
Advisory Panel on
Medicare Education

Annual Report

To the Secretary of the Department of Health
and Human Services

and the

Administrator of the Centers for Medicare &
Medicaid Services

January 31, 2002

Contents

Section	Page
EXECUTIVE SUMMARY	1
I. ADVISORY PANEL ON MEDICARE EDUCATION - BACKGROUND	3
II. NATIONAL MEDICARE EDUCATION PROGRAM - BACKGROUND	3
III. TARGET AUDIENCE: THE MEDICARE POPULATION	4
IV. INTRODUCTION TO RECOMMENDATIONS	6
V. RECOMMENDATIONS FOR IMMEDIATE ATTENTION	8
VI. RECOMMENDATIONS FOR LONG-TERM STUDY AND IMPLEMENTATION.....	9
Reaching Vulnerable Populations	9
Enrollment Protections	10
Information Intermediaries	11
Media and Communications Strategy.....	13
Research and Evaluation	14
Communicating about Health Care Quality	14
VII. CONCLUSION.....	15
ROSTER, ADVISORY PANEL ON MEDICARE EDUCATION.....	16

EXECUTIVE SUMMARY

The Advisory Panel on Medicare Education (APME) submits its Annual Report to the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services (CMS). The APME acknowledges CMS's progress in implementing the Medicare education provisions of the Balanced Budget Act of 1997 (BBA). The APME also recognizes the enormity of CMS's responsibilities for Medicare education particularly considering the magnitude and diversity of the Medicare population.

The Annual Report provides the legislative context for the National Medicare Education Program (NMEP), describes the Medicare population, and presents several recommendations for immediate and long-term implementation. The Report's overarching recommendation, however, is that CMS should conduct the NMEP within the framework of a comprehensive long-term strategy that incorporates various channels of communication including print and web-based materials, telephone assistance, local counseling, and the media. The recommendations are summarized below:

Recommendations for Immediate Attention

1. Suspend the enrollment "lock-in" which limits the time during which beneficiaries can change their Medicare health plan option. The "lock-in" is untimely because the majority of the Medicare population is unready to make informed health care choices.
2. Provide additional funding for CMS to implement the NMEP. The current funding level is inadequate for the scope of the NMEP.
3. Improve the Medicare Personal Plan Finder (MPPF). CMS should continually review and improve the MPPF in consultation with stakeholders.
4. Include Medicare+Choice comparison information in all relevant CMS materials including the *Medicare & You* handbook.

Recommendations for Long-Term Study and Implementation

- **Reaching Vulnerable Populations:** CMS should pay particular attention to meeting the information needs of vulnerable populations including racial and ethnic minorities and those with limited English proficiency, low literacy levels and cognitive deficits.
- **Enrollment Protections:** CMS should evaluate the Medicare enrollment process and assure that people with Medicare have the appropriate tools and knowledge to make informed health care choices.
- **Information Intermediaries:** CMS should work effectively with a variety of information intermediaries including State Health Insurance Assistance Programs, caregivers, community-based organizations that serve vulnerable populations, other government agencies, health care providers, employers, and unions.
- **Media and Communications Strategy:** CMS should develop a media and communications strategy that is part of an integrated marketing plan. CMS should develop the plan in consultation with national minority organizations and other stakeholders.
- **Research and Evaluation:** CMS should continue to measure and evaluate the components and outcomes of the NMEP. It should share the results with the public expeditiously.

- **Communicating about Health Care Quality**: CMS should continue and increase its efforts to assure that people with Medicare understand how to use quality of care information. The information should be targeted to diverse populations and eventually provided at the provider and practitioner level.

I. ADVISORY PANEL ON MEDICARE EDUCATION - BACKGROUND

The Advisory Panel on Medicare Education (APME), originally chartered on January 21, 1999, advises the Secretary of the Department of Health and Human Services (DHHS) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) on opportunities to enhance the federal government's effectiveness in implementing a national Medicare education program. Specifically, the APME advises DHHS and CMS on: educating people with Medicare about options for selecting a health coverage option under Medicare; using public-private partnerships; reaching out to vulnerable and under-served communities; assembling an information base of best practices; and, building a community infrastructure for information, counseling and assistance.

The APME has met seven times between February 2000 and October 2001. During these meetings, the Panel heard from CMS and other DHHS staff, health care, and social science consultants, a variety of private sector experts, health providers, consumers, and caregivers. In addition, the Panel has reviewed numerous documents including reports, research papers, legislation and Medicare publications prepared by CMS and by private agencies. The subjects of these meetings included: communicating with Medicare consumers about health care quality; meeting the information needs of vulnerable Medicare consumers including those with limited English proficiency; Medicare education implementation challenges including appropriate funding; how the private sector conducts Medicare education; and the role of the Social Security Administration (SSA) in Medicare. The minutes of the APME's meetings, its charter, and other information are available on the APME homepage at <http://www.hcfa.gov/events/apme/homepage.htm>. A list of members is located at the end of this Report.

