CHAPTER 8

How beneficiaries learned about the drug benefit and made plan choices

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Chapter summary

In this chapter, the Commission describes results from a study of how Medicare beneficiaries learned about the Medicare drug benefit and made choices. The study consisted of a beneficiary survey, focus groups with beneficiaries and their family members, and structured interviews with beneficiary counselors.

Individuals had many factors to consider when deciding whether to enroll in Part D, but many reported similar kinds of decisions. Most beneficiaries who signed up for the drug benefit or considered doing so reported that saving money on current drug costs motivated them. Having another source of drug coverage was the most common reason beneficiaries gave for not signing up. In general, individuals who did not sign up for the benefit were less likely to use drugs on a regular basis than those who did.

Beneficiaries who enrolled or are considering enrolling in a plan spent considerable time studying their options. More than two-thirds of beneficiaries surveyed researched and made decisions about signing

In this chapter

up for Part D by themselves. However, those who had signed up were twice as likely to have had help (e.g., from friends and family) than those who were not considering signing up. Although many beneficiaries discussed their choices with family, friends, and insurance agents, fewer beneficiaries used resources like the Medicare toll-free help line, the Medicare website, or counselors to help them understand their options. Beneficiaries found the large number of choices available to them confusing, but a majority in our survey said they had enough information to make a decision.

Most beneficiaries reported that saving money on drug costs was important to them when they considered signing up for the drug benefit. When choosing a particular plan, they considered drugs on the formulary, monthly premiums, overall savings, access to their local pharmacy, and reputation of the company offering the plan. Beneficiaries participating in our focus groups also said these factors were very important. In addition, they stressed the importance of good customer service.

Counselors reported strong demand for their services. Counselors consistently said that their offices were overwhelmed by the high volume of calls they received, particularly in November and December 2005. Noting that they only tend to see beneficiaries with problems, counselors reported that beneficiaries were confused by the number of plan choices and the variation in benefit structure. Counselors said that their outreach efforts led to increased contacts with disabled beneficiaries and beneficiaries dually eligible for Medicare and Medicaid. However, they were less successful in reaching other individuals eligible for the low-income subsidy. ■

Background

With the introduction of the Medicare drug benefit and the expansion of the Medicare Advantage (MA) program, beneficiaries have had to make many choices about their health care options in 2006. As noted in Chapter 7, beneficiaries in every region of the country who choose to participate in the drug benefit program have many plan choices, including stand-alone prescription drug plans (PDPs) and MA prescription drug plans (MA–PDs). The Commission examined what information beneficiaries used to learn about the drug benefit and their individual choices. Our goal was to understand how beneficiaries made decisions so that Medicare could learn how to best support their decision making in the future.

CMS developed information and counseling resources for Medicare beneficiaries through the National Medicare Education Program (NMEP). The Balanced Budget Act of 1997 (BBA) included funding for NMEP to inform Medicare beneficiaries about the different ways that they could receive their Medicare benefits, including through coordinated care plans. The program was designed to inform beneficiaries about their benefits, their health plan choices, and their rights and protections. It consists of five elements:

- *Medicare & You*, a guide to the Medicare program, including comparative information on health plans available to beneficiaries in local areas. CMS mails a guide annually to each household containing a Medicare beneficiary;
- a toll-free help line, 1-800-Medicare, to answer questions on the program;
- a website, www.medicare.gov, designed to provide information on plan choices and program benefits;
- community-based Medicare-sponsored health fairs and educational events; and
- increased funding for federally subsidized individual counseling offered by state and local agencies through the State Health Insurance Assistance Program (SHIP).

In 2006, beneficiaries need more information and counseling following the addition of the Medicare prescription drug benefit and other plan options established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The law also increased funding for the NMEP programs to inform beneficiaries about these new choices and help them understand their options. CMS budgeted $340.45 million for beneficiary education activities in fiscal year 2005 compared to about $150 million in 2003 (Justice 2005). Most funds were allocated to the Medicare call center ($181.6 million). Community-based outreach programs including SHIP grants, CMS regional office outreach activities, targeted outreach to minority communities, and programs to support grassroots coalitions totaled $48.8 million. Federal funding specifically for SHIPs rose from $12.5 million in 2003 to $21 million in 2004 and $32 million in 2005 (Wright 2006).

In addition to NMEP programs, CMS devoted resources to media advertising, coalitions of beneficiary groups developed their own outreach activities, and individual plans conducted their own advertising campaigns to let beneficiaries know about program changes.

Studying how beneficiaries made choices

The Commission worked with a team of researchers from the National Opinion Research Center (NORC) and Georgetown University to examine how beneficiaries learned about the Medicare drug benefit, their individual choices, and what factors affected their enrollment decisions. The studies included a beneficiary survey, six focus groups, and structured interviews with beneficiary counselors.

The beneficiary survey

NORC and Georgetown designed the beneficiary survey and International Communications Research (ICR) fielded the survey instrument as part of a larger survey. The survey was conducted by telephone from February 8 to March 2, 2006. Using a random-digit dialing approach, researchers identified and interviewed 1,411 respondents age 65 or older.

