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Designing Health Insurance Information for the Medicare Beneficiary: A Policy Synthesis

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Can Medicare beneficiaries make rational and informed decisions about their coverage under the Medicare program? Recent policy developments in the Medicare program have been based on the theory of competition in medical care. One of the key assumptions of the competitive model is the free flow of adequate information, enabling the consumer to make an informed choice from among the various sellers of a particular product. Options for Medicare beneficiaries in supplementing their basic Medicare coverage include the purchase of private supplementary insurance policies or enrollment in a Medicare HMO. These consumers, in a complex health insurance market, have only limited information available to them because many health plans do not make adequate comparable product information available. Moreover, since the introduction of the Medicare HMO option, the long-range plan for management of the Medicare budget has become based on the large-scale voluntary enrollment of beneficiaries into capitated health plans. The policy instrument that has been used to improve beneficiary decisions on how to supplement Medicare coverage is the informational or educational program. This synthesis presents findings regarding the relative effectiveness of different types of health insurance information programs for the Medicare beneficiary in an effort to promote practical use of the most effective types of information.

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Can Medicare beneficiaries make rational, informed decisions about their coverage under the Medicare program? This is a complex and important question. If these consumers are able to choose wisely, then their choices have the potential to protect their own financial security as well as the financial stability of the whole Medicare program. If they cannot, then they are placing both themselves and Medicare at financial risk.

Recent Medicare policy developments have been based on the theory of competition in medical care. These policies have been designed to compensate for the fact that the medical care market does not meet many of the key assumptions of the competitive model. This approach may be successful in reducing the cost of the Medicare program by enhancing the economic efficiencies inherent in a competitive market.

One of the key assumptions of the competitive model is the free flow of complete and costless information enabling the consumer to make an informed choice among the various sellers of a particular product. Unless the consumer can accurately assess the comparable value of products in the marketplace, he or she cannot select that product which provides the best value for the dollar. Medicare beneficiaries have two types of options for supplementing their basic Medicare coverage: first, they can purchase one or more private insurance policies designed to fill in some of the gaps that Medicare leaves uncovered or, second, they can leave the fee-for-service environment altogether to enroll in a Medicare HMO (health maintenance organization), which may provide benefits above and beyond the basic Medicare benefits. They are consumers in a complex health insurance market with only limited information available to them, because different health plans do not make adequate comparable product information available. This type of information deficiency, inherent in the health insurance and medical care markets (Arrow 1963; Stigler 1961), has resulted in fundamental inefficiencies that may be contributing to the continuing spiraling increase in health care costs.

The policy instrument used to improve decisions by Medicare beneficiaries on ways to supplement their Medicare coverage has been the informational or educational program (Greenfield 1986; Varner and Christy 1986). But our actual knowledge of the effect of such programs on the decisions made by beneficiaries is in question. What are the characteristics of the programs that have been implemented? What items of information are most useful for beneficiaries trying to make a decision? Which educational approaches are most effective? The purpose of this synthesis is to present findings about the relative effectiveness of different types of Medicare health insurance information programs in order to promote practical use by the Medicare beneficiary of the most effective types of information.

From the viewpoint of the beneficiary, the problem is paying for medical services not covered by Medicare. Only 48.8 percent (1984) of all personal health care expenses for persons over 65 are covered by Medicare (Dopkeen 1987; Wattenberg and McGann 1984). As a result, the cost of uncovered services may be substantial for an individual beneficiary. Some limitations to Medicare coverage resemble those of other insurance plans: deductibles and copayments; limits to the number of services (e.g., hospital days) or limited dollar amounts (e.g., for outpatient psychotherapy); and excluded services, usually either preventive care (e.g., immunizations, routine physical examinations, and dental care) or prosthetic devices (e.g., hearing aids or eyeglasses), and outpatient prescription drugs. Moreover, all covered services must meet a test of "medical necessity" that can be open to interpretation. This results, for example, in few approved stays in skilled nursing facilities making any substantial use of the 100 available days per benefit period. Much of the institutional care required by the elderly either is classified as "custodial" and is not covered by Medicare, or exceeds the 100-day limit.

A total of 67 percent of beneficiaries supplement their Medicare coverage with one of a variety of private supplementary insurance policies available on the market—the so-called "Medigap" policies (Garfinkel and Corder 1985; Rice and Gabel 1986). Overall, it is estimated that $13 billion is spent by or on behalf of about 21 million Medicare beneficiaries in the private market for Medicare supplementary policies (Rice and McCall 1985; Smeeding and Straub 1987; Wilson 1987). These policies usually meet the deductibles and copayments, and extend coverage beyond the Medicare service limitations for acute conditions meeting Medicare's test for medical necessity. Less frequently, they provide some coverage for excluded services, such as prescription drugs or lengthy medically necessary stays in a skilled nursing facility.

In addition to violation of the basic assumptions regarding the free flow of information, most economic analyses of the medical care market note that basic assumptions regarding the determination of prices through the interaction of demand and supply forces are also violated. Traditional retrospective fee-for-service reimbursement contributes significantly to the spiral of increasing medical care cost since the prices paid are not subject to normal market forces. New policies to set ceilings for payments to providers of care, such as DRG payments to hospitals and risk-based contracts with capitated health plans, have become a necessary means to simulate those market forces which, in a more competitive marketplace, would serve to limit price increases.

In particular, the Health Care Financing Administration (HCFA), the agency administering the Medicare program, has introduced and promoted the voluntary enrollment of Medicare beneficiaries into prepaid health maintenance organizations or similarly organized entities (Ginsburg and Hackbarth 1986; Iglehart 1985, 1987b; Langwell and Hadley 1986a; McMillan, Lubitz, and Russell 1987; Tanzer and Nudelman 1987). Two basic factors, at least in theory, make it possible that the enrollment of Medicare beneficiaries into HMOs will help control the federal government's Medicare expenditures. First, prepayment allows prospective budgeting, which puts the provider at risk and encourages efficiency in the provision of health care services and, second, there is some evidence that the pattern of care provided by HMOs (primarily in terms of hospitalizations) is less costly than that provided in the fee-for-service sector for similar outcomes (Luft 1981; Manning et al. 1984; Mott 1986).

For Medicare beneficiaries, facing the complexities of the health insurance market is generally a new experience. First, upon becoming eligible for Medicare, beneficiaries participate in Medicare itself—and in the supplementary health insurance market—for the first time. Of those with supplementary health insurance policies, about 36 percent (1983) receive it as a retirement benefit (Dopkeen 1987), leaving 64 percent to purchase one or more supplementary policies as individuals, rather than as members of a group. These individuals, in particular, must make new types of decisions about their health insurance coverage, decisions which may have been made for them when they were employed. They are not presented with a list of possible supplementary policies and HMOs to consider but, instead, must gather information on their own from each company offering individual coverage.

These policies vary considerably both in the scope of coverage and in the range of premiums. It is possible for a beneficiary to select a private supplementary plan that provides reasonable protection against the cost of some of the expenses not covered by Medicare, for a reasonable premium. However, it is more likely that the variety of supplementary policies available is so confusing and the fear of costly illness so overwhelming that beneficiaries find it difficult to weigh accurately the costs and benefits of their options.

