Contract No.: 500-95-0047(7)
MPR Reference No.: 8647-501

EDUCATING NEW MEMBERS OF MEDICARE+CHOICE PLANS ABOUT THEIR HEALTH INSURANCE OPTIONS: DOES THE NATIONAL MEDICARE EDUCATION PROGRAM MAKE A DIFFERENCE?

Final Report

July 25, 2001

Authors:

Merrile Sing
Beth Stevens
Anna Cook
Michael Sinclair
Julia Ingels

Submitted to:

Centers for Medicare & Medicaid Services
Office of Strategic Planning
Research and Evaluation Group
7500 Security Boulevard
C3-20-14, Mail Stop C3-19-26
Baltimore, MD 21244-1850

Project Officer: Peri H. Iz, Ph.D.

Submitted by:

Mathematica Policy Research, Inc.
600 Maryland Avenue, S.W.
Suite 550
Washington, DC 20024-2512

Project Director: Merrile Sing

CONTENTS

CONTENTS (*continued***)**

CONTENTS (*continued***)**

Chapter **Page**

CONTENTS (*continued***)**

Chapter **Page**

ABSTRACT

The National Medicare Education Program (NMEP) addresses one of the biggest challenges facing Medicare--educating beneficiaries about their insurance options. Data from a national survey of Medicare HMO enrollees and fee-for-service beneficiaries age 65 and over indicate that most of these beneficiaries are aware of at least one NMEP information source, such as the *Medicare&You* handbook. Recent Medicare HMO enrollees are more likely than fee-for-service beneficiaries to have searched for information about Medicare. About 44 percent of recent Medicare HMO enrollees recall using a NMEP source. Most beneficiaries who use NMEP sources find them helpful. About 40 percent of recent Medicare HMO enrollees and 67 percent of fee-for-service beneficiaries still do not understand key aspects of Medicare.

EXECUTIVE SUMMARY

The National Medicare Education Program (NMEP) addresses one of the biggest challenges facing Medicare--educating beneficiaries about their insurance options. To learn more about beneficiaries' understanding of Medicare concepts, their awareness and use of NMEP information sources, and the factors that affect their health plan decisions, Mathematica Policy Research (MPR), under contract to the Centers for Medicare & Medicaid Services (CMS), conducted a two-period, nationwide survey of recent Medicare HMO enrollees, beneficiaries who recently switched from one HMO to another ("switchers") and fee-for-service (FFS) beneficiaries age 65 and older. We interviewed 3,165 beneficiaries and achieved a 72 percent response rate.

Switchers and new enrollees demonstrate greater knowledge than FFS beneficiaries of basic aspects of the Medicare program, particularly of crucial facts about Medicare+Choice that would affect their willingness to join a Medicare managed care plan. For example, over 70 percent of switchers and new enrollees understand that if they were to leave a Medicare HMO, they would still be covered by Medicare. This is true for only 41 percent of FFS beneficiaries.

Approximately 73 percent of switchers, new enrollees, and FFS enrollees are aware of at least one NMEP information source. But beneficiaries *use* NMEP information sources at a lower rate than their substantial awareness might indicate. Forty-four percent of switchers and new enrollees have used an NMEP source, while 39 percent of FFS beneficiaries have done so. When beneficiaries do, however, use NMEP information, they find it helpful in learning about Medicare. Of those who read the *Medicare & You 2000* handbook, three out of four new enrollees, switchers, and FFS beneficiaries rate it "good," "very good," or "excellent." Furthermore, greater knowledge of Medicare and Medicare+Choice is associated with reading *Medicare&You* and with using other NMEP sources.

Switchers and new enrollees least likely to use NMEP information sources are those who are age 75 and older and those who have a low propensity to use general information sources such as newspapers and television. Our multivariate regression analysis also indicates that cohort 1 beneficiaries are not more likely to use NMEP sources than cohort 2 beneficiaries, and that switchers and new enrollees are not more likely to use NMEP sources than FFS beneficiaries. NMEP information channels disseminate general information about Medicare that should be useful to all beneficiaries, so beneficiaries who remain in Medicare FFS are just as likely to use this information as those who recently decided to enroll in a Medicare HMO.

The NMEP information sources are most useful to beneficiaries when the sources address the factors that beneficiaries rank highest in making a Medicare health plan decision. New enrollees and switchers told us that the three most important factors they consider when making that decision are the benefits covered by the plan, the quality of care offered by the plan, and the ability to stay with their current providers. All of these factors are more important to beneficiaries than the cost of the premium, which ranked fourth.

These and other findings suggest that NMEP is beginning to affect new enrollees and switchers. Reaching a substantially greater proportion of these beneficiaries or increasing the proportion who use and understand the information may require additional strategies.

I. INTRODUCTION

The introduction of the Medicare+Choice (M+C) program under the Balanced Budget Act of 1997 (the BBA) changed the Medicare program more than perhaps any other event since the program's inception in 1965. (M+C) made more health plans available to Medicare beneficiaries and, through more limited enrollment periods (as of January 1, 2002), changed the way beneficiaries enroll in and disenroll from plans. Many beneficiaries now have more health plan choices, as numerous managed care plans and one private fee-for-service insurer offer a variety of insurance products in many markets.

With this increase in choice comes an increase in the need to provide Medicare beneficiaries with information about both their Medicare options and the way the Medicare program works. Anticipating this need, Congress, in the BBA required the Centers for Medicare & Medicaid Services (CMS) to sponsor a nationwide campaign to educate beneficiaries about appropriate Medicare coverage options. CMS began its education campaign, called the National Medicare Education Program (NMEP), in 1998. In the fall of 1999, CMS contracted with Mathematica Policy Research, Inc. (MPR) to assess the effectiveness of its education program on the understanding of new M+C enrollees and to examine factors that govern beneficiaries' decisions about health plan options. The study focused on several questions:

- To what extent are Medicare beneficiaries who have recently made the decision to join M+C plans, or who switch from one M+C plan to another, aware of information from NMEP?
- How many of these new enrollees and "switchers" use NMEP information sources to learn about their Medicare options and to make decisions about Medicare coverage?
- Does beneficiary awareness and use of NMEP information differ by age, racial/ethnic group, education, or gender? Do awareness and use differ among new M+C enrollees and those who switched from one M+C plan to another, compared with those in Medicare fee-for-service (FFS)?

- Do new enrollees to M+C plans and switchers have a better understanding of Medicare and M+C than do FFS beneficiaries?
- Do those who use NMEP information have a better understanding of Medicare and M+C than those who do not use the NMEP information sources?[1]
- Have the NMEP information sources been helpful to those who have used them?
- What are some of the primary factors that new enrollees and switchers consider when choosing health plan coverage?

To address these questions and thereby assess the effect of the CMS campaign on the various Medicare beneficiary sub-populations, MPR surveyed two cohorts of Medicare beneficiaries: one interviewed in spring 2000 and one in summer 2000. We surveyed two cohorts during two different time periods to determine whether awareness and use of NMEP sources differ for beneficiaries who enroll in an HMO shortly after CMS's fall mass mailing campaign and those who enrolled in an HMO later in the year. Included in the survey are beneficiaries who were new members of a Medicare managed care plan, those who switched from one M+C plan to another, and a reference group of FFS beneficiaries. This report presents the findings from the survey cohorts combined and discusses the differences in key outcome variables between cohort 1 and cohort 2.