NORC and Georgetown developed a series of questions designed to obtain information about beneficiary decision making regarding the new Medicare prescription drug benefit. NORC interviewers extensively tested the

questions through cognitive interviews to ascertain whether or not beneficiaries understood the questions.

ICR asked a set of demographic questions in its larger survey and then added additional questions from a number of separate sponsors. ICR weighted the data to ensure that the survey was nationally representative with respect to key demographic variables. Beneficiaries who did not know about the drug benefit or reported that they had employer-sponsored insurance (ESI), Department of Veterans Affairs (VA), or TRICARE drug coverage that they intended to keep were not asked additional questions.

Focus groups

We conducted six focus groups in 2006: three in Richmond, Virginia, from February 27 to 28 and three in Tucson, Arizona, from March 20 to 21. Each focus group included 9 to 12 participants. In each location, one group consisted of family members who were helping beneficiaries make decisions and two groups of beneficiaries. In Richmond, we held one group with only beneficiaries who were enrolled in both Medicaid and Medicare (dual eligibles). Richmond has a low rate of enrollment in MA and none of the beneficiaries reported being enrolled in an MA plan. In contrast, each Tucson group included a mix of beneficiaries enrolled in MA plans and traditional Medicare.

We recruited groups to include beneficiaries with a mix of genders, incomes, and races. Because the purpose of the groups was to discuss decision making regarding the new drug benefit, we screened out beneficiaries who had ESI, TRICARE, or access to drugs through the VA. For the family member groups, we screened based on the insurance coverage of the beneficiaries they were helping.

Structured interviews

We interviewed counselors in all regions of the country who worked with different types of beneficiaries including seniors, nonelderly with disabilities, low-income beneficiaries, beneficiaries living in rural and urban areas, and beneficiaries from different racial and ethnic groups. We began with the 34 prescription drug plan (PDP) regions and grouped geographically contiguous states to create 15 regions, each of which included one or more PDPs. We did not split PDP regions among our geographic regions. In each of the 15 regions, we selected one state for interviews. In these states, we contacted a representative from the SHIP—either the state coordinator or a counselor—and someone from another agency that provides counseling about Medicare benefits to seniors and people with disabilities. We used several sources to create a pool of beneficiary contacts. These sources include lists of SHIP coordinators, individuals and organizations affiliated with the Access to Benefits Coalition, the Health Assistance Partnership, and the Medicare Rx group.

From January 18 to April 4, 2006, we completed about 30 interviews. Interviewees included 9 counselors at SHIPs, 7 SHIP coordinators, and 14 counselors at other organizations. Among these organizations were local advocacy organizations that work with seniors and people with disabilities, independent living centers, a state pharmacy assistance program, and one regional office of a national organization. SHIP counselors included those who work directly for the SHIP at local state offices and others who work with Area Agencies on Aging or other organizations that receive SHIP funding. Three interviewees counseled only people with disabilities and two helped only beneficiaries over 65. The remaining counselors served beneficiaries of all ages. Two counselors did outreach with specific ethnic groups in languages other than English.

In each study, we explored the following questions:

- Why did beneficiaries choose to enroll or not enroll in Part D?
- How did they decide on specific plans?
- What information sources did they use and was the information helpful to them?

In the following section, we consider the factors that lead individuals to decide whether to enroll in a Part D plan.

Choosing to enroll in the drug benefit

Beneficiaries have to consider many factors when deciding whether to enroll in Part D, but many report similar kinds of decisions. Most individuals who sign up for the drug benefit or are considering doing so report that saving money on current drug costs motivates them. Having another source of drug coverage is the most common reason beneficiaries give for not signing up. In general, beneficiaries who sign up for the benefit are more likely to use drugs on a regular basis than those who are not considering enrolling.

Beneficiaries must go through a multistep process before they decide to enroll in a drug plan.

- ***Knowing about the benefit.*** Beneficiaries must first learn about the benefit and then decide whether they should enroll. Many beneficiaries already have drug coverage from former employers, the military, MA plans, and other sources. These individuals must decide whether their existing coverage is better for them than enrolling in a stand-alone Part D plan. This is an important step because beneficiaries who enroll in a Part D plan while having other coverage could discover that they have been involuntarily disenrolled from their retiree health plan or MA plan.
- ***Accepting auto-assignment.*** Beneficiaries who had Medicaid drug coverage in 2005 received notices auto-assigning them to Part D plans. They have to decide whether to remain in the plan they are randomly assigned to or choose a different plan that better meets their needs. Similarly, beneficiaries enrolled in MA plans have to decide whether to receive drug coverage through their plan or choose a different option.
- ***Applying for extra help.*** Beneficiaries with limited incomes have to decide whether to apply for extra help from Medicare.
- ***Signing up for the benefit.*** If beneficiaries do not have another source of drug coverage that is at least as good as the Part D standard benefit, they must decide whether to sign up for the drug benefit and choose a specific plan.