In addition, beneficiaries now, if they wish, can leave the fee-for-service environment altogether by joining a Medicare HMO. About 1 million beneficiaries (3 percent) were enrolled in HMOs under the new risk-based capitation contracts by the end of 1987 (Kosterlitz 1988). It is possible that enrollment in an HMO broadens coverage even beyond that provided through a combination of traditional Medicare and a good private supplementary policy and, at the same time, that it reduces the out-of-pocket cost to the beneficiary. This potential financial benefit must be balanced, however, against the potential disadvantage of "lock-in" provisions that require enrollees to use only those physicians who are part of the HMO.

Second, the information commonly made available by insurance companies is often abstract, often filled with difficult, ambiguous terminology, and usually is confusing or misleading or both (Bonker 1987; Charles 1987; Hagen 1986). The paucity of information that clearly compares policies diminishes the ability of the beneficiary to choose among alternatives; direct comparisons cannot easily be performed using current Medigap marketing and advertising information. Third, the superabundance of Medigap policies available to the beneficiary—the great number of alternatives—can be overwhelming. Furthermore, HCFA has expanded even further the options available to the beneficiary through the introduction and support of Medicare HMOs.

Aside from the fact that the policies themselves are new and complex, there is considerable evidence that older persons process information differently than younger adults. It is just this type of new and complicated information that the elderly do not absorb and retain as readily. In particular, information-processing deficits have been identified in elderly consumers when large amounts of complex and unfamiliar information are presented. Deficits also occur if information is externally and rapidly paced, and if irrelevant information is mixed in with relevant information (Gaeth and Heath 1987; John and Cole 1986; Phillips and Sternthal 1977). Furthermore, Medicare beneficiaries may be more "information responsive" if they have certain characteristics: female, for instance, and/or white, of higher income, without a regular source of care, or in an early phase of illness (Orden 1980). Consequently, information must be structured specifically for the different segments of the Medicare population.

The beneficiary's choice of plan (HMO versus fee-for-service) and supplementary insurance, as discussed earlier, could greatly influence both the size of federal Medicare expenditures and of personal outlays on medical services above and beyond Medicare's limited coverage. Given the complexity of the decision that must be made by the Medicare beneficiary, and the weight of its impact on the magnitude and distribution of the funding of health services for the elderly, the health policy community must be concerned about the quality of this decision-making process.

In fact, little research is yet available on the effectiveness of specific consumer health insurance education programs. This synthesis will evaluate a sample of representative programs, therefore, based upon what we know generically about consumer education programs and about programs designed to educate seniors. In particular, an important conceptual framework, entitled "Consumer Education Guidelines for Providers of Health Insurance Information," will provide much of the structure for the analysis. This framework was developed in 1980 by Helen Schauffler of Arthur D. Little, Inc., under a contract with the Bureau of Health Education at the Centers for Disease Control, and will be cited as the Little/Schauffler study. Applied to the population of Medicare beneficiaries, the basic principles developed in the Little/Schauffler study can be summarized thus:

1. To reach the Medicare beneficiary through the employment of various media, and thereby induce the beneficiary to perceive a need to seek out the complex information required to make a difficult decision
2. To present this complex information in a format that can be easily understood and used by the beneficiary and, through interactive personal contact, to motivate and train the beneficiary actually to use this information
3. To assess the "quality" of the decision made by the beneficiary in terms of the real effect on the decision-making process of the consumer information provided.

Although many health insurance information programs have been implemented using various methods to provide health insurance information to Medicare beneficiaries, no systematic effort has been made to evaluate their relative effectiveness—an effort needed to provide credible evidence in this increasingly important policy discussion. Significant gaps in our knowledge remain. Existing programs do not have a system for testing alternative modes of information presentation, and usually do not evaluate adequately the effect of the information presented on the decision made. It is only through systematic reviews such as that undertaken in this article that we can sort out the known from the unknown in order to use and enhance our knowledge.

This synthesis draws from articles published in journals and from reports produced and distributed by governmental agencies and private organizations. None of the information presented here concerning research and demonstration programs has been published; projects were identified and reports collected through interviews with program directors and funding agency representatives. All are from the period beginning in 1980 and extending to the present. Material drawn from the published literature includes articles related to the effect of information on selection of health plan, the level of consumers' knowledge about their health insurance coverage, and consumer research on the role of information on buyer behavior in elderly populations. The frameworks for summarizing program types and for assessing the validity of program findings were derived from both published articles and governmental reports.

The first section, a background to the synthesis, reviews both the level of Medicare beneficiaries' knowledge about their health insurance coverage and the philosophy of responsibility for providing comparative insurance information. Next I present and analyze the characteristics of 12 example programs. Subsequent to a comparison of different criteria established for evaluating program effectiveness, and application of this framework to the 12 example programs, I discuss the policy significance of the findings.

MEDICARE BENEFICIARIES AND THE NEED FOR HEALTH INSURANCE INFORMATION

BENEFICIARY KNOWLEDGE ABOUT MEDICARE COVERAGE

In general, beneficiaries have a poor idea of their coverage under the Medicare program. Without this basic understanding, it is unlikely that they can make knowledgeable choices about supplementary private health insurance or Medicare HMOs. Altogether, only a few studies have examined the level of health insurance knowledge for any population.

Several studies of the Medicare population have documented a low level of knowledge about the types of services Medicare covers as well as about service limitations and the required deductibles and copayments (Cafferata 1984; Lambert 1980; LaTour, Friedman, and Hughes 1983; McCall, Rice, and Sangl 1986). Several studies of the general population have shown similarly low levels of knowledge of personal health insurance coverage (Little/Schauffler 1980; Marquis 1983). The Little/Schauffler study found Medicare beneficiaries to have lower levels of knowledge about health insurance than younger adults—not surprising when one considers that younger adults operate in less complex markets, and do not themselves appear to develop much understanding.

Beyond beneficiaries' lack of knowledge of basic Medicare coverage is their poor grasp of the nature of Medigap coverage. Beneficiaries frequently misunderstand the breadth of coverage provided by their Medigap policies, mistakenly assuming that services not well covered by Medicare (such as nursing home care) are covered by the Medigaps (Cafferata 1984; Lambert 1980; LaTour, Friedman, and Hughes 1983; McCall, Rice, and Sangl 1986). McCall, Rice, and Sangl do find, however, that beneficiaries holding Medigap policies are more knowledgeable than nonsubscribers about basic Medicare coverage. In addition, beneficiaries have a poor idea of the relationship between the size of Medigap premiums and the degree of financial protection provided. Finally, Medicare beneficiaries often mistakenly think it advisable to purchase multiple Medigap policies to provide themselves with more comprehensive coverage. Unethical sales practices by Medigap insurance salesmen have been documented (Bonker 1987) as contributing to these misunderstandings.

The introduction of Medicare HMOs has made the beneficiary responsible for deciding not only whether to choose a Medigap policy and which one to choose, but also whether to stay with the fee-for-service health care delivery system or leave it altogether. Because most beneficiaries are not familiar with HMOs, they have little experience by which to judge the service delivery capabilities offered. The fundamentally "closed" nature of the HMO system of providers is considerably different from the broad freedom of choice of provider offered under traditional Medicare coverage (Titus 1982). The decision beneficiaries must make concerns both the type of insurance and delivery system (fee-for-service versus prepaid HMO), as well as the particular delivery system (which HMO to select).

