
Project to Improve the Model Evidence of Coverage (EOC) Document, Phase 2:

**Results from Final Rounds of Consumer Testing of the
Revised Evidence of Coverage in 2002**

Prepared for the Centers for Medicare & Medicaid Services (CMS)

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INTRODUCTION

About the Model EOC 1
About the CMS project to improve the model EOC 1
Purpose of this report 2

TESTING METHODOLOGY

What did we test in Phase 2? 2
Who participated in the testing?..... 3
How did we conduct the interviews?..... 4

FINDINGS FROM PHASE 2 CONSUMER TESTING OF THE EOC

General impressions of the EOC 6
Features that helped and hindered navigation..... 8
Reactions to the Table of Contents..... 10
Reactions to Section 2 (Getting started as a member of Maple Health Plan)..... 17
Reactions to Section 3 (Getting the care you need, including some rules you must follow)..... 23
Reactions to Section 4 (Getting care if you have an emergency or urgent need for care) 26
Reactions to the section about member rights and responsibilities 31
Reactions to the section with the benefits chart..... 33
Reactions to the section on prescription drugs and the rows in the benefits chart that
tell about coverage for drugs 39
Reactions to the section about hospital care, skilled nursing facility care, and other services... 53
Reactions to the summary list at the beginning of the section about payment for coverage
and care 53
Reactions to the first part of Section 11 (Appeals and grievances: what to do if you
have concerns or complaints) 54

INTRODUCTION

About the Model EOC

Medicare+Choice (M+C) organizations are required by law to send certain information to their new members upon enrollment and to all members each year. They typically send this information in the form of an Evidence of Coverage (EOC). The EOC is part of the M+C organization's legal agreement with its members; it gives the details about benefits and services and how to use the plan. M+C organizations must get approval of their EOC from the Centers for Medicare & Medicaid Services (CMS) before they can mail it to their members. Each year CMS gives the M+C organizations a model EOC template that contains the type of information CMS expects in an EOC and the manner in which CMS prefers that it be presented. M+C organizations are not required to use the model language in this template, but by law those that follow the model language receive an expedited ten-day review of their EOC by CMS.

About the CMS project to improve the model EOC

In early 1999, the Senate Committee on Aging held a hearing to discuss the findings in a GAO report entitled "Medicare +Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature." As a result of the hearing, the Senate Committee on Aging directed CMS to standardize M+C beneficiary notification materials. CMS first standardized the Medicare +Choice Summary of Benefits, then began to standardize the EOC in 2000.

In 2001, when Congress enacted the law that allowed M+C organizations to receive an expedited review of their marketing materials (including the EOC) if they followed the CMS model, CMS changed the direction of the EOC project. Whereas the agency was going to standardize the document, the law made standardization unnecessary. Instead, CMS focused on improving the model EOC so that more M+C organizations would be able to use it and take advantage of an expedited review. The goal in improving the EOC model was to make it easier for Medicare beneficiaries to understand.

The EOC Project was conducted in two phases, each of which focused on revising particular sections of the EOC. Two contractors, McGee & Evers Consulting, Inc. and BearingPoint (formerly Barents Group, a division of KPMG Consulting), assisted CMS in this effort. Working closely with CMS staff, the contractors produced revised language for the EOC and conducted multiple rounds of consumer testing to test the revised versions and make further improvements. Using a variety of methods including website postings and email communication, the project asked stakeholders for suggestions about ways to improve the EOC and for feedback on draft revisions of the EOC that were posted for review. These stakeholders included representatives of the managed care industry, beneficiary organizations, and CMS staff in the regional and main offices.

During phase 1 of this project, the contractors conducted several rounds of consumer testing of revised versions of the EOC in summer 2001. The results from this testing are summarized in a written report to CMS (*Project to Improve the Model Evidence of Coverage (EOC) Document*,

Phase 1: Summary Report of Results from Consumer Testing of the Revised Evidence of Coverage, February 2002). There was further consumer testing in phase 2 of the project.

Purpose of this report

The purpose of this report is to summarize results from the consumer testing of the revised EOC that we did for CMS in phase 2 of the project. This final testing was done in two rounds: the first was in Long Beach, California on April 23-25, 2002 and the second was in Tampa, Florida on May 20-22, 2002. We used stakeholder feedback on revised versions of the EOC to prepare the mockups of the EOC that we tested with individual interviews with consumers in Long Beach and Tampa.

The mockups we tested were for a fictional M+C plan that we called “Maple Health Plan.” This report includes some examples from the mockups.

TESTING METHODOLOGY

What did we test in Phase 2?

CMS selected the following parts of the EOC as the areas for emphasis during the first round of Phase 2 testing in Long Beach:

- Table of Contents
- Section 2: Getting started as a member of Maple Health Plan
- Section 3: Getting the care you need, including some rules you must follow
- Section 4: Getting care if you have an emergency or an urgent need for care
- Section 5: Your rights and responsibilities as a member of Maple Health Plan
- Section 7: Prescription drugs (more information about covered services), and a page that describes drug benefits from the section with the benefits chart

We used the results from consumer testing in Long Beach together with feedback from stakeholders to improve the mockup, and then tested this revised mockup in the final round of testing in Tampa. In this final round, we did further testing of some parts of the EOC we had tested in the first round, and we added a few new topics as well:

- We did further testing of the Table of Contents, Section 2, Section 3, and Section 4. Our testing of these sections was selective, designed mainly to check on how well our revisions to these sections were working.
- We did further and more extensive testing of the information about prescription drugs in the EOC mockup, which included a revised section on prescription drugs and a revised part of the benefits chart that deals with drugs.

- We tested a revised version of the first few pages of Section 11 (Appeals and grievances: what to do if you have concerns or complaints).
- We also tested several parts of the EOC that had not been a main focus in previous testing, including the introduction and several other parts of the Benefits Chart in Section 6, Section 9 (Hospital care, skilled nursing facility care, and other services), and Section 10 (What you must pay for your Medicare health plan coverage and for the care you receive).

Who participated in the testing?

Using professional research facilities, we recruited a mix of participants for the testing. To help with recruitment of testing participants, CMS supplied us with samples of Medicare beneficiaries in the Long Beach and Tampa areas who were currently enrolled in Medicare managed care plans. About one month before each round of testing, we sent an advance notification letter from CMS to the beneficiaries in these samples. The letter explained our study and told that the person might be called and asked to participate in it. We included a toll-free number to a research staff member in case beneficiaries had any questions or concerns. We received a small number of calls from people who wanted more information.

The research facilities used recruitment scripts that we supplied to find respondents who would meet our demographic and education requirements. The script was designed to verify that people had sufficient literacy skills to feel comfortable about reading the EOC model. We sought a mix of education levels, ethnicities, ages, and disability status, paid the people for participating, and helped them with transportation as needed.

Most of our testing participants were Medicare beneficiaries. While the CMS sample was our main source for recruiting beneficiaries, we also recruited some beneficiaries using the research facilities' local databases. In addition, we used referrals from beneficiaries we spoke with on recruitment calls to recruit a few participants who were family or friends under the age of 65 who help a Medicare beneficiary with health care decisions (for convenience, we refer to these participants as "caregivers"). In Tampa, we also recruited three testing participants who were beneficiaries on Original Medicare with no previous experience in a managed care plan.

We recruited a total of 46 people (25 in Long Beach and 21 in Tampa), and 39 of them completed an interview. Of the seven appointments that did not result in completed interviews, most were terminated early because the respondent was fatigued or ill, or was having trouble focusing on and responding to the interview materials and questions. We also had to cancel a couple of interviews at the outset when we discovered that the respondent did not meet all of the requirements for the study.

The 39 people who completed interviews had the following characteristics:

- *Gender.* Nineteen respondents were female and 20 were male
- *Age.* Six respondents were under age 65, (2 people with disabilities, 4 caregivers); 25 were between the ages of 65 and 74; and 8 were 75 or older

- *Race/ethnicity.* Twelve respondents were Caucasian, 8 were Hispanic, 14 were African-American, and 5 were Asian
- *Education.* Twenty-five respondents had some college education or more, 10 respondents had a high school diploma; 3 had some high school; and 1 had between a sixth and eighth grade education. Of those with post-secondary education, 15 had some college, 5 had a college degree, and 3 had some graduate courses (detailed information on educational attainment was not available for two of those with post-secondary education). The average education of our testing participants was higher than the average education of Medicare beneficiaries in general because good literacy skills were a requirement for the study.
- *Health plan.* Seven health plans were represented by 23 respondents in Long Beach, and 3 health plans were represented by 13 respondents in Tampa. Three Tampa respondents had Original Medicare and supplemental policies.

How did we conduct the interviews?

The interviews generally lasted about an hour and a half and were conducted by either one researcher taking her own notes or a by a two-person team with one person serving as interviewer and the other as note taker. Before the interview, respondents signed a consent form that included a request for permission to audiotape and videotape the interview; all but five people consented to be taped.

We used a combination of cognitive and usability testing techniques to find out how easy it was for people to understand and apply information in the EOC, and to get ideas about ways to make improvements. We used a structured interview guide that began with a brief introduction to the project and its purpose. Then we showed people the mockup of an EOC for the fictional Maple Health Plan and asked them to imagine that they were members of Maple Health Plan and had just received the booklet in the mail. To get feedback that would be useful in guiding improvements to the EOC, we made an effort to put people at ease about the interview so they would feel comfortable enough to be candid. We encouraged them to be critical, explaining that we were doing the interviews because the booklet needed improvement, and their feedback would help a lot.

We gave participants a chance to look through the mockup and observed what they did. We asked them to “think aloud” by sharing their thoughts as they went through the mockup, and asked them to point out any places where they had to go back and read something over again. The interview guide was structured but flexible enough to let us follow up on respondents’ own questions and interests. Throughout the interview, we probed for the reasons behind people’s comments and answers to our questions. We did not ask directly about how hard or easy it was to understand the material, because people may have been unaware or reluctant to admit that they were confused. Instead, we took an indirect approach: we asked neutrally-worded, open-ended questions that encouraged people to share their impressions and reveal their baseline knowledge, attitudes, and interpretations. Sometimes we asked respondents to explain passages using their own words, and we included some navigation tasks to help us assess how easy it was for people to locate particular types of information. Responses to these indirect approaches are quite informative and useful in

guiding revisions because they reveal more fully how people interpret what they read and the strategies they use to locate information.

FINDINGS FROM PHASE 2 CONSUMER TESTING OF THE EOC

General impressions of the EOC

Initial reactions to the mockup

In general, respondents liked the EOC mockup, and found it to be understandable and straightforward, particularly when compared to the EOCs that they recalled receiving in the past. One respondent in Tampa remarked that with her own EOC at home, *“sometimes you read it and it says one thing in one place and another thing in another place. Sometimes it contradicts itself, leads you to believe one thing and it’s not.”* For the most part, people were able to use the document, experiencing major difficulty in only a few areas. While some less skilled readers struggled to understand some passages, ultimately they were able to use the EOC to find the information they were seeking. Some people said they much preferred to call and talk with someone at customer service than to read a booklet, but most of these made their way through the booklet without major difficulty. One such participant in Long Beach remarked, *“if I had a booklet like this I would have read it.”* Another reluctant reader complimented the EOC at the end of the interview, calling it a person’s *“little Bible or dictionary.”*

One caregiver in Long Beach said, *“right off the bat I can tell this is what they need for older people,”* and added that making the booklet easy to read was important *“not just for older people but for people like me, too.”* Several respondents said they appreciated how the booklet gave definitions of words and gave details in sections of the booklet such as rights and responsibilities and prescription drugs. Others liked the use of bold in the table that drew the reader’s attention.

While people were generally able to understand the EOC mockup, it contains some terms and topics that are inherently complex and therefore hard to convey in simple language. These include some terms that are unique to Medicare, such as "Original Medicare," as well as insurance terms such as "benefit period" and "coverage guidelines." Later sections of this report describe readers' problems with complex terminology and concepts.

Some respondents expressed concerns about the overall length of the document, especially when they first saw it. As one person said, *“most of these things are written in a way that’s too long – why not just have do’s and don’ts? Older people have trouble understanding,”* and *“all these insurance things are too complicated for people. They won’t read them. It has to be simple enough so that it’s like having an agent there [to explain information].”*

Topics of greatest personal interest

Based on comments people made while looking at the cover and glancing through the Table of Contents at the beginning of the interview, the topics of greatest personal interest included the following: what they would have to pay (premiums, copayments, etc.); prescription drug benefits; emergency care; information on what is covered during travel away from home; and information on

primary care providers. In Tampa, a few respondents also were interested in “Medicaid” and wondered about eligibility and the relationship with Medicare.

Familiarity with the content of the EOC

Similar to the results from previous EOC testing, we found that most participants in Phase 2 testing were unfamiliar with at least some of the information they read about in the EOC mockup. In particular, people tended to be unfamiliar with or misinformed about a number of the terms related to the prescription drug benefit (such as “formulary,” “generic drug,” and “benefit limit”) and they were unfamiliar with many of their beneficiary rights. They also had problems with certain terms and concepts that are often problematic for beneficiaries, including “Original Medicare,” “Medicare managed care plans,” and the difference between “urgent” and “emergency” situations. A few of the terms and concepts in the EOC seem to defy simplified explanation, such as the technical definition of a “benefit period,” and these remained confusing to many people despite revisions.