Knowing about the benefit

In both our survey and focus groups, we asked interviewees about their experiences at each step of this process. We found that most beneficiaries knew about the drug benefit. About 88 percent of beneficiaries participating in our survey reported that they were aware of the drug benefit.[1] While we only selected for our focus groups beneficiaries who knew about the benefit, their knowledge of specific aspects of the benefit varied. Some had a basic understanding of the benefit structure, while others knew only that a new benefit was available.

We did not explore survey respondents' knowledge of the details of the benefit, but we did ask focus group participants about the benefit structure. Beneficiaries were generally aware that different plans have different coverage levels for different drugs. Some were aware of the coverage gap but many did not seem to understand how it worked. Most beneficiaries were aware that there was a penalty connected to not enrolling in a drug plan, but few understood how the penalty worked or why it was established. SHIP counselors also reported that beneficiaries were confused about these issues; some individuals believed that they would be charged a penalty for not enrolling at all (the text box on page 186 provides more detail on the late enrollment penalty).

Many family members who were helping an elderly relative to enroll were not noticeably better informed about the benefit than the Medicare beneficiaries in our focus groups. They reported that they were having trouble finding the time to make sense of the options.

Accepting auto-assignment

Just over a quarter of beneficiaries (26 percent) without alternate credible drug coverage reported that they had received an auto-assignment letter. This group included dual eligibles and beneficiaries enrolled in MA plans in 2005. Of these respondents, more than half (15 percent of beneficiaries) said they planned to stay with the assigned plan. Almost a third of those receiving the letter (8 percent of beneficiaries) chose a different plan. The others had not yet made a decision. None of the beneficiaries in our focus groups who were dually eligible for Medicare and Medicaid chose a different plan from their assigned one. Additionally, all of the beneficiaries in our focus groups who belonged to MA plans before 2006 chose to receive their drug benefit through their health plan.

Applying for extra help

About 10 percent of survey respondents applied for extra help from the low-income subsidy. At the time of the survey, one-third of these individuals (3 percent) were approved. SHIP counselors reported that they saw a relatively small number of beneficiaries who seemed to qualify for the subsidy. If they thought that a beneficiary might be eligible, the counselors helped them with the application.

Signing up for the benefit

Of those beneficiaries who knew about the benefit and did not have employer-sponsored coverage, 30 percent reported that they had signed up for a plan and 16 percent were considering doing so (Figure 8-1, p. 187). About 34 percent of survey respondents said they did not plan to sign up for the benefit. Although beneficiaries with ESI were not asked this question, almost half of those beneficiaries who were not considering the benefit

The late enrollment penalty

In order to encourage broad initial enrollment in the drug benefit, Part D includes a penalty for late enrollment similar to that of Part B. Policymakers intended the penalty to ensure that healthy as well as sick beneficiaries would enroll in plans and create a broader risk pool. However, many Medicare beneficiaries may not be aware of or understand that provision. As in the case of Part B, beneficiaries who later sign up for the benefit are assessed a penalty for each month they waited to enroll. Thus, the penalty increases each month that the beneficiary delays enrollment following their initial enrollment period. Once beneficiaries sign up for Part D, the accumulated penalty is added to their monthly premiums throughout their lifetime. Those with drug coverage equal to or better than the standard Part D benefit, for example those with most employer-sponsored retiree coverage, are not charged the penalty if their coverage ends and they enroll in Part D at their earliest opportunity.

Beneficiaries may find that the initial late enrollment penalty—between $2 and $3 per month for those who postpone signing up until 2007—may be low enough to be worth delaying enrollment until they know more about the program. The penalty is tied to the national average premium. It is meant to reflect an actuarial assessment of the spending of late-enrolling beneficiaries, who may sign up when their need for medications increases, relative to the spending of the average enrollee. Previously the Commission suggested that CMS move as quickly as possible to determine whether the penalty amount fairly reflects any higher costs associated with delaying enrollment (MedPAC 2004). We also suggested that CMS inform Medicare beneficiaries of the penalty and how it could affect their premiums if individuals delay enrollment. ■

reported that the primary reason was because they had other sources of drug coverage. As noted above, about 15 percent of respondents chose to remain in plans to which they were auto-assigned.

Most survey respondents (93 percent) who signed up or were considering doing so said that saving money on current drug costs and protecting themselves against future costs were important reasons to sign up for the new benefit. Nearly three-quarters of beneficiaries also said avoiding the late enrollment penalty and being able to buy drugs they could not afford before were important (Table 8-1).

In contrast, beneficiaries in our focus groups seemed less concerned about insuring themselves against the cost of future drugs. Instead they focused on whether Part D would cover their current drugs and save them money. Survey results also indicate that beneficiaries with few current drug expenses were less likely to sign up for the drug benefit than those with higher expenses, casting some doubt on the importance they attached to protecting themselves against future costs (Table 8-2, p. 188).