Furthermore, beneficiaries must make difficult comparisons between the costs and benefits of Medigap policies and those of HMOs in order to make informed choices (Titus 1982). Beyond the one study by Titus, which examined this issue before the present HMO incentives were put in place by HCFA, examinations of the level of beneficiaries' knowledge of their HMO options were recently conducted by both the Senate Special Committee on Aging and the House Select Committee on Aging. In 1987, both committees published reports on hearings that documented examples of both abusive HMO marketing practices and poor choices by beneficiaries resulting from their lack of understanding of the HMO option (Heinz 1987; Roybal 1987).

IDENTIFYING THE PROPER SOURCE OF COMPARATIVE HEALTH INSURANCE INFORMATION FOR THE MEDICARE BENEFICIARY

The issue here is whether the responsibility for providing comparative information on Medicare-related health insurance is more appropriately shouldered by the government or by the private sector. This question can be briefly addressed by noting that, in general, the failure of markets to operate competitively has been taken as a justification for government intervention (Mazis et al. 1981; Rosen 1985). As the diversity of available health plan products increases, the combination of factors noted earlier in this section contributes to a deterioration of the competitive quality of this marketplace.

Moreover, the fact that Medicare is a federally funded program addresses the basic responsibility of the federal government to provide its own beneficiaries with the information required to function competently within its own structure. That beneficiaries generally have poor knowledge of their basic Medicare coverage reveals the potential for more extensive federal efforts to achieve, at the least, a minimum foundation upon which it will be possible to add knowledge of supplementary policies and HMOs. The large number of options, the extreme financial vulnerability of Medicare beneficiaries to the consequences of poor decisions, and the inability of the private sector to offer adequate comparative information all strongly suggest a need for government intervention.

Justifying government intervention does not necessarily mean that the government itself must actually implement any informational programs. The government can either provide information directly, or arrange for other entities to provide various types of comparative health insurance information to Medicare beneficiaries. There are precedents for governmental funding of other organizations in carrying out activities for the public good (Mazis et al. 1981). Ultimately, however, governmental intervention of some kind will both protect vulnerable citizens and promote efficiency in this marketplace.

The larger question of governmental versus private responsibility leads to the question of national versus state responsibility. To the extent that Medicare is a federal program, I argue that all of its beneficiaries should be supported in their use of it by the federal government, regardless of their state of residence. If adequate comparative information would indeed make the health insurance market (and the related medical care market) more competitive, then the federal government would be acting in its own best financial interest to provide such information. In fact, HCFA does believe that HMO enrollment is the key to federal cost savings under the Medicare program (Roper 1987), so considerable comparative information about this new health plan option might arguably be supported by a federal program.

Beyond the normative question of appropriate placement of responsibility for insurance information programs, it is useful to review briefly where this responsibility actually has been located. Insurance regulation was originally construed to fall within federal jurisdiction given its nature as interstate commerce. However, the McCarran Ferguson Act of 1945 preempted federal involvement as long as the states responsibly assumed this duty. The Act was passed at a time of heightened public outrage directed against unfair practices by insurance companies. Intensive lobbying efforts by the insurance industry successfully averted federal intervention and effectively exempted insurance from oversight by the Federal Trade Commission. Since then, regulation of the insurance industry has been carried on at the state level. More recently, the Federal Trade Commission Improvement Act of 1980 made it impossible for this agency even to study the insurance industry without a congressional mandate.

In fact, both federal and state governments have undertaken some efforts to provide insurance information to Medicare beneficiaries, sometimes in the form of insurance regulation and sometimes not. As it became apparent that, despite state regulation, various abuses were being perpetrated by insurers in the sale of Medigap policies, Congress enacted the so-called Baucus legislation, section 507 of Public Law 96-265, the Social Security Disability Amendments of 1980. This legislation, entitled "Voluntary Certification of Medicare Supplemental Health Insurance Policies," added section 1882 to the Medicare provisions of the Social Security Act, thus establishing a voluntary certification program in which individual states could choose to participate. Under this program, an insurance policy could be formally certified as a "Medicare supplement" if certain minimum requirements were met, including the use of standard language, the disclosure of certain types of information about the policy, and the paying out of a certain proportion of the premiums collected in the form of benefits.

Forty-six states voluntarily meet or exceed the minimum requirements, and so are exempted from the federal certification program. The remaining four states have their own requirements and, although the requirements are not much different from those of the Baucus legislation, these states are subject to federal certification (Bowen 1987). Despite this, however, a 1987 hearing of the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging revealed many unfair practices in the sale of Medigap policies

(Bonker 1987). These marketing abuses, which were not covered under the Baucus legislation, are largely covered under versions of the "Unfair Trade Practices Act" passed by all states, but often weakly enforced by them.

Furthermore, because HMOs were specifically exempted from the Baucus legislation, they are not subject to these minimal guidelines for the provision of comparative insurance information. Under the original HCFA demonstration project, which initiated the current incentives for HMOs to enroll Medicare beneficiaries, marketing materials developed by participating HMOs had to be approved in advance by HCFA. These have in fact been studied (Friedlob and Hadley 1985; Langwell and Hadley 1986b). Even now, marketing materials, which must be submitted to HCFA for review, are approved by default if not acted upon within a limited period of time. In any event, it is clear that a review of marketing materials is not the same thing as a requirement for standard comparative information about the health plans in question. The congressional hearings referred to provide documentation and anecdotal evidence of the inadequacy of this type of review for protecting the beneficiary.

Various efforts to provide Medicare beneficiaries with comparative insurance information, aside from the approaches accompanying insurance or HMO regulation, have been undertaken at both the federal and state levels. Federal efforts have been carried out by HCFA and by the Bureau of Health Education of the Centers for Disease Control, while state efforts generally have been under the auspices of the Department of Aging or the Department of Insurance. These projects, while under sponsorship of governmental agencies, are frequently carried out in collaboration with community-based organizations, such as the American Association of Retired Persons (AARP), area agencies on aging, senior centers, or legal services agencies.

At the federal level, the Little/Schauffler study developed extensive "Consumer Education Guidelines for Providers of Health Insurance Information." These guidelines apparently were not widely distributed and thus do not appear to have been used to any large extent. A number of research and demonstration programs have been initiated by the Health Care Financing Administration since 1983 to test or examine several different types of comparative insurance information for Medicare beneficiaries. Only two of these programs can be thought of as research endeavors, complete with experimental designs and carefully planned evaluations. The remaining efforts are collaborative demonstration programs, carried out with private organizations either national or regional in scope. Finally, HCFA produces a variety of pamphlets, maintains an ongoing liaison program with beneficiary organizations, and has been engaging in programs to train volunteer insurance counselors.

At the state level, a number of different programs have evolved. These programs are primarily designed to provide information of various types to Medicare beneficiaries, and not to evaluate the relative effectiveness of the type of information being provided. Departments of insurance frequently offer pamphlets and hotlines, and enforce the minimal regulatory information standards. The more extensive and creative programs are usually offered by departments of aging, although some of these are sponsored by departments of insurance. These programs train volunteer counselors and provide community education, counseling, and advocacy services. They appear to be funded largely, if not exclusively, from state budgets, so considerable variation may be expected from state to state.