Variation in reactions to the mockup

As in previous rounds of EOC testing, we found a good deal of variation in how people approached the tasking of reading the mockup and how easy it was for them to understand the information it contains. Many factors were involved, including degree of interest in the EOC, reading skills and habits, and knowledge and attitudes about Medicare and managed care. Some people commented that they liked to get information by talking with someone rather than, or in addition to, reading a booklet like the EOC. As one man said after he became frustrated looking for some information in the booklet, “*See-- this is where I would call and ask.*”

In general, participants with more formal education tended to have better reading skills and more accurate and extensive background knowledge, but this was not always the case. Some of those with limited formal education were able to understand the EOC quite easily, and some with a good deal of formal education had problems with reading and comprehension.

People differed in how skilled and confident they were about navigating through the booklet, and how carefully and thoroughly they read it. In each round of Phase 2 testing, our participants included several highly skilled readers who understood the booklet with great ease and suggested ways to improve it. These readers tended to be more knowledgeable about Medicare and managed care than others we interviewed. Each round also included a few people with very limited reading skills who struggled to find information in the booklet and understand what they read. These people tended to read very slowly and carefully, and seemed to lack the ability to skim for the headings and key points and to use basic navigational tools. Typically, they searched for information in the booklet by flipping through the pages and did not seem to think of going back to use the Table of Contents to look up topics and page numbers. They often overlooked the footers or headers that gave section numbers and titles, and several were unfamiliar with the concept of an appendix to a document. Overall, most of our participants fell somewhere between these two extremes: they were able to understand most of what they read, provided that they read all of it carefully, and they could generally find what they were looking for unless it was an area where they misunderstood the terms or concepts.

In answering our questions about what the booklet was telling them, some participants seemed to rely more heavily on their own experiences than on what was written in the booklet. While this reliance on personal experience sometimes made it hard for us to judge how much people had actually read and how well they understood it, it illustrates the active role of readers in interpreting what they read. To help keep people focused on reacting to the booklet, we guided them back to what was written when they seemed to be responding based on personal experience alone. In addition, to check on ease of comprehension by those with no background in M+C plans, we recruited a few respondents on Original Medicare for our last round of testing in Tampa.

As in previous testing, the results from Phase 2 revealed a range of attitudes and reactions to the topics covered in the EOC. Some people made comments that reflected feelings of vulnerability, intimidation, or concern. Some expressed doubt or cynicism about certain topics such as legal matters. We also found that respondents were often pleased or reassured to learn something that was new to them, such as some of the information about their rights or resources that were listed in Section 1, which included information about SHIPS and Medicaid. As one participant said about the SHIPS, *“This is one thing I didn’t know, that you get free help from the State Health Insurance Assistance Program. I didn’t know about that. I don’t think anybody else has that I’ve ever talked to.”* One man who noticed the reference to women’s health services in the bulleted list of services for which members may self-refer said he was going to go home and tell his wife about it. Some commented that after reading the EOC, they now understood something that had previously been puzzling to them, such as the difference between generic and brand-name drugs, or the rules about having ambulance services covered.

Features that helped and hindered navigation

Background

The Table of Contents is a key navigational tool for a large reference document such as the EOC. Other features such as headers and footers and placement of page numbers are important, too. In the first phase of EOC testing that we did in 2001, we tested a number of variations for the Table of Contents, and confirmed reader preferences for a relatively detailed Table of Contents. In this last phase of testing, our testing of the Table of Contents and other navigational tools such as headers and footers was oriented toward getting feedback that would help fine tune a few features. These included whether to show a separate page number for each topic covered in the benefits chart, and how much detail to show in the Table of Contents about the material in the Appendix. We also checked to see how well other features were working, including the titles and order of certain sections, and footer and headers.

Participants differed in their navigational skills

Most of our interview respondents were able to understand and use the Table of Contents with relative ease. For many, it was the first place they turned to when searching for answers not immediately found in the section that was being tested at the time. One respondent commented, *“I would look at the Table of Contents to see what is offered to me.”* In contrast, the participants with limited reading skills tended to have a lot of problems with navigation, and typically searched for

information in the booklet by flipping through the pages. Although they had looked at the Table of Contents at the beginning of the interview, they did not seem to think of going back to use it to look up topics and page numbers.

Headers worked better than footers

The mockup we used in the first round of testing in Long Beach had a footer on each page that gave the Section number and title and the page number. The footer did not work very well as a navigational tool because many participants did not seem to notice or use it as they read through the document. In the mockup for the final round of testing in Tampa, the footer was switched to a header. The header was more prominent, and seemed to work better in terms of attracting attention. Nonetheless, many people in the final round of testing continued to search for various sections and information by simply flipping pages rather than using the headers or other navigation tools.

Unfamiliarity with an “appendix” was a big barrier to navigation for some readers

While some of the participants turned to the Appendix on their own to look up answers to questions that arose during the interview, we noticed in both rounds of testing that the concept of an appendix was quite foreign to some people. They were unfamiliar with the word and concept, and did not know that an appendix is always at the end of a document. As a result, they were lost and confused when they encountered a reference to any part of the Appendix, such as text that referred the reader to Appendix A for a more detailed definition of a term. One respondent suggested that the word “appendix” may sound too technical for people and that sending people to a particular page number would be better. A couple of people who turned to Appendix A did not seem to understand how to look up a word in the alphabetical list of definitions it contains. For example, one person went to Appendix A to look up the meaning of “Medigap.” Rather than searching for the word, “Medigap,” she read the first entry she encountered, the one for “Appeals,” expecting it to give the answer to her question about “Medigap.” To help the readers who have limited experience with using reference documents such as the EOC, the revisions done after the final round of testing left the appendices at the end of the document but deleted the word “Appendix,” and changed each of the four parts of the appendix into a separate numbered section.

References to other sections were confusing to some people

The model EOC tried to minimize references to other sections within the text, since they can be distracting and frustrating to readers, making the booklet harder to use. In some situations, adding a brief definition or explanation made it possible to avoid the need to refer to another part of the booklet. In other cases, references to other sections seemed essential, such as when the booklet needed to point out the connection between summary information in the benefits chart and details given in another section.

In the last rounds of testing, several of the less-skilled readers we interviewed had a lot of difficulty when they encountered a reference to a different section of the EOC. A few became completely discouraged at being told to look in another part of the booklet. In some cases, the difficulty seemed to be lack of familiarity with the concept of reference to another section, and the conventions for

indicating one (such as “see Section X for...”). For example, near the end of Section 3, which gives the basics about getting care, one respondent read the following reference to Section 4: “See Section 4 for more information about emergency care and urgently needed care.” He did not understand that “See Section 4...” meant that he should turn to Section 4 in the booklet if he wanted to read more about the topic of emergency care and urgently needed care. Another person became concerned when he saw a reference to section 8 when he was reading Section 6: *“I haven’t even read Section 8 yet, I haven’t gotten there yet.”* Yet another person who saw references to other sections when he was reading Section 6 asked, *“Is Section 6 divided into sections of its own?”*

For readers who flip through the pages rather than turn to the Table of Contents or use the headers, the burden of finding the other section seemed to contribute to the frustration some people felt when they encountered a reference to another section. For example, one person suggested referring people to page numbers rather than sections. *“I mark my booklet at home up [with page numbers]. If they do that, I’ll have nothing to complain about.”* People also seemed to react negatively to references sending them to other sections if they couldn’t see any reason for them, or when they seemed to have little sense of what information they would find if they turned to the other part of the booklet.

People had mostly favorable reactions to the content summaries at the beginning of each section

Since the EOC is a large reference document with a lot of topics and information that may be unfamiliar to readers, it can be easy for people to lose their place or train of thought when they look things up. To help orient readers when they turn to a new section, each section included a brief list of the main topics for that section immediately after the section title (see Exhibits 5 and 7 for examples of content summaries). Some readers did use these content summaries as a navigation tool. Of those who made comments about them, several people said they were helpful, and a few thought they were “excessive” or not needed. One thought it would be better if the topics in the summary had page numbers.

Reactions to the Table of Contents

People liked many features of the detailed Table of Contents

Exhibit 1 below shows a small portion of the Table of Contents for illustration (there are other examples later in this report in Exhibits 2 and 3). Respondents noticed and appreciated the level of detail that was included in the Table of Contents, and some asked for even more to be added. They also commented favorably on the use of bolding to emphasize some key terms, as shown in Exhibit 1 below, saying that it helped them find certain topics in the booklet. It also drew attention to some terms, such as “service area,” that tended to be unfamiliar to many people.

Respondents mentioned that having “PCP” spelled out for them upfront (as shown in Exhibit 1 below). They said it was helpful in preventing them from having to guess at the meaning or turn to the section to look it up.

EXHIBIT 1. A portion of the Table of Contents as shown in the Round 1 mockup:

Section 3 Getting the care you need, including some rules you must follow

You must use “plan providers” to get your “covered services”	7
Choosing your PCP (P_rimary C_are P_rovider)	8
Getting care from your PCP	8
Getting care from specialists	9
There are some services you can get on your own, without a referral	9
Changing doctors	10
What is the geographic “service area” for Maple Health Plan?	10
What if you need medical care when your PCP’s office is closed?	10
Getting care when you travel or are away from the service area	11

Some respondents suggested that this same approach of spelling out the meaning of the acronym be applied to a couple of other acronyms such as “CMS” and SHIP” that they had noticed in the Table of Contents entry for Section 1, *Telephone numbers and other information for reference*, and themselves guessing about. While this entry for Section 1 explained the meaning of the acronyms (referring to SHIPs, for example, as “state organizations that provide free Medicare information and help”), a few respondents were curious about what the initials actually stood for and liked the way it had been spelled out for “PCP.” One respondent had problems with the acronym, “QIO,” which stands for Quality Improvement Organization. As he was skimming through Section 1, he noticed the letters “QIO” and read them as “Q-ten” because the letter “I” resembled the numeral “1.”

Readers found the more detailed versions of the Table of Contents easier to use

Since the EOC is costly to produce and distribute, it is important to keep it as short as possible, consistent with providing clear and complete information. This means that adding a page or two to the Table of Contents makes sense only if there is a real benefit to readers. In our final round of testing in Tampa, we sought reactions to two versions of the Table of Contents to see if adding more detail would be helpful to readers. Our variations focused on two areas: the itemized list of benefits in the benefits chart section, and the amount of detail used in describing the contents of the Appendix. As we describe below, reader reactions favored the more detailed versions in both cases.

Traditionally, the model EOC template has included only one general entry for the benefits chart in the Table of Contents, and has not listed each type of benefit and its page number (which would take a full page). In our final round of Phase 2 testing in Tampa, we checked on whether readers would find it helpful to see the full listing of benefits and page numbers by giving them some

navigation tasks and by comparing their reactions to the two versions of the Table of Contents shown in Exhibit 2 below.

EXHIBIT 2. Table of Contents entry for Section 6: two versions used in the final round of Phase 2 testing

SHORTER VERSION:

Section 6 Benefits chart – a list of the covered services you get as a member of Maple Health Plan

What are “ covered services ”?	19
There are some conditions that apply to getting covered services	19
What if you have problems getting covered services?	19
Can your benefits change during the year?	20
Benefits Chart – a list of covered services	20

LONGER VERSION:

Section 6 Benefits chart – a list of the covered services you get as a member of Maple Health Plan

What are “ covered services ”?	19
There are some conditions that apply to getting covered services	19
What if you have problems getting covered services?	19
Can your benefits change during the year?	20
Benefits Chart – a list of covered services	20
Inpatient hospital care	20
Inpatient mental health care	21
Inpatient services (what is covered for inpatients when hospital or skilled nursing facility inpatient days are not covered or no longer covered)	21
Skilled nursing facility care	22
Home health care	23
Hospice care	23
Physician services	23
Chiropractic services	23
Podiatry services	24
Outpatient mental health care	24
Outpatient substance abuse services	24
Outpatient surgical services	24

EXHIBIT 2., *continued*

Ambulance transportation	24
Emergency services.....	24
Urgently needed services	24
Outpatient rehabilitation services (physical therapy, occupational therapy, speech and language therapy).....	24
Durable medical equipment and related supplies	25
Prosthetic devices and related supplies.....	25
Diabetes monitoring	25
Medical nutrition therapy.....	25
Blood.....	25
Outpatient diagnostic and therapeutic services and supplies	25
Bone mass measurements	26
Colorectal screening	26
Mammography screening	26
Screening pap test, screening pelvic exam, and clinical breast exam.....	26
Prostate cancer screening	27
Immunizations.....	27
Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare).....	28
Maple Health Plan prescription drug benefit (outpatient prescription drugs)	29
Hearing services	29
Vision care	29
Routine physical exams	29

The longer listing was much more helpful to those who looked up specific information as part of one of our navigation tasks. For example, one man searched for whether Maple Health Plan covers chiropractic care, using a mockup with the *short* version of the Table of Contents for the benefits chart that is shown above in Exhibit 2. He was a highly skilled reader, and came up with a series of ideas about where to look. His first impulse was to look in *Section 7: Medical care and services that are not covered and a list of exclusions*, to see if chiropractic care was listed as *not* being covered. Then he changed his mind, thinking that maybe he should check under “Covered services” in Section 6: “*Yeah, well that would be what I’d be looking for is a covered service and I’d be looking at chiropractors.*” Although this was the correct answer about where to find the information, he changed his mind again without looking at the list of covered services in Section 6, deciding that Section 3 was actually the most likely spot: “*I’d have to go back to [the part about] getting care from specialists in section 3 because... [chiropractors] are considered specialists.*”

Overall, when we asked people to compare the short and long versions of the Table of Contents listing for the benefits chart, they strongly favored the long version. They felt that the extra detail was well worth the added space. Although the listing of topics and page numbers in the Benefits Chart section helped people find information on individual covered services more easily, the added length caused minor problems for a few people who seemed to lose their sense of the hierarchy of sections and subsections. Also, some people were looking for a more logical ordering or grouping of the benefits, so that it would be easier to find what they were looking for (someone suggested that the benefits should be arranged alphabetically). Based on this feedback, revisions that were done after the last round of testing grouped the benefits into the following major categories: inpatient services, outpatient services, preventive care and screening tests, other services (this included blood and drugs), and additional benefits (this included any optional additional services, such as prescription drugs, dental services, etc.).