Survey respondents were asked the primary reason why they decided not to sign up for the drug benefit. The most common reason cited was that they had another source of drug coverage (45 percent) even though beneficiaries with ESI were not asked this question. Other beneficiaries reported that they did not have many prescriptions or that they did not think the benefit would save them money (Figure 8-2, p. 189). About 5 percent of beneficiaries reported that they did not sign up because they found the choices too confusing. Note that beneficiaries could only list their primary reason for not signing up for plans and that other factors may have been of secondary importance.

In general, beneficiaries who have not signed up for the benefit are less likely to use prescription drugs on a regular basis than those who have signed up (Table 8-2, p. 188). Indeed, 52 percent of beneficiaries who are not considering signing up for a drug plan report that they take two or fewer drugs on a regular basis. They also spend less money for their drugs, with almost 50 percent reporting that they spend less than $20 per month.

Beneficiaries in our focus groups who were not considering signing up for Part D also generally reported that they had few prescriptions. Participants with few prescriptions who did sign up or were considering doing so often cited concern about the penalty they would face if they signed up later as the motivating factor. SHIP counselors also said that the main reasons beneficiaries

chose not to enroll were that they did not have high drug costs, did not believe the benefit would save money, or found the program too confusing. In some regions, counselors reported that beneficiaries were wary of drug plans after their experience with the pull-out of many Medicare+Choice health plans in their area in the period from 1999 to 2001.

Choosing a plan

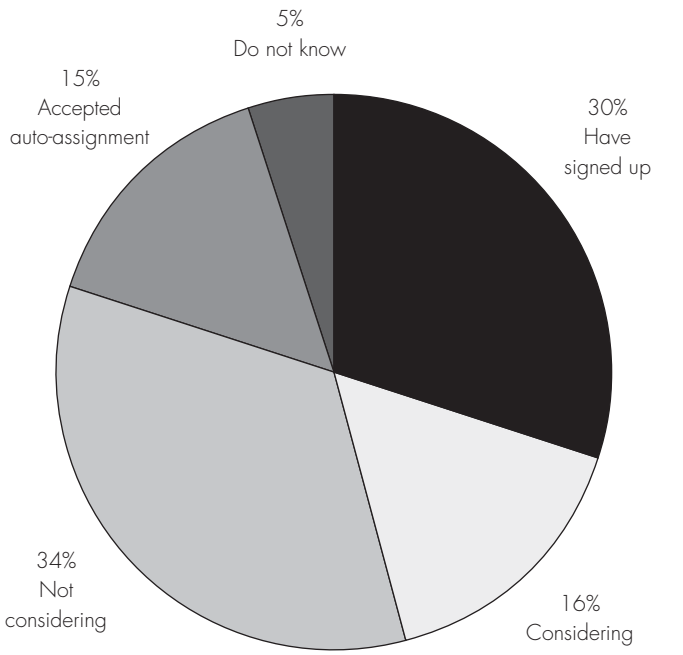
Most beneficiaries did research and made decisions about signing up for a Part D plan themselves. Consistent with other research, beneficiaries had difficulty deciding what they considered most important in a drug plan.[2] Most beneficiaries listed drug costs, premiums, drug coverage, and company reputation as critical factors in making their choices. We can not tell from the survey which of these reasons was most important to beneficiaries. Although many individuals took a lot of time considering their choices, a much smaller number used the Medicare website or 1-800-Medicare to help them with their decision. Beneficiaries were most likely to seek help from family, friends, and insurance agents.

How beneficiaries made their decision

Over two-thirds of survey respondents (68 percent) said they researched and made the decision about whether to sign up without assistance from another person. However, those who signed up were more likely to have had help than those who were not considering enrollment. In fact,

FIGURE 8–1

Have you signed up for a drug plan or are you considering signing up for a drug plan?



Note: Data are for respondents who were aware of the benefit and did not have employer-sponsored insurance, TRICARE, or Department of Veterans Affairs coverage (N=759).

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

TABLE 8–1

When you decided to sign up for the new program, how important were each of the following reasons?

Reason for signing up	Respondents who thought reason was important or very important: Have signed up for a drug plan	Are considering signing up	Total
Protecting yourself in case your drug costs go up in the future	91%	97%	93%
Saving money on drug costs	91	95	93
Avoiding a penalty for enrolling later in the program	68	78	72
Being able to buy drugs that you could not afford before	66	78	71

Note: Data are for respondents without employer-sponsored insurance, TRICARE, or Department of Veterans Affairs coverage who did not receive an auto-assignment letter (N=264).