[1]All of our measures of beneficiary understanding reflect conditions at the time of the interview, which occurred after the NMEP campaign began. Beneficiaries who used an NMEP source may demonstrate greater knowledge than those who did not because the NMEP source increased their knowledge. But it could also be the case that those who used the NMEP sources had greater knowledge about their options "a priori." Alternatively, those who did not use NMEP sources may have decided not to use them because they believed they already had adequate knowledge of Medicare. Given that we do not have a measure of understanding before the campaign, we will not be able to determine whether the effects of NMEP on knowledge were larger or smaller than the difference in knowledge a priori between the users and nonusers of NMEP.

A. EDUCATING MEDICARE BENEFICIARIES ABOUT THEIR CHOICES

The purpose of NMEP is to explain an extremely complicated set of eligibility rules, benefits, and insurance options to beneficiaries so that they can make an informed choice among their Medicare options. This is an enormous challenge because the Medicare beneficiary population is not an easy population to educate. For instance, 44 percent of those over the age of 65 score at the lowest level of literacy (Kirsch et. al. 1993). This means that they could not undertake relatively simple tasks such as reading labels on prescription bottles or understand the standard consent form (Williams at. al. 1995). In addition, nearly one-quarter of all Medicare beneficiaries have cognitive impairments (Kaiser Family Foundation 1999). And finally, two-thirds have multiple medical conditions that further complicate the education process (Huffman et al. 1996).

Most Medicare beneficiaries do not have a basic understanding about how the health care system works--knowledge that is essential to choosing appropriate coverage. Beneficiary understanding of the Medicare program itself is often poor (Blendon et al. 1995; Hibbard and Jewett 1998; Murray and Shatto 1998). Knowledge of benefits, out-of-pocket payments, private supplemental policies, and rights to appeal appear to be particularly problematic (Hash 1998). Hibbard et al. (1998) recently demonstrated that 30 percent of Medicare respondents know almost nothing about HMOs, and only 11 percent know enough about how FFS differs from managed care to make a truly informed choice.

Further complicating the twin issues of beneficiary choice and knowledge about the health care options is the structure of the Medicare market. An estimated 82 percent of beneficiaries have either private or public insurance that supplements traditional Medicare coverage. Twenty percent of beneficiaries supplement Medicare coverage through individual purchase of "Medigap" insurance; 33 percent supplement it through employer "retiree" insurance; 14 percent

supplement it through Medicaid; and 16 percent receive supplemental coverage by joining a M+C managed care plan (Stevens and Mittler, 2000). The decision about which Medicare options to select therefore involves more choices than the choice between FFS and managed care.

In response to these education-related challenges, CMS created NMEP, a multidimensional campaign for educating beneficiaries so that they may make informed decisions regarding Medicare benefits, health plans, rights and responsibilities, and positive health behaviors. Currently, NMEP has seven channels through which it distributes information about M+C to beneficiaries. The first channel is mass mailing of Medicare & You, a guide to basic Medicare that includes information on program features and rules, health plan options, and comparative information on health plans (where choices are available). The second channel consists of a toll-free telephone service to answer general questions on Medicare. The third is a website (www.Medicare.gov) that provides a wide range of information on program benefits, health plan choices, health plan performance, and healthy behaviors. The fourth channel includes national publicity such as health fairs, and the fifth makes use of mass media such as newspapers and public service announcements. The sixth channel is community-based, face-to-face counseling offered by state and local aging and insurance agencies (known as SHIPs). The seventh channel is a "train the trainer" model that teaches trainers from various non-profit agencies and organizations to go out to educate beneficiaries.

B. THE TARGET STUDY POPULATION

Not all Medicare beneficiaries are alike; they vary in terms of levels of education, work history, ethnicity, health status, family support, living arrangements, financial status, attitudes, and age. These differences lead to different needs and decisions, including whether to join a M+C plan. In fact, beneficiaries who have joined Medicare managed care plans are in the

minority— approximately 16 percent of beneficiaries over age 65 are in M+C plans. Do these beneficiaries seek out different information or use information in alternative ways compared with FFS beneficiaries?

This study focused primarily on two types of M+C enrollees: Medicare beneficiaries who were new enrollees in Medicare managed care plans and those who switched from one M+C plan to another. New enrollees are those who joined an HMO during the sample intake period, and include both those who were previously in FFS and those who first became eligible for Medicare during the period. Switchers were enrolled in one Medicare HMO and switched to a different HMO during the sample intake period. Throughout the study, new enrollees and switchers were compared with beneficiaries who were in Medicare FFS throughout the sample intake period.

Approximately one-third of our beneficiary sample comes from each of the three beneficiary subgroups. Our sample is not representative of all Medicare beneficiaries, since it does not include some beneficiary subgroups (such as those who were in a Medicare managed care plan before the sample intake period and who remained in their plan during the sample intake period.)

C. FINDINGS IN BRIEF

Switchers and new enrollees in both cohorts combined have some characteristics that distinguish them from beneficiaries in Medicare FFS. Switchers and new enrollees are younger than FFS beneficiaries, and they are more likely to be of Hispanic ethnicity. Switchers and new enrollees also demonstrate greater knowledge than FFS beneficiaries of basic aspects of the Medicare program, particularly of crucial facts about M+C that would affect their willingness to consider joining a Medicare managed care plan. For example, over 70 percent of switchers and new enrollees understand that if they were to leave a Medicare HMO, they would still be covered by Medicare. This is true, however, for only 41 percent of FFS beneficiaries. Despite the higher rates of understanding on the part of new enrollees and switchers, nearly 30 percent of them do

not understand that they would still be covered by Medicare if they were to leave their HMO. Overall, then, there is still educational work that has to be done to raise the level of knowledge about the rules governing Medicare for large portions of the Medicare beneficiary population.

Approximately 71 percent of switchers, 75 percent of new enrollees, and 73 percent of FFS enrollees are aware of at least one NMEP information source. But beneficiaries *use* NMEP information sources at a lower rate than their substantial awareness might indicate. Forty-four percent of new enrollees and switchers have used an NMEP source, while only 39 percent of FFS beneficiaries did so. When beneficiaries used NMEP information, however, they found it helpful for learning about Medicare. Of those who read *Medicare&You*, 76 percent of the new enrollees, 74 percent of the switchers, and 74 percent of the FFS beneficiaries rated it "good to excellent."

Beneficiaries who are least likely to use a NMEP information source are those who are age 75 and older and those who have a low propensity to use general information sources such as television, newspapers, and magazines. Our regression analysis also indicates that switchers with annual household incomes less than $40,000 and new enrollees without any college education are less likely to use NMEP information sources. If CMS wishes to target its education campaign on beneficiaries who are not using NMEP information sources, these are the types of beneficiaries that CMS needs to reach.

Beneficiaries also use non-NMEP sources for information. Switchers and new enrollees indicated that their health plan and their doctors are their most helpful information sources; the Medicare program ranks fourth. FFS enrollees cited the Medicare program and their doctors as the most helpful information sources.