Participants also liked the more detailed version of the contents listing for the appendix

In the final round of testing, we also sought reactions to two versions of the Table of Contents for the Appendix. As shown below in Exhibit 3, these versions differed in the amount of detail they offered. Again, participants favored the longer version as being more informative and more efficient because they would know what topics were covered without having to turn to the back and look.

Notice also that the longer version (“Round 2”) shown in Exhibit 3 has an expanded title for Appendix D that incorporates a definition of “advance directives” into the title using the parenthetical phrase “(legal forms such as a living will or power of attorney).” Results from our testing showed that people liked seeing information about advance directives in the EOC, but virtually no one was familiar with the term, “advance directive.” The expanded title includes mention of “living wills,” which is the term that people tended to use themselves.

EXHIBIT 3. Comparing Table of Contents entries for the Appendix in the round 1 and round 2 mockups.

Mockup tested in ROUND 1:

APPENDIX:

Appendix A	Definitions of important words in this booklet.....	59
Appendix B	More information about the appeals process: six steps for making complaints related to your coverage or payment for your care	63
Appendix C	Legal notices	74

Appendix D	Information about “advance directives”	75
	Information about using a legal form such as a “living will” or “power of attorney” to give directions in advance about how you want your health care to be handled, in case you become unable to make health care decisions for yourself.	

Mockup tested in ROUND 2:

----- **APPENDIX** -----

Appendix A	Definitions of some words used in this booklet	
	Definitions of some words used in this booklet.....	67
Appendix B	More information about the appeals process	
	What is the purpose of this Appendix?	71
	What are “complaints about your coverage or payment for your care”?	71
	How does the appeals process work?	71
	STEP 1 Maple Health Plan makes an “initial decision” about your medical care, or about paying for care you have already received	72
	STEP 2 If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an “appeal” or “request for reconsideration.”	75
	STEP 3 If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization.....	78
	STEP 4 If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge.....	79
	STEP 5 Your case is reviewed by a Departmental Appeals Board	80
	STEP 6 Your case goes to a Federal Court	80
Appendix C	Legal notices	
	Notice about governing law	81
	Notice about non-discrimination	81
Appendix D	Information about “advance directives” (legal forms such as a living will or power of attorney)	
	Introduction	83
	How can you use a legal form to give your instructions in advance?	83
	If you are hospitalized, they will ask you about an advance directive	84
	What if providers don’t follow the instructions you have given?	85

Reactions to wording and order variations in the titles of sections about benefits and exclusions

One section of the EOC has a benefits chart that lists all benefits offered by the M+C plan. Several of the benefits require a more detailed explanation than the chart format can easily accommodate, so there are additional sections that give the details. These include a section about prescription drug benefits (if offered) and a section about hospital care, skilled nursing facility care, home health care, and other services. There is also a separate section that gives exclusions.

In our Phase 2 testing, we got reactions to variations in wording and order for this group of sections that describe benefits and exclusions. Exhibit 4 compares the variations we tested.

EXHIBIT 4. Comparing the wording and order of selected section titles in the Table of Contents in round 1 and round 2 mockups.

NOTE: For simplicity in comparing order and wording, this exhibit shows only the section titles from each mockup. The actual Table of Contents for each mockup includes the major headings in each section.

ROUND 1:

- Section 6 Benefits Chart – a list of the covered services you get as a member of Maple Health Plan
- Section 7 Prescription drugs (more information about covered services)
- Section 8 Hospital care, skilled nursing facility care, and other services
- Section 9 Medical care and services that are not covered (list of exclusions)

ROUND 2:

- Section 6 Benefits chart – a list of the covered services you get as a member of Maple Health Plan
- Section 7 Medical care and services that are **not** covered (list of exclusions)
- Section 8 Prescription drugs
- Section 9 Hospital care, skilled nursing facility care, and other services

As shown in Exhibit 4, the title of the section on Prescription drugs in Round 1 included the phrase, “more information about covered services” in parentheses at the end. For the section on hospital care and other services, a similar reference was made to “more information,” although it was not part of the title for this section. Instead, the phrase, “More information about covered services for:” came right after the title, as a lead-in to the list of topics and page numbers for the section (this lead-in phrase is not shown in Exhibit 4 because the Exhibit shows only the titles). Instead of helping people understand the connection between the benefits chart and these two sections, both references to “more information” were confusing. Readers wondered, for example, where the other information was, if this part offered “more” information. The references to “more information” were dropped from the mockup as part of the revisions done before the final round of testing.

As shown in Exhibit 4, the mockups we tested in Rounds 1 and 2 put the sections about benefits and exclusions in a different order. In Round 1, the sections that tell more about certain topics listed in the benefits chart come immediately after the chart, and they are followed by the section on exclusions. Results from Round 1 of testing showed that some people expected and wanted to see the benefits exclusions immediately after the section that gives the benefits chart, without the interruption of the sections that elaborate on certain benefits. As shown in Exhibit 4, the order of sections was changed in this way before Round 2 of testing.

Reactions to Section 2 (Getting started as a member of Maple Health Plan)

General impressions

The purpose of Section 2, *Getting started as a member of Maple Health Plan*, is to help people understand what is distinctive about being in a Medicare managed care plan and how this differs from Original Medicare. The section also explains about the member card and membership records.

Overall, people felt that Section 2 outlined the basics of membership in Maple Health Plan well, and they seemed able to understand the key points reasonably well, despite problems with concepts and terminology that we describe below. Most respondents liked having the sample membership card as a reference in the book and seemed to understand how their Maple Health Plan member card was different from their red, white, and blue Medicare card. Some people commented that they appreciated knowing that they could give feedback to the plan (“Please tell us how we’re doing”), though one was concerned about confidentiality: “*Are comments confidential? Because it would make a difference.*” A few people added that the booklet should tell readers that they must qualify for Medicare Part A and Part B in order to be in the plan, feeling that it was important information for people to know up front (the booklet covers this topic later on).

Many people had problems understanding certain key terms and tended to be unclear about the relationship between Maple Health Plan and the Medicare program

Exhibit 5 below shows how the mockups we tested explained the differences between what it means to be in an M+C plan and what it means to be on Original Medicare.

EXHIBIT 5. Comparing first part of Section 2 in round 1 and round 2 mockups.

ROUND 1:

SECTION 2 ***Getting started as a member of Maple Health Plan (what it means to be in a Medicare managed care plan, your plan membership card, keeping your membership record up to date)***

What it means to be in a Medicare managed care plan

Now that you are enrolled in Maple Health Plan, you still have Medicare, but you are getting your Medicare as a member of Maple Health Plan. Since Maple Health Plan is a Medicare managed care plan, this means that you will be getting most or all of your Medicare health services from doctors and other providers who are part of Maple Health Plan.

Here are some important things to know about what it means to get your Medicare as a member of Maple Health Plan:

- Maple Health Plan is a Medicare HMO offered by Maple Corporation of California. An HMO is a type of managed care plan.
- The Medicare program pays Maple Corporation of California to manage the health care for people with Medicare who are members of Maple Health Plan. In turn, Maple Corporation of California pays certain doctors, hospitals, and other providers to provide this care. We call these our Maple Health Plan “plan providers.” **Since these plan providers are the ones we are paying to provide your care, they are the ones you must use** (except in special situations such as emergencies). As we explain below, you will use your Maple Health Plan membership card --instead of your red, white, and blue Medicare card-- to get your care from these plan providers.
- This booklet explains the benefits and services that are covered for you as a member of Maple Health Plan, what you have to pay, and the rules you must follow.
- The benefits and services you get as a member of Maple Health Plan include everything that is covered by Original Medicare, but you do not have to pay the Original Medicare deductibles and coinsurance. Maple Health Plan also gives you some additional services and supplies not covered by Original Medicare, including prescription drug coverage and world-wide emergency care. (As explained in Appendix A, “Original Medicare” is the traditional pay-per-visit Medicare. Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage. Maple Health Plan is **not** a Medigap or Medicare Supplement policy.)

ROUND 2:

SECTION 2. *Getting started as a member of Maple Health Plan (what it means to be in a Medicare managed care plan, your plan membership card, keeping your membership record up to date)*

What it means to be in a Medicare HMO

Now that you are enrolled in Maple Health Plan, **you still have Medicare, but you are getting your Medicare through Maple Health Plan.** Here are some things to know about what it means to get your Medicare as a member of Maple Health Plan:

- **Maple Health Plan is a Medicare HMO offered by Maple Health Corporation.** An HMO is a type of managed care plan. (Maple Health Plan is **not** a Medigap or Medicare supplement policy. See Appendix A for a definition of Medigap or Medicare supplement policy.)
- This booklet explains the benefits and services that are covered for you as a member of Maple Health Plan, what you have to pay, and the rules you must follow. As a member of Maple Health Plan, you get all of the benefits and services that are covered for everyone with Medicare. These are the benefits and services covered under Original Medicare. Maple Health Plan also gives you some *additional* services and supplies that are not covered by Original Medicare. (“Original Medicare” is the way most people in the country get their Medicare. Some people call it traditional Medicare. For more about Original Medicare, see the definition in Appendix A).

Since Maple Health Plan is a Medicare HMO, this means that you will be getting most or all of your Medicare health services from doctors and other providers who are part of Maple Health Plan. The Medicare program pays Maple Health Corporation to manage the health care for people with Medicare who are members of Maple Health Plan. In turn, Maple Health Corporation pays certain doctors, hospitals, and other providers to provide this care. We call these our Maple Health Plan “plan providers.” **Since these plan providers are the ones we are paying to provide your care, they are the ones you must use** (except in special situations such as emergencies).

Explaining Medicare managed care requires the use of terms and concepts that are unfamiliar and difficult for many people. Some of the people we interviewed were quite knowledgeable about managed care and understood this section and its terminology without difficulty, but it was a struggle for others. Sometimes when we asked people to tell in their own words what they thought this section was trying to say, it was clear that there were specific terms and concepts they did not understand. For many, however, confusion about some of the terms or details, such as “managed care” and “Original Medicare,” did not seem to affect their overall grasp of what it means to be in Maple Health Plan. One person felt that the section put too much emphasis on the relationship

between Medicare and Maple Health Plan; he thought it should simply highlight the impact that the relationship had on how people would receive their healthcare services.

People understood the term, “Medicare HMO,” better than “Medicare managed care plan”

Very few people we interviewed had ever heard of the term, “Medicare managed care plan,” before they saw it in the Maple Health Plan EOC. When they tried to make sense of this term, they drew on their existing knowledge and seemed to make some guesses based on the meaning of different parts of the term. Here are some examples:

- Instead of connecting “managed” with “care,” several people connected “managed” with Medicare,” and concluded that “Medicare managed care plan” meant that the Medicare program was directly involved in managing the plan.
- Thinking of “managing” in terms of coping and who is in charge, another person interpreted “Medicare managed care plan in the following way: *“To me, it looks like someone is going to help you out. Help you manage through this time in the person’s life when they need help. So, you don’t have to be in charge. Someone else is going to be in charge and manage that for you.”*

In contrast, most people we interviewed seemed familiar with and comfortable about using the term, “HMO.” Building on this recognition, the mockup we tested in Round 2 used “Medicare HMO” rather than “Medicare managed care plan” in the first heading (see Exhibit 5).