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

TABLE 8–2 **Beneficiaries who use few drugs are less likely to enroll in a drug plan**

Question	Respondents who: Have signed up for a drug plan	Are considering signing up	Are not considering signing up	Total
How many different drugs do you take on a regular basis?				
0	5%	15%	20%	12%
1–2	18	31	32	28
3–5	42	36	36	26
6–10	18	11	12	17
11+	7	6	4	5
Before you signed up for a drug plan (if you signed up for a plan) what did you pay on a monthly basis for your drugs?				
Took no drugs on a regular basis	5	15	20	12
Under $20 per month	10	9	28	20
Over $20 but under $50 per month	19	13	21	19
Over $50 but under $100 per month	18	18	13	16
Over $100 but under $200 per month	20	18	6	14
Over $200 but under $300 per month	10	8	2	6
Over $300 per month	11	15	3	8

Note: Data are for respondents without employer-sponsored insurance, TRICARE, or Department of Veterans Affairs coverage who did not receive an auto-assignment letter: Respondents who have signed up for the drug benefit (N=229), respondents who are considering signing up (N=119), respondents who are not considering signing up (N=260), and total (N=608). Columns do not sum to 100 percent because they omit respondents who answered 'Do not know' or refused to answer the question.

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

50 percent of those who said they had enrolled in a plan had help compared to 23 percent of those who decided not to enroll. Twenty-seven percent of beneficiaries who were considering enrollment said they have had help.

About half of those who said they had assistance making their decision turned to a family member or friend (49 percent). Insurance agents (17 percent) and health plans (8 percent) were the next most common sources of help. Relatively few beneficiaries reported they received help from a doctor (1 percent), pharmacist (3 percent), or counselor (6 percent) (Figure 8-3, p. 190).

Picking a drug plan

At least 90 percent of beneficiaries who enrolled or were considering enrolling in a plan cited financial considerations—such as how much plans charged for copays and premiums, whether particular drugs were covered, and overall savings—as important reasons for choosing a particular plan (Table 8-3, p. 191). The reputation of the company offering the drug plan was also considered important by 90 percent of beneficiaries. Beneficiaries believed that being able to use their current pharmacy was slightly less important (84 percent), followed by whether the plan had a deductible (77 percent) and provided extra coverage for doctor visits (63 percent).[3]

Beneficiaries in our focus groups also thought that cost and coverage of their drugs were the most important factors. They also stressed the reputation of the plan and were wary of companies with unfamiliar names. Additionally, they wanted to be able to use their neighborhood pharmacy. Some beneficiaries considered plan customer service a determining factor. For example, one participant contacted representatives of each plan and eliminated any plan that did not respond promptly and clearly to his questions.

A little more than half of survey respondents who picked a plan or are considering doing so tried to find out whether the specific drugs they were taking were covered by the plan. Focus group participants described calling plan customer service lines to ask whether their medications were offered by the plan. Many reported difficulty getting answers from this source.

Using Medicare sources

Only 19 percent of beneficiaries in our survey without ESI reported that they or the person who was helping them called 1-800-Medicare, and only 11 percent used the website, although we can not be sure that beneficiaries were fully aware of all of the sources being used by those who helped them.[4] Only 6 percent of beneficiaries reported that they had consulted a counselor (Figure 8-3, p. 190). None of the beneficiaries in our focus groups had met with a counselor.

We asked beneficiaries who had called 1-800-Medicare or used www.medicare.gov how helpful they found those resources (Figure 8-4, p. 191). About three-fifths of those who used them found the information helpful; two-fifths did not.

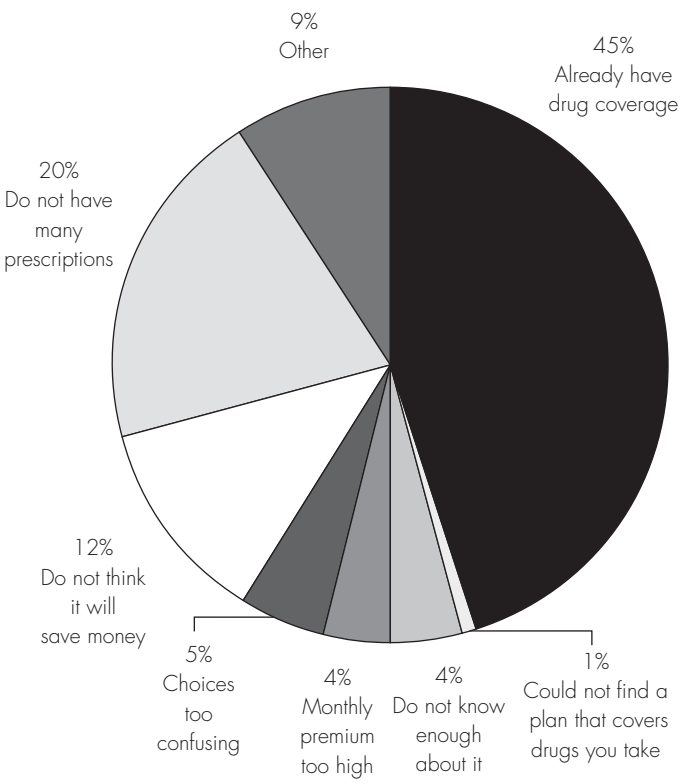
Although we did not ask about use of the Medicare handbook—*Medicare & You*—in our survey, many focus group participants reported that they had read about the drug benefit in the handbook. It was an important source of information for many of them, although some reported that they found it confusing and too "legalistic." One woman reported that she studied the handbook for several days, then used the information to contact possible plans and request information. Others also mentioned that they had used the handbook to find out what plans were offered in their area, then contacted the plans directly.