INFORMATION PROGRAM CHARACTERISTICS

This section addresses three major issues in characterizing the surveyed information programs: (1) identification of the agencies, federal and state, actually working to defend the best interests of beneficiaries, together with their types of information programs; (2) identification of methods these agencies use to reach and educate the Medicare beneficiary; and (3) conclusions about the sponsorship and implementation of the programs, and the role of local community organizations. In the section after, I address the question of our actual knowledge of the effect these information/education programs have had on the decisions made by beneficiaries.

FEDERAL AND STATE HEALTH INSURANCE INFORMATION PROGRAMS FOR MEDICARE BENEFICIARIES

This synthesis is not an attempt to gather a comprehensive survey of all existing consumer health insurance information programs for the Medicare beneficiary. Instead, I identify 12 programs, 6 federal and 6 state, which are representative of the efforts that have been undertaken. The Health Care Financing Administration has sponsored six Medicare health insurance information programs since the early 1980s, all of them presented here. No other federal agency appears to have sponsored such programs.

The six state-sponsored programs were selected to provide examples of their range, rather than their relative frequency. I identified three national surveys of state-sponsored consumer health insurance information programs for Medicare beneficiaries (ORD 1986). These surveys were carried out during the period 1982 to 1984, under the sponsorship of HCFA, the National Association of Insurance Commissioners (NAIC), and the National Association of Life Underwriters (NALU), respectively. The brief descriptions of state programs presented here are drawn from the summary reports of these surveys, or from the periodical literature or program documentation material.

Each of the 12 programs is described—the six federal programs first, then the six state programs. Using the terminology of HCFA, "grant" or "cooperative agreement" involves HCFA funding for an independently generated project based on HCFA's published priorities, whereas a "contract" provides HCFA funding to another organization for carrying out a specific project idea originated by HCFA staff.

HMO Informed Buyer Program

The AARP implemented this demonstration program with a grant from HCFA to educate and train senior citizens as volunteer coordinators in five sites: San Francisco/Oakland, California; Bridgeport, Connecticut; Tampa, Florida; Detroit, Michigan; and Philadelphia, Pennsylvania. These coordinators then trained other seniors as lay counselors through local AARP organizations. The counselors provided communitywide educational programs to inform Medicare beneficiaries about the HMO option and to encourage them to review their current coverage in light of this new information (Savage 1986).

Brokered Consumer Choice Program

An independent broker, HealthChoice, Inc., implemented this demonstration program under a cooperative agreement from HCFA to coordinate health maintenance organization fairs and to produce and distribute information comparing the options available under the Medicare program in two sites: Portland, Oregon and San Francisco, California. In Portland, HealthChoice conducted educational programs and performed beneficiary counseling and enrollment. In San Francisco, a coordinated open enrollment period for Medicare beneficiaries was established and, while fairs and information were made available, marketing representatives from HMOs enrolled beneficiaries at the fairs. HealthChoice received remuneration from HMOs for beneficiaries who enrolled as a result of their efforts (Connors 1986).

Health Insurance Decision Project

The Western Consortium for Public Health and the UCLA School of Public Health conducted this research-oriented demonstration project in Los Angeles, California under a cooperative agreement with HCFA. The purpose was to improve the capacity of seniors to make prudent choices in selecting supplementary health insurance plans and Medicare HMOs. Educational material was developed that compared out-of-pocket cost estimates for 13 representative illness episodes using Medicare coverage alone and using a variety of private supplementary plans and HMOs available in the Los Angeles area. The effectiveness of this information in improving beneficiaries' decision making was tested by enrolling beneficiaries in educational workshops and recording their use of the information through follow-up surveys (Farrell and Connors 1986; Sofaer 1988).

Testing Average Out-of-Pocket Cost as an Incentive for Changing Beneficiary Choice Behavior

This research-oriented program was conducted under the auspices of Morgan State University in Baltimore, Maryland and Rochester, New York, through a cooperative agreement with HCFA. Training materials were developed using average annual treatment costs for a number of illness episodes and then tested through educational seminars. Participants were followed up to determine their use of this information in their decision-making process (Connors 1986).

Consumer Health Insurance Planner for Seniors

Berkeley Planning Associates (BPA) set out to develop, pretest, and market a consumer-oriented guidebook under a Small Business Innovation Research contract with HCFA. The "planner" was to be a workbook designed for retirees and preretirees, using pencil and paper examples to explain Medicare, Medicaid, and major private supplemental health insurance coverage. Because of the complexity of the issues involved, BPA is instead producing a guide for choosing long-term care financing options focusing on insurance policies. The guidebook is intended for use both by individuals themselves and by those who provide advice to older people. Under this contract, HCFA funds only the development of the planner, and production must be supported by sales (Hanson, Altman, and Almond 1987).

Office of Beneficiary Services (OBS)

Since 1979, HCFA has provided ongoing beneficiary education, first through OBS and more recently through the Office of Public Affairs (OPA). Initially, beneficiary health insurance education was based on HCFA's distribution of the educational pamphlet, "A Guide to Health Insurance for People with Medicare," which OBS developed jointly with the National Association of Insurance Commissioners (NAIC). More recently, HCFA and NAIC jointly developed a training text, entitled "Medicare and Private Health Insurance," with accompanying visual aids and a checklist for comparing policies. HCFA regional staff in collaboration with state departments of insurance, aging, and other organizations, use this as the basic material in a nationwide program to train volunteers as counselors. By 1984, 800 training sessions had been held with a total attendance of about 40,000 volunteers (ORD 1986). OBS terminated its central role in this volunteer training program in 1986, as a result of federal budget cuts. Some of the regional offices have continued the program on their own.

Health Insurance Counseling and Advocacy Program (HICAP)

California established HICAP in 1984 under the Department of Aging to provide beneficiaries with education, counseling, and legal assistance in dealing with Medicare and other health insurance plans. Local HICAP agencies recruit and train volunteers as counselors, conduct community forums, provide health insurance counseling and advocacy services, and offer legal representation when needed. Counseling sites are located in a wide variety of settings. The state HICAP office provides an information clearinghouse and offers technical assistance as well as program monitoring services to grantee agencies. The program has expanded since its initiation, and HICAP grantees now serve the entire state (HICAP 1987).

Serving Health Information Needs of Elders (SHINE)

In Massachusetts, SHINE trains volunteer health benefits counselors to work out of local councils on aging. They provide beneficiaries with individual counseling on Medicare, private supplementary insurance, HMOs, and other relevent topics. In addition, volunteers coordinate community forums on health care issues. The State Executive Office of Elder Affairs provides training, supervision, and backup to the volunteer counselors (Greenfield 1986).

Mayor's Commission on Services to the Aging (MCOA)

As part of its community education program in Philadelphia, MCOA developed a two-part educational program called "How to be a Smart Health Care Consumer." Low-income senior citizens, employed by MCOA through a grant from the National Council on Aging, were trained to make presentations at senior citizen clubs and centers. They provided information on Medicare, supplemental insurance policies, and alternatives to fee-for-service care, such as HMOs and Philadelphia's health department medical centers (Savage 1986). This program, although intended as ongoing, has since terminated its activities due to lack of funding.

