiana Department of Economic Development, the largest employer in Jefferson and Orleans parish is a construction firm that has 14,600 employees. The other major employers in the two parishes have between 1,300 and 6,000 employees and are primarily in the banking, medical, grocery, and oil industries. The market consists mainly of small employers and is not heavily unionized. Employers generally do not offer retiree health benefits, and those that do have not been particularly interested in Medicare managed care options.</td>
<td>The parishes of Orleans and Jefferson have a collegial relationship, but few regional organizations officially link the two. Both have health insurance programs for seniors through their councils on aging. Jefferson's is considerably older and was a main resource for residents of both parishes before the Orleans program started in January 2000. We did not get a sense that there is an active, well-organized community infrastructure of neighborhood and volunteer organizations in the area.</td>
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<td>Twenty-eight hospitals operate in the MSA (NIHCM 1999). The hospitals are divided between public hospitals owned by the state (the Charity system) and those run by private firms. Private hospitals are divided further between local, not-for-profit hospitals and for-profit hospitals (Columbia and Tenet), respectively. There are no dominant multi-hospital systems in the area. Residents tend to have strong loyalties to particular hospitals, and much of the market is driven by geography. It is unusual for residents, especially elderly residents, to cross the Mississippi River to receive care.</td>
<td>The physician market is dominated by IPAs. There is one large, multigroup practice (Ochsner). While some physicians do not participate in Medicare managed care, many are in all the plans' networks. The exception is the Ochsner Foundation Hospital and affiliated physicians who participate only in Ochner Health Plan's (OHP) Medicare managed care product.</td>
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NEW ORLEANS, LOUISIANA

Provider Organization (cont’d)

Managed Care. Total managed care penetration in the New Orleans MSA reached 27 percent in January 1999. Commercial managed care entered the market in 1984, with Medicare following 10 years later. Medicare managed care penetration was 32 percent (58,813 total enrollees) in the MSA and 32 percent in Orleans and Jefferson parishes in March 2000. In general, local managed care firms dominate the market led by OHP, a provider-sponsored plan affiliated with a tertiary care hospital and multigroup and specialty practice.

Medicare Insurance Options

M+C MCOs. The New Orleans market is dominated by local firms, including two M+C MCOs that are provider sponsored. OHP has almost 40 percent the M+C enrollees in the MSA and the Tenet-sponsored Choices Demonstration product has another 20 percent (March 2000). Competition is based on premium and pharmacy benefits. Several of the other MCOs in the market are experiencing administrative turmoil, which affects both their commercial and Medicare businesses. In 2000, seven M+C MCOs are in the New Orleans market: (1) Aetna U.S. Healthcare, (2) Gulf South, (3) HMO Louisiana (BCBS), (4) Mexicare, (5) OHP, (6) SMA, and (7) Tenet Choices. (In 2001 both Aetna and HMO Louisiana will exit the market.) None of the MCOs serves all the parishes in the MSA, but all of them serve both Jefferson and Orleans parishes. HMO Louisiana and Maxicare entered the New Orleans market in 1999, and United Healthcare withdrew from New Orleans and the rest of the parishes it served in Louisiana as of December 31, 1999. Although it remains in New Orleans, OHP withdrew from several other markets in the state at the end of 1999: in many of these areas, its product had been the only M+C option available. New Orleans also experienced one withdrawal at the end of 1998 when Advantage Health Plan did not renew its contract.

M+C Products. The nine Medicare products offered in the New Orleans area are typically an HMO model with some supplemental benefits, including prescription drugs. Only Aetna offers more than one product with different levels of premiums, benefits, and copays (although the single Tenet Choices product is a triple-option product). Most products have a zero premium, and all but one M+C MCO retained this feature in 2000. In 2000, Aetna introduced premiums on all its products, ranging from $29 to $59 in 2000. All products include a prescription drug benefit, with coverage ranging from $500 for both generic and brand-name drugs to an unlimited generic drug benefit and as much as $1,200 in brand-name coverage. MCOs seemed to be considering whether to add a premium in the future and expected the M+C market to remain active.

M+C Capitation. The capitation for Medicare, at an average $671 for the MSA in 1999, weighted by the Medicare population in each parish, is well above the national average (33 percent greater).

