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MEDICARE

Program Designed to Inform Beneficiaries and Promote Choice Faces Challenges



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Abbreviations

ACRP	adjusted community rate proposal
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
CAHPS	Consumer Assessment of Health Plans Study
CMS	Centers for Medicare and Medicaid Services
CSR	customer service representative
FEHBP	Federal Employees Health Benefits Program
FFS	fee-for-service
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
M+C	Medicare+Choice
MCBS	Medicare Current Beneficiary Survey
NMEP	National Medicare Education Program
OPM	Office of Personnel Management
PPO	preferred provider organization
PRO	peer review organization
REACH	Regional Education About Choices in Health
SHIP	State Health Insurance Assistance Program



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Congressional Committees

The Balanced Budget Act of 1997 (BBA) established the Medicare+Choice (M+C) program to expand health plan choices available to beneficiaries. BBA permitted Medicare participation by preferred provider organizations (PPO), provider-sponsored organizations, and insurers offering private fee-for-service (FFS) plans or medical savings accounts. It also included provisions designed to encourage the wider availability of health maintenance organizations (HMO), which have long been an option for many beneficiaries. Other BBA provisions increased the significance of each beneficiary's selection of a Medicare coverage option by limiting beneficiaries' opportunities to make new selections outside of the newly established annual open enrollment period.

In creating the M+C program, the Congress recognized that choice should be accompanied by information that can help beneficiaries consider the full range of their Medicare options and make appropriate selections. Studies by us and others had found shortcomings in the limited information available to Medicare beneficiaries and that many beneficiaries did not adequately understand their Medicare coverage options.¹ Study findings suggested that, at the most basic level, beneficiaries needed information to increase their awareness that M+C alternatives to the traditional FFS program might exist in their geographic areas. Increasing awareness of M+C is particularly important because individuals who become eligible for Medicare are automatically enrolled in the FFS program and must complete a separate application if they want to enroll in an M+C plan. Beneficiaries also needed information to help them understand the key differences between the traditional FFS program and M+C program. For example, M+C plans generally limit beneficiaries' freedom to select their health care provider, but typically offer benefit packages that are more comprehensive than the benefits available under FFS. Finally, beneficiaries who were interested in M+C needed an objective source of information that would help them compare specific plans. Such information can facilitate beneficiary decision-making and

¹For example, see *Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance* (GAO/HEHS-97-23, Oct. 22, 1996) and Frank W. Porell and others, *Factors Associated with Disenrollment from Medicare HMOs: Findings from a Survey of Disenrollees* (Boston: Health Policy Research Consortium of Brandeis University, 1992).

spur competition among M+C plans, which could result in improved service and benefit packages that are more comprehensive and better reflect beneficiary preferences.

To help beneficiaries understand and consider all of their Medicare options, BBA provisions required the Secretary of Health and Human Services (HHS) to undertake several activities. Through the Health Care Financing Administration (HCFA),² which administered Medicare, the Secretary (at a minimum) was to

- establish and operate a toll-free help line;
- annually mail to beneficiaries information about Medicare, the M+C program, individual M+C plans, and other topics (and, throughout the year, mail the same information to individuals shortly before they are entitled to Medicare benefits if an M+C plan is available in their area);
- create and maintain an Internet site with information on M+C plan options; and
- provide for educational and publicity campaigns to inform beneficiaries about M+C plans.

HCFA established the National Medicare Education Program (NMEP) to organize these activities.

The Balanced Budget Refinement Act of 1999 (BBRA) mandated that GAO periodically report on HCFA's Medicare education activities.³ In this report we (1) describe major NMEP activities, (2) review NMEP spending and funding sources, (3) assess beneficiary and plan reactions to NMEP, and (4) discuss the future of NMEP.

To conduct our study, we met and discussed NMEP with officials representing HCFA, beneficiary advocacy groups, and health plan associations. We reviewed materials used for various education approaches, including the *Medicare & You* handbook, the contents of Medicare's Internet site, and the most common questions and answers for

²On June 14, 2001, the Secretary of HHS announced that the name of the Health Care Financing Administration (HCFA) had been changed to the Centers for Medicare and Medicaid Services (CMS). In this report, we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

³GAO reports to the Congress on Medicare education activities are required in 2001, 2004, 2007 and 2010.

the telephone help line. We obtained information on the funding sources and costs for operating the program for the first 3 fiscal years of the program (1998, 1999, and 2000), and reviewed the results of various assessments done by HCFA and its contractors on several aspects of the program. Appendix I provides additional information on our methodology. Our work was done from November 2000 through August 2001 in accordance with generally accepted government auditing standards.

Results in Brief

Under the umbrella of NMEP, HCFA addressed BBA requirements regarding the promotion of informed choice primarily by establishing a Medicare telephone help line, annually mailing to beneficiaries general information on Medicare and summary information on M+C plans, creating a Medicare Internet site, and organizing community outreach efforts. The telephone help line, which received approximately 300,000 calls per month during the period of our review, is staffed by operators who can answer common questions about Medicare, M+C, and related topics, or direct callers to other sources for answers to less common or more detailed questions. Beneficiaries can also call the help line to request printed material with premium, benefits, and other detailed comparative information on specific M+C plans or general information brochures on a variety of topics. The *Medicare & You* handbook, now mailed annually to all Medicare households, provides general information about Medicare coverage and beneficiary rights. The 2000 and 2001 editions also contained summary information on plan choices in a beneficiary's geographic area. The Internet site contains extensive and current information on a variety of Medicare topics, including detailed information on M+C plans available in each zip code. As a supplement to these information resources, HCFA established a targeted community outreach program that sponsored health fairs, media campaigns, and other local events designed to help educate beneficiaries who might need extra assistance or information presented in a different manner or language.

During each of the fiscal years 1998 through 2000, HCFA spent an average of \$107.8 million for NMEP, for a total of nearly \$323.3 million. The funds were spent primarily on the telephone help line, the *Medicare & You* handbook and other printed material, community outreach activities, and evaluations of NMEP activities; the Internet site involved limited expenditures. Most of the expenditures (76 percent) were funded from user fees collected from M+C plans, with the rest coming from other HCFA accounts. M+C plans objected to funding three-quarters of NMEP expenses because the vast majority of beneficiaries remained in traditional FFS and NMEP addressed other topics in addition to choice. The BBRA

subsequently reduced the user fees from \$95 million per year in each of the first 3 fiscal years to approximately \$17 million in fiscal year 2001. The effect of reduced user fee revenues is partially offset by surpluses in NMEP's accounts remaining from previous years. Nonetheless, to sustain NMEP activities in fiscal year 2001, \$54.1 million of the \$1.2 billion Medicare operations budget will be devoted to the program, more than double the previous annual average of \$20.2 million.

Reaction to NMEP has generally been positive among beneficiaries and beneficiary advocacy groups, but representatives of M+C plans offered a mixed assessment. One area of agreement concerned the telephone help line. More than 80 percent of beneficiaries who responded to a HCFA-sponsored survey stated that they were satisfied or very satisfied with the help line. Beneficiary advocates and M+C plan representatives also expressed a favorable view of the help line. Beneficiary advocates said that the other NMEP activities were worthwhile and that funding for Medicare education efforts should be substantially increased. In contrast, M+C plan representatives stated that NMEP does not sufficiently emphasize that beneficiaries have the option to choose an alternative to traditional FFS Medicare. They expressed specific concerns about the handbook's length, format, and description of M+C; health plan comparison information presented on the Internet; and HCFA's failure to adequately inform and involve health plans in local community outreach activities.