Senior Health Insurance Benefits Advisor Program (SHIBA)

The Washington State Insurance Commission sponsors SHIBA to train seniors and other volunteers to advise senior citizens about supplemental policies. Volunteer counselors are sponsored and supported through local organizations (ORD 1986).

Senior Citizen Health Insurance Counseling Program (SCHIC)

In Arizona, the State Association of Life Underwriters has developed a SCHIC program jointly with the Department of Insurance to provide interested persons with training to help senior citizens with Medicare supplementary insurance problems. Counseling is coordinated through the local office of the Department of Insurance and the local Association of Life Underwriters, and the overall program is endorsed by the National Association of Life Underwriters (NALU). Counseling focuses on explanations of policies owned by beneficiaries and is not a sales situation. If the beneficiary wishes to make a purchase after counseling, a list of sales representatives is provided (NALU 1986).

Newsletter/Hotline

The State of Wisconsin Department of Insurance sponsors a toll-free Medigap Hotline, staffed with volunteers trained to answer questions about supplementary insurance, and publishes a quarterly newsletter entitled "Insurance Update for Senior Citizens" (NAIC 1983).

The preceding six state programs provide examples of the range of such programs in terms of their sponsorship and focus. The NAIC and NALU survey results offer an idea of their relative frequency. NAIC received responses from 40 states and the District of Columbia, and of these, 24 reported programs. Special programs for senior citizens were sponsored by departments of insurance in 8 states, by departments of aging in 13 states, and by legal services associations in 3 states.

Of the eight special programs by departments of insurance, three provided Medicare supplement review, and four provided audiovisual presentations or newsletters; only one provided health insurance counseling. In addition, "an overwhelming majority of [respondent] states" reported that their department of insurance sponsors general consumer assistance programs that affect senior citizens, largely through distributing printed materials, providing speakers, sponsoring consumer hotlines, and disseminating public service announcements or consumer alert bulletins. Of the 40 states responding, 19 considered their senior citizens to be inadequately informed, 16 considered them to be adequately informed, and 5 did not respond to the question (NAIC 1983).

NALU reported that at least 14 state associations of life underwriters have held informational sessions on Medicare and health insurance, in collaboration with state departments of insurance. Eight also have held individual counseling sessions. Only two states have reported programs to train volunteers to counsel senior citizens on health insurance (such as the SCHIC program described earlier). Other special programs included a Medicare supplement review service, audiovisual presentations, and a newsletter (ORD 1986). These surveys suggest that a minority of states provide special counseling services similar to the HICAP or SHINE programs, and that a majority offer newsletter or hotline services comparable to Wisconsin's or limited explanatory presentations like the SCHIC program.

In Figure 1, the sources of each program's funding and implementational sponsorship are identified (in the order of their appearance in the foregoing text). In addition, Figure 1 classifies programs by type: limited in duration or ongoing, and demonstration, research, or service delivery (currently in operation). Programs are further classified according to the type of information they provide, indicating its focus on Medigap FFS options, Medicare HMO options, or both.

Programs are financed primarily by governmental sources, federal or state. In only two instances, both federal (the Brokered Consumer Choice program and the Consumer Health Insurance Planner), do private sources of funding exist in addition to governmental sources, and these represent a very small proportion of the budgets where they occur. All of the federal programs are sponsored by HCFA. Three of the six state programs are sponsored by departments or offices of aging (HICAP, SHINE, and MCOA), and three are sponsored by

Figure 1: Program Sponsorship, Type, and Focus

PROGRAM NAME	FINANCIAL SPONSORSHIP	IMPLEMENTATION SPONSORSHIP	PROGRAM TYPE	INFORMATION FOCUS
HMO Informed Buyer	Federal/HCFA	AARP	Limited Demonstration	HMO
Brokered Consumer Choice	Federal/HCFA + HMOs	HealthChoice	Limited Demonstration	HMO
Health Insurance Decision	Federal/HCFA	Western Consortium	Limited Research	HMO and Medigap
Average Out-of-Pocket Cost	Federal/HCFA	Morgan State University	Limited Research	HMO and Medigap
Health Insurance Planner	Federal/HCFA (Start-up Only)	Berkeley Planning Associates	Ongoing Book Sales	Long-Term Care
Beneficiary Services	Federal/HCFA	Federal/HCFA	Ongoing Service Delivery	HMO and Medigap
HICAP	California Department of Aging	Local County Nonprofit Organizations	Ongoing Service Delivery	HMO and Medigap
SHINE	Massachusetts Department of Aging	Local Consortia of Councils on Aging	Ongoing Service Delivery	HMO and Medigap
MCOA	Philadelphia Office of Mayor	Philadelphia Office of Mayor	Ongoing Service Delivery	HMO and Medigap
SHIBA	Washington State Insurance Commission	Local County Nonprofit Organizations	Ongoing Service Delivery	HMO and Medigap
SCHIC	Arizona Insurance Department + ALU	Local Association of Underwriters + Srs.	Ongoing Service Delivery	Medigap
Newsletter/Hotline	Wisconsin Department of Insurance	Wisconsin Department of Insurance	Ongoing Service Delivery	Medigap

departments of insurance (SHIBA, SCHIC, and the Newsletter/Hotline program).

Ordinarily, government agencies do not carry out program implementation, although they do usually exercise ultimate program supervision. Existing private consumer-oriented organizations or specially created organizations carry out the implementation of these government-funded programs. In state programs such as SHINE, SHIBA, and SCHIC, the government agencies provide training and technical support to volunteers. These individuals then provide counseling services at no cost to the local organizations that sponsored them. The two programs with explicit research evaluation components (the Health Insurance Decision Project and the Test of Average Out-of-Pocket Cost program) have been implemented in academic settings working jointly with community organizations.

Figure 1 illustrates the primary differences between programs with federal versus state sponsorship or funding. First, federally funded programs are of limited duration, whereas state-funded programs are usually ongoing. Second, the only programs implemented with explicit research evaluation components have been federally funded; state-funded programs are oriented entirely toward operation. Third, only federally funded programs focus on providing information about HMOs (the HMO Informed Buyer program and the Brokered Consumer Choice program), and only programs funded at the state level focus exclusively on providing information about Medigap policies (SCHIC and the Newsletter/Hotline program). The other state and federal programs provide information about both HMOs and Medigap policies.

METHODS USED FOR OUTREACH AND EDUCATION

Figure 2 further classifies these programs by the methods they use to reach and educate the beneficiary. The list of ten outreach and educational approaches used is drawn from "Consumer Education Guidelines for Providers of Health Insurance Information" (Little/Schauffler 1980). In this figure, programs are categorized both by the media used to reach the beneficiary and the approach used to educate the beneficiary. This is an important distinction that can have far-reaching implications for the effectiveness of information programs.