The NMEP information sources are most useful to beneficiaries when such sources address the factors that beneficiaries rank highest in making a Medicare health plan decision. New

Medicare plan enrollees and those who switched told us that the three most important factors they consider when making a health plan decision are the benefits covered by the plan, the quality of care offered by the plan, and the ability to stay with their current providers. All of these factors are more important to them than the cost of the premium, which ranked fourth. Indeed, after naming their most helpful information source (which could be an NMEP or non-NMEP source), 55 percent of new enrollees and 53 percent of switchers said that they used that source to help them decide to enroll in a managed care plan. FFS beneficiaries are less likely to use their most helpful source to make a health plan coverage decision or to compare benefits, costs, or quality across different plans. This is probably because few of these FFS beneficiaries are considering a change to their current coverage.

We interviewed the beneficiaries in cohort 2 three months after those in cohort 1. The main difference between beneficiaries in the two cohorts involves their awareness of HMO withdrawals from Medicare. Switchers, new enrollees, and FFS beneficiaries in cohort 2 are more aware of HMO withdrawals than are their cohort 1 counterparts. For each enrollee subgroup, the increase in awareness from cohort 1 to cohort 2 is 10 percentage points or more, and the difference is statistically significant at a 0.01 level. Awareness increased from 53 percent to 65 percent among switchers, from 43 percent to 58 percent among new enrollees, and from 31 percent to 44 percent among FFS beneficiaries. This increase in awareness is most likely due to two factors: many HMO withdrawals occurred in the exact period between the survey of the two cohorts, and the withdrawals were widely publicized.

In addition to the difference in awareness, the cohorts differ in terms of their use of information about HMO withdrawals. Switchers and new enrollees in cohort 2 are also more likely than their counterparts on cohort 1 to use information about HMO withdrawals in their decision about whether to enroll in a Medicare HMO.

These and other findings suggest that NMEP is beginning to have an impact on switchers and new enrollees. Reaching a substantially greater proportion of beneficiaries or increasing the proportion who use and understand the information may require additional strategies.

D. ORGANIZATION OF THE REPORT

This final report includes eight sections and seven appendices. Section II discusses the survey design and methods, and Section III outlines findings on beneficiary characteristics that may affect information use and decision-making. Sections IV through VII present the findings from our analysis of beneficiary information-seeking behavior, beneficiary understanding of Medicare and NMEP messages, beneficiary use of information in decision-making, and the factors that beneficiaries consider when they make a health insurance decision. Section VIII summarizes our findings and discusses the implications of these findings. Appendix A describes the sample design and survey weighting procedures. Appendices B through D contain additional tables for sections IV, V, and VII. Appendix E contains the tables that compare key outcome variables between beneficiaries in cohort 1 and cohort 2. Appendix F contains the survey instrument in English, and Appendix G contains the survey instrument in Spanish.

II. SAMPLE DESIGN, SURVEY DESIGN, AND ANALYTIC METHODS

To examine the effectiveness of NMEP and the factors that influence the decisions of new Medicare HMO enrollees and switchers, we conducted a survey with two cohorts of Medicare beneficiaries who made a Medicare enrollment decision. The first cohort joined or switched HMOs during CMS's autumn 1999 education campaign (October 1st – December 1st), and cohort members were interviewed 6 to 9 months after that campaign began. The second cohort joined or switched HMOs between January 1, 2000, and March 1, 2000, and was interviewed during the summer of 2000, which was 9 to 12 months after the 1999 education campaign began. The use of two cohorts of beneficiaries, separated by a 3-month interval, allowed us to assess differences in switcher and new enrollee awareness and use of NMEP and non–NMEP information sources relative to their decisions as they gain greater "distance" from the NMEP autumn 1999 education campaign. Any differences we observe between cohort 1 and cohort 2 could be due to the longer time lag since the information campaign, to events taking place during the three-month period between the interview, or to differences in the characteristics of beneficiaries. Given that the samples are random, we do not expect major differences in beneficiary characteristics between beneficiaries in cohort 1 and cohort 2, unless those who enrolled in an HMO immediately after the fall campaign differ systematically from those who enroll later. This could well be the case because enrollees in terminating plans are all forced to change plans by January 1. We controlled for some of the differences in the characteristics of beneficiaries in cohorts 1 and 2 in our regression analyses by using the data from the survey and from CMS's enrollment files.

A. SAMPLE DESIGN

Statisticians and survey researchers define the target population of a study as the complete group of individuals for which the study is collecting and analyzing data (Lohr 1999 and

Colledge 1995). The target population for this study includes three groups of beneficiaries as follows:

- ***Switchers*** in cohort 1 were enrolled in one Medicare HMO and switched to a different HMO on October 1, November 1, or December 1, 1999. Switchers in cohort 2 switched to a different HMO on January 1, February 1, or March 1, 2000.
- ***New enrollees*** in cohort 1 were in Medicare FFS and enrolled in an HMO on October 1, November 1, or December 1, 1999, or became eligible for Medicare during this time and enrolled in an HMO. New enrollees in cohort 2 were in Medicare FFS and enrolled in an HMO on January 1, February 1, or March 1, 2000, or became eligible for Medicare during this time and enrolled in an HMO.
- ***FFS enrollees*** in cohort 1 were in Medicare FFS as of October 1, 1999, and remained in Medicare FFS through December 1, 1999. FFS enrollees in cohort 2 were in Medicare FFS as of January 1, 2000, and remained in FFS through March 1, 2000.

Switchers and new enrollees, the first two subgroups in the target population, are the focus of this study. Switchers and new enrollees both made a decision to enroll in an HMO, but there are potential differences between the two groups with respect to knowledge about and attitudes toward Medicare managed care. Given that all switchers have experience with Medicare managed care, their information needs and decision-making process may be different from those of beneficiaries new to managed care. New enrollees, on the other hand, may have enrolled in an HMO for the first time, or they could have been members of an HMO before they became eligible for Medicare.

The FFS enrollees include those who lived in a county served by a Medicare HMO (56 percent in cohort 1 and 62 percent in cohort 2) and those who did not. Among those who had the opportunity to enroll in an HMO, some made a deliberate decision to remain in FFS, while others may not have been aware of their HMO option and remained in FFS by default. The FFS enrollees are the reference group for the study.

The target population of switchers, new enrollees, and FFS enrollees for cohort 1 excludes beneficiaries enrolled in a Medicare managed care plan in September 1999 who did not make a change as well as managed care disenrollees who switched to FFS between October 1 and December 1, 1999. For cohort 2, the target population excludes beneficiaries enrolled in a Medicare managed care plan in December 1999 who did not make a change as well as managed care disenrollees who switched to FFS between January 1 and March 1, 2000. For both cohorts, the target population excludes disabled beneficiaries under age 65 because they represent a small percentage of the overall Medicare population. Obtaining a sample of disabled beneficiaries that would be large enough to develop precise estimates for that subgroup would have required a significant increase in the overall sample size in order to maintain the same level of statistical precision for the 65-and-older beneficiaries as for the other subgroups. In addition, we excluded from the survey Medicare beneficiaries who had end-stage renal disease as well as those residing in a nursing home or receiving hospice care.[1]

We used CMS's Enrollment Database to develop the sampling frame. The Enrollment Database contains enrollment and demographic data on all people enrolled in Medicare. We stratified the sample so that we could separately examine how switchers and new enrollees use information and make decisions.