Medigap. The primary Medigap carriers in the market are Blue Cross/Blue Shield (BC/BS) and Physician’s. Medigap premiums seem to be increasing in recent years, but it is unclear by how much. The most popular plans are F and C. BC/BS also offers a Medicare Select product.
NEW ORLEANS, LOUISIANA

Key Organizations. The four key actors in Medicare education are (1) the state Senior Health Insurance Information Program (SHIIP), (2) the Part B educator (BC/BS of Arkansas), (3) Louisiana Health Care Review (the PRO), and (4) the Social Security Administration. These organizations are based primarily in the state capital, Baton Rouge, and conduct joint education seminars titled, “Medicare 101.” In Louisiana, the SHIIP is dominant and leads most education efforts, especially outside New Orleans. It also trains counselors with the local councils on aging and other groups and leads presentations on Medicare. In the New Orleans area, the SHIIP has trained staffs and volunteers of the New Orleans Council on Aging, the Jefferson Council on Aging, Seniors with Power United for Rights (SPUR), and the Catholic Archdiocese. Some not-for-profit hospitals run seniors programs, which provide information, billing assistance, and counseling.

Topical Focus. Education focuses on the Medicare program as a whole, only one part of which is M+C. Most education starts with basic concepts but covers the gamut of Medicare topics including programs for low-income beneficiaries and dual eligibles. Although they initially presented all the M+C options that could be offered, most educators have refined their efforts to mention only currently available options. Information on managed care structure and terminology was presented when Medicare managed care MCOs first entered the market several years ago. Currently, the greatest demand for information is in response to withdrawals and changes in benefits.

Education Activities. The dominant activities in New Orleans are seminars or presentations by the four key actors and one-on-one counseling by other groups.

Outreach. The councils on aging perform outreach in senior centers, meal sites, and housing projects to make seniors aware of their services, including health insurance counseling and information and assistance. Educators publicize their activities in newspapers (including a weekly senior issues column) and newsletters; on the radio; through direct mail; and at health fairs and senior centers. The councils on aging are developing methods to reach Hispanic seniors, but neither the Hispanic nor the large Vietnamese communities focus on elderly issues or on Medicare-related concerns.

Essential Questions. Medicare advisors say that Medicare beneficiaries in New Orleans seem to understand the concept of managed care but do not comprehend the interaction between Medicare and M+C MCOs and are confused about the basics of the Medicare program. In considering enrollment in an M+C MCO, beneficiaries are most concerned about plan cost and whether their physician participates in the plan. The generosity of the plan’s prescription drug benefit runs a close third. Most education groups are also asked questions about eligibility and specific billing issues. Disabled individuals are concerned primarily with becoming eligible to participate in the Medicare program and obtaining prescription drug coverage. Because advertising—and even product names—focus on the over-65 population, disabled beneficiaries may be unaware that M+C MCO options are available to them, and that these options are not restricted to the elderly population.
### NEW ORLEANS, LOUISIANA

#### Information Infrastructure (cont’d)

**Availability and Quality of Medicare Information.** Educators felt that reliable resources were available for those who were interested, but that most people generally do not seek information until after a problem has arisen. The educators also are concerned that much of the printed material on Medicare is not accessible to individuals with low literacy or cognitive impairments (a particular problem in New Orleans) and believe additional methods of reaching these people must be developed. One educator also was of the opinion that some minority communities, especially African American communities, were less trusting of government agencies and therefore less likely to request information from those groups, but this population also needed information.

**Resource Adequacy.** The organizations we talked with are small. Other than the state SHIIP program, most had only one or two staff devoted to education. Many had diverted resources from other services to develop insurance information programs or to respond to information about senior health insurance. Louisiana was affected by M+C MCO withdrawals at the end of both 1998 and 1999, although the impact was not as great in New Orleans. Organizations were more prepared to respond to withdrawal announcements in 1999, but this response often took over senior health insurance activity, diverting them from broader outreach tasks.

#### Unique Efforts

The four key actors in Medicare education have developed a presentation, “Medicare 101,” that discusses issues ranging from Medicare’s basic structure to eligibility and enrollment requirements to Medicare insurance options. The program is presented across the state and is often sponsored and publicized by other aging groups.

The Coordinator of Community Services for the New Orleans Council on Aging writes a weekly column on elder issues for the neighborhood section of the area’s large daily paper. This column, “Gray Matters,” covers a range of topics related to the senior community, including health care and health insurance.

#### Recommendations from the Field

**Beneficiaries need education about a range of Medicare topics.** Beneficiaries are unfamiliar with many aspects of traditional Medicare and are unaware of programs for dual eligibles. They also need information about Medigap plans and on how Medigap and M+C MCOs interact with the Medicare program.

