

**Testimony of  
Susan Kleimann, Ph.D.,  
Kleimann Communication Group, LLC  
before the  
Senate Special Committee on Aging  
May 6, 1998**

Mr. Chairman and Members of the Committee:

Good afternoon. My name is Susan Kleimann and I am President of Kleimann Communication Group, a small business that works with clients to communicate complicated information so that people can use it. I am accompanied by Jill Bernstein, Ph.D. from the National Academy of Social Insurance (NASI). I am pleased to be here today to testify on the results of focus groups that we conducted with Medicare beneficiaries for the National Academy of Social Insurance and the California HealthCare Foundation. Before I begin, I'd like to show you a videotape of some of the beneficiaries with whom we spoke. These beneficiaries are typical of the people who participated in our groups, which were evenly distributed by age, race, income, and education.

The focus groups research was conducted in support of a larger project, **Restructuring Medicare for the Long Term**, underway at NASI. The focus groups, conducted in three different areas of California in February 1998, provided an opportunity to hear in some detail about the experiences of individuals who are already dealing with a complex Medicare marketplace that offers an array of choices among managed care options and physician groups contracting with numerous health plans. These groups, therefore, can provide some insight into the new environment that will be created by the implementation of the Medicare+Choice options established in the Balanced Budget Act of 1997. The groups were structured to address two major topics: beneficiaries' understanding of and experiences with Medicare and the Medicare managed care options available to them in California; and their views about the future of Medicare, including the expansion of plan options, cost sharing, and individual and family responsibilities for health care now and in the future.

The changes that are planned for Medicare require that beneficiaries take a more active role in their health care planning and decisions--a more active role that could have dire consequences for them if they misunderstand the information they are given or are merely befuddled by the information. As you can tell from the videotape, the beneficiaries we spoke with are dignified, thoughtful, and concerned. I have enormous respect for the voices that we heard in our groups, and I make a point of saying that, as a context for my comments today. These people had a wide range of education, levels of activity, and willingness to learn, but they shared at least one sentiment about their health care choices, because they **do** understand the consequences of choosing poorly: "It's scary, so scary to make a choice."

For today, I would like to address the challenges of sharing information with Medicare beneficiaries so that they can act upon that information in their own best interests. I'd like to address four areas in this statement: (1) cognitive maps and the difficulty of changing maps, (2) the issue of information overload; (3) what our focus groups told us about the level of proficiency and knowledge among Medicare beneficiaries--somewhat experienced with choice; and (4) the implications for information given to these beneficiaries about the changes to Medicare.

### **Cognitive maps and the difficulty of changing maps**

Let's start with cognitive maps. We learn to do things by building a pattern in our minds (what we researchers like to call a schemata or cognitive map). We do this, so that we can approach the same task

or a similar task more easily the next time we encounter it. As we do a new task, we look in our mind's bag of maps for similar task maps and we build on those task maps if we can. If we can't find an appropriate map, we build a new schema or map, so that we can use it the next time. We all build maps and we all do this each time we encounter something new to do. On my way downtown this past April, I used the subway. As I approached the fare card machines, I noticed small crowds of tourists looking befuddled as they tried to understand the process of buying a fare card and how much cash they should put on the ticket. They read the instructions, they pulled out money, they looked around for a fare schedule, they read the schedule (after checking the name of the station they were at), they inserted their money, some of them upside down, they reinserted their money, they waited for the ticket to come out and they scanned the machine, looking at every slot waiting for the fare card to pop out. The commuters, the old hands, not necessarily smarter nor better-educated nor even better-tempered folks, these people tapped their toes impatiently while the tourists figured out the process or they approached the turn stile with card in hand and confidently breezed through the turnstile and down to the platform. They had developed a cognitive map for the Washington subway system; the tourists had not.

