

C H A P T E R

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**Structuring informed  
beneficiary choice**

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## R E C O M M E N D A T I O N S

- 4A** The Congress should allow HCFA more administrative flexibility in meeting its obligations to inform beneficiaries by relaxing legislative requirements pertaining to content of consumer information materials and means of dissemination.
- .....
- 4B** The Congress should fund HCFA's education initiatives adequately and directly through the appropriations process rather than through assessing user fees on Medicare+Choice organizations.
- .....
- 4C** The Secretary should develop and evaluate interactive tools that give beneficiaries a framework for understanding their choices and that help them to process information.
- .....
- 4D** The Secretary should define and regularly update appropriate standard terms for describing Medicare coverage options. HCFA should use these terms in its informational materials, require their use by Medicare+Choice organizations, and encourage their use by medigap policy carriers and others who provide beneficiary information.
- .....
- 4E** The Secretary should study the enrollment patterns of beneficiaries, giving particular attention to vulnerable groups, to assess whether their informational needs are adequately met.
- .....
- 4F** The Secretary should monitor the prevalence of aggressive marketing techniques or abuses, especially toward vulnerable populations, such as frail beneficiaries and those without functional literacy.

## Structuring informed beneficiary choice

**I**n the first year of the Medicare+Choice program, HCFA began to meet its congressionally mandated responsibilities to educate and inform Medicare beneficiaries about their insurance options. Although the first nationwide information campaign is set for fall 1999, early evidence reveals many challenges, including low levels of understanding and familiarity with core concepts among beneficiaries, problems with beneficiaries' use of detailed written materials, and beneficiary confusion resulting from misinformation and lack of coordination among information providers. HCFA must modify its initiatives to address these concerns and to incorporate new understanding of beneficiaries' information needs and ways to address those needs. To do so, the agency requires more administrative flexibility and a reliable source of adequate funding.

### In this chapter

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- Objectives of the informed choice initiative
  - First steps in promoting informed choice in Medicare
  - Helping beneficiaries make informed choices over the long term
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Enactment of the Medicare+Choice program paved the way for new types of private health plans to participate in Medicare. These plans could enhance Medicare beneficiaries' satisfaction with the program by offering them the combination of premiums, benefits, and cost sharing they want and can afford. They also could lead to improvements in health care quality and reduced costs if health plans begin to compete on value. For these improvements to happen, however, beneficiaries must have information about the choices they face and they—or people acting on their behalf—must use that information to make enrollment decisions that reflect their preferences. Providing that information and facilitating its use are particular challenges in Medicare, given the program's size and the diversity of the beneficiary population.

This chapter first examines the objectives of efforts to help Medicare beneficiaries make informed enrollment decisions. It then reviews initial steps taken toward meeting these objectives, describing the provisions of the Balanced Budget Act of 1997 (BBA) that relate to disseminating and disclosing Medicare+Choice information, reviewing the status of initiatives by the Health Care Financing Administration (HCFA) to educate and inform beneficiaries about their new options, and identifying short-term fixes needed to address fundamental problems that limit opportunities for future success. The chapter then looks ahead to what will be needed if the informed choice initiative is to succeed in the long run. It describes the conditions under which the initiative's objectives will be met, assesses the progress in doing so, and identifies ways to increase the likelihood of fulfilling those conditions.

The analysis draws upon:

- research on health care decisionmaking;
- data describing characteristics of the beneficiary population;
- lessons from the reform of the medigap insurance market under the Omnibus Budget Reconciliation Act (OBRA) of 1990; and
- lessons from the Nutrition Labeling and Education Act (NLEA) of 1990.

The analysis also incorporates the contributions of a panel of experts the Medicare Payment Advisory Commission (MedPAC) convened to discuss structuring informed beneficiary choice.<sup>1</sup> Panelists provided information and insights on first-year field experience with HCFA's information campaign, current research studies, models for structuring informed choice, and private consumer assistance initiatives.

Based on this analysis, MedPAC makes recommendations for improving efforts to help Medicare beneficiaries become more informed about their coverage options. The Commission recommends that the Congress take steps now to support informed beneficiary choice by providing the Secretary with the administrative flexibility to increase understanding of beneficiaries' information needs and an improved funding mechanism for the annual information campaign. MedPAC also recommends the Secretary take steps to build the infrastructure needed to foster informed decisionmaking by developing tools to help beneficiaries use information and standard terms to increase comparability and by ensuring adequate consumer protection for vulnerable beneficiaries.

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## Objectives of the informed choice initiative

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Efforts to help Medicare beneficiaries make informed decisions on enrollment have two underlying objectives: improving beneficiaries' satisfaction and increasing the value of the health care they obtain. Meeting these objectives will require addressing a number of challenges.

### Facilitating informed choice to improve consumer satisfaction

One objective of helping Medicare beneficiaries make informed enrollment decisions is to foster a higher level of satisfaction with health care and better health outcomes. Research suggests that consumers appreciate having options and access to information that allows them to evaluate those options (Sofaer et al. 1993). Consumers who are more informed in the selection of their health plans tend to have lower initial disenrollment rates and higher levels of overall satisfaction, in part because those who make informed enrollment decisions are more likely to have realistic expectations of their plans (Mechanic 1989). Improved health status also may result from informed decisions if individuals select the coverage and ultimately obtain the care that best meets their particular health care needs (Sangl and Wolf 1996).<sup>2</sup>

### Informed choice as a means of increasing value

Another objective of the beneficiary information initiative is to increase the value—or the quality-to-cost ratio—of the health care that beneficiaries obtain. This objective reflects the expectation that developing and disseminating easily used information about health care quality and health plan performance will spur value-based competition among plans participating in Medicare.

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1 MedPAC convened the panel on February 19, 1999. Members represented perspectives of consumer assistance groups, Medicare+Choice plans, employers, unions, and researchers.

2 Better information might have undesirable results if beneficiaries with certain types of illnesses or health concerns tend to enroll in particular plans because of the coverage they provide or the quality of care they furnish. For this reason, adequate risk adjustment of payments to plans is critical to account for the effects of any beneficiary self-selection that does occur.

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Such competition might be increased in any of several ways. The first way is for beneficiaries to consider value in making their enrollment decisions, thereby rewarding those plans that provide the preferred balance of quality and costs. Another way to induce competition is if a critical mass of purchasers considers quality in making contracting decisions. Finally, physicians and other health care providers also can spur value-based competition by considering information on quality when deciding which plans to participate in or to recommend to their patients.

Value-based competition among health plans is still a theory, rather than a reality, in most markets. In California, where competition among managed care plans is relatively high and consumers have access to an array of information on quality, technical quality of care may have improved (Sisk 1998). However, concerns exist with both the incentives and the ability of managed care plans to differentiate themselves on quality. One factor is the lack of tangible rewards in many markets for doing well on measures of quality and performance, because few consumers or purchasers now use those measures in their decisionmaking. Another factor is plans' constrained ability to contract selectively with physicians and providers—an important way plans can improve and monitor quality. This constraint results from a combination of “any willing provider” laws in certain states and purchasers' and consumers' demand for broad choice of providers (Berenson 1998).

### **Consumer pressures to improve the value of health care**

Value-based competition does not require universal use of information on quality and performance. A critical mass of knowledgeable beneficiaries who demand better value would induce health plans to improve the value of their products.

At present, however, most consumers do not find information on the quality of health care and the performance of health plans essential when selecting their health plans (Hibbard 1997). Some consumers do not find plan-level information on quality of care relevant to their enrollment decisions because they believe that health care providers are much more influential than health plans in determining quality. Others are confused by this information or are not aware that it is available.