II. NATIONAL MEDICARE EDUCATION PROGRAM - BACKGROUND

Congress created the Medicare+Choice program in the Balanced Budget Act of 1997 (BBA) to expand the health coverage choices available to people with Medicare, among other purposes. Before Medicare+Choice, people with Medicare could choose only traditional fee-for-service Medicare (now known as Original Medicare) or a Medicare HMO. In addition to coordinated care plans (e.g., HMOs), the BBA authorizes Preferred Provider Organizations, Provider Sponsored Organizations, Medical Savings Accounts, and Private Fee-for-Service Plans as options for people with Medicare.

To make informed health choices, people with Medicare must have a basic understanding of the following:

- the Medicare program,
- the advantages and disadvantages of the Medicare+Choice options,
- the ability to assess their health insurance needs over time, and
- the capacity to use available information resources.

In addition, they must understand:

- whether to purchase Medigap coverage and which policy to purchase,
- the relationship between Medicare and employer-sponsored health insurance, and
- whether they qualify for full Medicaid coverage or Medicaid assistance with Medicare premiums, deductibles and coinsurance.

To aid people with Medicare, the BBA requires the Secretary of DHHS to establish a process for them to exercise these choices through initial, annual and special elections and to conduct a National Medicare Education Program (NMEP) “to broadly disseminate information to Medicare beneficiaries (and prospective Medicare beneficiaries) on the coverage options provided under [the Act] in order to promote an active, informed selection among such options.”

Congress envisioned that an information campaign would enable people with Medicare to make informed choices about their health coverage. Thus, the BBA requires DHHS to provide information on: available Medicare+Choice options; comparative information about the choices; benefits provided under Original Medicare; election procedures; procedural rights (including appeal and grievance rights); Medigap and Medicare Select; and, the potential for contract termination by the private health plans. The comparative information must include plan benefits, premiums, service area, quality and performance information, as well as information about supplemental benefits beyond those provided under Original Medicare. The Act further requires DHHS to make this information available through a toll-free number, an Internet site, and an annual mailing to people with Medicare.

Congress also mandated that, starting in 2002, the window of time during which Medicare consumers could become informed and make these choices would narrow. Prior to 2002, people with Medicare could enroll in and disenroll from Medicare managed care plans (or move back and forth between Original Medicare and Medicare managed care plans) on a monthly basis, as long as the plans were open for enrollment. However, in 2002, CMS must phase in the so-called “lock-in,” limiting the period during which people with Medicare can switch plans or move between Original Medicare and a Medicare+Choice plan. In 2002, this period is January to June (or the first 6 months after enrollment for new beneficiaries). In 2003, this will shorten to a 3-month period during which changes can be made. Newly eligible beneficiaries, however, will have the ability to disenroll from a Medicare+Choice plan to Original Medicare at any time during the first twelve months after enrollment.

III. TARGET AUDIENCE: THE MEDICARE POPULATION

To fully appreciate the challenge of providing people with Medicare information that enables them to make informed health coverage choices among those available, one must consider the characteristics of the Medicare population. Nearly 40 million persons are enrolled in the Medicare program, including persons aged 65 and above (34.4 million¹), certain younger disabled individuals (5.6 million²), and those with permanent kidney failure treated by dialysis or kidney transplant (270 thousand³). The following characteristics are noteworthy:

¹Health Care Financing Administration, 2001 HCFA Statistics, US Department of Health and Human Services, July 2001.

² 2001 HCFA Statistics, US Department of Health and Human Services, July 2001.

³ 2001 HCFA Statistics, US Department of Health and Human Services, July 2001.

- The average age of people with Medicare is 72.⁴
- Thirty percent live alone.⁵
- Thirty-four percent have less than a high school diploma.⁶
- Seventy-one percent of adults age 60 and older have limited prose skills and sixty eight percent have difficulty finding and processing quantitative information in printed materials.⁷
- Forty percent have incomes at or below twice the poverty level.⁸
- Twenty eight percent (non-institutionalized) say their health is fair or poor.⁹
- Twenty-three percent have difficulty with mental functioning.¹⁰

Racial and ethnic minorities comprise approximately 22 percent of the Medicare population.¹¹ Their information needs may be affected by limited English proficiency, lower income, poorer health status, and lesser educational attainment levels than the general population. For example:

- Twenty-six percent of Hispanic elders have annual family incomes under \$10,000 as contrasted with twelve percent for non-Hispanic White elders.¹²
- The proportion of Hispanic elders with no formal schooling is approximately 9.8 percent as contrasted with 0.5 percent of non-Hispanic White elders.¹³
- Older African Americans are more likely to rate their health as fair or poor (43 percent) than are older White Americans (27 percent).¹⁴
- Nearly 60 percent of Indian elders live at or below twice the poverty level.¹⁵
- Older Asian/Pacific Islanders are more likely to lack formal education than are White elders (10 percent versus 1 percent).¹⁶
- Median income for older Asian/Pacific Islander men (65 years or over) is less than that of White men in the same age group (\$7,906 versus \$14,775).¹⁷

Older minorities may also have difficulty accessing traditional information resources such as telephone hotlines, Internet-based services and sites where they may obtain one-on-one counseling. For example, many Indian elders who live on reservations have difficulty arranging

⁴ Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey (MCBS), Centers for Medicare & Medicaid Services, 1999.

⁵ MCBS, Centers for Medicare & Medicaid Services, 1999.

⁶ MCBS, Centers for Medicare & Medicaid Services, 1999.

⁷ Helen Brown, Robert Prisuta, Bella Jacobs and Anne Campbell, Executive Summary of Literacy of Older Adults in America, 1992 National Adult Literacy Survey, National Center for Education Statistics, 2002.

⁸ Michael E. Gluck and Kristina W. Hanson, Medicare Chart Book, Second Edition, Fall 2001, Kaiser Family Foundation, 2001.

⁹ Medicare Chart Book, Kaiser Family Foundation, 2001.

¹⁰ Kaiser Family Foundation, The Medicare Program: Medicare at a Glance, Kaiser Family Foundations, June 2001.

¹¹ MCBS, Centers for Medicare & Medicaid Services, 1999.

¹² Centers for Medicare & Medicaid Services, HORIZONS Newsletter, Centers for Medicare & Medicaid Services, 2001.

¹³ HORIZONS Newsletter, Centers for Medicare & Medicaid Services, 2001.

¹⁴ AARP Minority Affairs, A Portrait of Older Minorities, AARP, 1995.

¹⁵ National Indian Council on Aging, Policy Statement, <www.nicoa.org/policy_061501.html 1999>, National Indian Council on Aging, June 2001.

¹⁶ A Portrait of Older Minorities, AARP, 1995.

¹⁷ A Portrait of Older Minorities, AARP, 1995.

transportation to sites where counseling may be available.¹⁸ In addition, many recent immigrants may not understand even basic concepts of health insurance, which they must grasp before they can understand Medicare.

The information that CMS must convey to this diverse population is complex. The importance to people with Medicare of making the right choices is critical; an unwise choice could have a devastating impact on their physical and financial well being. However, recent research shows that with some exceptions, most people with Medicare do not understand the basics of the Medicare program and Medicare+Choice.¹⁹ Other recent studies found:

- In high penetration Medicare managed care markets, only 11 percent of people with Medicare had “adequate knowledge to make an informed choice between HMOs and regular Medicare.”²⁰
- Based on a proxy measure of skill, an estimated 56 percent of the total Medicare population has difficulty accurately using comparative information to make choices.²¹

Finally, building an information infrastructure to support informed decision-making is costly--particularly when dealing with the diverse needs of nearly 40 million persons. Research indicates the importance of using multiple information channels. These include print, telephone, Internet, community-based outreach, and media. Of particular importance is the ability for people with Medicare and their families to receive one-on-one counseling which currently is provided primarily by the State Health Insurance Assistance Programs (SHIP) located in every state. The SHIP program is a grant program to states, typically to state units on aging and in a number of states to departments of insurance. States, in turn, may subcontract or delegate program responsibility at the local level to local community organizations. There are currently 53 state-level grantees, over 1,000 sponsoring organizations and 12,000 trained counselors most of whom are volunteers.

IV. INTRODUCTION TO RECOMMENDATIONS

In our interim report of June 5, 2001, the APME addressed a number of issues of immediate concern regarding CMS’s efforts to assist people with Medicare in making informed decisions about their health coverage. The focus of our interim recommendations was on the need to increase funding for Medicare education in the FY2002 Federal budget. We recommended that additional funds were needed to: enhance the NMEP, expand support for the SHIP, and enable CMS to collaborate more extensively with local community-based organizations in meeting the needs of vulnerable Medicare populations.

At the time of our interim report, all available evidence clearly showed that the majority of people with Medicare were unready to make informed decisions about their health care coverage.

¹⁸ Policy Statement, National Indian Council on Aging, June 2001.