For each cohort, we stratified our sampling frame into nine strata composed of a combination of the three analytic groups (switchers, new enrollees, and FFS enrollees) and three age categories (age 65 to 74, age 75 to 84, and age 85 and older). We designed the sample allocation procedure to yield an approximately equal number of completed interviews for each of the three analytic subgroups. Within each, we allocated the sample by age in proportion to the

[1]Beneficiaries who were alive as of the end of the sampling "window" (December 1, 1999 for cohort 1; March 1, 2000 for cohort 2) but who had died by the time we tried to interview them were classified as "ineligible" sample members.

population profile. Table II.1A and Table II.1B display both the number of eligible beneficiaries in the sampling frame for each of the nine sampling strata and the number of beneficiaries selected for the study sample from each stratum for cohort 1 and cohort 2, respectively.

For cohort 1, we selected a sample of 2,851 beneficiaries. We divided the sample into random replicates of waves for a potential staged release, and we released 2,356 cases. At an estimated eligibility rate of 92.9 percent, we completed 1,557 interviews, which is a 71.1 percent response rate. For cohort 2, we selected a sample of 2,997 beneficiaries, divided the sample into random replicate of waves for a potential staged release, and released 2,250 cases. At an estimated eligibility rate of 95.1 percent, we completed 1,568 interviews, which is a 73.3 percent response rate.

So that we could conduct subgroup analyses of switchers and new enrollees, we prepared a set of survey weights to account both for differences in the selection probabilities of the sample members interviewed and for potential demographic and socioeconomic differences between the survey population and the target population. The weights adjust the survey data so that the weighted totals reflect in magnitude the values that would be obtained from the population. Appendix A presents a more detailed explanation of our sample design and survey weighting procedures for cohort 1. The same survey weighting methodology was used for the cohort 2 sample.

For the analysis of both cohorts combined, which is the focus of this report, we created a normalized weight for each observation in each cohort. The normalized weights for each cohort are equal to the normalized value of each original weight in each cohort. For example, since there are 1,568 survey responses for cohort 2, the normalized weight for each observation in

TABLE II.1A

TARGET POPULATION AND SAMPLE PROFILE
BY SAMPLING STRATUM MEMBERSHIP
(Cohort 1)

Stratum Number	Enrollment Group	Age	Target Population Percent	Sample Selected	Sample Percent	Completed an Interview	Response Rate
1	Switcher	65-74	0.4	540	18.9	313	71.9
2	Switcher	75 -84	0.3	330	11.6	188	73.2
3	Switcher	85+	0.1	81	2.8	46	74.8
4	New enrollee	65-74	0.4	703	24.7	416	72.3
5	New enrollee	75-84	0.1	187	6.6	90	68.2
6	New enrollee	85+	0.0	60	2.1	18	54.9
7	Reference group	65-74	49.1	472	16.6	258	69.8
8	Reference group	75-84	36.5	351	12.3	179	70.3
9	Reference group	85+	13.1	127	4.4	49	71.5
	Total		100.0	2,851	100.0	1,557	71.1
Subtotals							
	Switcher		0.8	951	33.3	547	72.6
	New enrollee		0.5	950	33.3	524	70.5
	Reference group		98.7	950	33.3	486	70.3

TABLE II.1B

TARGET POPULATION AND SAMPLE PROFILE
BY SAMPLING STRATUM MEMBERSHIP
(Cohort 2)

Stratum Number	Enrollment Group	Age	Target Population Percent	Sample Selected	Sample Percent	Completed an Interview	Response Rate
1	Switcher	65-74	1.0	577	19.2	318	73.9
2	Switcher	75 -84	0.6	336	11.3	180	73.7
3	Switcher	85+	0.1	85	2.8	38	69.5
4	New enrollee	65-74	0.6	768	25.6	418	73.1
5	New enrollee	75-84	0.1	181	6.0	92	74.0
6	New enrollee	85+	0.0	49	1.7	21	78.8
7	Reference group	65-74	48.6	499	16.6	269	74.1
8	Reference group	75-84	36.0	369	12.3	182	71.2
9	Reference group	85+	12.9	133	4.4	50	71.7
	Total		100.0	2,997	100.0	1,568	73.3
Subtotals							
	Switcher		1.7	998[a]	33.3	536	73.5
	New enrollee		0.8	998	33.3	531	73.5
	Reference group		97.5	1,001	33.4	501	72.8

[a]We do not have 1,000 beneficiaries in each enrollee subgroup because we initially sampled 1,005 beneficiaries in each subgroup and we removed some beneficiaries who were also in cohort 1.

cohort 2 was set equal to the original weight multiplied by 1,568 divided by the sum of the original weights (which for cohort 2 is 22,693,894).

B. SURVEY DESIGN

We collected the data by using a mixed-mode methodology—computer-assisted telephone interviewing (CATI) with a mail follow-up for beneficiaries not reachable by telephone or those who preferred to participate by using a self-administered paper questionnaire. Approximately 81.4 percent of the completed interviews were conducted by telephone; the rest were self-administered through the paper questionnaire.

The survey instrument included questions about the respondents' awareness and use of NMEP and non–NMEP information channels, their understanding of the Medicare program, the factors they consider when making a health care decision, their physical and cognitive health, and their socioeconomic and demographic characteristics. Some of these questions were developed for this study, and others were taken from other surveys (such as the Medicare Current Beneficiary Survey). We pretested the instrument before we used it. The telephone instrument took an average of about 20 minutes to administer.

Sample members who were unable to complete the survey themselves due to cognitive, physical, or language difficulties were interviewed by proxy (e.g., a family member) when possible. So that we could interview Spanish-speaking beneficiaries, we translated the survey instrument into Spanish, and Spanish-speaking interviewers conducted the interview.[2] For both cohorts combined, approximately 9.7 percent of the interviews were completed by a proxy, and about 2.2 percent were completed in Spanish.

[2]The Spanish version of the survey instrument appears in Appendix G.

C. COMPARISON OF RESPONDENTS TO NONRESPONDENTS

The survey weights included an adjustment to account for the differences in demographic characteristics between sample members who responded to the survey and those who did not. We compared the characteristics of four groups of sample members: beneficiaries with identifiable telephone numbers who responded to the survey (either by telephone or mail); beneficiaries with identifiable telephone numbers who did not respond to the survey even after follow-up efforts; beneficiaries without an identifiable telephone number who responded to the survey; and beneficiaries without an identifiable telephone number who did not respond to the survey. These four groups of sample members are compared with respect to age, gender, race/ethnicity, and enrollment status for cohorts 1 and 2 in Tables II.2A and II.2B, respectively. The data in the tables come from CMS's Enrollment Database. As shown, there are no statistically significant differences between respondents and nonrespondents in cohort 1 or in cohort 2 with respect to age, gender, race/ethnicity, or enrollment status.