**Medicare&You has limitations.** Many educators noted that the handbook does not appear to be widely used; one noted that, “it’s too much” for the elderly to understand. Formatting issues caused some confusion and the “local” information still does not apply to many individuals. Most educators noted that beneficiaries consider more basic cost factors and access to specific providers and do not use quality indicators in making decisions about M+C plans. Several of the groups with whom we spoke had not received the handbook, or had received only limited numbers of copies.

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*Appendix A: Profiles of Each of the Six Communities*
### Recommendations from the Field (cont’d)

**Do not educate about choices that do not exist.** Beneficiaries are confused by presentations about options that are not currently available. Restrict discussion to options that are offered, and do not mention items that are only possibilities.

### Lessons

Beneficiaries are intimidated by change and often do not consider their insurance options until a crisis (often financial) exists. Information intermediaries are meeting the needs of beneficiaries who have identified a need for information and have found an information intermediary, but information may not reach other beneficiaries. This is especially true for disabled beneficiaries because advocates for people with disabilities seem less knowledgeable about the Medicare insurance options available and do not perceive this issue to be a priority with the disabled population.
## ORANGE COUNTY, CALIFORNIA

**Community Definition.** Orange County encompasses 800 square miles and borders Los Angeles, Riverside, San Bernadino, and San Diego counties. It has 32 cities and no distinct urban centers. The largest populations are in the older cities of Santa Ana and Anaheim in central Orange County (13 percent and 12 percent of the county's population, respectively). In the last 10 years, rapid economic and population growth have occurred to the south of I-405, around Irvine, where the University of California is located. The county is organized into three overlapping health services submarkets, each with its own hospitals and IPA groups: North County, Central County, and South County.

**Demographics.** Orange County has 2.7 million people (1997), 12 percent of whom receive Medicare benefits and 15 percent of whom receive Medicaid (1999). Orange County is young: with 64 percent of its population is younger than age 44 and only 9 percent is older than 65 (1990). Approximately 6 percent of over 65 seniors are below the poverty line. Roughly 58 percent of the total population is white, 2 percent African American, 13 percent Asian Pacific Islander, and 28 percent Hispanic (1998).

**Labor Market.** Orange County has mostly medium to small businesses in the services, wholesale/retail, and manufacturing areas. With the exception of Disneyland, few large private employers are headquartered in the county. The largest employers are in the public sector: the county, the University of California, and the local school system. Employers do not play a strong role in health care leadership, and few private employers offer retiree benefits.

**Political Infrastructure.** Orange County is governed by an elected Board of Supervisors. The Senior Citizens' Advisory Council (SCAC) is a volunteer advisory group to the board that has little power. Historically, Orange County has been politically conservative. Some county residents noted that the county's social support services to seniors are minimal, particularly those for low-income and minority groups. Although county supervisor-sponsored senior events are given high visibility, senior issues remain low priority in terms of budget resources. Five years ago, the board severely cut the resources to its Area Agency on Aging (AAA) when the county was in bankruptcy. The AAA, which contracts out the majority of services, is widely perceived as ineffective. Most of the active aging organizations are in the private or non-profit sectors.

### Provider Organization

**Hospitals.** Orange County has 32 hospitals, all of which are private. Of these, 21 are for-profit, and 11 are not-for-profit. There are 11 hospital systems. Memorial, St. Joseph, and Tenet are the three dominant hospital systems in the county. Orange County has three tertiary care providers, each of which covers one-third of the county's geographic area.

Orange County's hospitals have consolidated in the last five years to obtain administrative efficiencies and increase market leverage. Two large systems also have pursued physician integration: St. Jude's Heritage Foundation has exclusive arrangements with two large medical groups, and Tenet provides financial support for administration to several groups, including the now-defunct MedPartners.
Physicians. The physician market is well-organized, with most physicians practicing in large multispeciality groups or IPAs that contract with multiple MCOs and that serve specific areas of the county. Several major medical groups are located throughout the county, including Monarch, St. Jude Heritage Health Foundation, and several smaller groups, such as Talbert and Mulliken. Capitation is prevalent, and Orange County’s MCOs have delegated significant risk to physician organizations, including risk for primary and specialty care and for some ancillary services. Although physicians still retain risk for prescription drugs, they are trying to jettison it. In this market, physicians and the medical groups act as gatekeepers, controlling consumers’ access to affiliated hospitals and specialists. Because Medicare managed care remains the medical groups’ only profitable line of business, the groups are unlikely to quit the M+C program. Cost pressures have led to declining commercial revenue and cutbacks in staff and services by some large groups. In 1999, several prominent national physician practice management companies (PPMCs) that purchased IPAs in Orange County failed. This provider-level turmoil affected the M+C market by prompting some seniors to switch health plans as they sought provider stability.