In general, few focus group participants said they had used web-based tools or counselors to help them make decisions. They were more likely to mention company plan descriptions they received in the mail, phone calls to plans, and conversations with plan representatives at special events. While some indicated that they talked to their doctors and pharmacists, they did not report getting much information from this approach. More family members noted that they had used the Medicare website but those numbers were also small.

In contrast to beneficiaries, SHIP counselors got most of their information from CMS. They used the website daily in their work. Although they agreed that it was a good tool, some counselors questioned its accuracy and tried to confirm information with plans before they advised beneficiaries about specific choices. Interviewees reported that CMS conference calls were very useful. Many counselors reported that CMS regional offices have been a particularly good resource when they have had to help beneficiaries with Part D transition problems. Counselors also received useful information from nongovernmental sources like the Health Assistance Partnership, the Patient Advocate Foundation, and the Access to Benefits Coalition. Local groups like senior centers and beneficiary advocate groups also received information from state SHIPs.

FIGURE 8–2

What was the primary reason that you decided not to sign up for a drug plan?

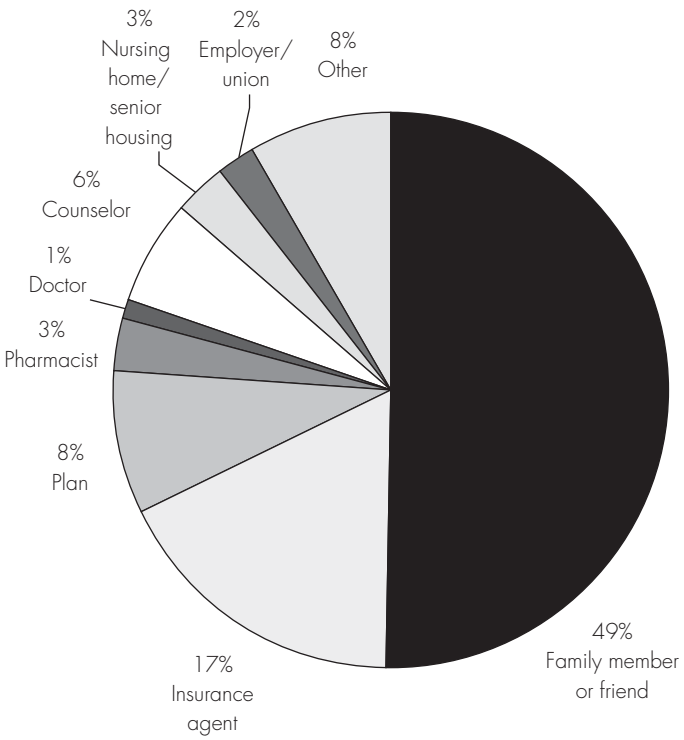


Note: Numbers may not sum to 100 percent due to rounding. Data are for respondents who were aware of the benefit; did not have employer-sponsored insurance, TRICARE, or Department of Veterans Affairs coverage; and were not considering signing up for a drug plan (N=260).

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

FIGURE 8–3

If you had help, who was the main person who helped you make a decision about signing up for a drug plan?



Note: Numbers may not sum to 100 percent due to rounding. Data are for respondents who had help making a decision (N=179).

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

Although they agreed that it was beneficiaries with problems who contacted them, counselors had a negative impression of the Medicare help line. Beneficiaries told them that they were not able to get through or that they could not get their questions answered. One SHIP counselor reported that the call center referred all questions to the local SHIPs.

The beneficiary counselor perspective

SHIP and other beneficiary counselors have a unique perspective on how Part D was implemented. Although they provide individual counseling to only a small percentage of beneficiaries, they have the most in-depth view of beneficiary decision making and are most likely to see individuals who experience difficulty making a choice or using the drug benefit. In this section, the Commission reports on some of the issues raised by SHIP counselors. Although state SHIP organizations vary greatly in terms of resources, organizational capacity, and the demographic character of the populations they served, many common themes emerged in the interviews.

Beneficiary use of counseling services

SHIPs are state-based organizations that receive federal funds to provide information and counseling about insurance issues to Medicare beneficiaries.[5] The MMA increased federal funding for the SHIP program from $12.5 million in 2003 to $21.1 million in 2004 and $31.7 million in 2005. For fiscal year 2006, CMS has allocated $32.7 million (CMS 2006b).

In addition, many other groups have been involved in providing information to beneficiaries about the drug benefit. These groups include senior centers, retirement communities, and beneficiary advocacy groups. Groups that address the needs of individuals with specific diseases or disabilities also provide information on drug plans to their constituencies. SHIP counselors say they are pleased about the increased resources available to beneficiaries through these organizations, but some complained about the lack of coordination among groups.