¹⁹ Beth Stevens and Jessica Mitler, Making Medicare+Choice Real: Understanding and Meeting the Information Needs of Beneficiaries at the Local Level, Mathematica Policy Research, Washington, D.C., 2000.

²⁰ Judith Hibbard and Jacquelyn Jewett, An Assessment of Medicare Beneficiaries' Understanding of the Differences Between the Traditional Medicare Program and HMOs, AARP, Washington, D.C., 1998.

²¹ Judith Hibbard, Paul Slovic, Ellen Peters and Melissa Finucane, Older Consumers' Skill in Using Comparative Data to Inform Health Plan Choice: A Preliminary Assessment, AARP, Washington, D.C., 2000.

Therefore, the Panel also observed that implementation of “lock-in” could undermine beneficiaries’ willingness to consider a Medicare+Choice option. Moreover, regardless of the implementation date, the “lock-in” provision could seriously disadvantage and disrupt care for a beneficiary who is locked-in but whose provider is not. Therefore, the APME also recommended that the enrollment “lock-in” provision of the BBA be indefinitely delayed until it could be determined that a majority of people with Medicare are able to make informed decisions about their health care coverage options. Recognizing that delaying the implementation of the “lock-in” requires Federal legislative action, the APME urged the Administration to seek Congressional support for legislation to suspend implementation of the “lock-in.”

The APME commends CMS for its efforts to date in implementing the NMEP although we still have concerns about the lack of specific comparative plan information in the *Medicare and You 2002* handbook. The APME believes that improvements have been made in the services provided by 1-800-MEDICARE, specifically the availability of Customer Service Representatives (CSRs) on a 24-hour a day, 7-day a week basis. Regarding the www.medicare.gov website, we recommend that CMS review and improve the Medicare Personal Plan Finder in consultation with all stakeholders. The APME recognizes the importance of decision support tools for people with Medicare and hopes to have the opportunity to participate in their further development.

The fall Medicare media campaign consisted of general market television and print, Spanish language television and radio, and Internet advertising. While the APME was not involved in the development of this campaign, we appreciated hearing about its objectives. We look forward to seeing an evaluation of whether these objectives were achieved. To date, the APME is not aware of additional media/communications initiatives CMS may be contemplating. We do believe, however, that any future media campaigns should be part of a long-term, comprehensive strategic plan.

This Annual Report offers recommendations for immediate and long-term implementation. However, it is focused primarily on CMS's need to develop a long-term, comprehensive strategic plan. The goals of this plan should be to achieve an educated Medicare population capable of making informed health care decisions and to enhance CMS's effectiveness in informing the Medicare consumer. Additionally, we recommend protections for those who are unable to make informed decisions because of cognitive or other deficits. The APME recognizes that this is a formidable challenge given the great diversity of the Medicare population. The task is made even more difficult by the fact that our target population does not have an adequate understanding of the basic Medicare program, much less the various coverage options available to them.

The APME believes that taking a long-term approach using an integrated, year-round, community-based outreach strategy can achieve measurable results over time. The strategy must be refined by continual feedback from consumers and other stakeholders. To implement this long-term approach, CMS will need far greater resources. The General Accounting Office issued a report in September 2001 titled *Medicare Program Designed to Inform Beneficiaries and Promote Choice Faces Challenges* (GAO-01-1071). The report explains that approximately 76 percent of funds for the first 3 fiscal years of operating the NMEP came from user fees collected from Medicare+Choice plans. According to the report, “The remaining amount came from Medicare program funds and other sources. Recent legislation substantially reduces the total

amount of user fees collected from M+C Plans. If this revenue source is not replaced, future NMEP activities may have to be curtailed substantially.” The APME is aware that large employers are estimated to spend a minimum of \$10 for each retiree (Towers Perrin, April 2001) for education and information, an amount far greater than CMS currently spends. We urge Congress to appropriate the funds necessary to ensure that people with Medicare are able to make informed choices and understand the implications of their choices.

V. RECOMMENDATIONS FOR IMMEDIATE ATTENTION

The APME has identified four issues that we believe require immediate attention: the Medicare+Choice enrollment “lock-in” that began in 2002, funding and flexibility for Medicare education; the design and content of the Medicare Personal Plan Finder; and, the availability of plan comparison information. The APME urges CMS to consider the following recommendations:

1. The Administration should aggressively seek Congressional support for the suspension of the enrollment “lock-in” provision. All available evidence indicates that most people with Medicare are unready to make informed decisions about their health care coverage. In addition, there is the question of whether most people with Medicare can use comparative quality information, a skill that is needed to make informed health plan choices. Further, the Medicare population is very different from the employed population in age, health status, cognitive ability, and literacy level. Implementation of “lock-in” at this point could discourage people with Medicare from selecting a Medicare+Choice option. We believe that people with Medicare need additional time to understand the importance of making informed decisions about their health care coverage. According to a recent issue brief, “2002 may not be the best time to implement... a sea change in Medicare + Choice enrollment and disenrollment rules.”²² A suspension of “lock-in” would also give CMS time to develop protections for consumers who, for good cause, need to change their health care choice. To our knowledge, there is virtually no opposition to postponing the implementation of a restricted annual election period for Medicare. Research has shown that relatively few people with Medicare voluntarily switch their Medicare+Choice option. (In 2000, 11% of people with Medicare voluntarily disenrolled from their Medicare health plan.²³) Therefore, we believe a “lock-in” suspension would not significantly increase the number of people with Medicare who change their health plan choice.
2. Additional funding and flexibility should be requested for the NMEP in the FY2002 and FY2003 Federal budgets to achieve the long-term objectives of this Report. The September 2001 GAO Report emphasized that CMS may have to curtail future NMEP activities substantially unless it obtains additional Federal funding for Medicare education. Along with additional funding, CMS needs the flexibility to implement new

²² Geraldine Dallek, Brian Biles, and Andrew Dennington, The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?, The Commonwealth Fund, New York, December 2001.

²³ Centers for Medicare & Medicaid Services, Medicare Consumer Assessment of Health Plan Study-Disenrollment Survey-Reasons Form, Centers for Medicare & Medicaid Services, January 2002.

programs and approaches to education. The GAO stated in the above-referenced report, “To better promote beneficiaries’ active and informed selections among their Medicare coverage options, the Congress may want to consider allowing CMS more flexibility in conducting NMEP activities, especially with regard to the context, format, medium, and timing of information that the agency distributes to its beneficiaries.”

3. The Medicare Personal Plan Finder should be regularly reviewed and improved in consultation with all stakeholders to assure that it will facilitate optimal decisionmaking. The APME suggests two immediate improvements: a.) CMS should develop criteria to determine which organizations or programs should be listed in the Personal Plan Finder; and b.) CMS should facilitate consumers’ access to Medicare Savings Programs by providing access to state applications through the medicare.gov website.
4. CMS should provide comparative information on Medicare coverage options in enough detail to be meaningful to people with Medicare in any appropriate beneficiary materials that it produces including the *Medicare & You* handbook. This should include comparisons of quality of care and access to care. CMS should move expeditiously to develop an appropriate methodology for computing out-of-pocket costs and provide comparisons of these costs at the earliest possible time. CMS should also provide increased information on Medicaid and Medicare Savings Programs to aid consumers with limited income and resources in making informed choices.

We make these recommendations for immediate action against the backdrop of significant long-term challenges including more effectively reaching vulnerable populations and meeting the needs of individuals with low literacy.

VI. RECOMMENDATIONS FOR LONG-TERM STUDY AND IMPLEMENTATION

We believe that it is critically important that CMS develop a long-term, comprehensive and integrated Medicare education strategy. This strategy should encourage people with Medicare to review their health care options annually, and to use information that helps them make informed decisions about their health coverage options. It should include assistance for those who need help in making health care choices. CMS should build upon the strengths of the NMEP initiatives to date and expand those efforts to include new approaches to meeting the needs of people with Medicare. Toward that end, the APME strongly believes that CMS will need substantial additional resources. The following recommendations are made to achieve these objectives:

Reaching Vulnerable Populations

CMS efforts should recognize the heterogeneity of the Medicare population by developing strategies and by targeting messages to reach Medicare's most vulnerable beneficiaries. These subgroups of the Medicare population include but are not limited to: 1.) beneficiaries with incomes below 150% poverty (26% of the Medicare population), 2.) those with cognitive limitations (23%), 3.) racial and ethnic minorities (22%), 4.) the under-65 disabled (14%), 5.)

those with limited English proficiency, 6.) recent immigrants, and 7.) those with low health literacy.