When we face an unknown task, it doesn't matter how smart or how educated or how important, we lose our ability to be competent until we have built a cognitive map for how to complete the task. So, the big question here is do the elderly (do Medicare beneficiaries) have a cognitive map to deal with the choices that soon face them? Let's assume for now that the choices are fairly simple--Plan A or Plan B.

First, they would need a cognitive map for making a choice. Some beneficiaries have had no experience selecting among plans because they have had no health insurance at all. In 1996, 13.6 percent of Americans aged 55-64 had no health insurance. Many of today's Medicare beneficiaries (and the baby boomer crowd behind them) have worked in small enterprises where no insurance was offered or only one plan was offered. Of the 95 million Americans with employment-based coverage, almost 40 percent work in establishments with fewer than 200 employees. Only about one in five workers in small firms that do provide health insurance have any choice of health plans at all, and less than one in 10 have the opportunity to choose from three or more plans. Even among larger firms, a significant proportion offer only a very limited choice of health care plans. So, most beneficiaries do not have a cognitive map for choosing a health plan.

Second, they would need a map about what an HMO is and how it differs from traditional health insurance. Much of the information is new to them: they have little experience with managed care, little experience with networks and the other activities of managed care. HMOs have begun only recently to be available to people in many parts of the United States. In fact, much of the current research indicates that many people, not just Medicare beneficiaries, know very little about these differences, even in markets that have had managed care options for a while. Certainly, our research with people who have had more exposure to managed care than most other Americans, shows that they had very mixed levels of knowledge, some of it accurate, some of it quite faulty. So, in general, most beneficiaries will not have a map for judging differences among types of health plans.

Third, for beneficiaries to take an active role, they would need to weigh all of the factors about choice and make a decision that considers multiple factors. Much of the research on decision-making suggests that as humans we are lousy decision makers--even when we are trying very hard. We assume that more information is better for making decisions, that if we collect enough information, or more information, eventually we will be able to make the "best" decision or find the "truth." What decision researchers tell us, however, is that this is not true. In fact, too much information distorts the decision-making process. We tend to cope with too much information by short-circuiting the decision-making: we fail to consider all of the factors, fixate on a few factors, and make our decisions based on these factors, often the factors with which we are most familiar. As a result, the multiplicity of choices that will face Medicare beneficiaries could well overwhelm their decision-making process--even before we consider that most of

the beneficiaries will not have cognitive maps about choosing a health plan from multiple choices or about choosing among traditional or managed care alternatives.

### **Information overload**

Next, let's consider information overload. Let me not cite the statistics about how fast the amount of data is expanding nor the statistics about how many pieces of information each of us face each day; we only need to look at our own in-boxes to assess that. Instead let's consider how well people are able to cope with some of the simpler tasks of life, like reading a bus schedule. If you'll look at Figure 1, you'll see a bus schedule. It's not particularly intimidating to most of us. However, according to the National Adult Literacy Survey, document tasks, such as reading this bus schedule are not well-handled by most people. In fact, of those between the ages of 55-64, 90% could **not** figure out how long they would have to wait for the next bus, if they missed the 2:35 bus on a Saturday. Of those 65 and older, 98% could not figure out the same task. If we assume that the task of choosing a health plan is no more difficult than finding the time of the next bus, if we assume that comparative charts such as Figure 2 (this is the comparative chart provided to California Medicare recipients) are as simple as a bus schedule, then we're looking at a staggering number of people who will not be able to use charts like these.

Let's look now to see how much information that Medicare beneficiaries will have to sort through. When I spoke about cognitive maps, I said let's assume a simple choice of Plan A and Plan B. In fact, Medicare beneficiaries will be faced with a far more complicated choice. According to regulations, beneficiaries will choose among Coordinated Care Plans, "including but not limited to health maintenance organizations plans (with or without a point of service options), plans offered by provider-sponsored organizations) and preferred provider organization plans. In addition, they can select a combination of a MSA plan and contributions to a Medicare+Choice medical savings account (MSA) and a private fee-for-service plan." Now even if we have only one of each, our Medicare beneficiary is choosing among six plans. In fact, in northern California, (I refer you back to Figure 2), a fairly well-developed managed care market, beneficiaries are choosing from 17 plans.