Based on reactions to Section 2 and other comments people made during the interview, it seemed that many people approached the EOC with well-entrenched ideas of what Medicare is and what an HMO is. They tended to become confused if the description of Medicare and HMOs in the booklet differed from their preconceptions. Several shared the view that “an HMO is a business” and is thus distinct from Medicare. For example, one person said, *“Medicare HMO’ – I don’t know what to think about that, [Medicare and HMO are] separate as far as I’m concerned.”* Another person who seemed to have a solid sense of M+C arrangements said he felt that the language about getting “your Medicare through Maple Health Plan” was a little ambiguous. He asked, *“Am I getting the health plan or is it through Medicare? They should mention Maple Health Plan more.”*

In general, the people we interviewed did not seem to conceive of “their Medicare” as a package of benefits and services that could be provided in a number of different ways, but more as a specific program in which they participate. However, in spite of the tendency to compartmentalize “Medicare” and “HMO,” people did not necessarily believe that they would lose Medicare-covered services by being a member of a Medicare HMO. As one respondent explained, *“you either have Medicare or an HMO, but you get the same services as Medicare.”* While they might use certain terms in a unique or misleading way, they did seem to grasp that with a Medicare HMO, they would still be getting all of the same basic coverage as under Original Medicare.

The term “Original Medicare” was often unfamiliar and confusing

Despite its prominent use in information materials such as *Medicare & You*, “Original Medicare” was an unfamiliar term to most people we interviewed. Some people guessed that the term referred

to Medicare when it was originally created. One respondent explained that it was “*something that used to be and is currently not available.*” Another had the impression that having Original Medicare meant being put in lower-quality “*county facilities.*” Still others understood from the context that Maple Health Plan, described as a Medicare managed care plan, was different from Original Medicare. However, they used several different terms – “*traditional Medicare,*” “*just Medicare,*” and “*straight Medicare*” as alternatives to “Original Medicare.” When we prompted respondents to turn to Appendix A for a definition of “Original Medicare,” the definition was usually helpful to them.

People were more familiar with the term “Medicare supplemental policies” than the term “Medigap”

As shown in Exhibit 5, Section 2 of the mockup tells people specifically that Maple Health Plan is **not** a Medigap or Medicare supplement policy. During the interview, we asked the people we interviewed to compare Medigap or Medicare supplement policies to Maple Health Plan, to see if they understood this message. We found that the term “Medigap” was unfamiliar to most of them. Many understood the concept of a Medicare supplemental policy, and those who did were far more likely to use the term “Medicare supplement policy” than “Medigap,” and they sometimes shortened it, calling it a “supplemental.” In Tampa, people seemed to be somewhat more familiar with Medicare supplemental policies than in Long Beach, with several who commented that they themselves did not have such plans because they were more expensive. As in Long Beach, however, few had heard of the term “Medigap.”

Reactions to information about the member card

Section 2 explained that the Maple Health Plan member card was to be used in place of the red, white, and blue Medicare card. People understood this explanation, and it was clear to them from reading the EOC that they would have to pay for the full cost of services if they used their Medicare card rather than their member card. Several people thought this point about consequences should have more emphasis. As one put it, “*bold this out – that neither Maple Health Plan nor Medicare will pay – so that you can see it!*” Another person spoke from experience; she was facing payment of a very large bill because she had used the Original Medicare card instead of her member card, and wished that she had known about this beforehand. Several of the people we interviewed understood the messages in Section 2, but seemed to be strongly attached to their Original Medicare cards and were hesitant to stop carrying them. One caregiver remarked that the beneficiary she cared for “*won’t let go of her Medicare card. It’s easy enough for a caregiver to understand [about the cards], but I wouldn’t want to be the one to explain it to her.*”

Exhibit 6 below shows the sample member cards included in Section 2 of the mockups we tested. For realism, the sample cards were modeled after real member cards, but the names and codes were all fictitious. Overall, participants liked seeing the sample Maple Health Plan card in the booklet, but results from Round 1 testing showed that the sample card itself needed some fine tuning. In Round 1, a few people took the sample too literally, as representing an actual card, rather than as a generic example to show what the card looks like. One woman tried to figure out the meaning of the

codes on the card, and decided that the “Medical plan copay code A” had to do with Medicare Part A. As shown in Exhibit 6, the sample card was changed for Round 2 of testing to make it look more like a generic sample card.

EXHIBIT 6. Comparing the sample member cards in Round 1 and Round 2 mockups.

ROUND 1:

Your plan membership card

Now that you are a member of Maple Health Plan, you have a Maple Health Plan membership card. Here is a sample card to show what it looks like:



ROUND 2:

Your Maple Health Plan membership card

Now that you are a member of Maple Health Plan, you have a Maple Health Plan membership card. Here is a sample card to show what it looks like:



SAMPLE CARD

Reactions to Section 3 (Getting the care you need, including some rules you must follow)

General impressions

Overall, the people we interviewed seemed to understand the main points in Section 3 with relative ease. As we describe below, when people did have trouble with this section, it was generally related to unfamiliarity with or confusion about a few key terms that are related to managed care.

Reactions to the term, “plan providers”

The term, “plan providers,” was challenging for a number of the people we interviewed. It appeared that very few people already had this term as part of their own everyday vocabulary. Exhibit 7 below shows how this term was explained in Section 3.

EXHIBIT 7. Beginning of Section 3 (version shown is from Round 2; there were very few changes from Round 1 to Round 2).

SECTION 3 **Getting the care you need, including some rules you must follow** (using plan providers to get your covered services, choosing your PCP, getting care from specialists, when you do and do not need a referral from your PCP, changing doctors, getting care when the doctor’s office is closed, Maple Health Plan’s service area, getting care when you are traveling or outside the service area)

You will be using “plan providers” to get your “covered services”

“**Providers**” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services.

- We call them “**plan providers**” when they are part of Maple Health Plan.
- We call them “**non-plan providers**” when they are **not** part of Maple Health Plan.

When we say that plan providers are “part of Maple Health Plan,” this means that we have arranged with them to coordinate or provide covered services to members of Maple Health Plan. “**Covered services**” is the general term we use in this booklet to mean all of the health care services and supplies that are covered by Maple Health Plan. Covered services are listed in the Benefits Chart in Section 6.

Now that you are a member of Maple Health Plan, **you must use plan providers to get your covered services**. As we explain below, you will have to choose one of our plan providers to be

your PCP, which stands for Primary Care Provider. Your PCP will provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies.

Most people seemed to understand the definition of “providers” shown in Exhibit 7 above. One respondent remarked that he had not previously known that plan providers could include hospitals and pharmacies.

While the basic definition of a provider seemed understandable to people, it was hard for some of them to keep its meaning in mind and to apply their understanding of it as they continued reading. For example, some who had learned the meaning of “plan providers” from the description in the EOC forgot when they read a later section, or became confused when they encountered the distinction between “plan providers” and “non-plan providers” shown in the bullet points in Exhibit 7. Some people thought that “plan providers” meant the same thing as “Maple Health Plan;” they had no sense of the business relationship between a health plan and its providers. Nonetheless, those who read the portion of the EOC shown in Exhibit 7 generally understood the concept of “plan providers” as a restricted network, though it was sometimes hard to tell how much of this understanding may have stemmed from personal experience with managed care.

As shown above in Exhibit 7, the explanation of plan providers includes the following sentence: “When we say that plan providers are “part of Maple Health Plan,” this means that we have arranged with them to coordinate or provide covered services to members of Maple Health Plan.” In our interviews, we asked people if they thought there was any difference between “coordinate” and “provide.” Overall, people seemed to grasp the basic meaning and did not seem troubled by the use of the two words. However, they differed in their interpretation of the two terms. For example:

- *“To coordinate is to provide... to me, I guess they would be the same thing.”*
- *“Aren’t they the same? They coordinate or provide covered services. They may have to coordinate with someone else... rather than to just provide. I don’t quite understand that one. As long as you’re covered I don’t think it matters.”*
- *“Well, ‘provide,’ that’s a commitment, a very strong committing word. You’re going to provide something, so you give your word. ‘Coordinate,’ that’s kind of a ‘let’s hope everybody’s there to put it together.’ So, I don’t like the word ‘coordinate.’ Kind of makes me think I’m going to be on the phone.”*

Reactions to other terms and concepts covered in Section 3

The term “covered services” was generally understood and worked quite well for nearly everyone we interviewed. One respondent thought it referred to only the most basic of services, or to those services covered under Original Medicare.

Section 3 included information about the role of a PCP and the need to choose one, and it mentioned the provider directory as a resource for members. Respondents appreciated having the

term, “PCP,” defined multiple times. One person commented, “I wouldn’t know what that meant—it helps to see that spelled out.” A number of respondents were quite interested in the topic of PCPs and some wanted the EOC to include more specific information about PCPs, how to choose them, and what happens if they leave the plan. Curious about how to change PCPs, one respondent turned to “Section 12 - Disenrollment: leaving Maple Health Plan and your choices for continuing Medicare after you leave” in order to find out.

When respondents saw the term “Provider Directory” in the EOC, they generally recognized it immediately. Most people had a concrete sense of what it was, often mentioning, unprompted, that it was the “list of doctors” that members of Maple Health Plan must choose from. Others wondered whether the provider directory would give details of which specific hospitals and pharmacies were included in Maple Health Plan’s network, or whether it would give more specific office information, such as the hours of business.

One caregiver we interviewed expressed doubt about how current the provider directory information would be. She told how she had called numerous providers listed in a directory and found that many of them were either no longer taking new patients or had dropped out of the network. She felt that the EOC should alert people to this possibility, perhaps telling them to check with member services when choosing a doctor to verify the status of providers on the list.

As shown in Exhibit 8 below, Section 3 included a summary of some of the beneficiary rights that are covered more fully in Section 5. One respondent had trouble comprehending these statements, and while others appeared to understand that these statements offered them protection, the concepts seemed to remain abstract to them. The term, “timely access,” in this summary caught several people’s attention, and they were interested in what exactly was meant by a “reasonable period of time.” This same phrase appears again later in the booklet in Section 5 on rights and responsibilities. One respondent who noticed it there also wanted a better definition: “*What is a ‘reasonable’ amount of time? You can’t pin the timeframe down [from the language].*” Despite the vagueness that troubled these respondents, the explanation did not seem problematic to most people.

EXHIBIT 8. Excerpt from Section 3 about Getting the care you need (Round 2 mockup).

As explained in Section 5, you have the right to get timely access to plan providers and to all services covered by the plan. (“Timely access” means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. The Medicare program does not allow us to have any rules that could keep your doctors from telling you what you need to know about your treatment choices. Also, the Medicare program does not allow us to pay our doctors in a way that would keep them from giving you the care you need. As explained in Section 5, you have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 5 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

While a few people mentioned “self-refer” as being a new word to them, it appeared to be sufficiently self-explanatory, particularly within the context of the section which explained, “there are some services you can get on your own, without a referral.” However, one woman did wonder if she would be able to get the same quality of services through self-referral.

Section 3 explains the meaning of the term, “service area.” While the term itself was unfamiliar to many people we interviewed, they seemed to understand the definition and the general concept of a service area fairly well. However, several people tended to equate “being outside of the plan’s service area” with being out of state or with long-distance travel.

Reactions to Section 4 (Getting care if you have an emergency or urgent need for care)

Many readers had trouble distinguishing between an “emergency” and “urgently needed care”

Section 4 is a very short section that gives definitions of “emergency” and “urgently needed care” and explains the coverage for each. Exhibit 9 shows the first part of this section, that includes the definition of an “emergency” and Exhibit 10 that follows shows a later part of this section with the definition of “urgently needed care.” Both exhibits compare the wording tested in Round 1 and Round 2.

EXHIBIT 9. Comparing text in the Round 1 and Round 2 mockups for the first part of the section on emergency care and urgently needed care

ROUND 1:

Getting care if you have an emergency

You are covered for emergency medical care whenever you need it, anywhere in the United States. Ambulance services are covered in situations where other types of transportation would endanger your health.

What is a “medical emergency”?

A “medical emergency” is when you believe that your health is in serious danger – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have an emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your PCP or other plan provider.** (Section 3 tells about your PCP and plan providers.)
- Make sure that your PCP knows about your emergency, because your PCP will need to be involved in following up when the emergency is over. You or someone else should call to tell your PCP about

your emergency care as soon as possible, preferably within 48 hours. The number to call is on your Maple Health Plan membership card.

ROUND 2:

What is a “medical emergency”?

A “medical emergency” is when **you believe that your health is in serious danger** – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What is covered if you have an emergency?

- You are covered for emergency medical care whenever you need it, anywhere in the United States.
- **Ambulance** services are covered in situations where other means of transportation would endanger your health.

What should you do if you have an emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your PCP (Primary Care Provider) or other plan provider.** (Section 3 tells about your PCP and plan providers.)
- Make sure that your PCP knows about your emergency, because your PCP will need to be involved in following up on your emergency care. You or someone else should call to tell your PCP about your emergency care as soon as possible, preferably within 48 hours. The number to call is 1-800-666-7777.

EXHIBIT 10. Comparing text about urgently needed care in the Round 1 and Round 2 mockups

ROUND 1:

What is “urgently needed care”?

“Urgently needed care” is care you need for a sudden illness or injury that is *not a medical emergency*. As explained above, a “medical emergency” is when you believe that your health is in serious danger. **“Urgently needed care” is when you need medical attention right away, but your health is not in serious danger.** As we explain below, how you get this care depends on whether you need it when you are inside or outside of the plan’s service area (Section 3 tells about the plan’s service area).