Media outreach can alert the beneficiary to the need for careful assessment of the adequacy of Medicare supplementation, and it can point the way to educational programs. It can even be used to present comparative information about the different insurance options, but it

Figure 2: Methods Used for Outreach and Education

PROGRAM NAME	RADIO OR TV	PRINT	BOOKLET/ BROCHURE	MAILINGS	TELEPHONE INFOTAPE
HMO Informed Buyer			X	X	
Brokered Consumer Choice			X	X	
Health Insurance Decision	X	X	X		
Average Out-of-Pocket Cost					
Health Insurance Planner					
Beneficiary Services			X	X	
HICAP		X			
SHINE	X	X			
MCOA			X	X	
SHIBA	X	X	X		
SCHIC		X			
Newsletter/ Hotline			X		

cannot be relied on to motivate recipients in actual use of this complex information. When one considers, in particular, the complexity of health insurance information and the learning characteristics of the elderly, information-only approaches tend to be ineffective (Little/Schauffler 1980). Personal contact in educational programs, on the other hand, contributes both to internalization of the information provided and to the modeling of appropriate ways to use the information in a decision-making context (Bandura 1971).

The greatest impacts on beneficiary decision making can be expected from methods that utilize fully interactive personal contact (Little/Schauffler 1980). These methods help motivate the beneficiary to consider or reconsider Medicare supplementation, and help build the analytic skills needed to make the most advantageous decision.

TELEPHONE HOTLINES	LECTURES	STAFF COUNSELORS	VOLUNTEER COUNSELORS	RETIREMENT COUNSELORS
	X		X	
	X	X		
		X		
		X		
		X		X
			X	
	X	X	X	
	X	X	X	
	X			
	X		X	
	X		X	
X				

This type of approach can be achieved best through the use of small-group workshops or individual counseling sessions led by trained counselors—either lay volunteers or professional employees of the sponsoring organization. Lay volunteers may or may not be seniors themselves.

Five categories of media have been used for outreach: broadcast media (radio or television); print media (newspapers and magazines); booklets or brochures; personalized direct mailings; and telephone-accessed informational tapes. Two additional methods fall midway between simple media outreach and interactive educational approaches: telephone hotlines, and lectures followed by question-and-answer periods. Both of these modalities provide personal contact and allow a limited amount of attention to specific problems and questions;

in general, however, beneficiaries must already be informed in order to make good use of them (Little/Schauffler 1980). Three fully interactive methods complete the list of ten categories in Figure 2: trained expert counselors and trained lay volunteers for persons already retired, and employee benefits counselors for those not yet retired.

Figure 2 shows that two of the six federally sponsored programs, the HMO Informed Buyer program and the Brokered Consumer Choice program, use methods both to reach and to educate the beneficiary. The Health Insurance Decision Project and the Test of Average Out-of-Pocket Costs program are research programs that focus on testing particular educational approaches. Their outreach components are designed to elicit participation in limited experimental workshops, rather than to have a broad effect in the community. Of the remaining two federally sponsored programs, the sale of the Consumer Health Insurance Planner is largely aimed at those who will implement educational programs, and so is not actually an educational program itself. Finally, the activities of the Office of Beneficiary Services, while heavily oriented toward mailings and brochures (now taken over by the Office of Public Affairs), have also included the training of volunteers who, in coordination with local organizations, assist beneficiaries in making Medigap purchasing decisions.

When the previously discussed program frequency estimates are brought to bear, most of the state programs are shown to focus (see Figure 2) on distributing printed materials and answering direct questions. The Arizona SCHIC program and the Wisconsin newsletter/hotline program can serve as examples. These programs, sponsored by state departments of insurance, do not recognize the need for additional efforts to motivate and train the beneficiary to use this information. A much smaller number of programs, such as HICAP and SHINE (sponsored through state departments of aging), have included interactive health insurance counseling. Thus, the majority of state programs that have been undertaken fall into those categories which are not likely to be very effective. Overall, these state programs vary widely and unsystematically in their characteristics.

SPONSORSHIP, IMPLEMENTATION, AND THE ROLE OF THE COMMUNITY

The overall conclusion drawn from this examination of program characteristics is that government, in its role as protector of the consumer, handles the financial sponsorship of programs to educate the Medicare beneficiary. On the other hand, local community organizations implement the majority of these programs. Moreover, federal programs appear to differ from state programs. The federal government has focused its efforts on the limited testing of certain types of educational programs, backed by the provision of basic written information through HCFA. However, while a large number of states do focus mainly on providing basic information, it is only the state-level agencies that have supported the implementation of ongoing programs of interactive counseling and education.

The federal government can play an important role by developing and testing the use of certain types of insurance information programs. Ideally, state agencies would benefit from sharing such centrally developed material. I identified one successful example of this type of federal-state interaction. The HCFA-sponsored HMO Informed Buyer Project developed educational materials which were adopted both by the SHINE program in Massachusetts and by the MCOA program in Philadelphia, Pennsylvania (Savage 1986).

However, in light of federal government sponsorship of extensive research to develop the "Consumer Education Guidelines for Providers of Health Insurance Information" with specific recommendations for the Medicare population (Little/Schauffler 1980), a more systematic approach to the testing, design, and implementation of operational programs should be possible. Unfortunately, no systematic use of these guidelines appears to have been made by HCFA either in its decisions to promote and fund various federal programs or, for that matter, in any kind of coordinated role with the states. The lack of an explicitly formulated coordinative role on the part of HCFA is disturbing given the existence of these guidelines.

In this absence of federal leadership, individual states have designed and implemented most of the truly educational information programs comparing health insurance options for Medicare beneficiaries. These states have exercised their commitment to this goal through their departments of aging, implementing educational modalities that show more promise than the simple dissemination of written information. Ultimately, the lack of a federal coordinative role in assisting states to develop the most effective Medicare insurance education programs leaves beneficiaries receiving widely varied assistance. Some states provide no assistance at all, or only minimal written materials; others provide limited educational programs; still others provide extensive educational programs. While all beneficiaries are covered by the same federal Medicare policies, their ability to use and supplement this coverage effectively varies with their state of residence.

The complexity of this problem suggests that 50 individual states, even if they differ in their regulatory approaches to health insurance, could benefit from some shared knowledge, especially since all efforts are ultimately directed toward the support of a uniform federal program. Each state's independent reinvention of this particular wheel is neither the most efficient nor the most effective way to assist this country's elderly citizens. Clearly, since specific health insurance options vary from state to state, the exact content of comparative information must vary. But Medicare coverage itself is uniform, and the need to educate beneficiaries effectively has national implications.

EFFECT OF HEALTH INSURANCE INFORMATION PROGRAMS ON BENEFICIARIES' DECISIONS

CRITERIA FOR EFFECTIVENESS

Three approaches may be used to evaluate health insurance information programs, the evaluations themselves ranging from relatively simple tabulations to complex experimental analyses. The "Consumer Education Guidelines for Providers of Health Insurance Information" (Little/Schauffler 1980) suggest that these approaches are (1) process and content evaluation, (2) volumetric reporting, and (3) impact evaluation. Regardless of the type of approach used, however, the guidelines recommend developing the evaluation strategy before implementing the educational program, to ensure its integration into the overall plan and to reduce ultimate costs.

First, a program can assess participant reaction to process and content during the pilot run. The guidelines identify two areas—program format and program materials—for process and content evaluation. Following these evaluations, programs should edit and modify both the format and the materials to meet more closely the needs of the target group prior to a full implementation of the program. The first of these areas, program format, focuses on aspects of the structure of the program itself, such as personnel, access, and time required. The second, program materials, focuses on aspects of the organization and presentation of the materials such as format of the information, ease of comprehension, and completeness.