NMEP activities have increased the amount and type of information regarding Medicare, the M+C program, and specific health plans that is available to beneficiaries and facilitated access to such information. However, the extent to which NMEP has spurred beneficiaries to actively consider their health plan options is unknown. What is known is that the importance of information about options will soon increase because beneficiaries will no longer be able to change plans on a monthly basis. Beginning in November 2001, beneficiaries will be faced with having to make a decision on the type of Medicare coverage they want for a full year with limited opportunities to change their initial decision. CMS' ability to modify NMEP and encourage more beneficiaries to consider their Medicare coverage options may be hampered by a combination of statutory requirements for specific activities and short time frames each year to prepare and distribute the necessary information. CMS recently announced that it would fund a \$30 million advertising campaign this fall to encourage beneficiaries to use NMEP information channels to learn more about the M+C program. At the same time, to encourage health plan participation in the M+C program, CMS has allowed plans additional time

to prepare their 2002 benefit proposals. This extension will further shorten the time frames for NMEP activities and hinder efforts to distribute plan-specific, comparative information to beneficiaries.

The BBA mandated NMEP's beneficiary education activities at the same time it created the M+C program in recognition that the health plan choices must be accompanied by information that helps beneficiaries make appropriate selections. To help ensure the success of the M+C program, the Congress may want to consider allowing CMS more flexibility in conducting NMEP activities, especially with regard to the content, format, medium, and timing of information that the agency distributes to beneficiaries. CMS reviewed a draft of this report and generally concurred with our findings and matter for congressional consideration.

Background

In 1997, before the establishment of the M+C program, about 5.2 million (14 percent) of Medicare's 38 million beneficiaries were enrolled in HMOs that contracted with HCFA to serve Medicare beneficiaries. At that time, PPOs and other health insurance arrangements that had become common in the private sector were not permitted in Medicare.⁴ The HMOs that participated in Medicare tended to concentrate in urban areas and certain states. Consequently, about 25 percent of beneficiaries had no alternative to the traditional FFS program. In creating the M+C program, the Congress sought to build on, and expand, the existing HMO option. BBA permitted new types of health plans, such as PPOs, to participate in Medicare and included provisions designed to encourage a wider geographic availability of health plans.⁵

⁴Like HMOs, PPOs typically contract with selected providers for services at a negotiated payment rate. In contrast to traditional HMOs, PPOs generally permit enrollees to use providers outside of the contracted network, although higher levels of coinsurance or deductibles routinely apply to these out-of-network services.

⁵In 2000, a private FFS plan—one of the newly eligible types of plans—began to enroll Medicare beneficiaries. However, the net number of Medicare health plans has substantially decreased since the creation of M+C. The number of beneficiaries enrolled in M+C plans grew until 2000 when it reached 6.3 million, but then fell to 5.6 million by January 2001, where it has remained roughly the same through June 2001. For a discussion of some of the reasons behind these trends, see *Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings* (GAO/HEHS-00-183, Sept. 7, 2000) and *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues* (GAO/HEHS-99-91, Apr. 27, 1999).

Medicare's experience with HMOs has demonstrated that choice, and the ensuing competition among plans for market share, can produce important advantages for some beneficiaries. At a minimum, all HMOs were required to provide the services covered by Medicare's traditional FFS program. In addition, HMOs that received Medicare payments that exceeded their costs of providing Medicare-covered benefits and normal profits had to use the excess to reduce beneficiary fees or provide additional benefits—such as coverage for prescription drugs or routine physical examinations.⁶ HMOs frequently exceeded program requirements and further reduced beneficiary fees or augmented their benefit packages to help retain existing members and attract new ones. As a result, nearly all Medicare beneficiaries enrolled in an HMO received a more comprehensive benefit package than those who remained in traditional FFS. For example, the average Medicare HMO in 1999 spent approximately \$660 per member (an amount equivalent to 11.5 percent of its Medicare payment) on beneficiary fee reductions or benefit enhancements that were not required by Medicare.

Medicare's HMO experience has also demonstrated that some beneficiaries need information and help understanding their choices if they are to select the option that best meets their needs. A 1998 study found that many Medicare beneficiaries are unfamiliar with managed care concepts.⁷ Nearly one-third of the study respondents who belonged to Medicare HMOs did not understand basic differences between HMOs and FFS. A similar percentage of FFS respondents were uninformed. The authors concluded that only 16 percent of those beneficiaries who had some basic knowledge of HMOs knew enough to make an informed selection between FFS and HMOs. Misunderstandings about managed care concepts—such as the need to obtain referrals for specialty care and a limited choice of providers—may partly explain why some beneficiaries disenroll from HMOs shortly after becoming members. In 1998 we reported that the percentage of new members who left their HMOs within 3 months of enrolling was 10 percent or higher at 21 of 194 Medicare

⁶Before BBA provisions took effect in 1998, in addition to reducing fees or adding benefits, an HMO could place the excess payment amount in an escrow account to be used to reduce fees or augment benefits in future years, or accept a reduced Medicare payment. BBA eliminated the option of accepting a reduced Medicare payment, but otherwise the requirements remain the same.

⁷Hibbard, et. al. "Can Medicare Beneficiaries Make Informed Choices?" *Health Affairs* (Nov/Dec. 1998, vol. 17, no. 6).

HMOs in 1996.⁸ Lack of a basic understanding of HMO processes can also hinder a beneficiary's ability to obtain care through a health plan. According to a study by HHS' Office of Inspector General, many beneficiaries who were denied services by their HMOs and subsequently disenrolled did not know they could appeal the HMOs' decisions.⁹

Information that helps beneficiaries to compare specific Medicare health plans is important because covered benefits, fees, and consumer satisfaction can vary substantially among health plans. In our 1998 report, we found a wide variation in one potential indicator of beneficiary satisfaction—the plans' disenrollment rates—among HMO plans that operated in the same market. For example, in Houston, Texas, the highest disenrollment rate was nearly 56 percent while the lowest rate was 8 percent. Many beneficiaries select a health plan based upon information contained in the plan's advertisements and marketing materials. However, in 1996 we found that it was difficult to use this literature to compare various benefit packages because plans' benefit descriptions were not required to follow a common format or use standard terminology.¹⁰ At that time there was no widely available, objective source of information to help beneficiaries compare their Medicare options. We recommended that HCFA compile comparative information and make it available to beneficiaries. In response to our report, HCFA agreed that beneficiaries needed more information and outlined several initiatives designed to help beneficiaries understand Medicare and compare their FFS and managed care plan options.

In establishing the M+C program, the Congress included provisions designed to help Medicare beneficiaries become better informed health care consumers. BBA mandated that HCFA take an active role in educating beneficiaries about Medicare and the M+C program. The law specifically mandated that the agency compile and distribute comparative information about M+C plans. To complement these mandated education

⁸*Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment* (GAO/HEHS-98-142, Apr. 30, 1998).

⁹*Beneficiary Perspectives of Medicare Risk HMOs 1996*, Office of Inspector General, Department of Health and Human Services, (OEI-06-95-00430, March 1998).

¹⁰*Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance* (GAO/HEHS-97-23, Oct. 22, 1996). In *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature* (GAO/HEHS-99-92, Apr. 12, 1999), we reported that health plans' literature was frequently misleading. Almost half of the health plans we reviewed distributed incorrect benefit descriptions.

activities, HCFA took steps to make it easier for beneficiaries to use health plans' marketing materials to compare benefit packages. Health plans are now required to make available a summary of benefits that follows a common format and uses standard terminology.

Future changes in the Medicare program will heighten the importance of informed decisions. Historically, beneficiaries have been able to change health plans or switch between a health plan and the FFS program on a monthly basis. However, starting in November 2001, beneficiaries generally will make choices only during an annual open enrollment period for the following year. Each November, beneficiaries must decide whether they want to enroll in a particular M+C plan, change from one M+C plan to another, or return to the traditional FFS program. They will then be "locked in" to that choice for the following calendar year.¹¹ Some proponents of this provision believed that constraining enrollment opportunities into a few weeks each year would encourage concentrated health plan advertising that would help make beneficiaries more aware of the M+C program and available health plans. The extent to which this will occur is uncertain. However, it is clear that the lock-in provision will magnify the consequences and importance of each beneficiary's decision.