The number of beneficiaries seeking help from SHIPs and other groups has increased significantly. Counselors consistently reported that their offices did not have the resources needed to meet the high volume of calls they received, particularly in November and December 2005. One office that reported an average of 800 calls each month received 1,500 calls in November. Another SHIP reported an increase in calls from 3,000 a month to more than 30,000 in November and December. In the past year, SHIP counselors have provided individual counseling on the drug benefit to 4.2 million beneficiaries (CMS 2006a). Call volume has declined since the first few weeks of January, but remains much higher than in previous years.

SHIP offices reported that they lack the resources necessary to support the volume of requests for assistance: Their voice mail systems are full and they can not return calls immediately. In early February, one local SHIP coordinator said her volunteers were still returning calls from December. Another reported that her office needed to return between 500 and 800 calls. In addition, many counselors have focused on resolving transition problems

TABLE 8–3

How important are each of the following reasons in picking a plan?

Reason for picking a plan	Respondents who thought reason was important or very important: Have signed up for a drug plan	Are considering signing up	Total
How much the plan charges you for each prescription	93%	98%	95%
How much the plan charges for monthly premiums	88	99	92
Whether the plan covers the drugs you currently take	92	91	92
How much money you will save on your prescriptions overall	89	90	90
The reputation of the company offering the drug plan	89	91	90
Whether you can continue going to the pharmacy you prefer	85	82	84
Whether the plan has a deductible	75	79	77
Getting extra coverage for doctor visits	55	77	63
Signing up with the same company as your spouse	39	49	42

Note: Data are for respondents who did not receive an auto-assignment letter and signed up or are considering signing up for a drug plan (N=264).

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

for individuals who have enrolled in plans and therefore had less time to continue education and outreach programs for beneficiaries who had not enrolled in Part D. Some interviewees mentioned that they expected to see another increase in beneficiaries looking for advice before the end of the first enrollment period.

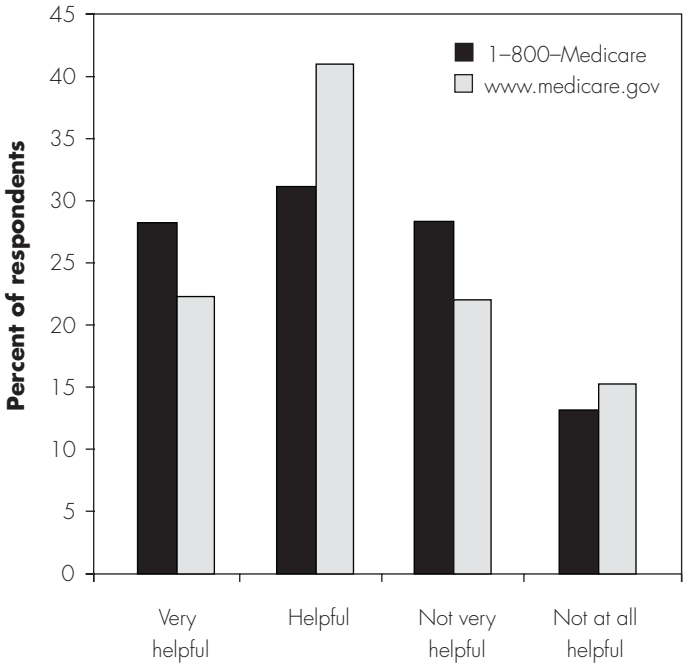
Counseling beneficiaries

SHIPs have had to extend their counseling services to more Medicare beneficiaries because of Part D. For example, they are serving more disabled beneficiaries under 65 than they previously served. This is particularly true for SHIP organizations that are part of state offices on aging. They are also receiving more calls from dual eligibles and family members of dual eligibles. These are not populations that traditionally seek assistance from SHIPs.

SHIPs and other groups offer their own meetings and seminars on Part D and give presentations at events sponsored by other local organizations. Counselors say that they speak with many beneficiaries who have attended multiple presentations before requesting assistance to select and enroll in a plan. There is so much information to present at events that beneficiaries often get overwhelmed. One counselor said that if several counselors are available at a presentation, she separates the attendees by their needs—for instance, people with retiree coverage, people

FIGURE 8–4

How helpful was the information provided by...?



Note: Data are for respondents who used 1–800–Medicare (N=115) or www.medicare.gov (N=65).

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

TABLE 8–4

Choosing a drug plan was time consuming but the majority of beneficiaries had enough information to make a decision

	Respondents who:			
Survey question	**Have signed up for a drug plan**	**Are considering signing up**	**Are not considering signing up**	**Total**
Was the overall information you had available for making your decision too much, too little, or about right?				
Too much	32%	20%	21%	25%
Too little	12	30	15	17
About right	53	42	55	51
Do not know/Refused	4	8	10	6
Overall, how difficult did you find it to choose (or not choose) a plan?				
Not at all difficult	28	13	50	35
Not very difficult	28	19	19	22
Difficult	22	34	11	20
Very difficult	19	31	17	20
Do not know	2	3	3	2
About how much time have you spent making a decision about signing up?				
Less than an hour	18	12	49	30
More than an hour, but less than 8 hours	27	40	31	31
8 hours or more	51	44	15	34
Do not know	3	4	4	4

Note: Numbers may not sum to 100 percent due to rounding. Data are for respondents without employer-sponsored insurance, TRICARE, or Department of Veterans Affairs coverage who did not accept an auto-assignment letter: Respondents who have signed up for the drug benefit (N=229), respondents who are considering signing up (N=119), respondents who are not considering signing up (N=260), total (N=607).