D. DATA AND ANALYTIC METHODS

We used univariate and multivariate techniques to examine M+C beneficiary awareness and use of Medicare information sources and to examine the factors that M+C beneficiaries consider when selecting health coverage. We conducted the analysis with a person-level analysis file we created by merging data from the beneficiary survey, the Enrollment Database, and county-level data on HMO plan enrollment and HMO plan drop-outs. The county-level HMO data were obtained from CMS's State-County Plan Penetration file and CMS's Geographic Service Area file. To conduct the analysis of both cohorts combined, we concatenated the analysis files for cohort 1 and cohort 2.

TABLE II.2A

COMPARISON OF RESPONDENTS AND NONRESPONDENTS
(Cohort 1)

Characteristics	With Locatable Telephone Numbers			Without Locatable Telephone Numbers		
	Percent		Acceptance	Percent		Acceptance
	Respondents	Nonrespondents	Rate	Respondents	Nonrespondents	Rate
Age						
65-74	60.0	56.1	78.1	69.5	65.1	32.0
75-84	30.6	34.1	74.9	27.4	23.3	34.2
85+	9.5	9.7	76.4	3.2	11.6	10.7
Race/Ethnicity						
White and non-Hispanic	84.6	84.6	76.9	74.7	62.3	34.6
Nonwhite plus Hispanic	15.0	14.4	77.6	25.3	35.3	24.0
Unknown	0.4	0.8	63.6	0.0	2.3	0.0
Gender						
Female	58.7	58.1	77.1	63.2	62.3	30.9
Male	41.3	41.9	76.7	36.8	37.7	30.2
Enrollment Group						
Switcher	33.8	31.1	78.4	37.9	32.1	34.3
New enrollee	32.9	31.1	77.9	35.8	40.5	28.1
Reference group	33.3	37.7	74.6	26.3	27.4	29.8
Total	1,574	472.0	76.9	95.0	215.0	30.6

NOTES: Respondents include people who completed an interview and known ineligible sample members we contacted.
The acceptance rate is equal to the number of sample members who completed the interview plus the number of known ineligible sample members we contacted divided by the number of attempted interviews.
None of the differences between respondents and nonrespondents is statistically significant at the 0.05 or 0.10 level.

TABLE II.2B

COMPARISON OF RESPONDENTS AND NONRESPONDENTS
(Cohort 2)

Characteristics	With Locatable Telephone Numbers			Without Locatable Telephone Numbers		
	Percent		Acceptance	Percent		Acceptance
	Respondents	Nonrespondents	Rate	Respondents	Nonrespondents	Rate
Age						
65-74	61.5	57.7	80.1	72.7	68.1	24.7
75-84	29.6	32.8	77.3	23.6	24.3	22.4
85+	8.9	9.5	78.0	3.6	7.6	11.1
Race/Ethnicity						
White and non-Hispanic	86.5	79.8	80.4	69.1	72.7	22.0
Nonwhite plus Hispanic	12.9	19.7	71.2	30.9	27.3	26.2
Unknown	0.6	0.5	83.3	0.0	0.0	0.0
Gender						
Female	58.6	55.8	78.0	50.9	57.6	20.4
Male	41.4	44.2	79.9	49.1	42.4	26.7
Group						
Switcher	33.4	34.2	78.7	34.6	31.1	25.7
New enrollee	33.3	29.7	80.9	36.4	39.5	21.3
Reference group	33.3	36.1	77.7	29.1	29.4	22.9
Total	1,591	421.0	79.1	55.0	238.0	23.1

NOTES: Respondents include the people who completed an interview and the known ineligible sample members we contacted.
The acceptance rate is equal to the number of sample members who completed the interview plus the number of known ineligible sample members we contacted divided by the number of attempted interviews.
None of the differences between respondents and nonrespondents is statistically significant at the 0.05 or 0.10 level.

For the descriptive univariate analysis, we computed weighted proportions of sample members overall and by subgroup for those who provided a given answer to a question about a control or outcome variable of interest, such as "read *Medicare & You 2000*" or "looked for information on quality of care ratings". We also used the SUDAAN software package to compare proportions across the study subgroups, since SUDAAN accounts for sample design effects.

We compared means and distributions of beneficiary characteristics (such as age, education, and health status) across enrollment subgroups within each cohort. We tested these differences for statistical significance.

We also compared mean outcomes for sample subgroups defined on the basis of characteristics such as age, education, income, and health status. These descriptive analyses provide useful information on such issues as how understanding managed care features varies with beneficiaries' education.

We conducted multivariate analyses for a few key outcome variables (such as beneficiary use of NMEP materials) to identify the characteristics that appear to have an influence on the outcomes. Since most of the outcomes are binary (for example, whether or not the sample member read *Medicare & You 2000*), most of the multivariate equations were estimated with weighted logit models. For both cohorts combined, we estimated the following model:

$$Y^* = \alpha + \beta X + \delta S + \varphi C + \varepsilon$$

where Y is the outcome variable for an individual (and Y = 1 if Y* > 0, Y = 0 otherwise), X is the set of beneficiary characteristics, S is a set of binary variables indicating whether the beneficiary is in a particular beneficiary enrollment subgroup, C is a binary variable indicating whether the beneficiary is in cohort 2, ε is an error term, and α, β, δ, and φ are parameters to be estimated.

To test for differences among the three enrollment subgroups, we used two binary variables to indicate enrollment group: one variable for new enrollees and one for switchers. (The reference group of FFS enrollees was the omitted category.) There is a statistically significant difference between new enrollees (or switchers) and the reference group if the estimated coefficient(s) for new enrollees (and/or switchers) is (are) significantly different from zero. We also estimate separate regression equations for switchers, new enrollees, and FFS beneficiaries and compare regression coefficients to see if there are any significant differences in beneficiary characteristics that affect the outcome variables.

We also test for any statistically significant differences between beneficiaries in cohort 1 and those in cohort 2. These differences are significant if the estimated coefficient for cohort 2 (φ) is significantly different from zero.

It is unlikely that our sample will fail to reveal important, sizeable differences among subgroups of our target population. Based on the effective sample sizes, the sampling precision for a binary variable with a 50 percent mean, as reflected by a 95 percent confidence interval, is plus or minus 3.19 percentage points overall for both cohorts combined (not shown).

III. BENEFICIARY CHARACTERISTICS THAT AFFECT THE ABILITY TO USE INFORMATION AND MAKE DECISIONS

Each Medicare beneficiary has certain characteristics that affect their likelihood of seeking information, understanding it, and then using it in making a decision about Medicare options. Such characteristics will influence the beneficiary's receptivity to the NMEP or other educational efforts. This section describes how switchers, new enrollees, and FFS enrollees differ with respect to demographic characteristics, health status, health insurance experiences, and awareness of M+C plan withdrawals before they enrolled in Medicare. These differences are factors that might affect the use of NMEP information by Medicare beneficiaries newly enrolled in M+C plans or those switching from one M+C plan to another, and are factors we will control for in our multivariate regression analysis.