Changes in the beneficiary population may add to the demand for information. A recent Kaiser Family Foundation survey found that 69 percent of Americans under age 65 want more private plans in Medicare.¹² The same survey found the opposite among those over age 65—only 31 percent want greater choice of private plans, while the rest are content with Medicare as it has been. These findings suggest that future beneficiaries may be more interested in a private health plan option, increasing the need for information.

Major NMEP Activities

To fulfill BBA's beneficiary education requirements, HCFA established a NMEP that included four major approaches for delivering information to beneficiaries (see table 1). A new telephone help line (1-800-MEDICARE)

¹¹In general, a beneficiary may change his or her selection only once outside of the open enrollment period. In 2002, such a change must be made within the first 6 months of a new benefit year. In any year thereafter, such a change must be made within the first 3 months.

¹²*Post-Election Survey: The Public and the Health Care Agenda for the New Administration and Congress*, Kaiser Family Foundation-Harvard School of Public Health, January 25, 2001.

handled about 3.9 million calls in 2000. The Medicare handbook, now titled *Medicare & You*, was expanded to contain comparative information on M+C plans and is now mailed annually to all households with a Medicare beneficiary (about 34 million). Prior to 1998, the Medicare handbook did not contain information on specific managed care plans and was generally mailed only to newly eligible beneficiaries or those who requested a copy. A Medicare Internet site (www.medicare.gov) was established to provide more detailed information on M+C plans and other topics. Community outreach efforts were implemented to inform beneficiaries who might face language or cultural barriers or otherwise need special assistance. Finally, to help ensure that its education efforts operated effectively, the agency sponsored a number of internal and external evaluations.

Table 1: NMEP Information Outlets

Information outlet	Description
Telephone help line (1-800-MEDICARE)	Allows beneficiaries to obtain information through an automated system or to speak directly to a customer service representative.
Medicare handbook (<i>Medicare & You</i>) and other published materials	The handbook describes Medicare FFS, M+C, supplemental coverage options including private policies known as Medigap, and other topics. Contains limited comparative information on the M+C plans available in each beneficiary's geographic area. Other printed materials contain more detailed information about specific topics.
Internet site (www.medicare.gov)	Lists by zip code the available M+C plans and provides detailed comparative information on each plan. Also contains comparative information on Medigap policies and nursing homes, in addition to general information about Medicare and other topics.
Community outreach efforts	Sponsors local health fairs and media campaigns to educate beneficiaries who may not be reached by other NMEP activities.

Source: HCFA

Medicare Telephone Help Line

HCFA phased in a Medicare telephone help line (1-800-MEDICARE) beginning in November 1998. First available in five states (i.e., Arizona, Florida, Ohio, Oregon, and Washington), the help line was expanded to cover all states in March 1999. As publicity about the help line increased and more beneficiaries became aware of its existence, the number of calls grew from an average of 27,000 calls per month shortly after the line went nationwide to an average of 326,000 calls per month in calendar year

2000.¹³ Even with the substantially increased call volume, most beneficiaries had no trouble getting through. According to a HCFA-sponsored study, during 2000 92 percent of calls were answered within 30 seconds.

About 60 percent of Medicare help line callers speak directly to a customer service representative (CSR). The most common reason why beneficiaries call is to request a copy of *Medicare & You* or another publication. Beneficiaries also frequently ask how to apply for Medicare or get a replacement Medicare card, or ask questions about Medicaid, Medicare coverage and claims payment, or M+C plans. CSRs attempt to answer beneficiaries' questions by following a prepared script. Because beneficiaries call with a wide variety of questions, about half the time the information required is not contained in the script. In those instances the CSR transfers the caller to an appropriate third party, typically a Medicare claims processing contractor (37 percent of the transferred calls); the state Medicaid office (19 percent); the Social Security Administration (16 percent); State Health Insurance Assistance Programs (SHIP) that support counselors who answer beneficiary questions about Medicare, Medigap, and Medicaid (10 percent); or other entities including M+C plans (18 percent).¹⁴

The remaining 40 percent of callers obtain the information they seek through the help line's automated system. The automated system processes requests for publications and provides answers to frequently asked questions.

Medicare Handbook and Printed Materials

HCFA produced and distributed a variety of printed materials to help beneficiaries understand the Medicare program and the options available to them. The most widely distributed document is the *Medicare & You* handbook. However, the agency also produces more than two dozen

¹³There were an average of 416,000 calls per month in the peak months of September through January and 281,000 calls per month in the off-peak months. Some of the call volume increase between 1998 and 2000 occurred when HCFA merged an existing automated telephone line with 1-800-MEDICARE. The automated telephone line, which typically received about 67,000 calls per month, recorded and processed beneficiary requests for Medicare publications. According to CMS officials, the number of calls to 1-800-MEDICARE continues to increase.

¹⁴Percentages based on calls received for the week of 9/3/00 to 9/9/00.

educational booklets and brochures on specific topics, including Medicare managed care. (Appendix II contains a list of these publications.)

Prior to the enactment of BBA, HCFA annually produced a Medicare handbook but generally distributed it only to newly eligible beneficiaries and other individuals who requested a copy. Every few years HCFA mailed a current copy of the handbook to all beneficiaries. The intervals between mailings varied and depended partly on the extent to which the Medicare program had changed since the last mailing. However, in response to BBA, HCFA changed its handbook distribution practices. BBA required that beneficiaries receive comprehensive written information about the Medicare FFS program, the M+C program, and available options prior to Medicare's newly established annual open enrollment period each November. To fulfill this requirement, HCFA began annual mailings of the Medicare handbook in 1998.¹⁵

The *Medicare & You* edition for 2001 contains between 80 and 92 pages, depending on the geographic area for which it is intended.¹⁶ The document's length is due, in part, to BBA provisions that require the annual mailing to describe Medicare FFS program benefits, cost sharing, and liability for uncovered services; grievance and appeal rights; supplemental coverage options; the process for enrolling in M+C plans; and the potential effects on beneficiaries enrolled in M+C plans that withdraw from the program or reduce geographic service areas. Another reason for the length is that HCFA-sponsored research indicated that the handbook must use a large type size and limit the amount of text on each page to make it readable for the majority of the Medicare population. The handbook is designed as a reference guide and contains instructions and telephone numbers for obtaining additional information.

Although every Medicare handbook describes both the traditional FFS program and the M+C program, the handbooks issued in geographic areas served by M+C plans also contain a section with comparative information tailored to those areas. These supplemental sections, which range in length from 24 to 36 pages, list every M+C plan that operates in the area

¹⁵HCFA first pilot tested the handbook in 1998 by sending it to beneficiaries living in Arizona, Florida, Ohio, Oregon, and Washington. Beneficiaries living in other states received a short brochure containing general information.

¹⁶CMS publishes versions of the handbook in Spanish, Braille, and large print formats. Audio tape versions are also available.

along with the plan's telephone number, the geographic areas it serves, the monthly premium it charges, and whether it provides coverage for prescription drugs. Beneficiaries are directed to call either the plan or Medicare's telephone help line or to log onto Medicare's Internet site to obtain more detailed information about a specific plan. The supplemental section also contains two quality indicators for each plan—the percentage of members who rated their care as the best possible and the percentage of female members who received a mammogram during a 2-year period. The results for each plan are compared with all M+C plans operating in the same state. The mammogram percentages are also compared with FFS program beneficiaries in the same state. Finally, the section lists the percent of each plan's Medicare members that disenrolled from the plan during the previous year.