1. Education materials (print and web-based) and communication supports (hotline, decision support tools) should be in English, Spanish and additional languages to support the communication needs of the beneficiary population, to the extent possible. Currently, CMS provides its educational materials and communication supports primarily in English and Spanish. It produces some materials in Chinese languages. However, Medicare's partner program, Social Security, offers educational materials in more than a dozen languages. Multilingual CMS Medicare materials should be easily accessed at Social Security offices, SHIPs, the CMS website and through other information sources.
2. In addition to the SHIPs, CMS should assess the potential for partnerships with a variety of community-based organizations to reach Medicare's most vulnerable beneficiaries. Many of these organizations use creative approaches to provide services and education that are culturally and linguistically appropriate. Representatives of some of these organizations, including Asian Health Services, Delta Community Partners in Care, and California Health Advocates, have appeared before the APME. Their compelling testimony has informed us of the difficulties faced by people with Medicare who have limited English proficiency and other special information needs when they try to use conventional information sources.
3. Strategies for reaching Medicare's most vulnerable groups should be targeted to achieve specific goals including reducing or eliminating disparities in health care among segments of the beneficiary population. This strategy builds upon CMS's current efforts, for example, to increase participation in Medicare Savings Programs. CMS could pursue a similar strategy to provide targeted information to assist groups with special needs, such as the under-65 disabled, recent immigrants, or other vulnerable populations identified in this report.

Enrollment Protections

Certain Medicare enrollment protections are critical to ensuring that older and disabled Americans get the accurate and useful information they need to make good health care choices. Large numbers of people with Medicare have cognitive limitations (23%), most have low health literacy levels, and many have limited English proficiency that may impede their ability to make good health care choices.

1. CMS should evaluate the current Medicare enrollment process and provide resources, tools, and services to ensure that people with Medicare are better equipped to make appropriate health plan choices.
2. Enrollment materials (print and web-based) and communication supports (hotline, decision support tools) should be written at a level that is no higher than the sixth grade reading level in English, Spanish and other additional languages, as needed, to help ensure that people with Medicare can select the Medicare plan that is most suitable for

them. Multilingual materials should be easily accessed at SSA offices, SHIPs, the CMS website and through other information sources.

3. CMS should provide resources, tools and services to ensure that people with Medicare understand the following important concepts before they enroll in a Medicare managed care plan: a.) plans have specific service areas and, in most cases, they must reside and obtain their health care within those areas; b.) they must choose from among certain health care providers and the providers may change during the year, c.) they may not need their supplemental policy, if they have one, but if they select back to original Medicare, they may not be able to get their policy back or it may cost more, d.) their retiree coverage may be affected if they join a Medicare+Choice plan and they should consult with their employer or union for guidance, e.) the Medicare+Choice plan may choose not to renew its Medicare contract or may change its benefits or cost-sharing amounts each year and f.) if a claim or service is denied, they have rights to appeal the plan's decision.

Information Intermediaries

Older and disabled individuals with Medicare obtain information about the Medicare program from a number of sources. Even individuals, who make use of Medicare's information resources (e.g. 1-800-MEDICARE and the *Medicare and You* handbook), rely on other sources for more detailed and up-to-date information. Those sources may be caregivers, family members, friends, local community-based organizations, or health plans. In all these cases, people may not be getting all the information they need to ensure that they make informed health care choices. Moreover, all too often, older and disabled Americans, their family members, and caregivers only seek information when they need health care. Otherwise, they do not see the need to review their health plan coverage on an annual basis to ensure that it is the best available choice to meet their health care needs.

Individuals, who have difficulty accessing or fully understanding the information provided through the NMEP initiatives because of language and/or cultural barriers, or limited English proficiency, rely almost exclusively on local sources for information about their Medicare coverage. Unfortunately, as a state-based program, SHIP funds are not available to Indian tribes or Indian organizations. Consequently, Indian Medicare beneficiaries, among the poorest, least educated and most isolated Medicare beneficiaries, may not have access to the information, counseling and assistance services available from SHIP to their non-Indian counterparts.

The challenge for CMS is to determine how to incorporate local information intermediaries into a national effort that not only encourages older and disabled individuals to review their coverage on an annual basis but also provides them with accurate information and assistance when they need it.

1. CMS should promote the availability of SHIP counselors more extensively. State and local SHIP programs are a critical source of information, counseling, and assistance for people with Medicare-related questions and problems.