ROUND 2:

What is “urgently needed care”?

“Urgently needed care” is **when you need medical attention right away for a sudden illness or injury, but your health is *not* in serious danger**. As we explain below, how you get “urgently needed care” depends on whether you need it when you are in Maple Health Plan’s service area, or outside the plan’s service area. Section 3 tells about the plan’s service area.

(The difference between an urgent need for care and an emergency is in the danger to your health. It’s “urgently needed care” if you need medical help immediately, but your health is not in serious danger. It’s an “emergency” if you believe that your health is in serious danger).

Results from the first round of testing showed that a number of people had trouble knowing where to draw the line between what would constitute an “emergency” and what would be considered “urgently needed care.” In reacting to the definitions, some people talked about specific situations. A few respondents suggested that a broken leg might constitute urgently needed care, while others pointed out that in some situations, the symptoms for emergency and urgently needed care could be identical. One respondent who was more comfortable with the definitions described them as differing in terms of the “*expectation of where you’ll end up [in the hospital or at home].*” Others summarized urgently needed care as “*any situation where the patient is not incapacitated,*” and “*when you need to see a doctor and don’t want to wait for an appointment.*”

The results from Round 1 showed that respondents were confused by a reference to a previous definition of emergency care that was embedded in the paragraph containing the definition of urgent care. The sentence that caused the confusion is shown below (it is the middle sentence of the three that follow): “Urgently needed care’ is care you need for a sudden illness or injury that is *not a medical emergency*. As explained above, a ‘medical emergency’ is when you believe that your health is in serious danger. **‘Urgently needed care’ is when you need medical attention right away, but your health is not in serious danger.**” As shown in the bottom part of Exhibit 10 above, this sentence was deleted before the last round of testing, and several other changes were made to respond to readers’ reactions in Round 1. These included consolidating the two-sentence definition of “urgently needed care” into a single sentence, and adding an explicit comparison of “emergency” and “urgently needed care” in parentheses at the end.

As shown in Exhibit 11 below, Section 4 acknowledges that it may be hard to distinguish between a genuine emergency and an urgent need for care, and tells about the coverage that applies if it turns out that it was not really an emergency.

EXHIBIT 11. Comparing text about coverage if it is not an emergency in round 1 and round 2 mockups.

ROUND 1:

What if it wasn't really an emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care, and the doctor may say that it was not really an emergency. If this happens to you, we will cover all of the care you got up to the point that a doctor says it was not an emergency. We will also cover any *additional* care you get *after* the doctor says it was not an emergency, as long as you get it from a plan provider. If you get any additional care from a *non-plan provider* after the doctor says it was not an emergency, we will usually not cover the additional care. Here is an exception: we will cover the additional care from a non-plan provider if you are out of our service area as long as the additional care you get meets the definition of “urgently needed care” that is given below.

ROUND 2:

What if it wasn't really an emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care -- thinking that your health is in serious danger -- and the doctor may say that it was not an emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, and whether or not it was an emergency (as long as you thought your health was in serious danger).

- If you need additional care after the doctor says it was *not* an emergency, **we will cover the additional care if you get it from a plan provider.**
- If you get any additional care from a *non-plan provider* after the doctor says it was not an emergency, we will usually *not* cover the additional care. Here is an exception: we will cover the additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that is given below.

Respondents differed in their understanding of this reassurance. Those who read the section more closely tended to have a better understanding. Especially in Round 1, some people believed that they would be responsible for the full cost of the services if it turned out that it was not really an emergency, a thought that made them uneasy. As shown in Exhibit 11 above, the rules for coverage of follow-up care after the immediate emergency are complex. People had some trouble understanding these rules that involve the type of provider and whether they were in or out of the plan's service area. As shown in the bottom part of Exhibit 11, this part of the mockup was revised

and reformatted with bullet points and bolding to try to clarify and emphasize some of the information that was confusing to people in Round 1.

Reactions to information about coverage of ambulance services

As shown in Exhibit 9 above, ambulance services are mentioned in the second sentence of the mockup that was tested in Round 1. In our interviews, several readers overlooked this sentence altogether. As one of the more skilled and careful readers we interviewed remarked, *“Isn’t it funny. But I completely went right over that sentence.”* Revisions done before the second round of testing drew more attention to this topic by making the sentence into a bullet and bolding the word “ambulance” (see the bottom part of Exhibit 11). Most respondents had no trouble envisioning “other types of transportation,” and gave examples such as taking a taxi or being driven by a family member or friend. Several people believed that ambulance coverage was guaranteed provided the medical situation was in fact an emergency. One woman suggested that the booklet explain more explicitly that ambulance services may not be covered under certain circumstances.

Other reactions to Section 4

The part of Section 4 that tells about coverage for urgently needed care when a member is outside the plan’s service area includes several sentences that contain the words, “we prefer.” These sentences are shown in Exhibit 12 below. A couple of respondents commented that the use of the word “prefer” in this section was ambiguous. They wanted to know, *“do I have to get care from a plan provider?”*

EXHIBIT 12. Excerpt from Section 4 that includes sentences that contain the words, “we prefer” (this excerpt is from the mockup used in Round 1; highlighting is added to identify the use of “we prefer”)

If you get emergency medical care while you are *outside* the plan’s service area, **we prefer** that you return to the service area to get your follow-up care from plan providers. However, we will cover services you get outside of our service area as long as the care you need still meets the definition for either a “medical emergency” or “urgently needed care.”

Another paragraph from later in the section:

If you need urgent care while you are outside the plan’s service area, **we prefer** that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the service area, **we prefer** that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan’s service area as long as the care you are getting still meets the definition of “urgently needed care” that is given above.

Reactions to the section about member rights and responsibilities

People liked the detailed explanation of their rights

The model EOC contains a separate section on member rights and responsibilities that was tested in Round 1 only. Overall, participants were generally pleased by what they read in this section. Many seemed vaguely aware that they had some rights (or assumed that they did). A few people remarked that they had never paid much attention to this topic before or had never seen their rights spelled out in such detail. A number of people commented on learning something new by reading this section, including a couple of the most knowledgeable people we interviewed.

The phrase, “you have the right” was repeated many times in this section, in the course of describing a number of specific beneficiary rights. During the interview, we asked people if they had noticed the repetition of this phrase, and if so, about their reaction to it. Most people we interviewed were not bothered by this repetition, and in fact, a number of them said they liked it. One respondent remarked that “*seeing ‘you have the right’ makes you feel good,*” and another described some of the rights as “*enlightening*” and mentioned that she “*better go crack open that little booklet [EOC] at home.*”

A couple of people admitted that they had a negative reaction to the topic of member rights and responsibilities, but changed their mind as they read the section. The dialogue between respondent and interviewer shown below gives an example:

Respondent: *I always hate these parts: Rights and Responsibilities.*

Interviewer: *Actually, before you go ahead and read the section, can you tell me a little bit more about how you hate these parts, the rights and responsibilities. What do they indicate to you?*

Respondent: *Your rights, which are, you know, what you’re entitled to. And your responsibilities in order to get these rights. So, I don’t know, this is the part you need to read so you don’t mess up. It just scares you a little when you start reading it.*

Later on, after reading some of the section:

Respondent: *Actually, that makes it pretty nice.....that’s easy, that shows you right there that they’re not going to be upset if you call up with a legitimate complaint.*

One man who was expecting responsibilities to be stressed more than rights was surprised and pleased to see that the opposite was true. One respondent appreciated that member rights were listed first and described in much greater detail than member responsibilities (which was a very short list at the end of the section). He used the example of the city’s metro transit rights and responsibilities he had seen posted at train stations which stressed passenger responsibilities above and beyond passenger rights, and said he was impressed that the booklet did not follow this pattern.

While most people liked the full explanations and didn’t mind repetition of the phrase “you have the right,” there were a few who thought the section could be shorter. One person thought the section should be shortened into “*one paragraph that covers all of it, instead of [covering each right in*

separate paragraphs]. I don't know how to tell you to do this, I'm just saying that it seems like you are going over things a lot, to me. But I'm not the most patient person on earth so that could make the difference right there too, you know."

Reactions to specific rights and terminology in Section 5

Several of the people we interviewed singled out the right to language interpretation services as important information, and one person felt that it deserved more emphasis.

Exhibit 13 below shows a paragraph from Section 5. Some of the people we interviewed were surprised to see a reference to the Office for Civil Rights in the booklet. One respondent noticed it and remarked that "*things are getting heavy.*" Another said that she had never heard of the Office for Civil Rights getting involved in medical rights disputes before. Overall, the reaction of those who commented was favorable; they thought it was good information to have.

EXHIBIT 13. Excerpt from Section 5 on member rights and responsibilities, mentioning the Office of Civil Rights (from mockup tested in Round 1).

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on the situation:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, call the Office for Civil Rights at (909) 222-0000.
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Maple Health Plan Member Services at the number on the cover of this booklet. You can also get help from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in California, which is called the HICAP.)

A number of respondents made remarks about specific rights that were described in this section. Many commented favorably on the right to confidentiality of medical records and personal health information and on the right to get full information about treatment choices and to participate in decision making. While respondents generally assumed that they had some protection of their privacy and some influence on their own care, they were surprised at some of what they read in the booklet. Several people were pleased to read about the right to get a copy of their own medical records. Another respondent was surprised to read that he had the right to get information from his health plan. He commented, "*Many of these rights are logical, but I was not aware of them.*"

People reacted positively to reading about their right to hear about all of their treatment choices and participate in decisions about their care. Many of them shared their own experiences, and a few discussed implications of this right. Here are some examples of their comments:

- *“Most doctors don’t tell you anything. They just say, take this....not having dealt with doctors that much, I don’t even know which questions to ask.”*
- *“This is great. You **should** have the right to decide what you want. Of course, if you’re not able to then that’s a different story. Whoever’s in charge of you should be able to make the decisions.”*
- *“‘You have the right’” makes me think that I can decide what I want to do and how I want it done.”*
- *“You have the right to full information—what is this? All I know is my right to choose a doctor; no one ever asks me what my rights are.”*
- *“Say you go to a doctor and say, “Hey Doc,” and doctor gives a diagnosis. You might have a choice[maybe of] a certain medication that costs more than the other medication.Well, I know I have a right to [hear about treatment choices], but they don’t have to give you that [more expensive treatment]. It depends on economic conditions-- they can give you alternative treatment.”*

Respondents also noticed the advance directive information and were additionally pleased to have a definition listed in the section. One respondent also suggested that this section on rights and responsibilities should tell about a patient’s right to seek a second opinion about his or her condition.

Reactions to the section with the benefits chart

In Round 2 of testing, we sought readers’ reactions to the introductory part of the section with the benefits chart. We also asked a few questions about several parts of the chart to check on navigation and comprehension of the way that certain types of coverage and costs of care were described in the chart.

Exhibit 14 below shows the introductory part of the benefits chart section.

EXHIBIT 14. Excerpt showing part of the introduction to the benefits chart (from the mockup tested in Round 2).

SECTION 6 Benefits Chart – a list of the covered services you get as a member of Maple Health Plan (introduction, conditions that apply to getting covered services, a chart that lists covered services)

What are “covered services”?

This section describes the medical benefits and coverage you get as a member of Maple Health Plan. **“Covered services” means the medical care, services, supplies, and equipment that are covered by Maple Health Plan.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 7) tells about **services that are *not* covered** (these are called “exclusions”). Section 7 also tells about **limitations** on certain services.

There are some conditions that apply to getting covered services

Some general requirements apply to *all* covered services

The “covered services” listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- In order to be covered, the Medicare coverage guidelines must be met.
- In order to be covered, the medical care, services, supplies, and equipment that are listed as “covered services” must be medically necessary or be a *covered* preventive care service (such as the screening tests that are listed in the Benefits Chart). (See Appendix A for a definition of “medically necessary.”)
- With few exceptions, covered services must be provided by plan providers, or approved in advance by plan providers, in order to be covered. The exceptions are emergency care, urgently needed care, and renal (kidney) dialysis you get when you are outside the plan’s service area.

In addition, some covered services require “prior authorization” in order to be covered

Some of the “covered services” listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets “prior authorization” (approval in advance) from Maple Health Plan. Covered services that need prior authorization are marked in the Benefits Chart.