Medicare Internet Site

Medicare's Internet site (*www.medicare.gov*) provides considerably more detailed information about the traditional FFS program and M+C plans than the *Medicare & You* handbook. Established in March 1998, the site includes a *Medicare Health Plan Compare* page that can generate a list of M+C plans available in a specific zip code, county, or state. It also provides detailed information on each plan's benefit package, including cost-sharing requirements and coverage for 36 categories of services, such as physician visits, inpatient hospital, doctor and hospital choice, outpatient prescription drugs, physical exams, and vision services. In addition, *Medicare Health Plan Compare* contains plan quality indicators, such as the percentage of plan members who received an influenza vaccination, and consumer satisfaction indicators, such as the percentage of plan members that disenrolled within the last 2 years. The amount of plan-specific information contained in *Medicare Health Plan Compare* far surpasses that made available about Federal Employees Health Benefits Program (FEHBP) plans on the Office of Personnel Management's (OPM) website. Medicare's Internet site also includes a *Medigap Compare* page with detailed information on policies that supplement FFS Medicare, and a *Nursing Home Compare* page with detailed information on nursing home costs, features, and quality. The site also provides a wide array of information on Medicare coverage, benefits, eligibility, enrollment, and participating physicians, as well as information on getting help with medical expenses and state prescription drug assistance programs.

In October 2000, the *Medicare Health Plan Compare* page was viewed about 629,000 times (see table 2). The number of individuals who viewed this page was likely less than 629,000 because this figure counts repeat

views by individuals during a single session or subsequent sessions. All the pages combined were viewed a total of 3.1 million times during the month.

Table 2: Number of page views for the most popular pages on Medicare’s Internet site, October 2000

Page category	Page views
<i>Medicare Health Plan Compare</i>	628,904
Publications	536,141
<i>Nursing Home Compare</i>	440,346
Medicare Home Page	411,683
Medicare Basics	189,204
Search Tools	182,401

Source: HCFA – *Medicare Site: Content Categories*, October 2000, SurfAid Analytics, January 29, 2001.

Community Outreach Efforts

HCFA’s Regional Education About Choices in Health (REACH) initiative sponsored a wide array of activities—such as health fairs and public service announcements—designed to reinforce other NMEP efforts and educate beneficiaries who might need extra assistance or information presented in a language other than English or in an alternative manner. REACH activities, conducted in conjunction with local community and business groups, were intended to meet the needs of the local community and its beneficiary population. By involving local groups and customizing its activities, HCFA intended to better communicate with beneficiaries from diverse cultural backgrounds or who lack proficiency in English, as well as those who may have difficulty reading printed material or obtaining information through other means.

REACH-sponsored community health fairs are designed to provide beneficiaries with information about Medicare-covered services, M+C plans, supplemental insurance policies, and other potential sources of additional coverage such as Medicaid. The health fairs are intended to provide beneficiaries with sources of information on Medicare-related questions. REACH also funds public service announcements on radio and television and in local newspapers. To help reach certain beneficiary populations, some announcements are made through media that target specific ethnic groups.

CMS’ partners in the REACH program are organized under the NMEP Alliance Network Partnership. The alliance consists of more than 100 partners—community organizations, business groups, national non-profit

organizations (such as AARP), and private companies that process Medicare claims. Partners both provide advice to CMS and help disseminate information to beneficiaries. Among the major NMEP partners are the SHIPs, which receive the vast majority of community-based outreach funds.¹⁷

REACH activities are proposed by partners and approved by CMS' regional offices. Every year, CMS formulates a national business plan to guide REACH activities. CMS' regional offices adapt the national plan to suit local needs and formulate regional business plans. Each CMS regional office then reviews the proposals submitted by its partners, evaluates the proposals according to the criteria specified in its regional business plan, and decides whether to fund the activity.

Program Support and Evaluation

To help ensure NMEP's success, HCFA initiated activities intended to assist in the design, support, and evaluation of the program. Some activities helped to lay the groundwork for NMEP. For example, HCFA consulted with experts on the best methods of conveying information to beneficiaries. HCFA established the Citizens Advisory Panel on Medicare Education. Along with the alliance partners, the advisory panel—which consists of 15 members from fields of senior citizen advocacy, health economics research, health insurers, providers and clinicians, and employers—provides input to guide NMEP activities.¹⁸ In addition, the agency surveyed beneficiaries about their preferred methods of receiving health care information. Other activities—such as training individuals in other organizations that help educate Medicare beneficiaries—are ongoing and serve to maintain and promote the program. This category also includes expenditures for the Consumer Assessment of Health Plans Study (CAHPS)—a survey of beneficiaries that provides, among other information, some of the comparative data on M+C plans presented on *www.medicare.gov*.

¹⁷SHIPs, which exist in every state, sponsor health fairs and other outreach activities. In addition, SHIPs operate telephone help lines that can provide individual counseling about Medicare, Medicaid, and state-specific programs.

¹⁸The members represent: AARP, Aging 2000, Consumer Coalition for Quality Health Care, General Motors Corporation, Henry J. Kaiser Family Foundation, Humana, Inc., Maryland Insurance Administration, Medicare Rights Center, Mid Minnesota Legal Assistance, The National Caucus and Center on Black Aged, Inc., National Hispanic Medical Association, National Health Council, National Indian Council on Aging, Inc., On Lok Senior Health Services, and Washington Hospital Center.

Research that HCFA has sponsored to evaluate NMEP activities and their effectiveness also falls into this budget category. For example, HCFA used focus groups and beneficiary surveys to evaluate the *Medicare & You* handbook. To determine the effectiveness of the help line, HCFA hired contractors to survey callers and gauge their satisfaction with the help line. The contractor also placed calls to the help line to assess the ability of CSRs to handle beneficiary inquiries. The agency sponsors similar research that surveys users of its Internet site and tracks how visitors use the site.

NMEP Expenditures and Funding Sources

Spending on NMEP totaled \$323.3 million during the first 3 fiscal years of its operation. Printed materials, the telephone help line, outreach efforts, and program evaluation and support services were responsible for most of the cost. Spending on the Internet site was relatively low. About 76 percent of the funds spent came from user fees collected from M+C plans. The remaining amount came from Medicare program funds and other sources. Recent legislation substantially reduces the total amount of user fees collected from M+C plans. If this revenue source is not replaced, future NMEP activities may have to be curtailed substantially.

Expenditures

On average, HCFA spent \$107.8 million annually to run NMEP in fiscal years 1998, 1999, and 2000.¹⁹ This average may somewhat understate the annual cost of NMEP because it includes expenditures in fiscal year 1998—the initial year when some activities were not fully implemented. For example, the Medicare handbook was not distributed to all beneficiaries and the help line did not go national until midway through the year. We report the 3-year average because limitations in HCFA's accounting systems did not allow us to obtain an accurate view of the expenditures associated with a single year's activities.²⁰ Nonetheless, it is clear that relative spending on some activities changed over time. For example, Internet site expenditures grew from \$1.5 million in fiscal year 1998 to \$7.1 million in fiscal year 2000. However, in other cases the year-to-

¹⁹For the purposes of this report, NMEP spending was calculated from HCFA-reported data by subtracting final carryover amounts from obligations. For the first 3 years of NMEP, HCFA generally tracked only obligations and carryover amounts. The agency tracked expenditures only for funds collected from M+C plans.

²⁰HCFA could not report expenditures for all NMEP activities. It could report NMEP obligations, but some obligations for services were based on contracts that extended for more than 1 year.

year variation in spending by category is difficult to interpret because activities may have been included in different categories in different years.

HCFA records showed that at least 73 percent of the expenditures were for direct information services, including the *Medicare & You* handbook and other printed material (20.2 percent), the telephone help line (26.3 percent), community-based outreach (23.6 percent), and the Internet site (3.3 percent) (see table 3). The remaining expenditures (26.6 percent) were for program support and evaluation activities related to NMEP's direct information activities.

Table 3: Annual Average Expenditures on NMEP Activities, Fiscal Years 1998 to 2000

NMEP activity	Average annual expenditures (millions)	Percent of average total annual expenditures
Printed materials	\$21.8	20.2
Telephone help line	28.3	26.3
Internet	3.6	3.3
Outreach	25.4	23.6
Program support and evaluation	28.6	26.6
Total	107.8^a	100.0

^aSum of expenditures in each category does not equal total because of rounding.