2. Funding for SHIP programs should be increased and their role should be expanded and more fully integrated into regional and local initiatives to reach out to all people with Medicare regardless of where they live.
3. SHIP funds should be made available to Indian-based organizations with the capacity and credibility to provide culturally-appropriate Medicare counseling to Indians enrolled in or otherwise eligible for Medicare.
4. CMS should provide SHIPs with the resources necessary to ensure that staff and volunteers receive adequate training and technical assistance to ensure their success and to meet the minimum national performance standards for SHIPs. CMS should also facilitate sharing of best practices among SHIPs to encourage exemplary performance in areas such as counseling, development and dissemination of educational information and outreach to vulnerable populations.
5. Regional CMS offices should be given greater resources to work with local organizations in educating older and disabled individuals about their health care choices. Many people see local consumer, civic, and religious organizations as trusted sources of information. Individuals who do not speak English, or those for whom English is a second language, often turn to their local cultural or religious organizations for assistance in understanding how to access health care and social services. These types of organizations or coalitions of organizations are often valuable partners in CMS's efforts to educate people with Medicare and their families.
6. Recognizing the value of local Medicare counseling, CMS should place representatives in local SSA offices or train selected SSA employees in those local offices to provide expanded Medicare information. In addition, CMS and SSA should develop a closer collaboration for disseminating Medicare information.
7. CMS should examine the role of SSA in providing Medicare education and outreach activities. This should include but not be limited to assessing the amount and use of Medicare Trust Funds by SSA, performing a cost and benefit analysis, and exploring how CMS could or would use these funds. A report on this examination and analysis should be provided to the APME and appropriate Congressional committees.
8. CMS should collaborate more closely with the Administration on Aging to help coordinate, train, and/or provide technical assistance to service providers who receive funding to counsel people with Medicare about Medicare and Medicare choices. These entities include legal services providers, information and referral services, and, of course, SHIPs.
9. People with Medicare often ask their family physicians, nurses, Medicare+Choice organizations, and other health providers for information and advice. CMS should distribute information or guides to Medicare resources to health care providers. By giving them Medicare education materials, CMS would enable them to respond to Medicare questions and refer their patients to sources of Medicare information. CMS should also

integrate Medicare+Choice organizations into the regional Medicare education training process.

10. Retirees, individuals nearing retirement and Medicare eligibility, and the employed children of people with Medicare often rely upon their employers or their unions for information about health care coverage. Many employers and unions already invest substantial resources in getting information to their employees and members. CMS should continue its partnerships and collaboration with employers and organized labor.

Media and Communications Strategy

We have yet to see the results of CMS's fall media campaign, but we understand that this campaign was intended simply to make people with Medicare aware of the Medicare information resources available from CMS. The Administration has not publicly articulated its long-term Medicare media strategy. However, the APME believes that a long-range strategy for CMS should involve Medicare media and communications as part of an integrated marketing plan. The plan should be part of an information infrastructure that would include initiatives with information intermediaries, the creation and dissemination of Medicare consumer materials, and coordination with regional CMS offices and other Federal agencies to ensure CMS's responsiveness to consumer activities resulting from the media plan.

1. The Medicare marketing plan should continue to use social marketing techniques - including consumer input, research, and partnerships - to determine the information needs of targeted communities. This approach should incorporate existing research and knowledge regarding established marketing techniques for targeted populations, innovative strategies, and recommendations generated by CMS's HORIZONS project. [The HORIZONS project is a CMS initiative designed to provide information to people with Medicare that is culturally and linguistically appropriate.]
2. The plan should promote a basic understanding of health care coverage for older and disabled individuals, including Medicaid. It should encourage people to explore their Medicare options and make informed choices about their care. In particular, the media plan should provide a foundation for the national branding of Medicare and serve as a bridge between local and national partnerships. It should be developed in cooperation with a panel of national minority organizations and other interested stakeholders.
3. The plan should deliver print, television, radio, and Internet messages through and in partnership with national, regional, and local media outlets, including those outlets used by minority and low literacy populations. Messages and educational efforts should target the diverse needs of the Medicare population as well as informal (family and other) caregivers and other information intermediaries.
4. Medicare messages should reinforce basic concepts of health insurance. They should be delivered in multiple languages, using positive and appropriate minority language and imagery.

5. Messages should emphasize the availability of local resources, such as one-on-one counseling, and promote local access to materials.

Research and Evaluation

In order to continually improve the effectiveness of the Medicare education program, CMS should build on current efforts to measure and evaluate the various components and outcomes of its education efforts. CMS should use a variety of evaluation methods such as surveys, focus groups, cognitive interviews, usability testing, and other assessment tools.

1. All CMS educational activities should include an evaluation component to measure and improve their effectiveness particularly in terms of increasing the knowledge of people with Medicare. For example, CMS should continually assess existing CMS activities, such as 1-800 MEDICARE, to measure the impact of changes, as well as new efforts, such as the Medicare Personal Plan Finder.
2. The particular effectiveness of educational efforts on sub-populations of the Medicare population, such as those with limited English proficiency or who are cognitively impaired, should be better understood in order to evaluate their ability to make informed choices.
3. CMS should survey Medicare consumers on a regular basis to determine whether they understand the quality information it provides them and find it helpful in making coverage decisions. CMS should provide additional quality information when research demonstrates consumers' need and desire for such information.
4. CMS should make available to the public the results of its research, assessment, and compilation of best practices concerning the NMEP in an easily understood format. By making this information available, as quickly as possible, CMS could document the effectiveness of the NMEP and assist information intermediaries in improving their work.