Do we have information overload yet? Before we decide, let's also consider the information that the Balanced Budget of 1997 (P.L. 105-33) Act specifies that the Health Care Financing Administration (HCFA) provide to beneficiaries to help them chose a Medicare plan:

(3) GENERAL INFORMATION- General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) BENEFITS UNDER ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION- A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including--

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) ELECTION PROCEDURES- Information and instructions on how to exercise election options under this section.

(C) RIGHTS- A general description of procedural rights (including grievance and appeals procedures)

of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

(D) INFORMATION ON MEDIGAP AND MEDICARE SELECT- A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

(E) POTENTIAL FOR CONTRACT TERMINATION- The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(4) INFORMATION COMPARING PLAN OPTIONS- Information under this paragraph, with respect to a Medicare+ Choice plan for a year, shall include the following:

(A) BENEFITS- The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) PREMIUMS- The Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium.

(C) SERVICE AREA- The service area of the plan.

(D) QUALITY AND PERFORMANCE- To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B in the area involved), including--

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) SUPPLEMENTAL BENEFITS- Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

We are well beyond the amount of information that cognitive psychologists say that we can process and hold in our short term memory --seven plus or minus two.

So now let's assume that we can get all of this information into charts or a booklet, in a font size that the elderly (or any of us who have hit middle-age) can read. We still need to consider how people read--or rather how they don't read. In fact, when adults read functional documents, that is documents which are not for pleasure, they read by skimming the text for answers to questions, their questions. If they can't find the answers or if they are intimidated by the size of the document or how it looks, they simply quit.

Even if reading charts is not a problem, the contents of the charts may be. We heard over and over from our focus group participants that the "devil is in the details." It's the information about specific things that make a big difference to them -- whether specific drugs are included in the HMO formulary, which diabetic supplies are covered, how much they would actually have to pay for a major dental procedure, what is really covered, and what is not, when they go to buy a pair of glasses and is far too specific to be included in the most complicated chart. Even if we spread this information over an entire booklet, we are beyond the amount of information that most of the beneficiaries can handle.

From these facts, what is the picture of the Medicare beneficiary that is emerging?

- a person who has no cognitive map for choosing a health plan (having had little or no choice before),
- a person who has no cognitive map for selecting between managed care and traditional care (having had little experience with managed care),
- a person with typically short-circuited decision-making processes,
- a person who has trouble reading documents like a bus schedule, and
- a person who doesn't read, but skims a document in search of answers to questions, but quits if the task is too difficult or there's just too much information.

Again, we are not talking about a minority of the Medicare beneficiaries, but as much as 98% of the population. As the videotape indicates, these people are overwhelmed by the information overload. And our participants were able-bodied, mobile, and motivated enough to come to our group (we had a 100% show rate for all of these groups). What if they were ill or bed-ridden or wheel-chair bound? What if they were dealing with a life-threatening illness of their own or of a spouse of 50 years? How would we expect them to process this information and to act upon it? The answer is obvious.

## **What these focus groups told us about the level of proficiency and knowledge among Medicare beneficiaries**

Research has shown that people have never really understood the features of Medicare; managed care adds another layer. People in our focus groups did not know if they were in traditional, fee-for-service Medicare or not; they sometimes thought that they were not in Medicare if they were in an HMO; they thought that the \$43.80 withheld from their social security checks was the full payment for HMO services. Because they thought they were no longer in Medicare, some were convinced that they had to deal with the HMO entirely on their own -- they did not know that Medicare HMO beneficiaries have rights that can be enforced by the Medicare program. Beneficiaries who were also eligible for MediCal (Medicaid) were confused about what benefits they could actually receive. This was a serious problem for some beneficiaries who said they could no longer get prescriptions that were covered under MediCal through their HMOs.