Source: Center for Beneficiary Services, HCFA

Funding Sources

During NMEP's first 3 fiscal years (1998 to 2000), approximately three-fourths of the expenditures were funded from user fees collected from M+C plans. As authorized by BBA, HCFA collected \$285 million from plans during the 3-year period. (The law authorized the agency to collect \$95 million each fiscal year.) Additional funding came from HCFA program management (\$60.7 million) and peer review organization (PRO)²¹ accounts (\$23.7 million). Not all of the funds earmarked for NMEP were spent in the 3-year period. Approximately \$40.5 million in user fees and

²¹PROs are independent physician organizations that CMS contracts with in each state, in part to review beneficiary complaints. Since the NMEP subsumes some PRO responsibilities for quality and beneficiary satisfaction data, CMS uses some PRO funding for NMEP. For example, PRO funds were allocated to cover the costs associated with the Consumer Assessments of Health Plans Study and the comparison information on nursing homes on the Internet.

\$5.5 million in other revenues remained available to help fund activities in fiscal year 2001.

BBRA significantly reduced the amount of user fees CMS can collect from M+C plans in fiscal year 2001 and subsequent fiscal years. The total of \$244.5 million in user fees spent in fiscal years 1998 through 2000 funded about three-quarters of the program. However, M+C plans objected to funding so much of NMEP because plans enrolled less than 20 percent of Medicare beneficiaries and because NMEP provided general information about Medicare in addition to information specific to the M+C program. To address this perceived inequity, BBRA specified that the total amount of user fees collected in a year would equal the percentage of Medicare beneficiaries enrolled in M+C plans multiplied by \$100 million. In fiscal year 2001, for example, BBRA's formula allows CMS to collect approximately \$17 million in user fees.

To adjust to the loss of approximately \$78 million in annual user fee revenues without scaling back NMEP activities, a larger portion of HCFA's Medicare operations budget had to be devoted to the program.²² In fiscal year 2001, \$54.1 million of the \$1.2 billion Medicare operations budget has been used to support NMEP, more than double the previous annual average of \$20.2 million. In fiscal year 2001, the effect of reduced user fee revenues was partially offset by surpluses in NMEP's accounts. CMS can draw on \$15.5 million in previously collected but unspent user fees, \$25.0 million in previously collected user fees allocated to a printing account, and \$5.6 million in previously funded program management money held in a postage account (see table 4). Therefore, the full impact of the reduction will not be apparent until fiscal year 2002, when CMS will have to devote an additional \$46.1 million of the agency's budget to NMEP to maintain historical spending levels or scale back NMEP's activities.

²²The Medicare Operations Budget is used to pay contractors that process Medicare claims, answer inquiries, deal with appeals, and otherwise support agency operations handled by carriers and intermediaries.

Table 4: Funding for NMEP, Fiscal Year 2001

Funding source	Dollars (in millions)
User fees	17.0
Program	54.1
PRO	11.5
Carryover funds ^a	46.1
Total	128.7

^aCarryover funds consist of unspent and unallocated user fees previously collected from plans (\$15.5 million), unspent user fees allocated to HCFA's account with the Government Printing Office (\$25 million), and previously allocated program management funds in HCFA's account with the U.S. Postal Service (\$5.6 million).

Source: Center for Beneficiary Services, HCFA

Beneficiary and Plan Reaction to NMEP

Beneficiaries and beneficiary advocacy groups generally praised NMEP's major activities. Industry officials representing M+C plans offered a mixed reaction to NMEP. Medicare's telephone help line is viewed favorably by beneficiaries and M+C plans. Beneficiary advocates and industry representatives both said that the Medicare handbook could be improved and perhaps shortened. Industry officials also raised concerns about Medicare's Internet site and the community outreach efforts. Overall, beneficiary advocates thought that current spending levels for NMEP—about \$3 per beneficiary—are inadequate and more comparative information should be made available. Industry officials believe that NMEP should place a greater emphasis on the M+C program and that M+C plans should have more input into the design of NMEP and its activities (see table 5).

Reaction to Medicare Telephone Help Line

HCFA-sponsored surveys of help line callers indicate that most beneficiaries are satisfied with the service. About 84 percent of surveyed callers were satisfied or very satisfied with the responses they received. About 11 percent of the surveyed callers indicated that they were dissatisfied or very dissatisfied. The remaining 5 percent of the surveyed callers either said that they were neither satisfied nor dissatisfied or did not answer the survey question.

According to beneficiary advocacy groups, the telephone help line has become the source of information most familiar to the Medicare population. These groups believe the help line is valuable because it provides beneficiaries with one information resource that can answer most Medicare questions. An Arthur Andersen assessment of help line

performance found that 95 percent of CSR calls were answered accurately or referred appropriately.²³ Industry representatives agreed that the help line provides a valuable service. They also liked the single, easy-to-remember telephone number for beneficiaries.

Reaction to Medicare Handbook

According to beneficiary focus group studies sponsored by HCFA, beneficiaries generally like the Medicare handbook and find it useful when they read it. Focus group participants said that the handbook was comprehensive, understandable, and a good reference. Most beneficiaries who responded to a survey included in some versions of *Medicare & You* said that the 2000 handbook was easy to read and contained the information they sought. Nonetheless, the focus group studies suggested that beneficiaries rarely read the handbook, but instead use it in a similar manner to the telephone help line. That is, most beneficiaries save the handbook and refer to it only if a change in personal circumstance or health status prompts them to seek information.

Beneficiary advocacy groups told us that a Medicare handbook is a necessary element of NMEP, but that the current version could be improved. Some groups thought that the handbook can be confusing for beneficiaries and does not contain enough comparative information on available M+C plans to enable beneficiaries to make an informed choice. One group said that the handbook should be condensed to emphasize a few key messages. It believes that the handbook should be translated into more languages. (HCFA produced English and Spanish language versions of the handbook.)

Of the four major NMEP information outlets, the Medicare handbook generated the most negative reaction from industry representatives. One industry group stated that the handbook over-emphasized traditional Medicare and that information about M+C plans appeared to be added as an afterthought. Representatives from this group said that annual written material is a necessary element of the NMEP, but felt that the handbook in its current form was not an appropriate mechanism for educating beneficiaries about choice. Another industry group said that the length of the handbook discouraged beneficiaries from reading it and learning about their Medicare choices.

²³The Arthur Andersen assessment was based on a sample of calls received during October 2000.

Reaction to Medicare Internet Site

Beneficiary advocacy groups believe that the Medicare Internet site is a good source of information. However, they added that that they thought advocacy groups and beneficiaries' families, not beneficiaries themselves, were the main users of the site. Although there are no data to indicate who uses the site, beneficiary access to the Internet has grown substantially in the last few years. According to CMS' annual Medicare Current Beneficiary Survey (MCBS), 31 percent of beneficiaries had reported that they had Internet access in 2000, an increase from 10 percent in 1999.²⁴ Of the people who used Medicare's site, 85 percent found it very or somewhat useful.

Although industry representatives stated that the concept of making M+C information available on the Internet was worthwhile, they expressed significant frustration with some of the information contained in the *Medicare Health Plan Compare* pages. Specifically, the representatives were concerned that CMS' process for translating plans' benefit package descriptions into standardized language for the *Medicare Health Plan Compare* pages sometimes produced benefit descriptions that could have confused beneficiaries.

Reaction to Community Outreach

Representatives from beneficiary advocacy groups said that local education was an essential element of NMEP and generally expressed a favorable opinion of REACH. They were most positive about the work of the SHIPs. The representatives said that the one-on-one nature of much of the SHIPs' outreach efforts was the preferred learning method of many beneficiaries. The representatives understood that community outreach can be expensive, but said that there is a large unmet need for these efforts. All three beneficiary advocacy groups we interviewed agreed that even though local community outreach cannot serve many Medicare beneficiaries, for those it does, it works very well.