Managed Care. Managed care has had a long history in California. In Orange County, total managed care penetration reached 46 percent (1997). Managed care is prevalent across commercial, Medicare, and Medicaid markets. Medicare managed care penetration was 39 percent (113,659 enrollees) in March 2000. The health plans serving the county are predominately for-profit ones. PacifiCare, the nation’s largest Medicare MCO, was established in Santa Ana in 1977. Kaiser Permanente was established in California in the 1940s. Other large commercial MCOs are Aetna, Foundation Health Plan, and HealthNet.

M+C MCOs. M+C is dominated by PacifiCare, which has 58 percent of market enrollment (March 2000). Both PacifiCare and Kaiser introduced their Medicare risk products in 1985. Both have experienced financial difficulties in the last year as cuts in Medicare reimbursement have taken effect. Some hospitals and physicians have refused to take over the management and financial burdens that PacifiCare currently requires. Both plans appear to be committed to the market, however.

M+C Products. The M+C MCOs in Orange County offer a zero-premium product with low office-visit and prescription drug copayments. There is an unlimited drug benefit, enhanced hospital coverage, and vision and rehabilitation coverage. This is due to the high Medicare capitation (see below). All of the M+C MCOs offer basically the same benefits, so they compete on the prescription drug benefit and price.

As Medicare reimbursement cuts take effect during the next few years, industry representatives predict that premiums will be introduced. Benefits are already being restricted. Until 1999, M+C MCOs in Orange County covered dental benefits; now, that benefit is offered separately as an option that beneficiaries can buy to add on. However, competition for M+C market share remains fierce, and some plans, such as Blue Shield, have foregone increases in copayments to attract beneficiaries in the 2000 plan year.
ORANGE COUNTY, CALIFORNIA

Medicare Insurance Options (cont'd)

Roughly 60 percent of PacifiCare's and Kaiser's Medicare risk populations age-in. The current trend is for large employers, such as in the technology industry, to provide defined contributions for retirees or not to provide retiree coverage at all. Therefore, MCOs see their future growth in the individual M+C market, rather than in the employer market.

M+C Capitation. The capitation in Orange County for 2000 is $609, which is about 20 percent higher than the national average. Northern and central California have lower capitation and less rich benefits (for example, premiums and prescription drug caps) than does southern California.

Medigap. Three companies offer Medigap policies in Orange County. The largest proportion of Medigap purchasers are middle class retirees.

Information Infrastructure

Key Organizations. Medicare education is largely uncoordinated among various private organizations, providers, health plans, and government agencies. The Orange County Health Insurance, Counseling, and Advisory Program (HICAP), which is housed under the Council on Aging, is the main provider of Medicare counseling and education; however, it reaches only a small fraction of beneficiaries in the county because its budget is limited. The Los Angeles-based Medicare Part B carrier also provides some M+C education. The Legal Aid Society of Orange County serves primarily low-income Medicaid and some dual-eligible beneficiaries but refers all Medicare counseling, education, and legal assistance requests to HICAP. After a weak response to workshops, the AARP reduced its M+C statewide efforts and is largely inactive in Orange County. Statewide, the Department of Insurance (DOI), which regulates Medigap, and the Department of Corporations (DOC), which regulates MCOs, refer complaints to one another from their consumer hotlines. Both the DOI and DOC attend some health fairs and make group presentations on request, but there is no coordination of these efforts with local M+C educators. The HCFA Region IX Office has visited health fairs and senior centers in Orange County, funds some Medicare radio and television advertising, and appears to coordinate its outreach activities with HICAP.

MCOs provide much of the M+C education as part of their marketing and member retention activities. Some large medical groups provide M+C benefits and billing assistance by phone, print comparative lists of the M+C MCOs with which the groups contract, and allow health plan representatives to give sales talks to groups of patients. Similarly, hospitals do not provide Medicare education other than billing assistance but have allowed plans to meet with seniors on their sites. Medical groups and hospitals do not refer beneficiaries to HICAP. Most providers did not know HICAP existed.