Consumers may understand the importance of this information better through improved consumer education, more familiarity, and improvements in presenting information. One survey of more than 5,000 employees of Fortune 500 companies enrolled in managed care plans found employees were more likely to select plans with better scores in preventive care measures (such as immunization rates and mammography screening rates), suggesting some level of consumer interest in this information (Chernew and Scanlon 1998).

### **Purchasers' use of quality information and value-based competition**

Although purchasers could be instrumental in promoting value-based competition among plans, value-based purchasing is not yet common. According to a recent study, only a few large private employers use information on quality to make contracting decisions and to monitor and screen plan performance (GAO 1998). Moreover, an annual national survey of employers with more than 200 employees found that accreditation of health plans and performance data play a growing but relatively minor role in employers' decisions to select among health plans (Gabel 1998). According to this study, only 9 percent of surveyed employers required accreditation by the National Committee for Quality Assurance

(NCQA) and about 1 percent provided HEDIS data to help employees select plans.<sup>3</sup>

Decisions by purchasers that represent a large portion of the market have the potential to spur value-based competition most directly, but public purchasers such as Medicare face other constraints that may limit their ability to act on information on quality and performance (see Chapter 2).

### **Health care providers' use of information on quality**

Physicians and other health care providers are an important potential audience for comparative information and could play a role in spurring value-based competition. Since 1991, the Pennsylvania Consumer Guide to Coronary Artery Bypass Graft (CABG) Surgery, has provided risk-adjusted mortality rates for all cardiac surgeons and hospitals in the state. While most patients who had undergone CABG surgery in one of the rated hospitals were unaware of or did not use the report cards, a 22 percent reduction in mortality rates since 1991 suggests that hospitals may be reacting to the information by making institutional improvements in quality (Schneider and Epstein 1998, Nash et al. 1998).

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### **First steps in promoting informed choice in Medicare**

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Medicare policymakers must harbor reasonable expectations for both short- and long-term success of the informed choice initiative in Medicare. The initiative promises to improve beneficiaries' satisfaction with their care by increasing choice and fostering appropriate decisionmaking. However, the notion of informed consumer choice as an avenue for quality improvement in health care is largely untested, and the size and diversity of the beneficiary

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3 HEDIS refers to the Health Plan Employer Data and Information Set, measures of health care quality and health plan performance developed by the NCQA.

population makes Medicare's efforts to empower consumers particularly challenging.

Empowering Medicare beneficiaries as value-based health care consumers must necessarily be a long-term goal. In the short term, limits in beneficiaries' knowledge of relevant health care concepts, a widespread unfamiliarity with alternatives in health care delivery, and considerable uncertainty about how to use comparative information in making enrollment decisions are significant obstacles. These problems should subside somewhat as more beneficiaries with experience making health care enrollment decisions and who have used different types of health care delivery arrangements age into the program. But addressing current limitations will require a sustained effort by the program and other stakeholders to increase understanding and beneficiaries' comfort with the informed choice process.

In the short term, Medicare needs to set goals for helping beneficiaries become informed health care consumers and to assess regularly its progress in meeting those goals. Medicare's education and information initiatives must consider the information Medicare beneficiaries need and the best ways of providing it. The program also must adapt its efforts to the information obtained through continued assessments of HCFA's efforts and research and demonstrations of health care decisionmaking.

### **Statutory measures to help beneficiaries make informed choices**

In the BBA, the Congress attempted to expand enrollment options available to Medicare beneficiaries and to ensure that beneficiaries would understand those new options. The BBA also established new user fees levied on health plans participating in Medicare to

fund efforts to educate and inform beneficiaries.

### **Expanding choices**

The Medicare+Choice program expanded the range of health plans eligible to participate in the program. Before enactment of the BBA, participation of private health plan was limited to health maintenance organizations (HMOs). Under Medicare+Choice, preferred provider organizations, provider-sponsored organizations, private fee-for-service plans, and medical savings accounts in conjunction with high-deductible plans may now contract with Medicare. These types of plans have been slow to join the program, however. In 1999, provider-sponsored organizations were the only new type of plan available in Medicare+Choice (MedPAC 1999).

### **Ensuring development and dissemination of information**

The BBA also included numerous specific provisions designed to ensure that beneficiaries would have adequate information to make decisions in the new Medicare+Choice environment. The law required HCFA to implement initiatives to help beneficiaries understand the choices available to them and established new requirements for plans participating in the program to disclose information.

The BBA requires HCFA to distribute general information to all beneficiaries about benefits and cost-sharing under traditional Medicare, Medicare+Choice enrollment procedures, supplemental coverage through medigap policies, Medicare SELECT, and beneficiary grievance and appeals processes. HCFA must also provide beneficiaries with a list of the Medicare+Choice plans available in their area and local information to compare characteristics of each plan offered, including:

- type of plan (for example, health maintenance organization);

- benefits offered (basic and supplemental);
- geographic areas the plan serves;
- beneficiary cost-sharing, copayments, and limits on out-of-pocket expenses;
- provider and physician networks; and
- quality of care furnished.

The BBA specifies that HCFA must disseminate this information widely through the Internet, printed materials, and a toll-free hotline, and that the agency must conduct campaigns nationwide to educate beneficiaries. The agency must also send printed materials to current beneficiaries at least 15 days before the annual election period (every November, beginning this year) and to prospective beneficiaries at least 30 days before they become eligible for Medicare.

Medicare+Choice organizations must also meet new information requirements prescribed in the BBA.<sup>4</sup> They must provide detailed information to HCFA about the plans they sponsor, including information describing the geographic areas, covered benefits, plan rules, grievances and appeals procedures, and quality assurance programs. The agency uses this information to prepare comparative materials for beneficiaries and to aid in administrative oversight. Upon request by beneficiaries, Medicare+Choice organizations must also disclose information about coverage, the number and type of enrollee complaints, limits on costs or use of services, and physician reimbursement procedures.

### **Financing beneficiary education and information**

The BBA authorized HCFA to collect user fees from Medicare+Choice organizations as a funding mechanism to carry out the agency's beneficiary education mandate.

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4 A Medicare+Choice organization is an entity that holds a contract with the Secretary of Health and Human Services and is responsible for meeting the terms and conditions of the Medicare+Choice program. A plan is set of benefits, cost-sharing, and premiums offered by a Medicare+Choice organization. A Medicare+Choice organization may offer more than one plan.

Although the law allowed the agency to collect up to \$200 million in user fees in fiscal year (FY) 1998 and \$150 million in FY 1999, the Congress authorized collection of only \$95 million in each year.

### HCFA's efforts to implement BBA requirements

Although HCFA has yet to fully implement its initiatives for educating and informing beneficiaries, early feedback on the agency's initial efforts suggests that they should be modified. Information from HCFA's own evaluations and current research on consumers' decisions can help to redirect these efforts, although the BBA's prescriptiveness is likely to constrain the agency's ability to adapt them.

### Experience of the first year

Since the BBA was enacted, HCFA and others have undertaken considerable work to understand beneficiaries' needs for information and to devise ways to meet those needs. With the Agency for Health Care Policy and Research (AHCPR) and the Office of Personnel Management, HCFA sponsored a conference on consumer information in December 1998 that brought together prominent researchers and those working to help consumers make decisions to discuss current issues (FACCT 1999). Research under way on consumer decisionmaking and development of information tools by HCFA, AHCPR, the Robert Wood Johnson Foundation, the Research Triangle Institute, and others will increase understanding of beneficiaries' needs for information and the best ways to address them.