Now, in each group, it's true that there was at least one incredibly active information gatherer. These people used the Internet, called the HMO and got the doctor's credentials, or went to hospital education classes and choose her doctor based on the doctor who most often spoke. But the majority of the beneficiaries were not active like this. They wanted information presented by people like us who were unattached to the plans and were giving them a chance to talk and were providing them with information. They thanked us for being allowed to come and for giving them information. Face-to-face interactions like these are essential if people are to truly understand the issues and options that come with Medicare choices.

## **Implications for Medicare+Choice**

Providing Medicare beneficiaries with information they need and that they can use to make good choices about enrolling in health plans is a daunting task. Tens of millions of beneficiaries have never really done anything quite like this--and HCFA hasn't either. There is some time -- beneficiaries won't have to make choices, or be bound by their choices, for a few years. But to handle the enormous education process that Medicare has committed itself to, it is crucial that there be a workable plan.

First, HCFA needs to decide what audience it is trying to reach. Active, informed consumers can take care of themselves. Too much information is, for most beneficiaries, wasted effort and time. HCFA needs to worry about the vulnerable population -- people who cannot sort through mounds of definitions and facts and figures, and who will be overwhelmed by too much information. Unfortunately, this is probably 98% of the beneficiaries. For people with low literacy skills, cognitive impairments, problems with vision, people who do not speak English or do not feel comfortable dealing with complicated issues in English, understanding Medicare options will be especially intimidating. HCFA needs to begin the education efforts with this in mind:

*Start with the most essential, basic messages that beneficiaries need:*

1. There are new options in Medicare;
2. You don't need to decide what sort of Medicare plan you will sign up with immediately, but you will need to find out about these options sometime; and
3. There are places you can call and people you can talk with to get more information.

Second, work out a strategy that will generate the kinds of information people can actually use. An

educational effort like this requires a great deal of technical expertise and skill, and targeted research and testing. HCFA has done an excellent job with "cognitive testing", which is designed to ensure that the materials it sends out can be understood. But in addition, HCFA needs to do "usability" testing, which can tell them whether people can actually use the materials to make decisions. This kind of testing includes actually watch people working through a pamphlet or other document with a task to complete, and seeing if they can apply the information in the document to the task at hand. Understanding is a prerequisite for use, but the one does not automatically follow the other.

Third, find ways to get the detailed information that consumers might need into the hands of people who can use it, or who can help others use it. The research evidence consistently shows that most Medicare beneficiaries prefer to get information on-on-one, from individual counselors, or in small groups where they can get answers to their specific questions. The Information, Counseling and Assistance (ICA) program has been providing beneficiaries in every state with help in dealing with Medicare questions about a range of complicated program issues, including Medigap insurance, since 1990. Organizations, such as these and other community based organizations that provide assistance to seniors and persons with disabilities, could be valuable resources for Medicare+Choice. To provide objective and useful information to beneficiaries, however, these organizations would need training about Medicare plan options, and access to up-to-date and complete information on plans (including all the information required by the Balanced Budget Act, e.g. benefits, cost-sharing, quality and satisfaction measures, etc.). They also need to be able to use on-line data bases to provide tailored reports that answer individuals' particular questions. Developing education and training programs for intermediaries who can help beneficiaries who need help (in person, over the telephone, via automated kiosks in shopping malls, and so on) should be a priority. This data base development and training will require a considerable investment in time and resources. Neither HCFA nor local community groups can take on a huge task like this without additional resources, both funding and people.

In conclusion, I would like to thank the Committee for allowing me come here to share some of the challenges in communicating information so that Medicare beneficiaries can use it to help them make choices that will be "a good deal" for them. I know that HCFA has been working hard to prepare for Medicare+Choice. I hope that the work that we have done has helped to bring the enormity of the task ahead into some perspective, and can help provide direction for the work that needs to be done. I would be pleased to answer any questions you may have.