Topical Focus. HICAP and MCOs have found that beneficiaries fall into two groups with different levels of knowledge about Medicare and managed care. Many beneficiaries still do not understand how Medicare works, and all presentations to them must include a Medicare 101 component. In contrast, newly retired beneficiaries are knowledgeable M+C consumers because they have had experience with managed care. Beneficiaries appear to make coverage decisions based on cost, drug coverage, and provider network. Therefore, MCOs make sure they discuss these areas.
**Outreach.** HICAP conducts most of its outreach and counseling by telephone through the state-supported toll-free line. HCFA materials and the HICAP's state association, the California Health Advocates, advertise this toll-free line. Materials are both mailed on request and given as handouts. HICAP has an active speakers' bureau and sends volunteers to make presentations at senior centers; retirement groups; churches; and retirement communities, such as Leisure World; and, increasingly, to meet with hospital case managers and discharge planners. HICAP also sponsor PSAs, and its presenters appear on local television informational shows.

HICAP's outreach to the large Hispanic and Asian communities in the county has been limited. Volunteers give presentations at the senior centers that serve these communities, and HICAP employs a part-time Spanish-language outreach worker. There does not appear to be significant outreach to the Asian community. Latino Health Access, an advocacy group for the Hispanic community, plans to develop an outreach and education program.

MCOs provide much of the M+C education as part of aggressive marketing activities to seniors at restaurants, senior centers, health fairs, home sales calls, and some provider sites. After 15 years of Medicare managed care, most Medicare beneficiaries have been exposed to plan marketing information. Because most have attended at least one event, MCOs are now disseminating information through mass mailings, free-standing inserts in newspapers, and ads. In February 2000, Kaiser launched a pilot marketing campaign on Spanish-language television, radio, and newspapers in Orange County to target the adult children of Latino beneficiaries. This campaign has received a positive initial response.

**Essential Questions.** Day-to-day inquiries to HICAP include basic questions about Medicare, requests for help in identifying the type of insurance the caller has, how to obtain Medi-Cals coverage, and how to choose a Medigap supplement. Common questions about M+C MCOs center on coverage for hospital care, skilled nursing facility care, and home health care.

MCOs have found that older beneficiaries with supplementary plans ask why premiums have increased so much. These beneficiaries feel they are being "pushed" into choosing an M+C MCO. Seniors who were enrolled in managed care while employed ask about cost, including copayments; prescription drug coverage; and provider network. MCOs have noted an increase in prescription drug formulary questions, particularly about coverage of brand versus generic drugs. Seniors are increasingly familiar with quality ratings systems, but few ask about this subject. MCOs have found that their recent financial turmoil has prompted prospective enrollees to ask about their financial viability and commitment to remaining in Orange County and in Medicare. Low-income populations are highly concerned about the market turmoil that has prompted some low-income beneficiaries to return to original Medicare without Medigap coverage, and to rely on not getting sick.

**Availability and Quality of Medicare Information.** Information on Medicare is readily available through statewide toll-free numbers; mailings, brochures, and other marketing materials; and on the Internet. However, the quality of the information varies and generally is poorly understood. Educators feel the subject matter is extremely difficult for beneficiaries to understand.
## ORANGE COUNTY, CALIFORNIA

### Unique Efforts

**Community Resource Referral Program.** PacifiCare's Care Advisor program conducts telephone screening of home-bound or disabled members to determine the members' social service needs and then makes referrals to the appropriate community-based organization. PacifiCare also publishes a HCFA-approved *Community Resource Guide* that lists all the social services in the county.

**Health Care Facilitator Program.** The University of California piloted a health care facilitator program at UC-Irvine and UC-Berkeley in 1999. The health care facilitator, a full-time position, helps individuals navigate MCOs' health care systems, acts as an advocate and insurance counselor, and conducts outreach and education about health insurance coverage to employees and retirees.

**Marketing Efforts Targeting Beneficiaries’ Adult Children.** As noted, at its Santa Ana facility, Kaiser Permanente is piloting a marketing campaign targeting the adult children of Spanish-speaking beneficiaries and the use of bilingual Spanish providers.

### Recommendations from the Field

**Simplify written materials.** The language in HCFA's written materials is full of "legalese," which HCFA requires M+C MCOs to use in their materials as well (for example, "contracted physician"). Written materials must be simplified.

**Use different media to educate beneficiaries about Medicare.** Educators, employers, and health plan staff recognize that people have different styles of learning and therefore strongly recommended that multiple approaches—from in-person presentations, to media, to video, to the Internet—be used to reach seniors.

**Outreach and education to minority communities must increase.** Special efforts must be made to target minority groups, which are closed communities spread across the county. HICAP's efforts to hire and retain bilingual staff to conduct outreach with minority communities have been relatively limited, because staff and volunteer turnover is a problem.