The Institute of Medicine's (IOM) Committee on Choice and Managed Care convened a two-day workshop in March 1998 on developing an information infrastructure for Medicare beneficiaries. It resulted in several specific recommendations for work at the national, state, and local levels. The committee addressed short-term concerns

about the initial stages of HCFA's beneficiary education campaign, recommending that HCFA test market its mailing materials; enlist national, state, and local partners in the education initiative; and request more time from the Congress to develop an adequate information infrastructure at the beginning of the process (Jopeck and Lewin 1999). Because the committee was concerned that program changes might panic beneficiaries, it also recommended emphasizing in HCFA's initial beneficiary information materials that beneficiaries need not change their current health care arrangements if they were satisfied with them.

In response to these recommendations, its own research, and the research of other groups, HCFA decided to test its National Medical Education Program (NMEP) in five states, rather than launch a nationwide campaign in the fall of 1998. Beneficiaries in the pilot states received a copy of HCFA's 36-page *Medicare & You* handbook (which included comparative information on options), and they could call a toll-free consumer assistance hotline. Beneficiaries in other states received only a short informational bulletin. HCFA plans to use the findings from its evaluation of the pilot test to modify its consumer information initiative and will launch a nationwide information and education campaign in the fall of 1999.

## HCFA's national Medicare education initiative

The goals of the National Medicare Education Program (NMEP) are to enable beneficiaries to access information when they want it; foster understanding of coverage options; and encourage the perception that NMEP, HCFA, the federal government, and its partners are credible sources of information (Jopeck and Lewin 1999). NMEP is a multifaceted plan that includes assessment components to provide for program accountability and to generate data for continuous quality improvements.

- Beneficiary mailings: Due to time and fiscal constraints, HCFA scaled back the first mailing of the *Medicare & You* handbook from all Medicare beneficiaries to 5.5 million beneficiaries in five pilot states—Arizona, Florida, Ohio, Oregon, and Washington—in early November 1998. Residents of those states also may request the handbook in Spanish, audiocassette, or Braille. Simultaneously with the handbook mailing, HCFA sent out an abridged bulletin version to

beneficiaries in the remaining 45 states.

- Toll-free hotline: The availability of this hotline was phased in over one year. It first was accessible only in the five pilot states but now is available nationally. Customer service representatives staff the phone number during business hours on weekdays. At all other times, an automated system allows beneficiaries to obtain answers to most frequently asked questions, order Medicare publications, or order a disenrollment form in either English and Spanish.
- Internet resources: Early in 1998, HCFA launched its beneficiary-oriented Web site at [www.Medicare.gov](http://www.Medicare.gov). This site contains the *Medicare & You* handbook and a list of resources for beneficiaries and those who assist them. Both general

*continued on page 62*

## HCFA's national Medicare education initiative

*continued from page 61*

and comparative information are available online through the Medicare Compare database. This resource allows beneficiaries to learn about plans in their service area and the plans' benefits, costs, consumer satisfaction scores, and standardized indicators of performance. HCFA has partnered with public libraries nationally in an effort to help beneficiaries access relevant information on the Web.

- **Local initiatives:** These initiatives include a train-the-trainer program, which provides national, state, and local organizations with the necessary tools to train other local groups to educate beneficiaries. HCFA and its local offices have partnerships with a group of about 125 such organizations called the National Alliance Network. This local partnership is in addition to a longstanding relationship between HCFA and State Health Insurance Assistance Programs, state counseling programs supported, in part, by federal money.
- **Assessment of the NMEP:** HCFA is undertaking an assessment of NMEP to provide data for continual quality improvement in NMEP activities and for program accountability. HCFA is taking a two-prong approach in assessing the NMEP: channel-specific assessments and cross-cutting assessments. The channel-specific approach assesses the performance of the different media by which beneficiaries receive information. For example, analysis of the toll-free hotline includes collecting data from taped calls, conducting focus

groups with customer service representatives, and collecting data from a call-back survey. As part of assessing the effectiveness of the Internet activity, a bounce-back form surveys visitors as they are leaving the Medicare.gov Web site. Cross-cutting assessments will provide feedback on how various components of the NMEP work individually and together. In-depth analysis of six communities will help identify best practices—especially those related to providing accessible sources of information, understandable presentation of information, and model efforts of local coordination. An ongoing beneficiary survey of the Medicare population, the Medicare Current Beneficiary Survey, will include questions assessing beneficiary knowledge of Medicare in general and preferences among alternative sources of information. Cross-cutting assessments will also give attention to special subgroups, such as disabled beneficiaries, Spanish-speakers, and those who are newly enrolled in Medicare.

- **The Consumer Advisory Panel on Medicare Education (CAP-ME):** HCFA is assembling a 10-member panel to provide advice on effective education programs that help beneficiaries make informed decisions under Medicare+Choice. CAP-ME members will be appointed for one- to four-year terms and will include individuals representing such groups as disabled beneficiaries, consumers, women, and minorities. Individuals who represent plan and insurer perspectives, senior groups, employers, and providers are also candidates for membership. ■

The NMEP features a toll-free telephone hotline, an annual handbook mailed to every beneficiary household, a Web site featuring local comparative information on plans, and a community-based education and outreach campaign. To help meet the goals of the NMEP, HCFA has developed a network of more than 125 partner organizations, including public and private employers, educational institutions, consumer and advocacy organizations, and unions.

The Congress authorized HCFA to collect \$95 million, or approximately \$2.40 per beneficiary, in each of two years: FY 1998 and FY 1999. In FY 1998, HCFA used about half of the total NMEP budget to establish and support a fully operational toll-free hotline and about 20 percent to cover the cost of printing the *Medicare & You* handbook and the shorter bulletin. In FY 1999, HCFA faced higher costs associated with sending a handbook to every beneficiary household and implementing the toll-free hotline nationally. The remaining costs, including the Web site, community-based outreach, and program support activities (such as assessment, surveys, social marketing, and planning) are not likely to decrease in the next two years because the Web site is still in its initial market-testing phase. Furthermore, basic outreach is still needed to increase the general awareness of beneficiaries, and program evaluation will continue to be necessary to glean lessons learned from the NMEP's initial years.

### **Preliminary evidence suggests problems with HCFA's efforts**

Although it is too early to assess whether the NMEP will ultimately meet its goals, preliminary evidence from the pilot and reports from consumer advocates, practitioners, and others actively involved in educating beneficiaries suggests the first stages of HCFA's initiative achieved only limited success. Although some problems may relate to low interest and knowledge of enrollment options among beneficiaries, others relate to the specific information provided and how that information was conveyed.

## RECOMMENDATION 4 A

**The Congress should allow HCFA more administrative flexibility in meeting its obligations to inform beneficiaries by relaxing legislative requirements pertaining to content of consumer information materials and means of dissemination.**

MedPAC's preliminary assessment of the beneficiary education and information program suggests its limited initial success resulted from a general lack of interest among beneficiaries considering enrollment options, confusion about the significant changes in Medicare over the past year, and fundamental problems with the informational materials and their distribution. Continuing research and findings from HCFA's NMEP assessment should provide information to remedy the latter problems, but the detailed prescriptive requirements of the BBA limit the agency's ability to make substantive modifications and to focus resources where needed.

As information about the decisionmaking process of Medicare beneficiaries accumulates, the information and education infrastructure should evolve in response. By relaxing legislative requirements, the Congress would help HCFA improve its efforts to educate and inform beneficiaries. Such adjustments would provide the agency with the latitude to change the program in response to continuing research on consumer decisionmaking, feedback from consumer groups, and the agency's own assessment of the effectiveness of its efforts.