Confusion about the requirements that apply to covered services

Many of the people we interviewed were puzzled or perplexed about one or more of the bullet points in the list of general requirements that apply to all covered services shown in Exhibit 14. The phrase, “Medicare coverage guidelines must be met,” that appears in the first bullet point triggered some confusion because it was an unfamiliar term and was unexplained. Unclear on what was meant by “Medicare coverage guidelines,” people’s interpretations ranged from general guidelines set by Maple Health Plan to additional requirements that the beneficiary would have to meet in order to receive covered services. One respondent wondered, *“if I have this booklet, it means that I have met the requirements to be in this plan. What other requirements are there that I have to meet?”* Another laughed when he read the term and said *“You know, it just seems like it keeps going round and round, and it just creates more doubt. You know here it says Section 7 limitations, and then over here it tells the services,...and it just doesn’t seem clarify it too much.”*

The second bullet point also caused problems for some respondents, due in part to confusion about the meaning of the terms, “medically necessary” and “preventive care.” Several people understood “medically necessary” to mean whatever their doctors felt was necessary for them. Another respondent described her impressions of “medically necessary” as *“I’ve got to really need to be treated – I gotta be real sick.”* The longer definition of “medically necessary” located in the Appendix A was helpful to most people who read it, though it created more confusion for one respondent. When he read the part that said such services “are not mainly for the convenience of you or your doctor,” he felt that a service that would be provided mainly for the convenience of his doctor sounded like it had *“diagnostic reasons.”*

While many of the people we interviewed seemed to understand the terms, “preventive care” and “screening test,” these were unfamiliar and difficult terms for some people. One person who misread “preventive” as “preventing” struggled to figure out what “preventive care” might mean: *Preventing.... like preventing care. That’s like taking something from you. Is it a word I can look up for this? Is it because it must be medical necessary to be covered? Preventing care service. You have to [have] something really wrong with you to be covered under that preventing care service. You know, before [it becomes] necessary for them to screen you to see what’s wrong.”* Another respondent guessed that preventive care meant *“a preventing or conditioning program, like weight management for diabetes and heart conditions....Screening tests might be related to preventive care by seeing if you are physically able to do the preventive care.”* Sensing that he might not have an accurate idea of a screening test, he looked to Appendix A for the definition. When it was not there, he suggested it should be added, since *“quite a bit is made of the screening tests, and I’m not sure I have the right definition.”*

The final bullet point also caused problems for a couple of people. Reacting to the first sentence of this bullet that reads, “With few exceptions, covered services must be provided by plan providers, or approved in advance by plan providers, in order to be covered,” one person wondered, *“which one is it? Does it have to be provided by plan providers or [does it have to be] approved in advance?”*

Can your benefits change during the year?

Exhibit 15 below shows how the booklet explained possible changes in benefits during the calendar year. Several respondents who read the passage shown in Exhibit 15 concluded that the prescription drug benefit could not be decreased during the year. One person who misinterpreted it the first time he skimmed it felt that the specifics on changes to the formulary were buried in the paragraph and easily overlooked. Another read the statement aloud, “Except for the drug formulary, we cannot *decrease* your benefits during the calendar year,” and misunderstood it, thinking that the drug formulary could not be changed in a way that would result in a decrease in drug benefits. The passage was also hard for people to understand if they were not familiar with the term “formulary” and its meaning.

EXHIBIT 15. Excerpt showing part of the introduction to the benefits chart (from the mockup tested in Round 2).

Can your benefits change during the year?

The Medicare program has rules for Maple Health Plan about when and how we can make changes in your benefits:

- **We can *increase* your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, 2003). If we decide to increase any of your benefits during the calendar year, we will let you know in writing.
- The Medicare program allows us to make changes in our prescription drug formulary at any time during the calendar year. As we explain in Section 8, the formulary is a list of drugs. A change in our drug formulary could affect how much you have to pay when you fill a covered prescription. If the formulary changes, you might pay less or you might have to pay more, depending on the particular change. Note that the formulary applies only to the covered services listed in the Benefits Chart under the heading that says, “Maple Health Plan Prescription Drug Benefit (outpatient prescription drugs).” The formulary does *not* apply to the covered services listed in the Benefits Chart under the heading that says, “Drugs that are Covered under Original Medicare (these are the drugs that are covered for everyone with Medicare)”.
- **Except for the drug formulary, we cannot *decrease* your benefits during the calendar.** We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits.
- We will tell you in advance (in October 2003) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2004.

Looking up information in the benefits chart

The order in which the covered benefits were listed made it more difficult for people to find information on specific services (Exhibit 2 shows how they were listed). Several looked to see whether they were organized alphabetically (they are not), and were frustrated at not being able to figure out the system. People typically searched through the chart by flipping through the pages rather than by referring back to the Table of Contents. People who read the chart were generally able to figure out information on copayments and deductibles for a particular row of services. However, the services themselves at times confused or sidetracked people, particularly the chart sections on “Drugs that are covered under Original Medicare” and the “Maple Health Plan Prescription Drug Benefit,” where the names of the services sounded highly technical or were difficult to pronounce. Issues pertaining to coverage of prescription drugs are discussed in detail in the section entitled “Reactions to the section on prescription drugs and the rows in the benefits chart that tell about coverage for drugs” on [page 38](#).

Confusion about the meaning of “benefit period”

The term “benefit period” caught the attention of a number people who wondered how long it was. Besides appearing in several places within the benefits chart, the term “benefit period” appears in Section 9 (about hospital care, skilled nursing facility care, home health care, and other services). Regardless of where respondents encountered this term within the booklet, they tended to be perplexed by its definition. Exhibit 16 below shows how the benefit period was defined in Section 9 and in Appendix A, which gives definitions of certain words used in the booklet. When respondents read the definition of “benefit period” in either Appendix A or Section 9, they struggled with the concept for some time before giving up on comprehending it. Even the most sophisticated readers we interviewed were unable to feel confident that they had grasped the meaning of “benefit period.”

The most confusing part of the definition seemed to be the description of when the benefit period ends: “The benefit period ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a hospital nor an inpatient of a skilled nursing facility (SNF).” A few ventured that the benefit period was either 60 or 100 days, but seemed to be uncomfortable with those guesses. One person asked the question, “*would the benefit period start with a hospital stay or a skilled nursing facility stay if you stayed in both in a row?*” Others expressed more frustration, such as the man who commented: “*This part’s written for lawyers, not your average person. That’s as far as I’ll ever get with it.*” Another said, “*if I was in a hospital [trying to figure this out], I’d say ‘just kill me.’*”

EXHIBIT 16. Definitions of the “benefit period” (as shown in Round 2 mockup).

As shown in Section 9:

What is a “benefit period” for hospital care?

Maple Health Plan uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A “**benefit period**” begins with the first day of a Medicare-covered inpatient hospital or skilled nursing facility stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a hospital nor of a skilled nursing facility (SNF). (Later in this section we explain about skilled nursing facility services). As shown in the Benefits Chart in Section 6, you must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

As shown in Appendix A (this Appendix gives definitions of selected terms):

Benefit Period – For both Maple Health Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* with the first day of a Medicare-covered inpatient hospital or skilled nursing facility stay. The benefit period *ends* with the close of a period of 60 consecutive days during which you were neither an inpatient of a hospital nor an inpatient of a skilled nursing facility (SNF). There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays:

- You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must have required skilled services on a daily basis and received daily skilled services that could, as a practical matter, only have been provided in a SNF on an inpatient basis. (Section 9 tells what is meant by “skilled services.”)
- Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Reactions to the section on prescription drugs and the rows in the benefits chart that tell about coverage for drugs

Background

Most topics covered in the EOC are very similar from plan to plan, and the language in the model EOC for these topics can be used with only minor modifications to create a customized EOC. The language that describes prescription drug coverage is an exception. The prescription drug benefit is an optional additional benefit, and the way this benefit is structured differs enormously among the M+C plans that offer it. To accommodate the wide range of variation in prescription drug benefit design, the model EOC language for this topic allows for many variations in the most common features including use of a formulary, distinctions between generic and brand-name drugs, multiple levels of copayments and/or coinsurance that include mail order options, and a benefit maximum that can be applied for different time periods and for different categories of drugs.

When we prepared for the Phase 2 consumer testing, we had to design a fictitious prescription drug benefit to include in the Maple Health Plan mockup of the EOC. To maximize the opportunity to test as much of the draft language as possible, we gave Maple Health Plan a fairly complex prescription drug benefit that included a formulary, a mail order option, several copayment levels, and an annual benefit maximum. Since we wanted to get reactions to this language from some people who had prescription drug benefits of their own, we selected Long Beach and Tampa as sites for Phase 2 testing based in part on the widespread availability of M+C plans that offered a prescription drug benefit.

When participants did have prescription drug coverage through their own Medicare HMO, interviewers asked some questions about this coverage before turning to the section on prescription drugs in the booklet. These questions covered such topics as how much they had used the benefit, what types of drugs were covered, how much they usually had to pay when they filled a prescription, and whether there was a limit or maximum amount for this coverage. When people mentioned terms such as “copayment,” or “generic drugs,” interviewers probed to see what these terms meant to them. By discussing people’s own coverage before turning to the text in the booklet, we were able to get a sense of their baseline knowledge about common terms and the rules that apply to prescription drug benefits, and compare this baseline knowledge to their reactions after reading the booklet.

Overall reactions to the information about drug coverage

Respondents were very interested in the content of the prescription drug section. As they read about the Maple Health Plan benefit, they often shared their own personal experiences with prescriptions and drug benefits. Those with prescription drug coverage sometimes compared their own coverage to the coverage described in the booklet. Overall, people liked the way the section described the prescription drug benefit, and a number of them commented that it was easy to read and understand. One respondent said that it was very easy to read and that the section was laid out well and thoroughly explained prescription drug coverage. Some of those with prescription drug coverage

through their own plan said the booklet was easier to understand than the materials they had received about their own benefit.

A few people noted that they had learned something new by reading this section, or had identified and cleared up a misunderstanding (such as a mistaken impression of the differences between brand-name and generic drugs). They liked the diagram in this section and said it helped them understand the copayments and the yearly limit on the drug benefit. While the overall reaction to this section was positive, there was one major area of confusion concerning drug coverage under Original Medicare. As we explain below, most of the people we interviewed did not seem to think of Original Medicare as covering any drugs, and they were surprised and confused by seeing information about this in the benefits chart and in the introduction to the section on prescription drugs. (Besides covering drugs administered in the hospital, Original Medicare covers a very small number of drugs that are self-administered or provided in outpatient settings, such as certain cancer drugs. Drug coverage for Original Medicare and the plan's prescription drug benefit are mentioned separately in the benefits chart because the cost sharing can differ.)

How drug coverage was described in the benefits chart

The benefits chart in the model EOC has separate descriptions of drug coverage under Original Medicare, which applies to all M+C plans, and the plan's prescription drug benefit, which applies only to the M+C plans that offer this optional additional benefit. Both of these descriptions were included in the mockups we tested. The two exhibits below show the drug coverage portions of the benefits chart. Beginning on the next page, Exhibit 17 shows what we tested in Round 1. Exhibit 18 that follows shows the revised version that we tested in Round 2.

EXHIBIT 17. Entry in Benefits Chart about drug coverage (Round 1).

Covered Services	What You Pay for Covered Services
<p>Drugs</p> <p>See Section 7 for more information.</p> <p>(We are using the word “drugs” in a general way to include certain “biologicals” that are used in medical treatment. “Biologicals” are substances that are naturally present in the body, such as blood clotting factors and insulin.)</p> <p><i>The following are covered under Original Medicare:</i></p> <p>Drugs and biologicals that usually are given to patients by health professionals rather than taken by patients on their own;</p> <p>Drugs you take using durable medical equipment that was authorized by Maple Health Plan. (See Appendix A for a definition of “durable medical equipment,” which is reusable equipment ordered by a doctor for use in your home).</p> <p>Clotting factors if you have hemophilia;</p> <p>Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare;</p> <p>Injectable drugs for the treatment of osteoporosis, if you are confined to your home and cannot give yourself the drug;</p> <p>Antigens;</p> <p>Certain oral anti-cancer drugs and anti-nausea drugs; and</p> <p>Erythropoietin that you take on your own, if you are a home dialysis patient.</p> <p><i>The following are covered under the Maple Health Plan prescription drug benefit:</i></p> <p>Outpatient prescription drugs, as described in Section 7.</p>	<p><i>For drugs covered under Original Medicare:</i></p> <p>There is no copayment and no coinsurance for drugs covered under Original Medicare.</p> <p>There is no yearly limit on the drugs covered under Original Medicare.</p> <p><i>For drugs covered under the Maple Health Plan prescription drug benefit:</i></p> <p>Section 7 tells what you pay for covered prescriptions and rules you must follow to have prescriptions covered.</p> <p>There is a \$600 yearly limit.</p>

EXHIBIT 18, part 1. Entries in Benefits Chart about drug coverage (Round 2)

Covered services

**What you must pay
when you get these
covered services**

Drugs that are covered under Original Medicare
(these drugs are covered for everyone with Medicare)

\$ 0

“Drugs” includes substances that are naturally present in the body, such as blood clotting factors and insulin.

There is no benefit limit on these drugs covered under Original Medicare.

Your covered services include the following drugs that are covered under Original Medicare:

Drugs that usually are not self-administered by the patient.

Drugs you take using durable medical equipment (such as insulin pumps) that was authorized by Maple Health Plan. (See Appendix A for a definition of “durable medical equipment,” which is reusable equipment ordered by a doctor for use in your home).

Clotting factors if you have hemophilia.

Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.

Injectable drugs for the treatment of osteoporosis, if you are confined to your home and cannot give yourself the drug.

Antigens.