### Lessons

Orange County demonstrates that in a competitive, mature managed care market where the public and private sectors have little interest in health care issues, commercial health plans become the primary sources of information on Medicare and M+C.
### ORLANDO, FLORIDA

| Community Characteristics | Community Definition. | The Orlando MSA consists of Lake, Orange, Osceola, and Seminole counties. For Medicare education purposes, the Orlando Public Service Area is defined as Brevard, Orange, Osceola, and Seminole counties. The city of Orlando is in Orange County. Most residents think of Orlando as extending beyond dense Orange County into parts of Lake, Osceola, and Seminole, so we use this definition here. The area becomes more suburban as one travels outward from Orlando, and interviewees made definite distinctions between Orlando and more rural areas and counties, such as northern Florida and Brevard County. |
|---|---|
| Demographics | The Orlando MSA has 1.5 million people, 13 percent of whom receive Medicare and 9 percent of whom receive Medicaid (1999). Orlando is a fairly young city; 65 percent of its population is younger than age 45 and 13 percent is older than age 65 (1997). In 1990, roughly 82 percent of the total population was white, 12 percent African American, and 9 percent Hispanic. In 1990, about 9 percent of seniors were below the poverty line. |
| Labor Market | The overwhelmingly largest employer in Orlando is Walt Disney World (51,000 employees), but it has a small retiree population. The other major employers have from 5,000 to 22,000 employees and are from the public and private sectors. They include the federal government, public school systems, Florida Hospital, Publix Supermarkets, and Orlando Regional Healthcare System. In Orlando, employers are more active in the commercial market—organizing to pursue value purchasing—than in the Medicare market. The number of active employees is larger than the number of retirees. Unionization is not a factor in this market. |
| Political Infrastructure | The Orlando community crosses county lines and its self image is that of a metropolitan area. These factors affect the delivery of Medicare education. No one city or county government represents the Orlando area, and no single metropolitan entity facilitates unified educational efforts. None of the several municipalities appears to be involved substantially with aging issues. The push for Medicare education comes from players outside of local government, who have received funding from the state. |

| Provider Organization | Hospitals. | Two hospital systems dominate the Orlando market: (1) Florida Hospital Healthcare System, and (2) Orlando Regional Medical System. A third system (owned by Columbia HCA) exists but is not a major player. At the time of our visit (January 2000), it was up for sale. The market is not carved up geographically; rather, the two dominant hospital-based systems offer a continuum of care across the Orlando MSA. Both provider systems briefly offered their own M+C MCOs, but neither now participates in Medicare except as providers (see next section). Only recently have some M+C MCOs exclusively contracted with only one of the two dominating systems. Most M+C MCO members can choose the hospital they want. |
|---|---|
| Physicians. | The physician market is relatively unorganized, with most physicians practicing individually or in small groups and contracting with multiple MCOs. Physicians have little experience managing risk: most are paid on a fee-for-service basis, especially for Medicare. |
**ORLANDO, FLORIDA**

|--------------------------------|--------------------------------------------------------------------------------------------------|

### Medicare Insurance Options

**M+C MCOs.** The Orlando market is dominated by national firms. Regional and local participants are leaving the market. Competition is mostly on premium and some benefits. Several of the M+C MCOs are in holding patterns (for example, closed enrollment) while waiting for possible increases in the capitation rate. In 2000, six M+C MCOs are in the market: (1) Aetna U.S. Healthcare/Prudential, (2) AvMed, (3) BCBS, (4) CIGNA, (5) Humana, and (6) Wellcare. Only three have open enrollment (January 2000) and in 2001 Aetna/Prudential and CIGNA will exit the market. Humana led the Medicare market with a 44 percent market share, followed by BCBS (26 percent) and CIGNA (14 percent). Wellpoint entered the market in 2000, but all other 2000 market activity has consisted of exits or service area reductions. MCOs sponsored by the (Florida Hospital Healthcare System and Orlando Regional Medical System) two dominant hospital systems, exited the market in 1999 and 2000, respectively. United Healthcare exited in 1999 and in that same year AvMed and Humana reduced their Orlando service area, most notably by exiting Lake County, which had no other M+C MCO option.

**M+C Products.** The 11 Medicare products offered in the Orlando area are typically an HMO model, with some supplemental benefits, including prescription drugs. Two of the MCOs offer more than one product with different levels of benefits and copays. The biggest change in products occurred in 2000, when all the MCOs introduced premiums ranging from $25 to $109. Two products are still offered at zero premium by the MCOs offering more than one product.

**M+C Capitation.** The average capitation for Medicare is $538 in 2000. This payment is about the same as the national average but is substantially below Miami’s average payment, which is 60 percent greater than the national average. In 2000, the difference between the Orlando MSA’s highest and lowest paid counties is $106.