Source: MedPAC-sponsored beneficiary survey conducted by the National Opinion Research Center (NORC) at the University of Chicago and Georgetown University, February–March 2006.

with Medicaid, and people without coverage—so that they receive only the information that applies to them.

Counselors believe that their efforts are most successful when they are able to provide information to beneficiaries in a series of encounters. Counseling sessions may take as long as two hours. Several counselors described a typical scenario. First, a counselor provides basic information to a group of beneficiaries at a senior center or other facility. Next, beneficiaries visit or phone a SHIP office for individual help. Using beneficiary information and the Medicare website, the counselor provides the beneficiaries with descriptions of three plans that would best suit their needs. After the beneficiaries have had a chance to study the materials, the counselor may help them enroll in a plan.

If beneficiaries might be eligible for additional assistance due to their limited incomes, the counselors help them fill out the necessary forms. They also give them information on other programs that may be available (e.g., the Medicare savings programs).[6] To date, most counselors have reported that, except for dual eligibles, the population eligible for the low-income subsidy has been difficult to reach.

The beneficiaries who contact SHIPs are confused by the number of plan choices, the variation in benefit structure, how to apply for extra help, the coverage gap, and the penalty for late enrollment. Counselors note that

because of the nature of their work they only tend to see beneficiaries with problems.

Information and decision making

Beneficiaries in our survey who had to make a decision about Part D generally believed that they had enough information to decide whether to enroll in the drug benefit. Those who enrolled or were considering enrolling found it time consuming to make a decision. Both in our focus groups and counselor interviews, individuals suggested ways that Medicare could make it easier for beneficiaries to understand the benefit and choose a plan.

About half (51 percent) of beneficiaries in our survey who had to make a decision thought the amount of information available to them was about right (Table 8-4). About half of those who have signed up or are considering doing so, however, have found the decision difficult. Those who have signed up were more likely to say they had too much information than too little; those who are still considering were more likely to say they had too little information.

Many beneficiaries found choosing a plan to be very time consuming. A majority of those who have already chosen a plan report that it took eight or more hours to make a decision (51 percent). Those who are still considering signing up are likely to have spent eight or more hours (44 percent), and 40 percent have already spent between one and eight hours. Beneficiaries not considering signing up tended to spend much less time on the decision; 49 percent reported taking less than one hour to come to a decision. Our findings from both the survey and focus groups suggest that beneficiaries spent much of their time comparing information they had received from individual plans rather than using the resources provided by CMS.

In our focus groups, beneficiaries complained about the lack of comparability in the information they received from plans. Several wanted one document that compares plans in an apples-to-apples way. Others suggested a comparison chart or a simple checklist that clearly shows the prices and coverage of each plan or provides answers to frequently asked questions. Although the Medicare website provides this type of information, focus group participants wanted a hard copy. Some suggested that Medicare standardize the benefit packages that plans offer so that beneficiaries could more easily compare their options. Counselors were more likely to emphasize that plan offerings should be limited because beneficiaries were confused by the large number of plan choices. As noted in Chapter 7, CMS will limit the number of plans that an organization can offer in a region in 2007. Some policymakers have discussed a need for standardization of plan offerings.

In future work, the Commission will continue to monitor whether beneficiaries are able to make informed choices about plan offerings. Other questions of interest include:

- Does beneficiary age, gender, or income affect decision making?
- Are there examples of programs that have had particular success educating and enrolling the types of beneficiaries eligible for the low-income subsidy? ■

Endnotes

1 Survey participants who did not know about the drug benefit were not asked any additional questions.

2 There is a large body of research analyzing differences in the way elderly populations make choices compared to younger populations. See, for example, research by Sing and Stevens (2005), Hibbard and colleagues (2001), and Hibbard and colleagues (1998).

3 This question refers to whether a beneficiary considered joining an MA plan and receiving coverage for other services along with the Part D drug benefit.

4 These numbers are not included in tables presented in this chapter.

5 The program was authorized in 1990 as part of the legislation that standardized Medicare supplemental policies. SHIP resources vary considerably from state to state. Some SHIP programs are well funded and supplement their staff through a large base of volunteer counselors in a wide variety of field locations. All provide one-on-one counseling to beneficiaries through outreach meetings with beneficiary groups, office visits, and phone calls.

6 These are programs that provide help with Medicare premiums and, sometimes, cost sharing to beneficiaries with incomes that exceed state requirements for Medicaid but are below a set percent of poverty and meet an asset test (MedPAC 2005). See Chapter 9 for additional details.

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