Certain oral anti-cancer drugs and anti-nausea drugs.

Erythropoietin that you take on your own, such as if you are a home dialysis patient.

As shown in the list above, the drugs covered under Original Medicare are generally drugs that must be administered by a health professional, and coverage is very limited for outpatient prescription drugs. In addition to the drugs listed here that are covered under Original Medicare, Maple Health Plan offers an outpatient prescription drug benefit. This outpatient prescription drug benefit is described below, in the next row of this chart.

EXHIBIT 18, part 2.

Covered services

**What you must pay when
you get these covered
services**

**Maple Health Plan Prescription Drug Benefit
(outpatient prescription drugs)**

“Drugs” includes substances that are naturally present in the body, such as blood clotting factors and insulin.

The Maple Health Plan prescription drug benefit covers the following:

Certain outpatient prescription drugs, as described in Section 8. (Section 8 explains about rules you must follow to have prescriptions covered and tells about drugs that are not covered by this benefit.)

This benefit provides additional drug coverage that goes beyond what is covered under Original Medicare for everyone with Medicare (drugs covered by Original Medicare are described just above in this Benefits Chart).

Your copayment for a covered prescription ranges from \$5 to \$40, depending on the drug and whether you get it from a plan pharmacy or from our mail order service.

We pay up to a maximum of \$1,000 for your covered prescriptions in a calendar year.

Section 8 gives you the details about copayments and the benefit maximum.

How the two types of drug coverage were explained in the introduction to the section on prescription drugs

In the EOC, a separate section on prescription drugs gives the details about the plan’s outpatient prescription drug benefit. The introduction to this section on prescription drugs makes reference to the information about drug coverage that is in the benefits chart, distinguishing between the limited drug coverage for all beneficiaries that is part of Original Medicare (described only in the benefits chart), and the plan’s additional prescription drug coverage (described in the benefits chart and in this separate section). The two types of coverage are handled separately because the rules and cost sharing differ and because the prescription drug benefit is optional.

The exhibit that follows shows how these two types of drug coverage were explained at the beginning of the section of prescription drugs.

EXHIBIT 19. Comparing the introductory part of the section on prescription drugs in Round 1 and Round 2 mockups.

ROUND 1:

Your benefits as a member of Maple Health Plan include the drugs that are covered by Original Medicare. Most of these drugs must be given to you by a health professional, such as drugs you are given in a hospital or skilled nursing facility. There is *no* maximum limit for drugs that are covered by Original Medicare. To get more information about the drugs covered by Original Medicare, see the Benefits Chart in Section 6 under the heading, “Drugs”.

As a member of Maple Health Plan, you also have *additional* prescription drug coverage that is above and beyond what is covered by Original Medicare. We call this additional coverage “the Maple Health Plan prescription drug benefit.” Unlike the drugs covered by Original Medicare, there is a maximum limit on this additional coverage. The purpose of this section is to give you the details about this additional prescription drug benefit.

ROUND 2:

Introduction to the Maple Health Plan prescription drug benefit

The purpose of this section is to give the details about the Maple Health Plan prescription drug benefit. This benefit is listed in the Benefits Chart in Section 6 under the heading that says, “Maple Health Plan Prescription Drug Benefit (outpatient prescription drugs).” This benefit covers certain drugs that require a prescription and that have been approved by the Food and Drug Administration (the FDA). **This prescription drug benefit provides additional drug coverage that is separate from-- and goes beyond-- what is covered for everyone with Medicare.** (This section does *not* tell about the drugs that are covered for everyone with Medicare, such as drugs you get in the hospital and certain other drugs that are administered by a health professional. To find out about these drugs, look at the Benefits Chart in Section 6 under the heading that says, “Drugs that are covered under Original Medicare (these are the drugs that are covered for everyone with Medicare)”.)

People were confused by the distinction between Drugs covered by Original Medicare vs. the plan’s prescription drug benefit

Results from both rounds of testing showed that the concept of drugs covered under Original Medicare was difficult for people to understand. This difficulty was apparent in people’s reactions to both the benefits chart (shown in Exhibits 17 and 18) and the introductory part of the section on

prescription drugs (shown in Exhibit 19). One reason, as we discussed earlier, is that the term, “Original Medicare,” was unfamiliar to many of the people we interviewed. But the main reason for confusion was that when people we interviewed thought of “drug coverage,” they automatically tended to envision *outpatient prescription drug coverage*, rather than the type of drug coverage provided under Original Medicare, which consists largely of drugs administered during a hospital stay and a few outpatient cancer drugs. As a result, when they read any of the text in the booklet that mentions the drug coverage members have under Original Medicare, some people were quite surprised. As one put it, *“I don’t know what this means. Why would they make a statement like that?”* Another person seemed to understand Maple Health Plan drug benefits as being tied exclusively to either a hospital stay or a doctor’s visit, and another asked *“why are my drugs limited to being in the hospital? You may not be in the hospital, but you still need the drugs.”*

After looking over the list of drugs covered under Original Medicare, a few people developed the impression that the coverage was for the drugs that were absolutely necessary or that were for the most serious of health conditions. One respondent assumed that according to what she read, the health plan *“covers everything that you have to have.”*

Reactions to terminology in the benefits chart information about drug coverage

A number of people we interviewed found it hard to fully understand the description of drug benefits in the benefits chart (as shown in Exhibits 17 and 18 above). As mentioned above, besides being confused by references to drug coverage under Original Medicare, people had problems with some of the terminology used in the chart. Many of the words are technical, unfamiliar, and difficult to pronounce, such as “clotting factors,” “hemophilia,” “immunosuppressive drugs,” “antigens,” and “erythropoietin.”

As shown in Exhibit 17, the text incorporated a definition for the term, “biologicals.” Respondents varied in their reactions to the definition of “biologicals.” One person gave his reaction to the term itself: *“That’s throwing a curve... it’s a scary word, like terrorists.”* Another man read aloud the definition of “biologicals” and then shrugged, asking, *“Why do we have to know that?”* In contrast, one other participant said that including the definition was “good”: *“I didn’t know what that [word, ‘biologicals,] meant. But it gives the explanation here.”* As shown in Exhibit 18, the revised wording that was tested in Round 2 included the definition of “biologicals” without using the term itself.

As shown in Exhibits 17 and 18, the text in the benefits chart also incorporated a definition for the term, “durable medical equipment.” In contrast to the mixed reactions to the word, “biologicals,” people generally found the definition of “durable medical equipment” helpful. When we asked directly, most said they thought the level of detail was appropriate to include.

In both rounds of testing, the word “outpatient” appeared at least once in the benefits chart information about drug coverage. Testing showed that some people understood this word immediately, and others were puzzled and tried to make sense of it by studying the word. For example, one person thought that “outpatient” means *“you go to the doctor every so often.”*

Results from testing the language in the benefits chart showed that it sometimes does not work to replace a difficult word with a simpler one. As shown in Exhibit, the text in Round 1 uses the simpler words “given by health professionals” and “taken by patients on their own,” rather than saying “administered by health professionals” and “self-administered by patients.” Reactions from people we interviewed showed that the word “given” was too ambiguous for accuracy in this context, even though it was easier for people to read and to understand. Some people interpreted “given” as meaning “handed to” and one thought it meant that the drug was provided for free. As shown in Exhibit 18, the revised text we tested in Round 2 replaced the ambiguous simpler words with more precise words.

Problems with navigation in the benefits chart

People’s reactions to the layout of the benefits chart revealed some problems with navigation. In Round 1, some people failed to connect the description of benefits on the left side of the table with the information about cost sharing on the right side; the alignment of the text on both sides was too subtle a cue (see Exhibit 17). In Round 2, one woman was confused by the reference to the outpatient prescription drug benefit “described below, in the next row of this chart.” This reference comes at the end of the row of the chart that describes drugs covered under Original Medicare (see Exhibit 18, part 2), and this row happened to fall at the end of a page. The woman who was confused did not see the end of the page she was looking at as representing the end of a *row* in the chart, so she was not sure where to go for information on the outpatient drug benefit. It is also possible that she thought of “below” as referring to something that appears immediately below on the same page, rather than in the broader sense of “below” as sometime afterwards, which includes the possibility that it may appear on a subsequent page.

Reactions to terminology and concepts in the section on prescription drug benefits

We found a great deal of variation in people’s baseline understanding of both terminology and concepts related to prescription drug benefits. When we talked with those who had prescription drug coverage about their own experiences before they looked at the booklet, we found that some were very knowledgeable and others were not. Sometimes people couldn’t come up with a term or used the wrong one, but seemed to understand the concept, such as one man who understood “generic drugs” even though he called them “*genetic drugs*.” At other times, people thought they understood a concept when they did not. Quite a few people corrected their own mistaken impressions or said they had learned something new by reading the booklet. This tended to happen after they had read about the formulary and about the benefit maximum, which, as we describe below, were two of the more difficult concepts in the section.

The term “formulary” was unfamiliar and confusing to many people

Exhibit 20 below shows how the booklet we tested explained the formulary.

EXHIBIT 20. Excerpt about the formulary and generic and brand-name drugs from Section 7 on prescription drug benefits (from mockup tested in Round 2).

Maple Health Plan has a list of drugs called the “formulary”

The Maple Health Plan formulary is a list of prescription drugs (including insulin) that Maple Health Plan doctors refer to when they need to prescribe drugs. Often they prescribe drugs that are included on the formulary list, but sometimes they prescribe drugs that are not on the list. As we explain a little later, **whether a drug is on the formulary list or not affects how much you have to pay when you fill a prescription for a covered drug.**

The Maple Health Plan formulary was created by a group of doctors and pharmacists. They picked the drugs that are on this formulary list **based on how safe and effective they are, and how much they cost.** We call the drugs that are on this list “formulary drugs.” We call drugs that are *not* on the list “non-formulary drugs.” **To get a copy of the formulary list,** call Maple Health Plan Member Services at the telephone number on the cover of this booklet. The formulary is also available on the *Maple Health Corporation* web site on the Internet at www.maplehealth.com.

The formulary includes selected “brand-name” and “generic” drugs

The Maple Health Plan formulary includes selected brand-name drugs and generic drugs.

- **Brand-name drugs** are drugs that are produced and sold under the original manufacturer’s brand name.
- **Generic drugs** are produced and sold under their chemical names, rather than under the names of the companies that manufacture them. A generic drug is a lower cost version of a brand name drug. Some brand-name drugs have a generic equivalent and others do not.

Generic drugs cost less, but **generic and brand-name drugs are the same in terms of quality and how they work.** The law requires that a generic drug must contain the same amount of the same active drug ingredient as the brand-name drug. However, a generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains.

For many of the people we interviewed, “formulary” was an unfamiliar word, and a number of them struggled to even pronounce it. Common mispronunciations included “formula,” “formularity,” and “formulation.” A couple of people asked the interviewer for help with pronunciation. Reacting to first mention of this term, participants made comments such as the following:

- *“Formulary’ brings to mind formulas and Einstein.*
- *“[It means that] the pharmacies and doctors get together and they decide. ‘Formulary’ means the drugs they’re ‘familiar with,’ guessing from the name.”*

- *“Formulary’ means the formula – the amounts of medication in the prescription”* (this comment was made before reading the explanation in the booklet)
- *“Formulary’ means the drugs that they go for – the ones that fit into their plan.*
- *“Formulary’ – it’s a funny word. Doesn’t seem like the right word to use”* (He thinks “assigned drugs” or “provided drugs” would be better labels for what he refers to as the *“list of drugs you should be getting and it’s going to cost less if you get those”*)
- *“It’s what is covered – what they can prescribe”* (This respondent has seen her own doctor looking in a little book when she needs to write a prescription, and figures this little book is the formulary)

Although a few people struggled to understand the concept of a formulary, most people who read the explanation shown in Exhibit 20 found it helpful and reached a fairly good understanding of the concept. Since the term itself cause so much difficulty, the revisions after the last round of testing generally used the term “formulary list” instead of “formulary.”

During testing of this section, several people wanted more information regarding formulary changes; specifically, they wanted to know when changes would occur and how much this would affect the amount of their copayments. As one respondent commented, *“You have to pay more for prescription drugs if they’re not on the formulary but some are still covered. It’s still confusing whether they [Maple Health Plan] will or won’t pay.”*

Understanding the difference between “brand-name” and “generic” drugs

The bottom part of Exhibit 20, above, shows how the booklet explained about brand-name and generic drugs. This explanation worked well to help people understand the difference between brand-name and generic drugs. For instance, before one respondent read through the section, he thought that generic brands of drugs were impure and that brand-name drugs were pure. After reading the definition, he learned that the drug type does not reflect its purity or effectiveness, and he commented, *“I learned that generic drugs and brand-name drugs have different shapes and colors, but this is not important.”*

Understanding of copayments

Exhibit 21 below shows how the booklet described the copayments for the Maple Health Plan prescription drug benefit. To check on understanding, interviewers gave some examples and asked people to tell how much the copayment would be. Most people who read the copayment explanation carefully were able to figure out the correct answers. A few people had trouble understanding how the mail order service worked and how much drugs would cost if they got them through this service.