MedPAC anticipates HCFA would use the administrative flexibility granted by the Congress to focus its efforts to educate and inform beneficiaries more effectively and efficiently, rather than to increase the scope

Current evidence suggests that most beneficiaries do not use the informational materials HCFA mailed to them. For example, while every beneficiary household received either a bulletin or handbook from HCFA in 1998, a recent national telephone survey showed that less than half of seniors recall receiving these materials (Consumer Action 1999). Of those who remembered receiving the materials, 22 percent said they did not read them.

Use of HCFA's toll-free hotline was also less than expected. Private consumer assistance groups and other observers suggest the low volume of calls reflected a low use of the Medicare handbook rather than a lack of questions among those who did. The low volume of calls might also be explained by HCFA's decision not to advertise the hotline (in order to test its capacity) and a low awareness of the service among beneficiaries and counselors.

Limited use of the informational materials and consumer assistance services may partly reflect limited interest among beneficiaries in changing their enrollment. Some beneficiaries may have saved the unread information for future reference. Furthermore, limited beneficiary use might also be a predictable response to one message prominently displayed in the materials: "If you are happy with your current coverage, you do not have to change" (HCFA 1998).<sup>5</sup>

Consumer advocates and counselors closely involved in helping beneficiaries interpret and understand the new materials report concerns about the content of the information mailed and its presentation. Some noted they found HCFA's consumer information handbook very complex and confusing and said that it required them to spend inordinate time and resources clarifying messages (MedPAC Expert Panel February 19, 1999).

Employee benefit counselors who advise retirees about their employer-sponsored Medicare coverage have also expressed concerns about the information HCFA disseminated in November 1998. Some representatives of both employers and unions said the materials did not adequately address the information needs of beneficiaries who have employer-sponsored Medicare coverage (MedPAC Expert Panel February 19, 1999). For example, although the handbook states that beneficiaries who have insurance through a former employer should contact that employer or union before choosing a health plan, representatives noted that many beneficiaries missed the message because it lacked prominent placement. These representatives also said that some confusion might have been averted had HCFA worked with employers to coordinate education efforts.

Some methods the BBA prescribed to disseminate information may not be the most effective or efficient for reaching and increasing the awareness of beneficiaries. Printed materials, for example, are relatively costly to produce, cannot directly help those with low literacy, and are subject to accuracy problems because of deadlines for obtaining and publishing information.<sup>6</sup>

### **Immediate steps needed to support informed choice**

MedPAC offers two recommendations to increase the potential success of HCFA's education initiatives and to address immediate concerns. First, the Congress should provide the Secretary with the administrative flexibility needed to improve the utility of the information initiatives based on ongoing research and assessment efforts. Second, the Congress should ensure that HCFA's efforts have an equitable and reliable source of adequate funding.

5 This message, although intended to minimize anxiety, could be a disservice to those beneficiaries who lack supplemental insurance and others who might benefit from enrolling in a Medicare+Choice plan.

6 Because of time constraints, comparative information may be outdated by the time of the open enrollment mailing. The information HCFA receives from plans to include in the comparative information reflects plans' benefit decisions as of July. By November, when beneficiaries receive the information, plans may have chosen to expand their benefit packages.

of those efforts. For example, the agency's self-assessment and evaluation efforts might suggest scaling back efforts to mail comprehensive comparative materials to each beneficiary annually. Instead, the agency might inform beneficiaries of the opportunity to change enrollment and provide them with a toll-free number to request written materials or obtain other assistance. Alternatively, HCFA might reallocate resources from printing costs of the handbook to other condensed materials or to more effective methods of dissemination, such as personal communication.<sup>7</sup>

#### RECOMMENDATION 4 B

**The Congress should fund HCFA's education initiatives adequately and directly through the appropriations process rather than through assessing user fees on Medicare+Choice organizations.**

MedPAC recommends the Congress directly appropriate adequate funds for the NMEP to ensure reliable financing for HCFA's annual education program. Under the current funding scheme, health plans, whose enrollees represent about 15 percent of Medicare beneficiaries, are funding efforts to educate and inform all beneficiaries. Medicare+Choice organizations thus are paying to disseminate information on the availability of their services in addition to those of their competitors. Moreover, when Medicare+Choice plans drop out of the market, the user fee assessed on each remaining plan increases (MedPAC 1999). User fees are thus unreliable to support a continuing program, especially if increases in fees reduce plans' incentives to participate in Medicare+Choice.

Adequate funding would help ensure beneficiaries receive needed information on a timely basis. NMEP funding must

cover the costs of mailing information to each beneficiary household, maintaining the Internet site, undertaking community-based outreach, and assessing and evaluating the agency's activities. Although the Congress must provide HCFA the resources to fulfill its legislated responsibilities, the agency also should make the most of available funds while improving its effectiveness by collaborating with private groups that provide consumer assistance services and help beneficiaries obtain and process information.<sup>7</sup>

#### Helping beneficiaries make informed choices over the long term

Although increased administrative flexibility and improved funding mechanisms would help HCFA improve its efforts to support informed decisionmaking by beneficiaries in the short term, additional steps are needed to foster appropriate choices and promote value-based competition over the longer term. If HCFA's efforts are ultimately to succeed, they must be founded on the best available evidence of consumers' needs for health care information and must consider specific characteristics of the beneficiary population that affect those needs and the best ways of meeting them.

Achieving the objectives of the informed choice initiative depends on three points. Beneficiaries must:

- have enrollment options available,
- obtain information to understand and to compare their options, and
- use and incorporate that information into their enrollment decisionmaking process.

Numerous challenges must be addressed in meeting these conditions.

#### Availability of enrollment options

Making informed choices requires having options from which to choose.<sup>8</sup> To make enrollment decisions, beneficiaries must consider the types of coverage available to them, including Medicare+Choice options, supplemental insurance options (medigap policies), employer-sponsored plans, and Medicaid.

Most, but not all, beneficiaries live in areas served by Medicare+Choice organizations. Between June 1996 and March 1998, the share of beneficiaries with access to at least one risk plan rose from 65 percent to 72 percent (MedPAC 1998). While 7 percent of all risk enrollees were affected by nonrenewed contracts with the start of Medicare+Choice in January 1999, only about 1 percent of former risk enrollees were left with no managed care option (HCFA 1999). Beneficiaries who live in certain areas, particularly rural counties, still are limited to traditional fee-for-service Medicare because no private plans serve their areas, although most such beneficiaries have other types of supplemental coverage options to consider.

Some analysts believe that Americans are accustomed culturally to a market economy in which choices abound (Schaeffer and Volpe 1999). However, choices also can become overwhelming. According to the perspective of consumer advocates and beneficiary counselors, beneficiaries seem to prefer a small range of choices from which to select coverage (MedPAC Expert Panel February 19, 1999). This preference, however, may not reflect interest in having fewer choices but a desire for simpler decisionmaking.<sup>9</sup>

7 While face-to-face communication is very labor and resource intensive, local organizations have effectively reached vulnerable beneficiaries in their communities and educated them about Medicare. If granted administrative flexibility, HCFA might consider reallocating resources of its consumer information program to bolster such community-based outreach.

8 Beneficiaries also face choices of primary care physicians, specialists, hospitals, and treatment alternatives. Chapter 2 discusses the need to develop provider-specific information on health care quality to aid in these decisions.

9 This interpretation conforms with research indicating a strong correlation between consumers' satisfaction with their health plan and the availability of choices among health plans (Davis et al. 1995). In other words, the availability of choices appears to improve the satisfaction of consumers who have options in health coverage.