The second approach to evaluation discussed in the guidelines, volumetric reporting, is a simple count of the number of people reached or services provided. Volumetric reporting is most useful in evaluating programs designed to increase access to information, but it does not address

Figure 3: Methods of Program Self-Evaluation

PROGRAM NAME	PARTICIPANT REACTION	VOLUMETRIC EVALUATION	IMPACT EVALUATION
HMO Informed Buyer	X	X	X
Brokered Consumer Choice		X	X
Health Insurance Decision	X		X
Average Out-of-Pocket Cost	X		X
Health Insurance Planner	X		
Beneficiary Services		X	
HICAP	X	X	
SHINE	X	X	
MCOA	X	X	
SHIBA	X	X	
SCHIC		X	
Newsletter/Hotline		X	

the effect of the information on the knowledge level or decision skills of participants. Its main virtue is its relatively low implementation cost.

Finally, impact evaluation is the approach that measures actual changes in the knowledge, attitudes, and behaviors of participants. This type of evaluation is generally very costly, primarily because of the need to gather data from participants over a period of time in order to assess adequately their absorption and use of the information presented. The guidelines recommend that impact evaluation be performed after process and content evaluations and volumetric evaluations have already demonstrated that the program is reaching sufficient numbers of people and that the methods and materials are reasonable and well received.

Furthermore, impact evaluation should not occur too early in the life cycle of a program; sufficient program maturation beyond the developmental phase should be allowed. Because of the high cost of impact evaluations, they usually are undertaken only by programs specially funded for that purpose. The guidelines strongly recommend funding of impact evaluations for a number of programs that use a variety of approaches to health insurance education.

PROGRAM SELF-EVALUATIONS

Figure 3 categorizes the 12 example programs according to the approaches they used to evaluate their own respective effectiveness.

Volumetric reporting was most common, undertaken by 9 of the 12 programs. Participant reaction to content and process was undertaken by eight programs, and impact evaluation by only four. This ordering is to be expected, largely because collecting volumetric data is relatively simple and low in cost, and it is important that potential participants approve of the proposed format of the information and the intervention.

In particular, it appears to be the ongoing state-funded programs that favor volumetric reporting. Since this type of evaluation tends to equate success with high volume, it cannot address a program's actual ability to educate the population of Medicare beneficiaries. Volumetric reporting may be adequate, however, for an assessment of a program's success in simply reaching this population. Further, a number of programs have used participant reaction to program content and process as a preliminary means of refining the structure of their informational intervention. Volumetric evaluations and participant reaction usually do seem to be planned and designed prior to program implementation.

In contrast, only federally funded programs have attempted to evaluate their actual effect on participants (impact evaluations). This may be understandable insofar as the cost of impact evaluation is likely to be prohibitive for an individual state government. Ultimately, there is little inherent efficiency in a situation where each state performs similar impact evaluations on a similar array of program types. By centralizing the costs of impact evaluations, the federal government has the opportunity to evaluate the effects of a series of generic program types; results can be shared by the states in the design and implementation of their own programs.

The cost and complexity of impact evaluations suggests that there is strong potential for such a federal role. Nevertheless, it is rare, even on the federal level, to find an impact evaluation designed as an integral part of an overall program. In fact, only the two research-oriented federally sponsored programs have impact evaluation designed into their main objectives. Furthermore, as suggested in the previous section, I found little evidence of any effort by the federal government at systematic evaluation of the relative effects of the various possible program types.

PROGRAM EFFECTIVENESS

Only limited conclusions can be drawn from the programs that have been implemented, and strong statements cannot be made about which program types are most effective in practice. Volumetric reporting and participant reaction appear to suggest a considerable demand for insurance information programs by Medicare beneficiaries. The actual effects of the programs on knowledge, attitudes, or decision behaviors, however, cannot be derived with any certainty from these data.

Nor do the four programs with explicit impact evaluation components provide any firm answers. The HMO Informed Buyer program designed and performed an impact evaluation after the implementation of the program. A telephone survey of a sample of participants from three of the five sites was performed, since participant telephone numbers were unavailable for the other two sites. This survey showed a self-reported knowledge gain in the area of understanding the difference between HMOs and other health insurance options, but minimal shifts in behavior—only 6.8 percent of the sample reported that they had joined an HMO (Savage 1986).

The measure of impact used by the Brokered Consumer Choice program was the number of beneficiaries enrolling in an HMO who also attended an informational session. In Portland, about 7 percent of the 150,000 beneficiaries who were notified about the 550 sessions actually attended (about 11,000) and, of these, approximately 72 percent went on to enroll in an HMO afterward (Connors 1986). While this measure does assess a behavioral change on the part of beneficiaries, it does not provide much insight into the use they made of the information. Enrollment of such a large proportion of those attending sessions suggests that the majority of attendees had more-or-less made the enrollment decision before they received the information.

The Health Insurance Decision Project and the Test of Average Out-of-Pocket Cost Information program are both research endeavors, specifically designed to evaluate the effect on beneficiaries of particular types of educational programs. Since neither one has completed its impact evaluation, these results are not yet available. Given the range of approaches to providing insurance information, however, additional systematic impact evaluations are needed in order to gauge relative program effectiveness more accurately.

POLICY SIGNIFICANCE

The importance of voluntary decisions made by beneficiaries regarding supplementation of their basic Medicare coverage has increased in recent years. In the past, the issue of supplementation has been related only to the purchase of private Medigap policies, which can protect the beneficiary from some of the acute care costs not covered by Medicare. The private Medigap marketplace is complex and confusing, and beneficiaries require assistance for their own protection as consumers as they attempt to select a Medigap policy. This issue has become even more important since the recent enactment by Congress of a program to cover some of the costs of acute catastrophic illnesses through Medicare (Iglehart 1987a).

However, the issue of supplementation has taken on a greater weight, not only in relation to the financial protection of the beneficiary but also as it relates to the long-term financial stability of the Medicare program. With the introduction of risk-based capitation contracts as a reimbursement reform, the long-range plan for management of the federal Medicare budget now rests heavily upon the large-scale voluntary enrollment of beneficiaries into capitated health plans. For beneficiaries, enrollment in an HMO can mean more comprehensive coverage or lower out-of-pocket costs, or both, than they would receive with basic fee-for-service Medicare. Thus, HCFA places a considerable emphasis on the voluntary decision by beneficiaries to supplement their basic Medicare coverage through enrollment in an HMO as a means for shifting the Medicare program to a predominantly capitated system and thereby controlling the expenditure of federal funds (Dobson et al. 1986).

This competitive strategy reflects current governmental beliefs that self-regulating forces can be brought into play in the Medicare health insurance market. If beneficiaries can make economically rational voluntary decisions to join HMOs, efficiencies that can limit the overall cost of their care will be introduced automatically. Despite the increased importance of beneficiaries' decisions about their Medicare coverage, an equivalent increase in attention to understanding and improving this decision-making process is not evident.

This is particularly disappointing because it reflects a critical misunderstanding of economic theory on the part of those public servants who are the stewards of this important social program (Spitz and Abramson 1987). There is no question that basic economic assumptions regarding the free flow of information are violated in this market. Yet despite these fundamental violations, relatively little effort is being made to produce empirical evidence, one way or the other, that beneficiaries can become more rational in their consumption of various types of coverage as a result of health insurance information programs.