A. DEMOGRAPHIC CHARACTERISTICS AND HEALTH STATUS

Basic demographic characteristics such as age, gender, and level of education can affect information-seeking behavior in important ways. Beneficiary age plays a role not only in terms of its possible effects on cognitive capacity (Neuman and Langwell 1999) but also in terms of the beneficiary's likely prior exposure to managed care and willingness to change insurance options. Gender could play a role in that women tend to use informal networks more than men. The level of education affects the number and types of media that beneficiaries pay attention to and therefore influences both the probability that they are aware of the availability of information on Medicare and the probability that they will comprehend the messages (Neuman and Langwell 1999; Sofaer and Fox 1998).

Beneficiary health status can also affect information-seeking behavior, understanding of the information, and the decision on a health care plan. Beneficiaries with serious or chronic health

conditions might be more likely to track information on Medicare and consider their available insurance coverage options in their decision. On the other hand, those with cognitive difficulties might be less likely to collect information or use it in decision-making. We specified the following measures of health status to capture physical and cognitive limitations: measures of the amount of health care services used, the presence and number of chronic medical conditions, and measures of cognitive capacity (Table III.1).

The largest statistically significant differences among switcher, new enrollee, and FFS sample members (in the combined cohort sample) involve age and ethnicity. There are also statistically significant differences, though to a lesser extent, with respect to income, marital status, education, health, and functional status. There are no statistically significant differences with respect to gender or race (Table III.1).

New enrollees are much younger than switchers and FFS enrollees. Nearly 61 percent of new enrollees are age 65 to 69 compared with 30.8 percent of switchers and 26.4 percent of FFS sample members. The oldest age category (age 85 and older) also has the smallest percentage of new enrollees--4.1 percent compared with 7.5 percent of switchers and 9.9 percent of FFS sample members. Thus, the majority of new enrollees are selecting a Medicare managed care plan within a few years of becoming eligible for Medicare.

Consistent with their age, new enrollees are less likely than switchers and FFS enrollees to have been in the hospital, or to have had heart disease, difficulty participating in games or hobbies, or a visit to a hospital emergency room during the past year. There are no statistically significant differences among switchers, new enrollees, and FFS enrollees in the number of physician office visits they had during the previous three months. Compared with FFS beneficiaries, new enrollees also account for a higher percentage of Hispanic individuals and a higher percentage with some college education; they are also more likely to be married.

TABLE III.1

DESCRIPTIVE COMPARISON OF BENEFICIARY SAMPLE MEMBERS
(COHORTS 1 AND 2)

Characteristic	Enrollment Group		
	Switcher	New Enrollee	Fee-for-Service
Demographic Characteristics			
Age	††	††	
65-69	30.8	60.9	26.4
70-74	27.7	17.8	26.8
75-79	22.7	11.8	23.1
80-84	11.2	5.5	13.8
> 85	7.5	4.1	9.9
Sex			
Female	58.4	56.4	59.4
Race			
White	91.2	87.2	90.3
African-American or Black	7.1	9.4	7.8
Native American, Alaskan Native, Native Hawaiian, or other Pacific Islander	0.6	1.2	0.8
Asian	1.2	2.2	1.2
Ethnicity			
Hispanic	8.1**	9.0**	3.9
Income	††		
< $20,000	49.6	42.9	47.9
$20,000 to $30,000	21.2	22.5	21.0
$30,000 to $40,000	13.8	11.6	9.8
≥ $40,000	15.4	23.1	21.3
Marital Status		††	
Married	58.9	61.6	56.3
Widowed	30.1	24.6	33.3
Divorced or separated	8.2	10.0	6.2
Never married	2.8	3.8	4.1
Education	††	††	
High school graduate or less	61.8	59.0	64.2
Some college	24.2	25.0	18.7
College graduate	6.7	9.4	8.4
Graduate studies	7.3	6.6	8.7
Health and Functional Status			
Percent with a History of the Following Health Conditions			
Hypertension	53.4	53.5	53.4
Hardening of the arteries	7.7	8.4	10.4
Heart disease	22.5	19.4**	25.7
Stroke	9.3	6.4	8.2
Cancer	16.8	12.7	15.5
Diabetes or high blood sugar	20.1*	18.7	15.8
Rheumatoid arthritis	14.3*	16.7	18.2

TABLE III.1 (*continued*)

Characteristic	Enrollment Group		
	Switcher	New Enrollee	Fee-for-Service
Percent with One or More of the Above Health Conditions			
One condition	34.0	30.9	32.7
Two conditions	20.8	22.0	22.4
Three conditions	12.5	10.0	11.2
Four or more conditions	6.6	6.1	7.5
Percent Needing Help with			
Handling finances	10.4	9.6	12.5
Filling out forms	16.8*	17.0	20.0
Participating in games or hobbies	8.4	6.1*	9.3
Typical Health Service Use			
Number of Physician Office Visits in Past Three Months			
0	22.7	25.7	24.5
1-2	46.1	45.4	43.8
3-5	23.7	21.4	24.2
6-9	5.1	4.3	5.0
≥ 10	2.5	3.2	2.6
Number of Visits to the Emergency Room		†	
0	88.4	90.7	86.8
1	9.0	7.2	10.6
≥ 2	2.6	2.1	2.7
Number of Hospitalizations		††	
0	81.6	85.5	79.5
1	13.6	11.0	13.7
2-4	4.6	3.2	6.1
≥ 5	0.3	0.3	0.8

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

†Difference in the distribution of this variable between the enrollment group examined and the FFS reference group is statistically significant at the 0.05 level, chi-square test.
††Difference in the distribution of this variable between the enrollment group examined and the FFS reference group is statistically significant at the 0.01 level, chi-square test.
*Difference in the mean of this variable between the enrollment group examined and the FFS reference group is statistically significant at the 0.05 level, chi-square test.
**Difference in the mean of this variable between the enrollment group examined and the FFS reference group is statistically significant at the 0.01 level, chi-square test.

Switchers differ from FFS enrollees with respect to age, ethnicity, income, education, ability to fill out forms, and incidence of diabetes and rheumatoid arthritis. Switchers, who might be seen as "committed" consumers of managed care, are younger than FFS enrollees, have a higher percentage of Hispanic members and members with diabetes, and a lower percentage of members with rheumatoid arthritis and members who need help filling out forms.

These differences in demographic characteristics, relative to the characteristics of FFS enrollees, might influence the willingness and ability of new enrollees and switchers to use information and make insurance decisions. Their relative youth and greater education could influence their awareness of materials and their use of media channels. For example, younger Americans and those with higher education are more likely to own computers and to use the Internet. Differences between those who speak Spanish or English as their first language might also be a factor in the differences between switchers, new enrollees, and FFS beneficiaries, given the fact that switchers and new enrollees are more likely to be Hispanic. These differences might affect their awareness of educational materials and their use of media channels.

B. HEALTH INSURANCE EXPERIENCES AND AWARENESS OF HMO WITHDRAWALS

Most Medicare beneficiaries bring to their health insurance decision attitudes and knowledge based on their personal history of heath insurance (Kleinman 1998). Thus, measures of beneficiaries' health insurance experiences are critical to understanding whether they will search for information on M+C and, ultimately, what factors they consider when making decisions about Medicare coverage. Switchers and new enrollees are more likely than FFS enrollees to have been enrolled in a managed care plan before they became eligible for Medicare (in part, reflecting their younger age). Nearly 35 percent of new enrollees and 24 percent of switchers had been enrolled in a commercial managed care plan compared with about 10 percent

of FFS enrollees (Table III.2). Thus, switchers and new enrollees are possibly more likely to attend to messages about the availability of Medicare managed care and to use such information to confirm or otherwise test their preferences.