## Helping beneficiaries obtain relevant information

To be effective, Medicare's beneficiary education initiatives must account for wide diversity in beneficiaries' personal circumstances that affect both the information they need and how they receive it. Increasing beneficiaries' ability to be informed consumers must necessarily be a long-term goal. Many beneficiaries lack the basic knowledge of health systems they need to use comparative information on options, and most are unfamiliar with the measures of health care quality and health plan performance that can be used to differentiate options. Further study will be needed to determine the best ways to provide comparative information to beneficiaries and to answer their particular questions about health care coverage effectively and efficiently.

### Information to support beneficiaries' enrollment decisions

Developing materials to help beneficiaries make enrollment decisions involves considering the information they need, the appropriate messages to stress, and the details to present.

### Types of information needed

Medicare program decisions about what information to provide to beneficiaries should be based on what beneficiaries know and what experts believe they need to know to make informed enrollment decisions.

Because beneficiaries lack basic knowledge of Medicare and the health care delivery system, and because they are unfamiliar with health care decisionmaking pertaining to Medicare+Choice, efforts to inform beneficiaries must educate them about the key components of health care delivery systems and the Medicare+Choice program (see box on this page). Many beneficiaries' understanding of health care concepts and terms is inadequate to enable them to use comparative information to assess their enrollment options. Further, many beneficiaries are unfamiliar with

managed care and other types of health care arrangements. Beneficiaries are also uncertain about which features of their enrollment options they should consider and compare, given their own circumstances and preferences.

General information on the health system and the Medicare program—such as benefits the program covers, the difference between traditional Medicare and Medicare+Choice, and the purpose of supplemental insurance coverage—would

## Current beneficiary knowledge

### Knowledge of the health care delivery context

Evidence indicates that many consumers do not understand the differences between traditional fee-for-service and managed care plans. Results from a national survey find that consumers failed to identify key terms and could not differentiate major characteristics of managed care or fee-for-service insurance. For example, only about 25 percent of respondents correctly identified the type of insurance that uses primary care physicians as "gatekeepers" (Isaacs 1996).<sup>a</sup>

Lack of familiarity is even more pronounced among Medicare beneficiaries, 85 percent of whom still receive their coverage through the traditional fee-for-service program. A recent survey of Medicare beneficiaries found that 30 percent of respondents knew virtually nothing about health maintenance organizations (HMOs), even though half were enrolled in one at the time of the survey. Researchers also found that respondents who were HMO enrollees have poorer understanding of the differences between HMOs and fee-for-service than do fee-for-service enrollees (Hibbard and Jewett 1998).

### Knowledge of Medicare

Knowledge of the traditional Medicare program appears to vary. About 40 percent to 50 percent of beneficiaries believe they know most or all of what

they need to know about Medicare in general—which services are covered, what beneficiaries must pay to cover those services, and supplemental insurance (Murray and Shatto 1999). But some specific aspects of the Medicare program are better understood than others. For example, a nationally representative survey conducted in 1998 found that 85 percent of those 65 years and older knew that Medicare pays for hospital bills and doctor bills. About 63 percent of the same group understood that Medicare does not pay for prescription drug coverage. However, only 44 percent said they know Medicare does not pay for long-term nursing home care (Kaiser Family Foundation and Harvard School of Public Health 1998).

One reason beneficiaries may be uninformed about HMOs and their health plan options but relatively informed about other aspects of the Medicare program is that most tend to seek specific information to address situations that arise. According to the 1997 Medicare Current Beneficiary Survey, 94 percent of beneficiaries said they "did not need to find information about the availability and benefits of HMOs" in the previous year, and 57 percent of beneficiaries said they knew little about HMOs (Reilly 1998). Moreover, few actually tried to learn about HMOs and their functions.

*Continued on page 66*

<sup>a</sup> Certain managed care organizations do not require referrals from primary care physician to access specialists but most Medicare HMOs do.

## Current beneficiary knowledge

*Continued from page 65*

Beneficiaries' plan-specific knowledge stems primarily from experience—their own and that of friends and family. Knowledge or use of information on plan quality, for example, is poor and this information is not deemed essential by consumers in choosing plans, even if it is readily available (Tumlinson et al. 1997). On the other hand, beneficiaries understand general Medicare-related information, such as the lack of prescription drug coverage, because most beneficiaries have likely encountered the need to obtain a prescription. By contrast, the general lack of understanding about long-term care coverage could result, in part, from most beneficiaries not seeking this information until they need nursing home care.

### Knowledge of supplemental insurance

Medicare beneficiaries' understanding of their supplemental insurance options also varies. Understanding of private supplemental insurance options seems to have increased following enactment of legislation to standardize medigap benefit

packages. For example, the number of beneficiary complaints to state insurance departments has dropped significantly since the standardization measures took effect (McCormack et al. 1996a, Rice et al. 1997). But it is not clear that beneficiaries understand the difference between basic and supplemental coverage. Focus group research among state-based counselors indicates confusion among elderly and disabled beneficiaries about what to do to ensure adequate coverage (Frederick Schneiders Research 1998). Recent evidence shows that poor and low-income beneficiaries who qualify for state Qualified Medicare Beneficiary or Specified Low-Income Medicare Beneficiary programs do not take advantage of these options, in part, because they are not aware that they are eligible (Rosenbach and Lamphere 1999). Awareness of these programs and their eligibility criteria is further limited by cultural and language barriers, administrative and bureaucratic hassles, and a stigma attached to receiving a payment perceived as welfare (GAO 1999a). ■

- out-of-pocket costs (premiums and cost-sharing),
- benefits,
- service area,
- plan performance,
- access to primary care physicians and specialists,
- convenience (location of care, amount of paperwork and other administrative burdens), and
- rights as consumers and patients.

Beneficiaries also may benefit from information that provides guidance on which points to consider and compare in choosing among enrollment options. The Committee for Choice and Managed Care of the IOM identified several questions that Medicare's informational materials should provide to help beneficiaries assess enrollment options, including:

- Will I be able to continue to see my current physician or a specialist if the need arises?
- Will the plan save me money and, if so, how?
- How will my prescription drug costs be covered?
- Can I leave the plan if I'm dissatisfied?
- How can I resolve a complaint I may have?

### Emphasis on key messages

Emphasizing key messages in materials designed to educate and inform beneficiaries can help them decide whether and how to use them. For instance, the IOM recommended HCFA's first-year mailing materials state prominently that beneficiaries were not in danger of losing traditional Medicare coverage and that they could delay making any choice indefinitely while still covered by traditional Medicare (Jopeck and Lewin 1999). This message may have prevented

provide a context for beneficiaries to assess their specific circumstances and choices (Hibbard et al. 1998, Jopeck and Lewin 1999, FACCT 1999).

Beneficiaries also need information related to their personal circumstances that influence the availability and appropriateness of their choices. Information beneficiaries should consider in making an informed enrollment decision include whether they are eligible for Medicaid coverage or for coverage under the Qualified Medicare Beneficiary (QMB) or Supplemental

Low-Income Medicare Beneficiary (SLMB) programs, whether they have Medicare+Choice plans available in their area, and whether they are eligible for health benefits through a current or former employer.

Beneficiaries also need specific information to compare coverage options. This information allows for comparison shopping by particular characteristics and promotes value-based decisions. Information of this nature should include:

panic among beneficiaries, as it was intended to do, but it also may have reduced their interest in changing enrollment status.