### Medigap

Forty-one insurers offer plan A (a state-required offering). Thirty-four offer plan F, and 30 offer plan B.

<table>
<thead>
<tr>
<th>Information Infrastructure</th>
<th>Key Organizations. In contrast to other sites, Medicare education is carried on by a variety of groups. Five key actors educate seniors about Medicare and M+C: (1) the Serving Health Insurance Needs of Elders (SHINE), the SHIP (2) the Part B educator (BCBS of Florida), (3) the Peer Review Organization (PRO), (4) the Social Security Administration (SSA), and (5) the Department of Insurance (DOI). These educators provide education services to senior centers, meal sites, employers, and senior groups, including on-site education and staff training. Other senior organizations refer seniors to these key sources or bring them in to aid with education. The core group, led by the PRO and the</th>
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Appendix A: Profiles of Each of the Six Communities
Part B educator, are working to better coordinate their education efforts. The other front-line senior organizations, particularly organizations that deal specifically with vulnerable populations, including those under 65, may not be involved in this effort. Organizations that deal with vulnerable populations are often unaware or uninvolved in Medicare education. Thus far, MCOs operate their marketing and education efforts separately.

**Topical Focus.** Education focuses on Medicare as a whole and partly on M+C. Most education starts with basic concepts but covers all Medicare topics. Educators talk about every potential choice, though many are not available in Orlando. This has been a source of confusion to beneficiaries.

**Education Activities.** The dominant activities in Orlando are health fairs (where materials are distributed, presentations are given, and some individual counseling is conducted) and oral presentations to the community by the five key organizations—together and separately. One-to-one counseling is provided almost exclusively by SHINE (which consequently employs the largest volunteer force). Most of the key organizations also have toll-free numbers for seniors.

**Outreach.** Outreach is active along among "traditional" aging groups and senior organizations. So far, the few efforts to expand this definition (for example, to ethnic churches) have not been successful. Educators reach seniors through advertising in newspapers, radio, public television, newsletters, direct mail, and health fairs (heavily advertised). MCOs traditionally have engaged in advertising in the media.

**Essential Questions.** We learned from community educators that Medicare beneficiaries still are confused about the basics of the Medicare program. In addition, beneficiaries who are making decisions are most concerned about (1) what MCOs cost (especially premiums), and (2) what benefits are offered (mostly pharmacy). They are also concerned, albeit to a much lesser extent, about whether their provider is in the MCO. (This issue is less important partly because the provider market has not yet been carved up geographically.) Other questions center on specific billing issues and on solving problems after an issue has arisen. Orlando educators reported that seniors demand clear, concise information about options available in the marketplace.

**Availability and Quality of Medicare Information.** The key actors felt they were doing a good job, but the secondary senior organizations were concerned that beneficiaries were confused, and that different educators were delivering different messages.

**Resource Adequacy.** Senior organizations feel that resources for education must be increased, with dollars for national education sent to the local level, where it is more effective. Although many believe they are managing demand adequately, some community members note that many seniors, most notably vulnerable groups, are not being reached at all. Furthermore, although many feel that substantial information is available, they also feel that much of it is contradictory and that many seniors are not accessing it. Thus, resources to develop more organized education need to be generated. In particular, we heard that one-to-one counseling—the most expensive activity—is the most effective method to develop an informed senior.
ORLANDO, FLORIDA

Unique Efforts

The PRO and Part B Carrier have led the effort to develop the Volunteer Outreach Interagency Communication for the Elderly (VOICE) coalition in the Orlando area. The aim of this coalition is to develop communication among senior organizations to produce clear, consistent information. Its primary focus is on Medicare education. VOICE is in the early stages of forming in Orlando, and various types of organizations have been invited to participate, including federal, state, and local agencies; health care providers (such as senior groups, acute care hospitals, case managers at rehabilitation centers and at independent living centers, and home health agencies), members of the aging network (such as senior centers); and advocates (such as AARP and the American Cancer Society). Activities in the established VOICE coalitions include in-person meetings, development of best practices, newsletters, and training.

Recommendations from the Field

Promote better coordination among educating entities. Many organizations agreed that coordination and partnership among organizations that educate seniors would improve service for seniors through coordinated information, reduced overlap in activities, increased ability to refer to the appropriate organization, and efficiency.

Educate beneficiaries before they enroll in Medicare. Seniors need to know up front what Medicare makes available to them and what types of criteria they should use to make decisions. They are more likely to be motivated to listen at the time of retirement.