Industry representatives said that HCFA often did not include M+C plans in local education efforts or inform them of local events. Consequently, M+C plans were sometimes unprepared for the volume of beneficiary telephone calls following a NMEP media campaign.

²⁴The MCBS did not include this question in the 1998 survey.

Table 5: Summary of Reaction to NMEP by Beneficiaries and Groups Representing Beneficiaries and M+C Plans

	Beneficiaries and beneficiary advocates^a	M+C plan representatives^b
Overall program	<ul style="list-style-type: none"> should increase spending and provide more comparative information 	<ul style="list-style-type: none"> should emphasize M+C more
Telephone help line (1-800-MEDICARE)	<ul style="list-style-type: none"> valuable, one place to go for answers to Medicare questions more than 80 percent of callers satisfied or very satisfied 	<ul style="list-style-type: none"> useful for beneficiaries to have a single, easy-to-remember number to call
Medicare handbook (<i>Medicare & You</i>)	<ul style="list-style-type: none"> comprehensive and understandable generally read only when a question arises limited comparative information 	<ul style="list-style-type: none"> sometimes contains incomplete or misleading information about plans does not emphasize M+C enough length discourages beneficiaries from reading and learning about their options
Internet (www.medicare.gov)	<ul style="list-style-type: none"> useful, detailed information available small but growing share of beneficiaries have access to Internet main users likely individuals who advise beneficiaries, not beneficiaries themselves 	<ul style="list-style-type: none"> worthwhile concept HCFA's standardized language used in <i>Medicare Health Plan Compare</i> sometimes poorly reflects plans' actual benefits, may confuse beneficiaries
Local education (REACH)	<ul style="list-style-type: none"> local education efforts essential one-on-one approach preferred method of learning for many beneficiaries too expensive to do on a large scale 	<ul style="list-style-type: none"> plans should be included more in local education efforts

^aBeneficiary reaction summarized from multiple HCFA-sponsored studies issued from June 1998 through October 2000. Reaction of beneficiary advocates gathered during interviews conducted from December 2000 through January 2001.

^bReaction gathered through interviews with managed care trade associations conducted in December 2000.

Future Challenges for NMEP

The focus of NMEP over the first 3 years has been to make more information available to beneficiaries. Most of HCFA's research and implementation efforts concentrated on improving the mandated information outlets—the Medicare handbook, telephone help line, Internet site, and local education programs—and the content of the information

available through those outlets. These efforts have aided beneficiaries ready to make a choice. However, HCFA-sponsored research suggests that NMEP may need to adopt new education strategies to encourage other beneficiaries to actively consider their Medicare options.

Beginning in the fall of 2001, it will become more important for beneficiaries to be aware that M+C health plan alternatives to the traditional FFS program may be available in their geographic area and to understand each option and its implications. As required by the BBA, Medicare will now have an annual open enrollment period each November when beneficiaries may select either the FFS program or a specific M+C plan for the following calendar year. Beneficiaries who do not specify a different selection during that period will remain in the FFS program or their M+C plan. Beneficiaries will have strictly limited opportunities for changing their selection outside of the open enrollment period, a constraint known as “lock-in.”

Although modifications to NMEP may be indicated to promote active, informed choice, CMS is constrained in its ability to alter certain aspects of the information campaign. BBA provisions specify the content and timing of many existing NMEP activities. Altering these activities could require statutory changes. In addition, short time frames each year hamper the agency’s ability to compile and distribute comparative information in advance of the open enrollment period.

Recently, CMS announced changes to NMEP activities planned for this fall. The agency will undertake a \$30 million advertising campaign to increase awareness of M+C and recent changes in the Medicare program. CMS also announced it will allow plans to submit their benefit package proposals for the 2002 contract year by September 17, 2001, instead of the July deadline specified in BBRA. This extension is intended to encourage plan participation in the M+C program. However, it will hamper the ability of both CMS and plans to distribute information to beneficiaries before the start of the annual enrollment period in November. To help minimize the impact that this delay might have on beneficiaries, the agency has also announced it will extend the enrollment period through December 2001.

Promoting Active, Informed Choice

To date, HCFA has improved NMEP by enhancing or fine tuning existing activities. During the first 3 years of NMEP, the agency increased the amount of comparative information available through the handbook, telephone help line, and Internet site. It also improved the presentation of some information. For example, in response to focus group findings and

comments from literacy experts, HCFA made the handbook easier for beneficiaries to read by increasing the typeface size and amount of white space surrounding the text. To make finding information easier, HCFA expanded the handbook's table of contents and added color tabs for the telephone section. The agency modified portions of the handbook that focus group participants identified as confusing. HCFA also sought efficiencies to limit NMEP costs. For example, it evaluated the types of inquiries CSRs received and used the findings to modify the information available through the automated menus. As a result, the number of calls handled by the automated menus increased from 20 percent to 40 percent. Because calls that do not involve a CSR are substantially less expensive, these actions have helped to control the cost of the help line.

HCFA recently began studying alternative education strategies that could require more substantial changes to NMEP. Research suggests that NMEP primarily helped the minority of beneficiaries who were already considering their Medicare coverage options. The comparative information and improved access to information may have enabled those beneficiaries to make more informed decisions. However, NMEP did not appear to motivate the majority of beneficiaries to consciously examine their present Medicare arrangements and consider whether alternatives might be better for them. Although health plans, through their marketing efforts, seek to move beneficiaries to such a decision point, the language in BBA indicates that CMS is expected to play a role too. Specifically, BBA directs the Secretary of HHS (and thus, by extension, CMS) to undertake activities that "promote an active, informed selection." To that end, CMS is researching how NMEP might encourage more beneficiaries to consciously consider their Medicare options.

Mandates and Short Time Frames

Whether CMS decides to maintain the existing NMEP efforts or replace or augment them with new activities, the agency faces two major constraints.

- **BBA requirements.** The prescriptive nature of BBA's NMEP provisions may limit CMS' flexibility to alter existing activities. The Medicare handbook illustrates one of the major constraints facing CMS. Beneficiary advocacy groups and organizations representing health plans indicated that the current handbook is too long and raised doubts about whether it is the best vehicle to educate beneficiaries about their options. One beneficiary advocate questioned whether mailing the handbook annually to all Medicare households was the best use of NMEP resources. They suggested that CMS could distribute the handbook to new enrollees and make it available to others upon request, but conduct mass mailings only

when changes in Medicare required an update. However, BBA requires an annual mailing and specifies an extensive list of topics—in addition to a list of available M+C plans and a comparison of plan options—that must be covered. For example, the mailing must include information on the FFS program’s covered benefits and cost sharing; procedures for selecting an M+C plan or the FFS program; beneficiary rights and the appeals process in both M+C plans and the FFS program; and descriptions of benefits, enrollment rights, and other requirements of Medicare supplemental policies (Medigap). Significantly modifying the content of the handbook or changing how frequently it is mailed may require a statutory change.

- Short time frames. Compressed time frames each year hampers the agency’s efforts to distribute more complete comparative information in printed form. A complaint voiced by beneficiary and health plan representatives is that the Medicare handbook contains limited comparative information about M+C plans. According to HCFA officials, plan benefit package details have not been available until late September when plans’ Medicare contracts for the coming year were approved.²⁵ That left the agency too little time to assemble extensive data in a handbook that must be mailed out by mid-October, as required by BBA. HCFA therefore pre-approved selected aspects of each plan’s contract. The agency focused on the basic information it believed would most help beneficiaries make some initial decisions: plan service area, monthly premium, whether prescription drugs are covered, and how to contact the plan for detailed information. HCFA included other information, such as rates of mammography screening exams and beneficiary satisfaction with plans’ primary care physicians, that was not dependent on the contract approval package. Complete benefit information for each plan was not available until more than a month after the Medicare handbook was printed (see fig. 1). At that time, the information was posted on the *Medicare Health Plan Compare* pages of the Medicare Internet site.