Emphasizing certain messages is also likely to make those messages more salient and to encourage consumers to seek any additional information they need to make an informed decision. For example, health care consumers may not understand that quality varies among plans. If they understand the “quality varies” message, consumers may be inclined to consider information on quality during the decisionmaking process (FACCT 1999). Repetition of certain information is an important educational strategy that both emphasizes key messages and guides consumers to incorporate these messages into the decisionmaking process. To effectively draw consumers’ attention to specific important messages, each component of the education campaign—including printed materials, information fairs, and the Internet—must incorporate and repeat key messages.

**Level of detail** Although researchers believe health care consumers need a certain amount of information to make fully informed enrollment decisions, it is not clear that consumers value detailed information on coverage. Consumers primarily factor costs, access to their doctors, and benefits into their decisionmaking (Lubalin and Harris-Kojetin 1999, Edgman-Levitan and Cleary 1996, Isaacs 1996, Tumlinson et al. 1997). Evidence suggests that less may be more—that is simple, accurate, and credible information is most effective—in increasing awareness and helping beneficiaries decide whether to consider different coverage options initially. Experience from nutrition labeling demonstrates the value of providing fewer information pieces to help consumers obtain the basic information they want.<sup>10</sup> Medicare’s information initiative might give a core set of key information to all beneficiaries, while making more detailed information easily accessible to those who want it.

### **Effective methods of disseminating information**

Dissemination methods affect whether relevant information is accessible to beneficiaries. Methods used by Medicare should reflect understanding of when beneficiaries seek information, their sources of information, and the modes of dissemination effective in reaching them.

**Timing of dissemination** Beneficiaries’ needs for information to compare enrollment options arise at different times. One critical time when such information is likely to be useful is when they first become eligible for Medicare. Some beneficiaries also may desire this information to prepare for scheduled open enrollment periods; however, beneficiaries will be more likely to consider changing enrollment during those periods if their personal circumstances have changed, such as when

- the health plan in which they are enrolled leaves their service area,
- the price of their supplemental insurance policy changes substantially,
- their employer no longer offers retiree health benefits,
- their health changes, or
- their income changes.

Dissemination of comparative information should be timed to address information needs of prospective Medicare beneficiaries and of beneficiaries affected by plan withdrawals and service-area changes. Reaching beneficiaries whose personal circumstances have changed is more difficult but could be addressed by highlighting situations in which beneficiaries should pay special attention to materials. One model of such an effort is the informational material designed to assist in preparing income tax returns.

Common core information applies to all taxpayers and includes statements designed to draw attention to those whose particular circumstances warrant special steps.

**Sources of information** HCFA is only one of many important sources of information for beneficiaries. In fact, beneficiaries and those who act on their behalf are more likely to seek information from friends, family, and physicians than from the government. Consumer advocates, counselors, hospital social workers, community groups, Medicare+Choice plans, and health care providers also play key roles as information sources.

For sources of information to disseminate information effectively, beneficiaries must perceive them to be credible and reliable. According to focus group research, consumers are wary of information about plan performance and quality—especially information that comes from the plans themselves. Health care consumers seek information from their friends, family, and physicians—sources they perceive to be reliable. They are also likely to respond more favorably to data collected and reported by an independent, knowledgeable third party (Edgman-Levitan and Cleary 1996).

Consumers also want information from sources that understand their particular circumstances or those of “people like them.” They are interested in the experiences individuals with similar characteristics have had in accessing appropriate care. This is why beneficiaries tend to rely on friends and family more than experts for their information (Edgman-Levitan and Cleary 1996).

Because a significant portion of the Medicare beneficiary population relies on adult children, spouses, or others to act as decisionmakers on their behalf, these agents must be considered when designing Medicare education campaigns and information services. Some

10 For analysis of the NLEA measures to standardize food labels, see Appendix A.

beneficiaries rely on agents because of physical or cognitive limitations. Others may have become accustomed to relying on agents, such as employers. When they no longer have this type of help, they may feel poorly equipped to make enrollment decisions for themselves (Gibbs et al. 1996).

Adult children, spouses, other family members, and friends who serve as caregivers to Medicare beneficiaries also seek information about health insurance. Preliminary assessment of HCFA's toll-free hotline has shown that about 40 percent of callers are caregivers seeking to answer questions about a beneficiary's claims processing or coverage. This group may need specific information that differs from the general information needs of beneficiaries. HCFA has made strides in bringing together umbrella organizations of caregiver groups, as well as consumer advocates on the national, state, and local levels specifically to address the needs of this population through collaboration. These organizations—including the American Association of Retired Persons, the International Longevity Center, and the Older Women's League—have devoted resources and energy to develop materials and methods to serve beneficiaries and their families.

Beneficiaries tend to trust and seek the advice of their physicians, whom they believe are well-positioned to gauge the health care needs of their patients and make recommendations accordingly (Jopeck and Lewin 1999). In the current health care environment, physicians are expected to be knowledgeable about everything from health policy to health insurance options and the quality of health plans. Physicians must know about coverage options characteristics to give their patients reliable information. To meet patients' expectations, physicians must be able to answer their patients' questions directly or know where to refer the patient for answers. However, physicians and

others have raised concerns about possible conflict of interest in providing information to patients about plans. Partly to address these concerns, the American Medical Association (AMA) has begun to educate its members about Medicare+Choice changes and how to address patients' questions while conforming to ethical guidelines.

**Modes of dissemination** Research continues to assess the relative value of various modes of disseminating information to Medicare beneficiaries, including print, television, radio, the Internet, and personal communication.

In general, face-to-face counseling appears to be the most effective way to assess and meet beneficiaries' informational needs. Local organizations, State Health Insurance Assistance Programs (SHIPs), and Area Agencies on Aging play a role in counseling beneficiaries about general Medicare issues. SHIPs have been particularly effective in outreach and education efforts (McCormack et al. 1996b). Familiarity with local or resident populations and enrollment options gives local organizations, counselors, and volunteers an advantage in addressing beneficiaries' needs and in reaching vulnerable beneficiaries.

HCFA's toll-free hotline could serve as a valuable source of personal communication, particularly for homebound beneficiaries and their caregivers. In using this service, however, beneficiaries dislike automated menus and often demand responses from a live person. Because HCFA staffs its hotline during business hours, this service could meet beneficiaries' needs, depending on the volume of calls and the waiting time.

The Internet is a potentially attractive dissemination medium because it incurs relatively low costs and facilitates interactive use of information. But it is not yet a leading source of information for Medicare beneficiaries; only 7

percent of beneficiaries now have direct access to the Internet (Reilly 1998). The Internet is likely to play a greater role in providing enrollment information in the future as more of those aging into Medicare have experience and familiarity with its use. In the short term, adult children, caregivers, physicians, and employers' health benefit representatives are among several potential users who are also decisionmaking agents or provide credible information to beneficiaries.<sup>11</sup>

The appropriate medium for reaching beneficiaries may vary among segments of the population. For example, according to consumer advocates for Latinos, Spanish-speaking beneficiaries heavily rely on Spanish-speaking television stations for information.

### **Helping beneficiaries use information in the enrollment decisionmaking process**

Obtaining relevant information is necessary, but not sufficient, to ensure value-based choices. Beneficiaries also must be able to use this information in their decisionmaking processes. Information on coverage options is difficult for the average health care consumer to use and process and is even more complicated for certain segments of the Medicare population. Information processing is influenced by characteristics of both the information provided and the intended user of that information.

### **Information-related factors that influence appropriate use of information**

The design of materials intended to help Medicare beneficiaries understand, use, and process information about their enrollment choices can either aid or hamper individuals' ability to use and process relevant messages appropriately. The formats used to provide information, the language used to describe options,

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11 Most users of HCFA's Website (Medicare.gov) describe themselves as researchers, consumer advocates, or representatives of employee or union groups, according to preliminary analysis of responses to the bounce-back questionnaire users encounter when exiting the site.

and the comparability of those options also affect how well consumers can use materials and judge among their choices.