Although it is now eight years since the release of the "Consumer Education Guidelines for Providers of Health Insurance Information" (Little/Schauffler 1980), the basic recommendations of that study still stand. No findings contradict those recommendations, but despite the recommendations, no systematic studies have yet been completed to advance our ability to evaluate the effectiveness of informational programs for Medicare beneficiaries. (The two federally funded impact evaluations should be releasing their findings in the near future.) Despite the longstanding acknowledgment of the complexity of the decisions that must be made by the Medicare beneficiary, we have advanced very little in our ability to enhance the quality of the decision-making process.

If it is true that this nation is committed to the market model of health care delivery, and that our government relies upon it for the management of cost and quality in the federally sponsored Medicare program, what excuse can there be for this continuing discrepancy between political rhetoric and program support? Certainly expense would be involved in a large-scale federal effort to develop and implement a beneficiary insurance education program. But how large could this expense be in comparison with the $13 billion spent on Medigap premiums (Rice and McCall 1985; Smeeding and Straub 1987; Wilson 1987) and the $70 billion spent on Medicare (Waldo, Levit, and Lazenby 1986)? And if it is true that informed decisions by beneficiaries will result in future Medicare program savings, then it is these estimates of future savings that should be used to justify current investment in insurance information programs.

Insurance information programs provide an example of government intervention to rectify a market distortion in order to permit that market to more closely approach the competitive model. Such a policy instrument should be justifiable in the current political climate. The most plausible excuse for a lack of effective federal leadership in this area has been a president "with a commitment to unregulated markets probably unmatched by any president since Coolidge" (Rauch 1988). In this instance, such a shortsighted perspective borders on the irresponsible, considering the likely future cost of Medicare in the absence of present insurance information programs.

This synthesis recommends the distribution of systematic guidelines, such as those developed by the Bureau of Health Education at the Centers for Disease Control (Little/Schauffler 1980), and the explicit use of such guidelines as a blueprint for a joint federal-state initiative. Acknowledgment of this undertaking as a legitimate role for the federal government to assume could have a far-reaching effect on ensuring that all Medicare beneficiaries are provided with the most helpful information programs available on Medicare supplementary coverage. Federal sponsorship can play an important role in the development and dissemination of knowledge about the relative effects on the decision-making process of different types of consumer information—a role not adequately addressed to date.

The responsibility for program sponsorship has fallen on governmental agencies and the responsibility for implementation on community or advocacy groups. This is probably an appropriate division of accountability for avoiding the appearance of conflicts of interest and ensuring that the sources of information used are completely credible to the beneficiary. Furthermore, networks of community organizations can achieve the collaboration often needed to overcome particular deficiencies in implementing these programs: the groups that are best at reaching seniors are not always the groups that are best at educating them or the groups that are best at evaluating programs.

Several specific statements can be made regarding design of the health insurance information programs for Medicare beneficiaries. The basic objectives remain the same as those developed for the "Consumer Education Guidelines for Providers of Health Insurance Information" (Little/Schauffler 1980). Restated here, they are summarized as three principles:

1. To reach the Medicare beneficiary through the employment of various media, and thereby to induce the beneficiary to perceive a need to seek out the complex information required to make a difficult decision
2. To present this complex information in a format that can be easily understood and used by the beneficiary, and through interactive personal contact to motivate and train the beneficiary to actually use this information
3. To assess the "quality" of the decision made by the beneficiary in terms of the real impact on the decision-making process of the consumer information provided.

On the other hand, insurance information programs may not have the anticipated beneficial effect on beneficiaries' selection decisions (Hibbard and Weeks 1987; Wilkie and Gardner 1974). With so little evidence to refer to, we cannot say for sure. If insurance information programs are found not to be helpful, what can be said regarding the government's reliance on a market model for managing the costs of the Medicare program? If the implementation of policy instruments designed to enhance "competitive" outcomes fails to have the anticipated effects, and the cost of the federal health program for the elderly cannot be managed by this means, should this approach be abandoned? These are the larger questions that hang in the balance as we contemplate the delineation of standards for the design of comparative health insurance information programs for Medicare beneficiaries.

In both cases, it is clear that the federal government has an important role to play. Policy instruments must be developed and implemented either to enhance "competitive" outcomes in the distorted health insurance market or to achieve desired efficiency and quality goals by organizing the delivery of health services to Medicare beneficiaries in a more directly regulated manner. The proper choice between types of policy instrument depends upon whether beneficiaries can become informed consumers. Thus, regardless, the incremental policy step at this juncture must be a serious federal effort to determine the effect that can be expected from insurance information programs for Medicare beneficiaries. The jury is still out.

Of course, federal Medicare coverage for acute "catastrophic" illness, under the Medicare Catastrophic Coverage Act of 1988 can replace many of the coverage provisions in most private Medigap policies currently on the market (Cohodes 1986; Feder, Moon, and Scanlon 1987; Iglehart and White 1986; Perse 1987; Schramm 1987). According to the summary of the *Conference Agreement on H.R. 2470, the Medicare Catastrophic Coverage Act of 1988*, released on May 31 by the Conference Committee, this new Medicare coverage will require all beneficiaries to pay a basic monthly premium increase of about $4 in 1989, rising to about $10 in 1993. This amount is considerably lower than most commercial plans but, in addition, the 40 percent of beneficiaries who pay federal income tax will pay a supplemental premium equal to a 15 percent surcharge on that tax, up to a maximum of $800 for a single taxpayer and $1,600 for couples, beginning with 1989 income tax returns. The supplemental premium will result in a higher cost than many beneficiaries are now paying for similar coverage, especially for those beneficiaries who receive employer-paid private supplements as a retirement benefit.

Now that such a plan for catastrophic coverage has been enacted, both the benefit structures and marketing strategies of Medigap policies are likely to be revised substantially. The new legislation calls for the National Association of Insurance Commissioners to establish new standards for Medigap policies. Some insurers may begin to offer coverage for different types of risks, such as long-term care, in order to differentiate their policies more fully from the new federal program. Others might try to limit their policies to the few remaining gaps in acute care coverage that remain in the new federal program. In any case, a definite need now exists for additional insurance information programs to assist beneficiaries in understanding the differences between these new private plans and the new Medicare plan.

Nevertheless, we still must find out whether insurance information programs can enable Medicare beneficiaries to recognize and value the advantages of capitated health plans. Of the 30 million Medicare beneficiaries, only 1 million, or 3 percent, are enrolled now. Although since only an estimated 16 million beneficiaries actually live within the geographic service area of existing prepaid plans with Medicare contracts (Fackelmann 1988), these 1 million enrollees represent about 6 percent of those who actually have the opportunity to enroll. In any case, the rate of enrollment of beneficiaries must be maintained if HCFA is actually to achieve "control" over the Medicare budget through this means. If a sufficient number of beneficiaries will not enroll voluntarily in capitated plans, then other means to achieve goals of efficiency and quality must be developed. It is likely that "teaching our oldest and sickest citizens how to buy health insurance" (Schauffler 1987) is not the best way to achieve the efficiency, quality, and access goals desired by our society. For the Medicare program, a more regulated approach may be necessary.

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