Promote stability in the market. Stability in M+C MCO participation helps seniors become comfortable with their managed care choices and encourages them to make efforts to understand these options. We often heard that seniors were reluctant to learn about choices because they thought they would just “change the next day” and that the seniors believed they should wait until they had to make a choice. Stability in MCO participation also encourages MCOs to invest in educating Medicare beneficiaries, as the MCOs will benefit from a senior who understands managed care and thus follows the plan rules.

Increase awareness of materials available. Most felt that information was available, but that beneficiaries did not know how to access it.

Simplify materials and convey a clear, consistent message. Educators felt that information was often presented in forms that were too complicated and too difficult to understand. They suggested that reading level be reduced, content focus on basic program information, and short materials be used.

Do not educate about choices that do not exist. Talking about possibilities is confusing. Seniors want to know what is available to them and what is relevant to them.

Educate about the basics. Repeatedly, we heard that most Medicare beneficiaries do not understand the basic facts about Medicare and managed care. Thus, education needs to start there. After they have become knowledgeable about the basics, seniors must receive education Medicare, an MCO or a supplemental plan is the right choice; and which MCO or supplemental plan is the right one?
ORLANDO, FLORIDA

Recommendations from the Field (cont’d)

Local one-to-one counseling is the optimal activity. Beneficiaries want direction and education that applies to their individual needs. Several educators noted that the Medicare & You books are a "complete waste," as the general nature of this material on whether original and general referrals for more information increases seniors' confusion. Educators stressed that education should not be a "one size fits all" effort, and that local, customized efforts are thought to be most effective.

Lessons

Inconsistent information is an obstacle to successfully educating Orlando seniors. For example, we were told that some seniors visited many tables at a health fair, and received different information from each table about how the M+C program works for them. The seniors did not know what information was correct, what to base their decisions on, or whom to trust.
APPENDIX B

10 STANDARD MEDIGAP PLANS
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## 10 STANDARD MEDIGAP PLANS

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**Source:** Health Care Financing Administration 2000e.

<sup>a</sup>Plans F and J have a high-deductible option. A beneficiary must pay $1,530 out-of-pocket per year before the plan will pay, but annual premiums are generally lower under this option than under those F and J plans with lower deductibles.

<sup>b</sup>Includes Part A coinsurance plus coverage for 365 additional hospital days during a beneficiary's lifetime after Medicare benefits, Part B coinsurance, and the first three pints of blood each year.
APPENDIX C

DUAL ELIGIBLES
# Dual Eligibles

<table>
<thead>
<tr>
<th>Income Limits&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Individual</th>
<th>Couple</th>
<th>Benefits Medicaid Pays For</th>
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<tr>
<td>Qualified Medicare Beneficiary with Full Medicaid (QMB Plus)</td>
<td>≤100% FPL ($716) and Medicaid eligible</td>
<td>≤100% FPL ($958) and Medicaid eligible</td>
<td>Medicare's Part A and B premiums, deductibles, and coinsurance and full Medicaid benefits</td>
</tr>
<tr>
<td>QMB</td>
<td>≤100% FPL ($716)</td>
<td>≤100% FPL ($958)</td>
<td>Medicare's Part A and B premiums, deductibles, and coinsurance</td>
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<tr>
<td>Specified Low-Income Medicare Beneficiaries with Full Medicaid (SLMB Plus)</td>
<td>Between 100% and 120% FPL ($855) and Medicaid eligible</td>
<td>Between 100% and 120% FPL ($1,145) and Medicaid eligible</td>
<td>Medicare's monthly Part B premiums and full Medicaid benefits</td>
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<td>SLMB</td>
<td>Between 100% and 120% FPL ($855)</td>
<td>Between 100% and 120% FPL ($1,145)</td>
<td>Medicare's monthly Part B premiums</td>
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<td>Qualifying Individuals 1 (QI-1)</td>
<td>Between 120% and 135% FPL ($960)</td>
<td>Between 120% and 135% FPL ($1,268)</td>
<td>Medicare's monthly Part B premiums</td>
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<tr>
<td>Qualifying Individuals 2 (QI-2)</td>
<td>Between 135% and 175% FPL ($1,238)</td>
<td>Between 135% and 175% FPL ($1,661)</td>
<td>A small part of Medicare's monthly Part B premiums</td>
</tr>
</tbody>
</table>

Source: Health Care Financing Administration 1999a

<sup>a</sup>An individual or couple cannot have resources that exceed twice the limit for SSI eligibility. In addition, slightly higher income limits are allowed in Alaska and Hawaii.