**Making sense of multifaceted information** Most people have difficulty processing multifaceted information, which may hamper their ability to make value-based decisions. According to decisionmaking theory, the average person has difficulty processing more than five to seven bits of information at a time (Sofaer 1994). Too much information may result in overload—shutting down consumers’ will to use any of it.

Each category of information relating to health care enrollment options can include many different units of measurement and levels of detail. For example, health plan performance data might include information on NCQA accreditation status, several HEDIS measures, or member satisfaction rates. Similarly, assessing costs may require beneficiaries to judge different items across plans, such as copayments for different services and caps on out-of-pocket spending.

One approach to help beneficiaries use multifaceted information is to develop indices or summary scores that capture multiple aspects of a specific category of information in one information bit. For example, HEDIS scores, NCQA accreditation status, and other quality information might be combined to develop an overall quality rating for beneficiaries’ use. However, because developing such summaries requires determining appropriate weights and other potentially controversial decisions that could tend to favor one plan or plan type over another, consumer assistance groups might have greater latitude to develop these items than HCFA.

**Comprehending complex and unfamiliar information** If consumers do not understand certain characteristics of a plan they may decide those characteristics are unimportant or not

salient to making enrollment decisions. Quality-related information, such as indicators used in report cards of managed care plans, can be complex and difficult to understand, and those consumers who have access to this information often do not consider it (Hibbard and Jewett 1997). Consumers have difficulty interpreting quality measures, in part because they often lack a clear benchmark or standard for comparison. These findings emphasize the need for simple, clearly presented information accessible to consumers, and the need for education designed to demonstrate the value and use of certain types of information.

**Formats used to present information** The format is critical to determine how consumers frame a decision, analyze the alternatives, and rank their options. Presenting the same information in different formats, with varying emphasis on different options, can lead to different decisions because consumers construct preferences while processing information (Slovic 1998).

**Standardization to increase comparability** To compare health care options, beneficiaries must assess products that can vary in subtle, yet important ways. Standardization of options has been shown to increase comparability and to help consumers make better, more value-based choices. However, too much standardization can stifle the ability of the market to respond to evolving preferences.

The experience with food labeling provides an example of how standard information formats and terms can foster informed decisions. The NLEA of 1990 standardized and prioritized nutrition and health claims messages on all packaged foods in an effort to inform consumers’ decisions in selecting healthful foods. The Food and Drug Administration required the food industry to follow a specific layout that positioned serving size and caloric information first, nutrition content information next, and

the list of ingredients below that. Regulations also defined specific terms (such as “low fat” and “high fiber”) to facilitate comparisons of food products. Research suggests these efforts helped consumers to compare products and to choose more nutritious foods (Levy and Fein 1998).

The medigap insurance example illustrates potential problems with standardizing benefits, however. In OBRA 90, the Congress limited the variation in medigap policies that could be offered to 10 standard packages to increase comparison shopping among Medicare supplemental options, to decrease misinformation and fraudulent practices among medigap policy carriers, and to encourage competition.<sup>12</sup> Before medigap packages were standardized, beneficiaries were confused about the availability, cost, and coverage of Medicare supplements. Confusion among beneficiaries apparently decreased after benefits were standardized, but the legislation has hampered the ability of the insurance market to evolve in response to the rapid changes in the health care delivery system.

Standard benefits under Medicare+Choice similarly could lead to lower consumer satisfaction with available benefits. For example, the snowbird/sunbird population—beneficiaries who change their residence seasonally—is a unique group that innovative plans now can cover through various reimbursement mechanisms. In fact, certain plans offering reciprocity and similar arrangements that provide out-of-area coverage might not be able to do so if benefit offerings were limited to standard packages. An equally important consideration is that standardization could lock in current plan design, limiting plans’ ability to adapt to changes in demand.

12 For analysis of the OBRA measures to standardize the Medicare supplemental benefits, see Appendix A.

## **Beneficiary characteristics that influence use of information**

The diversity of beneficiaries makes efforts to educate and inform them particularly challenging. Certain segments of this population—particularly those with low education and income levels—have difficulty using relevant information (because of low general literacy or low health literacy). Beneficiaries with cognitive impairments also require special attention in designing education and information efforts.

### **Functional literacy and health literacy**

Limitations in the ability of many beneficiaries to read and understand information about enrollment options present a barrier to the use of written materials. Functional literacy, a measure of an individual's ability to function in society based on reading ability, is low among the elderly. Findings from the National Adult Literacy Study show that 44 percent of those 65 years and older read at the lowest reading level—in other words, they do not read well enough to function fully in society (Kirsch et al. 1993). Health literacy, a measure of an individual's ability to read and comprehend health-related materials, is also low in the beneficiary population. For example, interviews with new enrollees in four Prudential SeniorCare plans indicate that 34 percent of English-speaking and 54 percent of Spanish-speaking respondents had marginal or inadequate functional health literacy, as measured by the *Short Test of Functional Health Literacy in Adults*.<sup>13</sup>

Beneficiaries who cannot competently read and comprehend relatively simple health-related materials will not be able to use multifaceted comparative information without outside help (Baker 1998, Gazmararian et al. 1999). Medicare could target this population and develop education strategies that increase awareness of basic terms and coverage

options. For example, television or radio advertisements could reach this population more effectively, increase basic Medicare awareness, and provide information about sources of insurance assistance counseling.

### **Low education and income levels**

Efforts to educate and inform Medicare beneficiaries might appropriately target segments of the beneficiary population with low income and education levels because these characteristics are strongly associated with lower levels of knowledge about the health care delivery system. Beneficiaries in these categories are not likely to have access to or use available information. In a survey of Medicare beneficiaries in high HMO penetration areas, researchers found those with lower incomes and lower education levels knew less about the differences between HMOs and fee-for-service—even if they were enrolled in an HMO (Hibbard and Jewett 1998).

**Cognitive impairments** People with cognitive impairments make up a significant portion of the beneficiary population and are particularly unlikely to be able to access or process adequately the information needed to make appropriate health care decisions on their own. Approximately 10 percent of Medicare beneficiaries have some form of cognitive disorder, such as Alzheimer's disease. Caregivers, such as adult children and other family members, must be targeted by education and information efforts to help them make appropriate enrollment decisions for this group.

### **Additional steps needed to build the informed choice infrastructure over the long term**

To build a sustainable informational and educational infrastructure that promotes value-based choices, Medicare must assist beneficiaries in becoming active

participants in the informed choice process. Medicare's information strategies can facilitate beneficiaries' receipt, use, and processing of consumer information. Information strategies also must address the concerns of a diverse Medicare population with varied needs and provide consumer protections.

### **Investing in decisionmaking tools**

One important way to help beneficiaries process information is through decisionmaking tools designed to help them frame their enrollment decisions, consider relevant issues, and make trade-offs. These tools would lead the user through a series of steps to a range of manageable, understandable choices. For example, such tools first might narrow the list of coverage options to the least expensive ones based on co-payments, deductibles, or other out-of-pocket spending, then further narrow coverage options based on desired benefits and measures of health care quality or health plan performance. Finally, a decisionmaking tool could rank options according to beneficiaries' priorities. By making small decisions sequentially, beneficiaries would face choices that are easier to process.<sup>14</sup>

## **RECOMMENDATION 4C**

**The Secretary should develop and evaluate interactive tools that give beneficiaries a framework for understanding their choices and that help them to process information.**

HCEA is in partnership with AHCPH and the Research Triangle Institute to customize a decisionmaking aid known as the "Quality Navigation Tool" for the Medicare population. This document is designed to guide health care consumers through different kinds of decisionmaking, including the choice of health plans, doctors, nursing homes, and treatments. An interactive computer guide

13 Those who had inadequate health literacy often misread materials written at about a fourth-grade reading level, including prescription bottles and appointment slips. Those who had marginal health literacy had difficulty comprehending passages from the Medicaid rights and responsibility statement, written at about a 10th grade reading level.