Compared with switchers and new enrollees, FFS enrollees are more likely to have had employer-based supplemental insurance at the time of the interview (Table III.2). Beneficiaries with such coverage may be less likely than beneficiaries without such coverage to use NMEP information sources for two reasons. First, they are not as likely to search for alternatives because employer-sponsored plans typically provide better coverage at lower cost than supplemental insurance purchased individually. Second, these beneficiaries may already be receiving information on their health plan options (if any) from their employer, minimizing the need to look for other information sources.

The annual withdrawals of plans from the Medicare program have been widely publicized and could affect the attitudes of beneficiaries toward Medicare managed care. Among the 310 M+C contracts in existence in July 1999, 41 were not renewed effective January 2000, and another 58 contractors reduced their service area by withdrawing from at least one county. At the beginning of 2000, about 327,000 M+C enrollees were directly affected by these withdrawals (Medicare Payment Advisory Commission 2000) and had to enroll either in another M+C plan (if there was one) or in FFS. We therefore analyzed the impact of awareness of health plan withdrawals on beneficiary use of information and decision-making.

Depending on their experience with M+C plan withdrawals, people aware of these withdrawals could either be more or less likely to use NMEP information materials. Some beneficiaries who are aware of the withdrawals may feel skeptical about Medicare managed care and may decide that they do not want to invest any time in learning more about it. On the other hand, other beneficiaries may be aware of M+C withdrawals because they keep up with current

TABLE III.2

HEALTH INSURANCE EXPERIENCE AND
AWARENESS OF HMO WITHDRAWALS

	Enrollment Group			Age		
	Switchers	New Enrollees	FFS	65-74	75-84	85+
Enrolled in HMO before becoming eligible for Medicare	24.0**	34.9**	10.5	16.3**	5.6**	1.0
Had employer-based supplemental insurance at time of interview	7.5**	19.7**	34.4	38.2	33.3	12.5**
Lives in a county where a Medicare HMO dropped out in 2000	67.4**	50.2**	35.7	35.0	38.7	33.9
Aware of HMO drop-outs	61.2**	52.2**	37.3	40.1	37.8	24.0*
Did not have supplemental insurance at time of interview	23.2**	40.2**	67.1	67.6	69.9	46.1**
Average HMO penetration rate as of March 2000	31.0*	25.0**	12.0	11.0*	13.0	14.0

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: Medicare HMO drop-outs refer to HMO contract withdrawals and service area reductions in a county

The age subgroups (65-74, 75-84, and 85+) pertain to all enrollee groups (switchers, new enrollees, and FFS).

*Difference between the enrollment group examined and FFS (or age group examined and those age 75-84) is statistically significant at the 0.05 level, chi-square test.
**Difference between the enrollment group examined and FFS (or age group examined and those age 75-84) is statistically significant at the 0.01 level, chi-square test.

events. Accordingly, they may want to use NMEP materials to increase their knowledge about Medicare and Medicare managed care.

Approximately 67 percent of switchers resided in a county affected by an M+C withdrawal or service area reduction effective January 2000 (Table III.2). Many individuals may have switched plans because they were directly affected by a withdrawal or reduction in service area. In contrast, about 50 percent of new enrollees and 36 percent of FFS enrollees resided in a county affected by a withdrawal or service area reduction. Clearly, those who have little choice are less likely to be motivated to attend to NMEP messages. Switchers who have seen their M+C plan withdraw are, in contrast, more likely to attend to information about Medicare.

Withdrawals affect not only beneficiary attitudes toward managed care, but also the availability of choices for beneficiaries to consider. The extent to which choices are available affects whether and how beneficiaries search for information and use it in their decision-making. Forty-one percent of the FFS beneficiaries in both cohorts combined have no M+C plan in their county. Many of these FFS beneficiaries may therefore have been less inclined to collect information about Medicare compared with beneficiaries who had a M+C plan in their county.

C. SWITCHERS, NEW ENROLLEES, AND FFS BENEFICIARIES IN COHORT 2 ARE MORE AWARE OF HMO DROP-OUTS.

Cohort 2 sample members were interviewed three months after sample members in cohort 1. Given the short period of time between cohort interviews and the random selection of the cohort samples, we would not expect to find any statistically significant differences between beneficiaries in cohort 1 versus those in cohort 2 with respect to demographic characteristics, health, or functional status. As indicated in Table III.1 in Appendix E, there are no statistically

significant differences between sample members in cohort 1 and cohort 2 with respect to age, gender, race, ethnicity, income, marital status, or education.[1]

We do observe a difference between the cohorts with respect to their awareness of Medicare HMO drop-outs, and this difference is consistent with events that occurred during the three-month period between the cohort interviews. Switchers, new enrollees, and FFS beneficiaries in cohort 2 are more aware of HMO drop-outs than are their cohort 1 counterparts (Appendix E, Table III.2A). For each enrollee group, the increase in awareness among cohort 2 is 10 percentage points or more, and it is statistically significant at a 0.01 level. Awareness among switchers increased from 53 percent to 65 percent, awareness among new enrollees increased from 43 percent to 58 percent, and awareness among FFS beneficiaries increased from 31 percent to 44 percent. This increase in awareness is most likely due to the fact that many Medicare HMO withdrawals occurred in the exact time period between the survey of the two cohorts and the withdrawals were widely publicized.

Switchers in cohort 2 are also different from switchers in cohort 1 with respect to other aspects of their health insurance experience. Switchers in cohort 2 are more likely to have been enrolled in an HMO before becoming eligible for Medicare, more likely to have had employer-based supplemental insurance at the time of the interview, and less likely to have lived in a county where a Medicare HMO dropped out in 2000. The latter difference is probably due to the fact that switchers in cohort 1 include beneficiaries who switched plans at the end of 1999, after

[1]Statistically significant differences between the cohorts are indicated by a * or ** in Table III.1 in Appendix E. The only statistically significant differences between sample members in cohort 1 and cohort 2 for any enrollee subgroup pertain to functional status and probability of having a hospital admission. For example, switchers in cohort 2 are more likely to have difficulties participating in games or hobbies (10 percent) compared with switchers in cohort 1 (5 percent), and switchers in cohort 2 are less likely to have an inpatient hospitalization during the past year (16 percent) compared with switchers in cohort 1 (23 percent). There are no logical explanations for why we observe these differences, because the samples were randomly selected.

many of them learned that their HMO was dropping out of the Medicare market. Since the cohorts do not differ from each other with respect to age, income, or education, there is no obvious explanation for why switchers in cohort 2 were more likely to be enrolled in an HMO before becoming eligible for Medicare or why they were more likely to have employer-based supplemental insurance at the time of the interview.

IV. INFORMATION-SEEKING BEHAVIOR OF BENEFICIARIES

The search for information is the first step for many switchers and new enrollees when they decide to enroll in a Medicare+Choice plan. Nearly one in five beneficiaries feels the need for more information about benefits to feel better able to participate in the Medicare program (Eppig and Poisal 1996). Without information, it is impossible for beneficiaries to understand their alternatives and then make a decision that is best for them, given their characteristics, circumstances, and tastes.