²⁵CMS approves plan benefit packages through a process formally known as the adjusted community rate proposal process, which is intended to ensure that Medicare does not pay plans more than a commercial purchaser would pay for the same benefits, after adjusting for differences in Medicare beneficiaries’ use of services. Because Medicare payments to plans are established according to a predetermined formula, plans adjust their benefit packages to comply with this requirement.

Recent CMS Announcements Regarding Fall 2001 NMEP Activities

CMS recently announced that it would fund a \$30 million advertising campaign this fall to increase beneficiaries' awareness of the choices available to them and to encourage them to use the NMEP information channels to learn more about those choices. In addition, the advertising campaign is intended to help beneficiaries learn about Medicare's new features—such as the annual enrollment and lock-in provisions, and coverage for preventive services and medical screening examinations. The agency will also extend the operating hours of the help line and add an interactive feature to the Internet site designed to help beneficiaries select the Medicare coverage option that best fits their preferences.

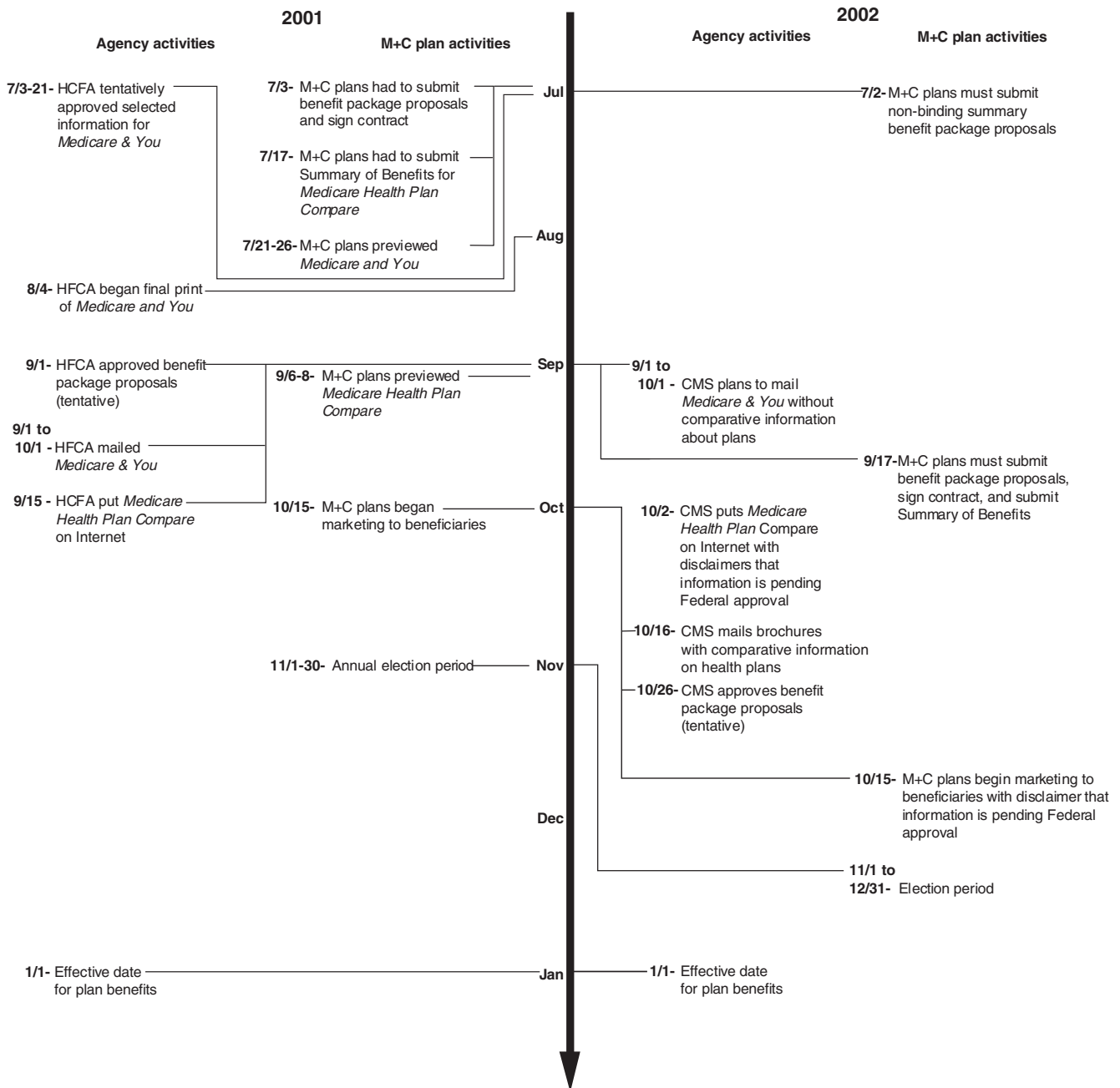
CMS has made other decisions about the fall information campaign that illustrate the sometimes difficult trade-off between accommodating plans and serving beneficiaries. To encourage health plan participation in the M+C program, CMS has allowed plans additional time to prepare their 2002 benefit proposals. In a June 2001 memorandum, CMS notified M+C plans that for contract year 2002 the deadline for filing complete cost and benefit information in their adjusted community rate proposals (ACRP) would be moved from July 2, 2001 to September 17, 2001. M+C plans were still required to submit a non-binding summary by July 2, 2001. According to CMS officials, the agency expects to review and approve all of the ACRPs by October 26, 2001.

The ACRP extension further shortens the time frames for NMEP activities, hampering the ability of CMS and health plans to disseminate information before the BBA-established November open enrollment period (see fig. 1). For example, 2002 cost and benefit information will not be posted on the Medicare's Internet site until October 1. Plan benefit packages that have not been approved by CMS will include a disclaimer that the information is pending approval. CMS had planned to not include any information about specific health plans in the annual handbook mailed to Medicare households. However, an August 9, 2001 court order requires the Secretary of HHS to mail comparative information on health plans to beneficiaries at least 15 days before the beginning of the November open enrollment period (October 16), the deadline specified in BBA.²⁶ To comply with the court order, CMS will prepare separate brochures containing comparative plan information and mail them by October 16. To reduce the potentially adverse effects of an abbreviated fall information campaign, the agency

²⁶Gray Panthers Project Fund v. Tommy G. Thompson, Secretary of the Department of Health and Human Services C.A. No. 01-1374; U.S. DIST. CT. (D.C.); August 9, 2001.

will allow health plans to distribute marketing materials with proposed benefit package information marked “pending Federal approval.” CMS will also extend the open enrollment period through the end of December.

Figure 1: Timeline of Events Preceding Start of Medicare 2001 and 2002 Benefit Years



Source: HCFA/CMS

Conclusions

HCFA fulfilled the BBA's basic requirements for NMEP by making information readily available through a number of communication devices such as printed materials, telephone help line, Internet site, and community outreach efforts. However, several HCFA-sponsored studies have suggested that these activities primarily aided those beneficiaries who were already reevaluating their Medicare options. NMEP activities did not appear to encourage other beneficiaries to learn more about choices available in the program. In this sense, NMEP has not been fully successful in promoting active, informed choice.

Beneficiaries' coverage decisions will soon become more important because these choices will be binding for a much longer period of time. Currently, beneficiaries may change health plans or switch between the traditional FFS and M+C programs monthly. However, in November and December 2001 beneficiaries will select how they will receive Medicare coverage during 2002—under the traditional FFS program arrangements or through a specific M+C plan. After beneficiaries make their initial selection they typically will have only one opportunity to switch their coverage arrangements until the start of the new benefit year in 2003.