**EXHIBIT 21. Excerpt about copayments from Section 7 on prescription drug benefits
(from mockup tested in Round 2).**

What are your copayments?

For drugs that are included on the Maple Health Plan formulary, here are your copayments for up to a 30-day supply (or whatever other amount is the maximum for one copayment):

- **\$10 for a generic formulary drug** if you get at a plan pharmacy. If the drug is available through our mail order service, the copayment is **\$5** if you get it by mail (where the minimum order is a 60-day supply for two copayments).
- **\$20 for a brand-name formulary drug** if you get at a plan pharmacy. If the drug is available through our mail order service, the copayment is **\$10** if you get it by mail (where the minimum order is a 60-day supply for two copayments). NOTE: If you get a brand-name formulary drug when there is a generic version also available on the formulary, you must pay the difference between the cost of the brand-name and generic versions, *in addition to* your copayment.

For drugs that are **not** included on the Maple Health Plan formulary, here are your copayments for up to a 30-day supply (or whatever other amount is the maximum for one copayment):

- **\$20 for a generic non-formulary drug** if you get it at a plan pharmacy (non-formulary drugs are not available through our mail order service).
- **\$40 for a brand-name non-formulary drug** if you get it at a plan pharmacy (non-formulary drugs are not available from our mail order service).

Understanding the concept of a yearly limit on prescription drug benefits

Exhibit 22 below shows the first part of how the booklet explained about the yearly limit on the Maple Health Plan prescription drug benefit.

**EXHIBIT 22. Excerpt about the yearly limit from Section 7 on prescription drug benefits
(from mockup tested in Round 2).**

There is a yearly limit on how much we pay toward your covered prescriptions

Your **maximum prescription drug benefit** for the calendar year is \$ 1,000. By “calendar year,” we mean the 12-month period from January 1 through December 31 of a given year. **This yearly maximum applies to all prescriptions covered by the Maple Health Plan prescription drug benefit.** It does *not* apply the drugs that are covered for everyone with Medicare, such as drugs you are given in the hospital (The Benefits Chart in Section 6 has a list of the drugs that are

covered for everyone with Medicare).

What we pay for your drugs is what counts toward your benefit limit

As shown in the diagram on the next page, it is the payments we make as our share of the cost of your covered prescriptions that count toward the yearly limit on your prescription drug benefit.

After reading the explanation shown above in Exhibit 22, people generally understood that there was a dollar amount limit on the prescription drug benefit. However, when interviewers gave examples that required them to apply their understanding of how the limit worked, a number of people were either unclear or mistaken about which dollars actually counted toward the yearly limit. Instead of understanding that the limit was a cap on how much Maple Health Plan would pay toward covered prescriptions, some people assumed that it was their own copayments that counted toward the dollar limit. One asked, “*Does the \$600 include your part of the total cost of medication?*” He wanted more explanation about the maximum, and whether it would include his payments, just Maple Health Plan’s payments, or the total cost of the drug.

For those who were confused, re-reading the section shown above often helped clear things up, and so did studying the diagram that is referred to at the end of Exhibit 22 and shown in Exhibit 23 that begins on the next page.

**EXHIBIT 23. Comparing diagrams in the prescription drug section in Round 1 and Round 2 mockups
(size of type in the diagrams is shown slightly reduced in size)**

ROUND 1:

The diagram for Round 1 shows a flowchart where a box labeled "\$ Total cost of the prescription" is equal to a box labeled "\$ Your copayment" plus a box labeled "\$ Maple Health Plan's payment". A bracket above the two boxes on the right is labeled "The cost of each covered prescription has two parts:". Below the diagram are three columns of explanatory text.

\$ Total cost of the prescription = **\$ Your copayment** + **\$ Maple Health Plan's payment**

The cost of each covered prescription has two parts:

Total cost is the amount agreed upon by Maple Health Plan and our participating pharmacies. It is usually less than the regular retail cost.

The amount *you* pay when you fill a covered prescription is called your "**copayment.**"

As shown above, your copayments vary from \$10 to \$40, depending on the drug.

After you have paid the copayment you owe, we pay the rest.

During each calendar year, we keep track of the payments we make for your prescriptions. When our payments reach the yearly maximum of \$600, we stop paying.

ROUND 2:

The diagram for Round 2 shows a flowchart where a box labeled "\$ your copayment" plus a box labeled "\$ Maple Health Plan's payment" is equal to a box labeled "\$ total cost". A bracket above the two boxes on the left is labeled "The cost of each prescription covered by the Maple Health Plan prescription drug benefit has two parts:". Below the diagram are three columns of explanatory text.

\$ your copayment + **\$ Maple Health Plan's payment** = **\$ total cost**

The cost of each prescription covered by the Maple Health Plan prescription drug benefit has two parts:

The amount **you** pay when you fill a covered prescription is called your "**copayment.**"

After you have paid the copayment you owe, **we pay the rest.** Our payments for your prescriptions that are covered by the Maple Health Plan prescription drug benefit count toward the yearly maximum of \$1,000.

Total cost is the amount agreed upon by Maple Health Plan and our plan pharmacies.

Overall, most of the people we interviewed found this diagram very helpful. As one person put it, “*there are no if’s, and’s or but’s about it—this helps.*” Several people said that while they found the written explanation so clear that they did not need the diagram themselves, they thought it should stay in the booklet because it would probably be very helpful to other people.

In Round 1, one woman pointed out that the equation in the diagram did not follow the usual order of an equation, where the equals sign comes last (see top part of Exhibit 23). As shown in the bottom part of Exhibit 23, the revised diagram we tested in Round 2 reflects this advice.

Exhibit 24 below shows the rest of the explanation about the yearly limit from the booklet.

EXHIBIT 24. Excerpt about how the yearly limit works from Section 7 on prescription drug benefits (from mockup tested in Round 2).

What happens if you use up the \$1,000 prescription drug benefit before the end of the calendar year?

Once our payments reach the yearly maximum of \$1,000, we stop paying for our share of the cost of your covered prescriptions that come under this benefit limit. Then you have to pay the full cost of your prescriptions that are covered by the plan’s prescription drug benefit through the end of the calendar year. We start paying our share of the cost of your covered prescriptions again on January 1 of the following year.

What happens if you do not use up the \$1,000 benefit by the end of the year?

If our payments for your covered prescriptions are less than the \$1,000 maximum during a calendar year, you are *not* allowed to “carry over” the unused portion to the next calendar year.

How can you find out how much of your additional prescription drug benefit has been used?

It may be hard for you to keep your own record of how much we pay for your covered prescriptions. The pharmacy will always tell you how much *you* owe, but may not give you the total cost, or tell you how much we have to pay as our share of the cost. Since we keep track of our payments for your prescriptions, you can ask us anytime to tell you how much of your \$1,000 benefit has been used. To find out, call Maple Health Plan Member Services at the number on the cover of this booklet.

Interviewers used some examples that asked people to demonstrate their understanding of what they read in Exhibit 24. These included situations that involved reaching one’s limit before the end of the year, and falling short of the limit. Most people were able to tell what would happen in these situations without difficulty. After reading the last paragraph shown in Exhibit 24, several people

thought it was too burdensome for people to know where they stood in terms of how much of their benefit limit was left. Some thought that the booklet should have a phone number they could call at any time to find out how many dollars remained in their benefit.

Reactions to the section about hospital care, skilled nursing facility care, and other services

When we asked people to read the sections that discussed the details of coverage for hospital care and skilled nursing facilities, the only issue that arose was confusion about how benefit period is defined. We have already noted this problem in our discussion of people's reactions to the benefits chart.

Most people understood that skilled nursing facilities offer a more intensive and skilled type of care than other nursing homes and convalescent homes. One respondent referred to skilled nursing facilities as "*where you go to get rehab or therapy.*"

Reactions to the summary list at the beginning of the section about payment for coverage and care

Exhibit 25 below shows the beginning of the section about member's financial responsibilities. As shown in this exhibit, the section begins with a summary list of obligations.

Testing showed that many people tended to skim quickly over this first page rather than reading it closely, perhaps because of the list format. Especially among those who skimmed, many missed the point that the first page was a reference list of key points discussed in the section. Several people who initially mistook this first page for the whole section were very critical of its brevity. Another reacted with the following comment: "*according to this [chart], it looks like you have a lot of paperwork to do.*" He continued by saying that the information was all "*very vague,*" and when asked what he would expect to be in the rest of the section, he replied, "*to be honest, if I read this without explanation from anyone, they'd have lost me, right there.*" The less-skilled readers we interviewed tended to have trouble linking a summary point on the first page to its corresponding discussion later in the section. While some of the people we interviewed readily understood that the first page was just a summary, most thought it was unnecessary and distracting. This summary list was dropped during revisions after testing was completed.

EXHIBIT 25. First part of Section 10, What you must pay for your Medicare health plan coverage and for the care you receive (from mockup tested in Round 2).

A summary list of what you must pay

The purpose of this section is to explain your financial responsibilities as a member of Maple Health Plan. We begin with a summary list of what you must pay. Then **the rest of this section gives you the details about each item in this summary list.**

1. To be a member of Maple Health Plan, you must have both Medicare Part A and Medicare Part B. This means that **you must continue to pay your Medicare Part B premium.** Most people do not have to pay a Part A premium, but if you are required to pay for Medicare Part A, you will have to continue paying for Part A as well. (We tell more about this below under the heading “Paying for Medicare Part A and Part B.”)
2. You must pay your **monthly plan premium.** (We tell more about this below under the heading “Paying the premium for your health plan coverage as a member of Maple Health Plan.”)
3. You must pay any **deductibles that you owe.** (We tell more about this below under the heading “Paying your share of the cost when you get covered services.”)
4. You must pay any **copayments or coinsurance that you owe.** (We tell more about this below under the heading “Paying your share of the cost when you get covered services.”)
5. You must pay **the full cost of any services that are not covered.** (We tell more about this below under the heading “You must pay the full cost of services that are not covered”).
6. **You must pay the full cost for services you receive after you have used up a benefit that has a limitation (such as a prescription drug benefit)** (We tell more about this below under the heading “You must pay the full cost of services that are not covered.”)
7. **You must keep us up-to-date about other health insurance coverage you have,** so that we can “coordinate your benefits.” (We tell more about this below under the heading “What if you have other health insurance coverage besides Maple Health Plan?”)

Reactions to the first part of Section 11 (Appeals and grievances: what to do if you have concerns or complaints)

The information about appeals and grievances was a major focus of the consumer testing done in Phase 1 of the project to improve the model EOC. In Phase 2, we did a limited amount of testing to get reactions to a revised introduction to the main section on appeals and grievances. This section had been rewritten to clarify some areas of confusion that were identified in the Phase 1 testing. Exhibit 26 below shows the subsections we tested.

Respondents understood the text shown in Exhibit 26 without difficulty. When we gave them scenarios and asked for their reactions, they were able to classify them correctly into one of the three types of situations that are described in this subsection. Participants had positive reactions to the content of this overview about appeals and grievances. One person approached this section with skepticism about the utility of filing a complaint, saying that a person “*won’t call if it won’t do any good.*” He changed his mind as he read this section: “*It’s pretty good what it [says] about the waiting time and a doctor’s behavior. It would be worth complaining.*”

EXHIBIT 26. Excerpt from the beginning of the section on appeals and grievances (from the mockup tested in Round 2).

SECTION 11 Appeals and grievances: what to do if you have concerns or complaints (how to handle problems related to your coverage, including payment for your care; problems about hospital discharge; and other types of problems)

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Member Services at the number on the cover of this booklet.

This section explains what you can do to deal with any problems you may have. It gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a member of Maple Health Plan. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be dropped from Maple Health Plan or penalized in any way if you make a complaint.

What are “appeals” and “grievances”?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make:

- An “**appeal**” is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for**. For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If Maple Health Plan or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If Maple Health Plan or one of our plan providers reduces or cuts back on services you have been

receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal.

- A **“grievance”** is the type of complaint you make **if you have *any other type of problem with Maple Health Plan or one of our plan providers***. For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor’s office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell how to make a complaint in each of the following situations:

- 1. Making an appeal to Maple Health Plan to change a decision about what we will cover for you or what we will pay for.** If Maple Health Plan or your doctor or another plan provider have refused to give you a service you think is covered for you, you can make an appeal. If Maple Health Plan has refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced too soon, or ended too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).
- 2. Making an appeal to the Quality Improvement Organization (“QIO”) if you think you are being discharged from the hospital too soon.** There is a special type of appeal that applies only to hospital discharge dates. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to the Quality Improvement Organization. The Quality Improvement Organization is a group of health professionals in your state that is paid to handle this type of appeal from Medicare patients. You must act very quickly to make this type of appeal, and it will be decided quickly.
- 3. Making complaints (“filing grievances”) about any other type of problems you have with Maple Health Plan or one of our plan providers.** If you want to make a complaint about any type of problem other than the two that are listed above, a grievance is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor’s office. Generally, you would file the grievance with Maple Health Plan. But for many problems related to quality of care you get from plan providers, you can also complain to the Quality Improvement Organization in your state.