

INTERIM ANNUAL REPORT
ADVISORY PANEL ON MEDICARE EDUCATION
June 5, 2001

The members of the Advisory Panel on Medicare Education (APME) present this Interim Annual Report which summarizes the findings and recommendations resulting from our discussions since our inaugural meeting on February 15, 2000.

ADVISORY PANEL ON MEDICARE EDUCATION

The Advisory Panel on Medicare Education, originally chartered on January 21, 1999, advises the Secretary of the Department of Health and Human Services (DHHS) and the Administrator of the Health Care Financing Administration (HCFA) on opportunities to enhance the federal government's effectiveness in implementing a national Medicare education program. Specifically, the APME advises DHHS and HCFA 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 five times between February 2000 and April 2001. During these meetings, the Panel heard from HCFA 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 HCFA 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; and, how the private sector conducts Medicare education. 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>.

BACKGROUND

Congress created the Medicare +Choice program in the Balanced Budget Act of 1997 (BBA) to expand the choices available to people with Medicare. Before Medicare +Choice, people with Medicare could choose only traditional fee-for-service Medicare (now known as Original Medicare) or a Medicare HMO. 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 understand:

- the difference between Original Medicare and a Medicare +Choice plan,
- the differences among available Medicare +Choice options,

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- 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 in making choices, 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 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.”

The BBA requires DHHS to provide information on: available Medicare +Choice options; comparison 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 comparison information must include plan benefits, premiums, service area, quality and performance information, and supplemental benefits beyond those provided for under Original Medicare. The Act further requires DHHS to provide this information through a toll-free number, an Internet site, and an annual mailing to people with Medicare. Congress envisioned that this information campaign would enable people with Medicare to make informed choices about their health coverage.

To make informed choices among Medicare coverage options, people with Medicare must have a basic understanding of the Medicare program, the advantages and disadvantages of their Medicare +Choice options, the ability to assess their health insurance needs over time and the capacity to use available information resources.

Starting in 2002, Congress mandated that the window of time during which Medicare consumers can become informed and make these choices will narrow. Currently, people with Medicare may 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 are open for enrollment. However, in 2002, HCFA 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 will be 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.

TARGET AUDIENCE: THE BENEFICIARY 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. They are comprised of persons aged 65 and above,

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certain younger disabled individuals, and those with permanent kidney failure treated by dialysis or kidney transplant.

- The average age of people with Medicare is 72.¹
- Thirty percent live alone.²
- Thirty-four percent have less than a high school diploma.³
- Forty-four percent of persons 65 and older read at a fifth grade level or less. An additional thirty percent read at the fifth to eighth grade level.⁴
- Forty percent have incomes at or below twice the poverty level.⁵
- Thirty percent say their health is fair or poor.⁶
- Twenty three percent have difficulty with mental functioning.⁷

Racial and ethnic minorities comprise approximately 22 percent of the Medicare population.⁸ Their information needs may be complicated by limited English proficiency, and 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 12% for non-Hispanic White elders.⁹
- The proportion of Hispanic elders with no formal schooling is approximately 9.8% as contrasted with .5% of non-Hispanic White elders.¹⁰
- Older African Americans are more likely to rate their health as fair or poor (43%) than are older White Americans (27%).¹¹
- Nearly thirty percent of Indian elders live in poverty.¹²
- Older Asian/Pacific Islanders are more likely to lack formal education than are White elders (10% versus 1%).¹³
- 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 \$14,775.¹⁴

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 no telephones or vehicles available.¹⁵ In addition, many recent immigrants may not

¹ Medicare Current Beneficiary Survey (MCBS), 1999.

² MCBS, 1999.

³ MCBS, 1999.

⁴ National Adult Literacy Survey, 1992.

⁵ Kaiser Family Foundation (KFF), 2001.

⁶ KFF, 2001.

⁷ KFF, 2001.

⁸ MCBS, 1999.

⁹ HORIZONS Newsletter, HCFA, 2001.

¹⁰ HORIZONS Newsletter, HCFA, 2001.

¹¹ AARP, 1997.

¹² National Indian Council on Aging, 1999.

¹³ AARP, 1995.

¹⁴ AARP, 1995.

¹⁵ National Indian Council on Aging, 1999.

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understand even basic concepts of health insurance, which they must grasp before they can understand Medicare.

The messages that HCFA must teach to this diverse population are complex and 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 +Choice¹⁶. 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”¹⁷.
- Based on a proxy measure of skill, an estimated 56 percent of the total Medicare population has difficulty accurately using comparative information to make choices¹⁸.

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 families to receive one-on-one counseling which currently is provided primarily by the State Health Insurance Assistance Programs (SHIP) located in every state.

IMPLICATIONS/FINDINGS

The Advisory Panel on Medicare Education, cognizant of the crucial decisions that the Medicare population must make about their health choices, and the daunting task that faces HCFA in assisting them to make those choices, has reached the following findings:

1. Funding for the National Medicare Education Program has been inadequate to meet the goal of supporting informed choice by people with Medicare including those with limited English proficiency, low health literacy, and cognitive impairments, and those from various cultural backgrounds. HCFA’s administrative budget has not kept pace with the number of major new programs and initiatives including Medicare +Choice. The proposed Medicare education budget for 2002 provides for a spending level of \$2.00 per beneficiary. A private sector benefits consultant informed the Panel that employers spend \$10 to \$30 per retiree for Medicare education.
2. Funding for the State Health Insurance Assistance Program (SHIP) in particular is not sufficient to meet the existing demand for services. The Panel heard testimony that SHIPs are unable to meet the demands in their communities for one-to-one counseling on Medicare.

¹⁶ Stevens and Mitler, 2000.

¹⁷ p. vi, Hibbard and Jewett, 1998.

¹⁸ Hibbard, Slovic, Peters and Finucane, 2000.

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3. Research has shown that many people with Medicare still do not understand basic Medicare, let alone the choices available under the Medicare +Choice program. Further, many people with Medicare may not understand the consequences of being locked in to a Medicare +Choice health plan. The Panel therefore concludes that, presently, many people with Medicare do not have sufficient understanding of the Medicare program or adequate information about their Medicare coverage options to make truly informed choices.

RECOMMENDATIONS

The Advisory Panel on Medicare Education, therefore, makes the following recommendations:

1. The Medicare enrollment “lock-in” provision of the Balanced Budget Act of 1997, scheduled to be phased in beginning in 2002, should be indefinitely delayed until it can be determined that a majority of people with Medicare are able to make informed decisions about their health coverage options.
2. Funding for the National Medicare Education Program in FY 2002 and beyond should be increased to levels that will more effectively meet the information needs of people with Medicare including those with low health literacy levels, limited English proficiency and diminished functional status, and those from various cultural backgrounds.
3. Financial support for the SHIP program should be increased.
4. HCFA should use some of these additional resources to develop grant-funded demonstration projects to identify and test successful practices in community-based Medicare education efforts. We also recognize the importance of culturally competent staff, services and information to serve the needs of consumers with limited English proficiency and others with special information needs.

We submit this Interim Annual Report with these initial findings and recommendations in recognition of the time constraints and other issues affecting the FY 2002 federal budget process. In upcoming meetings, the Panel looks forward to reviewing the first two years of experience gained from the National Medicare Education Program (NMEP). It will develop a more extensive annual report with more detailed recommendations regarding existing and potential components of the NMEP by the end of 2001.

This Interim Annual Report reflects the views of the members of the Panel and not necessarily those of their respective organizations.

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