The agency only recently began studying approaches that might encourage more beneficiaries to actively consider their Medicare coverage options. However, CMS' ability to modify NMEP to better promote active, informed choice or even to maintain current activities, may be constrained by BBA's statutory provisions and the short time frames that precede each open enrollment period. Moreover, future NMEP activities will have to compete with other Medicare priorities for funding.

Matters for Congressional Consideration

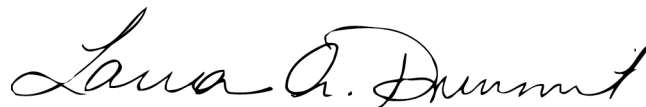
To better promote beneficiaries' active and informed selections among their Medicare coverage options, the Congress may want to consider allowing CMS more flexibility in conducting NMEP activities, especially with regard to the content, format, medium, and timing of information that the agency distributes to beneficiaries.

Agency Comments

In written comments, CMS stated that the agency generally agreed with the findings and observations in our report. CMS said that one of its primary goals is to ensure that Medicare beneficiaries have the information they need to make informed choices. The agency stated that it has been working to improve NMEP each year. It noted that recent and planned major improvements include an expansion of the hours of operation for the telephone help line, new information tools that telephone

customer service representatives can use to help callers consider their health plan choices, and an advertising campaign designed to publicize Medicare information resources. CMS concurred with our matter for congressional consideration, stating that additional latitude in the conduct of NMEP activities could assist agency efforts to respond to beneficiary information needs in an appropriate and timely manner. CMS also provided technical comments, which we incorporated as appropriate. (CMS' comments appear in app. III.)

We are sending copies of this report to CMS Administrator and other interested parties who request them. If you or your staffs have any questions about this report, please call me at (202) 512-7119. This report was prepared under the direction of James Cosgrove, Assistant Director, by Cam Zola, Linda Radey, Jennifer Podulka, and Richard Neuman.

A handwritten signature in black ink that reads "Laura A. Dummit". The signature is written in a cursive style with a large, flowing initial "L".

Laura A. Dummit
Director, Health Care – Medicare Payment Issues

List of Congressional Committees

The Honorable Tom Harkin
Chairman
The Honorable Arlen Specter
Ranking Minority Member
Subcommittee on Labor, Health and Human Services, and Education
Committee on Appropriations
United States Senate

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Ralph Regula
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The Honorable David R. Obey
Ranking Minority Member
Subcommittee on Labor, Health and Human Services, and Education
Committee on Appropriations
House of Representatives

The Honorable Michael Bilirakis
Chairman
The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Appendix I: Scope and Methodology

To do our work we reviewed relevant sections of BBA and BBRA. We also interviewed various HCFA officials responsible for operating the different elements of NMEP. We also spoke with representatives from beneficiary advocacy groups (AARP, Medicare Rights Center, and the Center for Medicare Education) and health care plan associations (American Association of Health Plans and the Health Insurance Association of America). We analyzed information on the funding sources and costs for operating the program for the first 3 fiscal years (1998-2000). Further, we analyzed various operating results for the telephone help line and the Internet site. We reviewed the results of various assessments done by HCFA and its contractors on several aspects of the program. In addition we spoke with officials in two HCFA regional offices about NMEP and specifically the community-level education effort known as REACH. Our work was done from November 2000 through August 2001 in accordance with generally accepted government auditing standards.

Appendix II: Medicare Publications that Supplement the *Medicare & You* Handbook

HCFA produced and distributed a variety of printed materials to help beneficiaries understand the Medicare program and the options available to them. The most widely distributed document is the *Medicare & You* handbook. However, as listed in the handbook and below, the agency also produces more than two dozen educational booklets and brochures on specific topics, including Medicare managed care.

Services Medicare Covers:

- *Medicare and Your Mental Health Benefits*
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*
- *Medicare Coverage of Skilled Nursing Facility Care*
- *Medicare Coverage For Second Surgical Opinion*
- *Medicare Home Health Care Services*
- *Medicare Hospice Benefits*
- *Medicare Preventive Services*

Health Care Choices:

- *Choosing a Doctor*
- *Choosing a Hospital*
- *Choosing Treatments*
- *Your Guide to Choosing a Nursing Home*
- *Private Contracts Fact Sheet*
- *Nursing Homes Fact Sheet*

Medicare Health Plan Choices and Supplemental Coverage:

- *Health Plan Comparison Information (with quality data)*
- *Learning about Medicare Health Plans*
- *2000 Guide to Health Insurance for People with Medicare*
- *Your Guide to Private Fee-for-Service Plans*
- *Your Guide to Medicare Medical Savings Accounts*
- *Worksheet for Comparing Medicare Health Plans*

Beneficiary Rights and Protections:

- *Medicare Appeals and Grievances (Complaints)*
- *Medicare Fraud and Abuse*
- *Medicare Patient Rights*
- *Medigap Policies and Protections*

Health Care Costs and Payment:

- *Do You Need Help to Pay Health Care Costs?*
- *Does Your Doctor or Supplier Accept Assignment?*
- *Medicare and Other Health Benefits: Your Guide to Who Pays First*
- *Your Guide to Outpatient Prospective Payment System*

Appendix III: Comments From the Centers for Medicare and Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: SEP 24 2001

TO: Laura Dummit
Director, Health Care—Medicare Payment Issues

FROM: Ruben J. King-Shaw, Jr.
Chief Operating Officer and Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, *MEDICARE: Program Designed to Inform Beneficiaries and Promote Choice Faces Challenges* (GAO-01-1071)

We appreciate the opportunity to review and comment on the above-referenced subject report. The Centers for Medicare & Medicaid Services (CMS) generally agrees with the findings and observations cited in the report.

One of our primary goals is to ensure that Medicare beneficiaries have the information they need to make informed choices when selecting health plans. We continue to assess the education program each year to make product improvements and service enhancements that provide more relevant, accurate, consistent, and understandable information on a timely basis. And, as cited in the GAO report, we fully recognize the importance of “motivating the majority of beneficiaries to consciously examine their present Medicare arrangements and consider whether alternatives such as Medicare+Choice, might be better for them.” We have been aggressive in pursuing and implementing several major improvements to assist beneficiaries in this examination. Some examples of these major improvements are as follows:

- Effective October 1, 2002, we will expand beneficiary and caregiver access to telephone customer service representatives from 8 hours a day, 5 days per week to 24 hours a day, 7 days per week through 1-800-MEDICARE (1-800-633-4227). The customer service representatives will also be available to walk customers through their health plan choices using a Web-based decision support tool. This approach will allow callers to get health plan information immediately by phone with an option of receiving a copy for their personal reference.
- Another major activity planned for some time in the fall is to more fully publicize the Medicare information resources and expanded services through a planned and organized information campaign. We want to make every effort to ensure that beneficiaries know they have choices and understand the resources available to them for assistance.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS).
We are exercising fiscal restraint by exhausting our stock of stationery.

Page 2 - Laura Dummit

We were also pleased with GAO's conclusion that "Congress may want to consider allowing CMS more latitude in conducting the National Medicare & You Education Program activities, especially in regard to the content, format, medium, and timing of information that the agency distributes to beneficiaries." More latitude will enable CMS to use assessment results and feedback to operate an education program that can respond to beneficiary information needs in an appropriate and timely manner.

We look forward to working with GAO on this and other issues in the future.

Related GAO Products

Medicare+Choice: HCFA Actions Could Improve Plan Benefit and Appeal Information ([GAO/T-HEHS-99-108](#), Apr. 13, 1999).

Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature ([GAO/HEHS-99-92](#), Apr. 12, 1999).

Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices ([GAO/T-HEHS-98-162](#), May 6, 1998).

Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information ([GAO/T-HEHS-97-109](#), Apr. 10, 1997).

Medicare HMOs: Potential Effects of a Limited Enrollment Period Policy ([GAO/HEHS-97-50](#), Feb. 28, 1997).

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance ([GAO/HEHS-97-23](#), Oct. 22, 1996).

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