Communicating about Health Care Quality

Comparative information about the quality of services provided by health plans and providers is a critical component of an informed choice strategy. However, most individuals are not familiar with performance information or how they can use it in evaluating coverage options. Moreover, there is evidence that many people with Medicare do not understand comparative information about health care quality when they are shown such information. Although the APME recognizes that CMS has taken a leadership role in providing consumers with comparative information, we urge even greater effort, particularly because the Medicare+Choice program rests so heavily on an informed consumer.

1. Educating people with Medicare about the availability of information about quality of care and how to use it should continue to be a major focus of an integrated Medicare consumer education strategy.

2. CMS should continue to pursue efforts to provide people with Medicare with comparative information about all Medicare options, including Original Medicare. This information should include information about quality.
3. CMS should continue to pursue efforts to develop information that can be presented at the provider and practitioner level, the unit of analysis most meaningful to consumers.
4. Educational efforts need to be targeted to the diverse needs of the Medicare population. Presentation of information about quality needs to take into account how different segments of the population receive and understand information. CMS should tailor information to ensure that all people with Medicare understand the information that is presented to them.
5. People with Medicare, and their information intermediaries, should be educated about CMS's efforts, including the tools that are available, to evaluate health plan and provider quality. The public needs access to information about the source and potential usefulness of HEDIS, CAHPS and other available quality information as well as their limitations.

VII. CONCLUSION

Clearly, providing useful and understandable information to people with Medicare and their families and caregivers regarding health care coverage in a rapidly changing environment is a daunting task. Encouraging people with Medicare to reassess their own health care needs annually and to evaluate which available health coverage options best meet their individual needs is an even greater challenge. Meeting this challenge will require a sustained long-term effort.

The NMEP has made significant progress in implementing a series of impressive Medicare consumer education initiatives. The APME Annual Report is focused on the need to develop and implement a comprehensive, multi-year strategic plan that builds upon the foundation created by the NMEP. It also looks for opportunities to make effective use of other resources.

The APME report recognizes that CMS will need increased funding to implement its recommendations. Determining appropriate levels of funding will be an important component in the development of a long-term strategic plan.

The APME stands ready to work with CMS in the development and implementation of a comprehensive strategic plan to help people with Medicare make informed health care choices. We believe that the APME can be a valuable resource for CMS in achieving this goal.

ROSTER
ADVISORY PANEL ON MEDICARE EDUCATION

Carol A. Cronin, Chairperson
Annapolis, MD
cacronin@erols.com

Diane Archer, J.D.
Special Counsel
Medicare Rights Center
New York NY
darcher@medicarerights.org

Dave Baldrige, B.A.
Executive Director
National Indian Council on Aging, Inc.
Albuquerque NM
dave@nicoa.org

Bruce E. Bradley, M.B.B.
Director, Managed Care Plans
General Motors Corporation
Detroit MI
bruce.e.bradley@gm.com

Jennie Chin Hansen, R.N., M.S.
Executive Director
On Lok Senior Health Services
San Francisco CA
jchansen@onlok.org

Joyce Dubow, M.U.P.
Senior Policy Advisor, Public Policy Institute
AARP
Washington, D.C.
JDubow@aarp.org

Elmer E. Huerta, M.D., M.P.H.
Director, Cancer Risk and Assessment Center
Washington Hospital Center
Washington, D.C.
EEH1@MHG.edu

Bonita Kallestad, J.D., M.S.
Attorney-at-Law
Mid-Minnesota Legal Assistance
Willmar MN
(320) 235-9600x21

Steven B. Larsen, J.D., M.A.
Maryland Insurance Commissioner
Maryland Insurance Administration
Baltimore MD

Brian W. Lindberg, M.M.H.S.
Executive Director
Consumer Coalition for Quality Health Care
Washington, D.C.
bwlind@erols.com

Heidi Margulis, B.A.
Vice President, Government Affairs
Humana, Inc.
Louisville KY
hmargulis@humana.com

Patricia H. Neuman, Sc.D.
Director, Medicare Policy Project
Henry J. Kaiser Family Foundation
Washington, D.C.
pneuman@kff.org

Elena V. Rios, M.D., M.S.P.H.
President
National Hispanic Medical Association
Washington, D.C.
nhma@nhmamd.org

Samuel J. Simmons, B.A.
President and C.E.O.
National Caucus and Center on Black Aged
Washington, D.C.
simmons@ncba-aged.org

Nina M. Weinberg, M.A.
President
National Health Council
Washington, D.C.
weinberg@NHCouncil.org

Edward Zesk, B.A.
Executive Director
Aging 2000
Providence RI
ezesk@home.com