14 The use of decisionmaking tools presents potential conflicts of interest between the consumer and the designer or sponsor of the tool, however, particularly if the tool steers a user toward a particular option.

would be the next step to enhance usability and assist beneficiaries in processing choice information. While most beneficiaries do not currently have access to the Internet, such products might be made more widely available through local seniors' centers or other venues.

The Medicare Compare database, although not designed as a decisionmaking tool, could potentially be a useful comparative resource. The interactive database now allows beneficiaries to key in their ZIP code and view the various plans available in their area. However, comparisons among more than two plans by cost, coverage, and quality require several steps and multipage printouts (Francis 1999). Furthermore, the database does not allow users to use hyperlinks to move to the Web sites of Medicare+Choice organizations, a potential source of more detailed information, although HCFA is issuing guidelines that explain how plans may request a link from Medicare Compare.

Examples of useful consumer guides and decisionmaking tools are found in the private sector, especially among large employers. For example, Ford Motor Company prepares and distributes information on health plan performance to its current and retired employees—more than half a million individuals. These documents explain the important characteristics consumers should consider when choosing a health plan, including quality measures. Sponsored plans then are scored in a simple, user-friendly format. Benefits counselors are available to help workers and retirees use and interpret these materials.

In April 1999, the GAO recommended that HCFA develop materials that would allow beneficiaries to compare the characteristics of several plans simultaneously, taking the information materials of the Federal Employee Health Benefits Program (FEHBP) as an example.<sup>15</sup> The FEHBP distributes a booklet with costs, benefits, and quality

measures of participating plans in a chart that facilitates comparisons among several plans at once. The Office of Personnel Management also has a Web site from which users may download comparative information in different formats. The Web site also facilitates access to more detailed information by providing hyperlinks to the Web sites of organizations that sponsor health plans available to federal employees.

### Developing standard terms

An important first step in making education or information materials relevant and useful for beneficiaries is to standardize terms. Materials that HCFA, Medicare+Choice organizations, and medigap policy carriers disseminate should present the most important factors in standard terms so the materials will reduce confusion, reinforce key messages, and be useful resources in decisionmaking. For example, a standard description with key messages and key components of a specific coverage option could allow beneficiaries to compare the basic characteristics of different options and narrow their choices.

### RECOMMENDATION 4 D

**The Secretary should define and regularly update appropriate standard terms for describing Medicare coverage options. HCFA should use these terms in its informational materials, require their use by Medicare+Choice organizations, and encourage their use by medigap policy carriers and others who provide beneficiary information.**

HCFA has a workgroup charged with developing standard language for describing benefits to enhance beneficiaries' use of materials. The agency plans to include some components of the standard summary of benefits in materials mailed for the enrollment open season in the fall of 1999.

MedPAC urges the Secretary to assess periodically whether the standard terminology HCFA develops is understandable and easy to follow and whether it provides effective definitions. The agency should update terms according to the findings from this periodic assessment and as warranted by changes in the health services market.

### Ensuring consumer protection

Even if efforts to promote informed choice meet the needs of many beneficiaries, specific segments of the population still may be vulnerable to inadequate coverage, poor quality care, or financial barriers to care. Because the preferences and needs of the average beneficiary may not be the same as the preferences and needs of the most vulnerable segments of the population, an information and education infrastructure must ensure adequate protections for them by assisting them or their caregivers to make appropriate decisions.

### RECOMMENDATION 4 E

**The Secretary should study the enrollment patterns of beneficiaries, giving particular attention to vulnerable groups, to assess whether their informational needs are adequately met.**

Analysis of Medicare beneficiaries' enrollment patterns could yield information on plan performance and on beneficiaries' satisfaction with their decisions and with the information and services they receive. HCFA is administering a disenrollment survey under the Consumer Assessment of Health Plans initiative to learn why beneficiaries disenroll from plans. Using this information, HCFA should study the enrollment patterns of the Medicare population as a whole and groups of beneficiaries who might be particularly vulnerable to problems. Research on enrollment patterns and evaluation of the NMEP, specifically cross-cutting assessments that focus on various segments of the population, should shed

15 FEHBP is a program administered by the Office of Personnel Management and is the health insurance benefit package for federal employees nationwide.

additional light on beneficiaries' informational needs, satisfaction with their coverage, and ability to navigate the Medicare environment.

MedPAC believes that it is important to study the enrollment patterns of all beneficiaries, but that beneficiaries who do not speak English and cognitively impaired beneficiaries may be particularly vulnerable to making inappropriate enrollment decisions. Moreover, the enrollment patterns of low-income beneficiaries should be studied to identify areas in which Medicare and state governments can coordinate education and outreach efforts to enroll qualifying beneficiaries into the QMB and SLMB programs.

One approach HCFA could take in studying the different segments of the beneficiary population would be to draw upon findings from professional market analyses. These analyses have shown that segments of the Medicare population differ in their needs for health care information (Etheredge 1999). Targeted educational efforts could learn from this body of knowledge and additional research of this type.

#### **RECOMMENDATION 4 F**

**The Secretary should monitor the prevalence of aggressive marketing techniques or abuses, especially toward vulnerable populations, such as frail beneficiaries and those without functional literacy.**

Because beneficiaries frequently use health plans' marketing materials as a source of information, ensuring the accuracy of these materials must be an important part of any effort to promote appropriate enrollment decisionmaking. Unlike the under-65 population, most Medicare beneficiaries—about 67 percent—do not obtain any health benefits through an employer. They are therefore more likely to obtain information about coverage options directly from the sponsoring organizations that sell individual policies.

Researchers and consumer assistance groups have raised concerns that health plans are not providing beneficiaries with accurate and reliable information about their Medicare options. A recent study of HMO marketing techniques and materials in four cities found key information gaps regarding eligibility requirements, medigap insurance coverage, potential changes in premiums and benefits, and appeal rights and protections. Plans in specific markets were found to engage in inappropriate—and in some cases, illegal—marketing activity, such as telling potential enrollees that an agent had to visit their home before they could join the plan (Gerontology Institute 1999). Similarly, in two recent reports, GAO found that health plans have failed to provide accurate and useful information to Medicare beneficiaries (GAO 1999b, 1999c). Findings from a study of 16 HMOs showed that all of the surveyed plans had provided some inaccurate,

incomplete, or misleading information. For example, some erroneously informed beneficiaries that they needed a referral for a mammogram. Others told beneficiaries that they provided less comprehensive prescription drug coverage than originally promised in their contracts with HCFA.

GAO reports also criticized HCFA's oversight of Medicare+Choice organizations and identified several weaknesses in the agency's monitoring protocols, such as a failure to enforce existing regulations related to the beneficiary appeals process. GAO recommended that HCFA develop more comprehensive marketing standards and guidelines for Medicare+Choice organizations and that the agency monitor marketing materials more thoroughly (GAO 1999b). HCFA plans to implement a pilot test to determine whether centralized review of marketing materials by an independent contractor will improve and standardize the process (Cronin 1999). ■

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