Fulfilling this need, however, means more than just making the information available. Beneficiaries must be *aware* that it is available, willing to seek it out, and receptive to it. Both public and private organizations have been developing education resources to assist Medicare beneficiaries in the process of selecting an appropriate health care plan. But for them to be effective, beneficiaries must be made aware of these efforts.

This section presents our findings on the awareness and use of NMEP and non-NMEP information sources and on the topics frequently sought by new enrollees, switchers, and FFS enrollees. Most of these individuals in both cohorts combined are aware of at least one NMEP information channel. Furthermore, most switchers and new enrollees look for information about their health insurance benefits, cost, or quality, while fewer than half of all FFS enrollees do so. About 44 percent of switchers and new enrollees collect health insurance information from an NMEP source. They collect information at an even higher rate from non-NMEP sources, such as health plans and doctors.

A. MOST BENEFICIARIES ARE AWARE OF AT LEAST ONE NMEP SOURCE

Seventy-three percent of beneficiaries in both cohorts combined are aware of at least one NMEP information source (Table IV.1 and Appendix B, Table B.1). Switchers and new

TABLE IV.1

BENEFICIARY AWARENESS OF NMEP INFORMATION CHANNELS

Information Channel	Percentage of Beneficiaries Aware of Each NMEP Channel, by Enrollment Subgroup		
	Switchers	New Enrollees	FFS
Saw *Medicare & You 2000*			
Yes	47.3	50.3	46.2
No	42.9	39.8	43.3
Don't know	9.8	10.0	10.4
Aware of toll-free telephone number			
Yes	42.2	47.8	46.6
No	49.1	44.3	43.5
Don't know	8.7	7.9	9.9
Aware of insurance counseling service			
Yes	30.1	31.1*	27.8
No	49.8	50.2	47.9
Don't know	20.1	18.7	24.2
Aware of health fairs or meetings			
Yes	25.5*	23.3	19.7
No	70.8	72.8	76.4
Don't know	3.6	3.8	3.9
Aware of website			
Yes	13.5	18.0**	10.9
No	82.5	76.9	85.0
Don't Know	4.0	5.0	4.0
Awareness of at least one information source	71.3	75.1	72.7

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Difference between switchers (or new enrollees) and FFS is statistically significant at the 0.05 level, chi-square test.
**Difference between switchers (or new enrollees) and FFS is statistically significant at the 0.01 level, chi-square test.

enrollees are most aware of the *Medicare & You 2000* handbook (49 percent) and least aware of the Medicare website (15 percent). Forty-five percent are aware of the toll-free telephone number, 31 percent of the federally sponsored state insurance counseling program, and 24 percent of lectures about Medicare or local health fairs. Switchers and new enrollees do not differ in their awareness of the NMEP handbook or toll-free telephone number from FFS beneficiaries. But new enrollees are more aware of the NMEP website and the insurance counseling service than are FFS beneficiaries. The greater awareness of the Medicare website is consistent with the younger age of new enrollees. Switchers are more aware of health fairs or meetings than are FFS beneficiaries, perhaps because of the publicity often given to health fairs by their health plans.

Awareness is influenced by a few personal characteristics. Beneficiaries who have more than a high school education are more aware of the handbook than are those with a high school education or less (Table IV.2). Beneficiaries who are high users of health services (that is, those who had four or more visits to a doctor during the previous three months) are more aware of the handbook, website, and health fairs. Compared with beneficiaries age 75 to 84 (which is the reference group for our age subgroup comparisons), both younger and older beneficiaries are less aware of health fairs. Beneficiaries with cognitive difficulties are less aware of the website, health fairs, and insurance counseling services. Beneficiaries who live in a county with a high HMO penetration rate (a rate of at least 30 percent) are more aware of insurance counseling services. Beneficiaries with employer-based supplemental coverage are more aware of the website than are those without this type of coverage. One would think that income level (which is related to health and thus general awareness) would be related to beneficiary awareness of information, but it is not.

TABLE IV.2

BENEFICIARY CHARACTERISTICS ASSOCIATED WITH AWARENESS OF NMEP INFORMATION SOURCES

Beneficiary Characteristic	Percentage of Beneficiaries Aware of Each NMEP Information Channel, by Characteristic				
	Handbook	Toll-Free Telephone Number	Website	Health Fairs	Insurance Counseling
Age					
65-74	46.7	48.3	12.3	18.8*	27.5
75-84(R)	46.3	45.8	9.4	23.5	29.8
85+	43.7	40.5	10.2	11.4**	22.8
Education					
High school or less	43.8*	45.3	9.4	18.0	26.0
More than high school	51.0	49.4	13.8	23.5	31.9
Income					
Less than $40,000	45.3	47.9	9.5	20.6	26.6
$40,000+	51.0	45.4	13.3	20.4	30.4
Has a chronic condition					
Yes	45.2	47.3	11.0	19.6	27.6
No	48.0	45.1	11.4	21.3	28.0
Had heart attack, cancer, or stroke					
Yes	43.1	50.5	11.3	21.1	27.5
No	47.7	44.4	10.7	19.0	28.5
Purchases Medigap on own					
Yes	50.4	51.8	13.3	22.2	29.0
No	44.3	44.2	9.7	18.5	27.4
Has employer-based supplemental coverage					
Yes	49.1	50.3	12.8**	22.6	30.6
No	44.8	44.7	10.0	18.2	26.1
Has cognitive difficulties					
Yes	44.2	45.3	8.6*	14.2*	22.1*
No	46.9	46.9	11.7	21.6	29.8
HMO penetration rate					
0 – 0.14	45.9	46.6	11.5	17.2	27.6
0.15 – 0.29 (R)	49.0	45.0	10.5	24.7	26.0
0.30 or more	43.4	49.6	9.7	23.9	32.7**

TABLE IV.2 (*continued*)

Beneficiary Characteristic	Percentage of Beneficiaries Aware of Each NMEP Information Channel, by Characteristic				
	Handbook	Toll-Free Telephone Number	Website	Health Fairs	Insurance Counseling
Visits to doctor during past 3 months					
4 or more	54.3**	54.3	14.5**	30.7**	32.2
Less than 4	44.8	45.3	10.3	18.0	27.7
Hospital admissions during the past year					
One or more	46.9	50.1	9.3	23.3	28.2
None	46.2	45.9	11.4	19.1	28.1

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Difference is statistically significant at the 0.05 level, chi-square test.
**Difference is statistically significant at the .01 level, chi-square test.
(R) refers to reference group, and is indicated when a beneficiary characteristic (such as age and HMO penetration) is divided into three categories.

The survey results probably understate the true level of awareness of the handbook because we found that beneficiaries who responded to the survey by mail exhibit a significantly higher awareness level than those who responded by telephone. The telephone respondents (about 81 percent of both cohorts combined) were asked about their awareness of the handbook as described by the telephone interviewer. Those who responded by mail saw a picture of the handbook in their paper questionnaire. It appears that a picture *is* worth a thousand words: awareness among the group that received the survey by mail is much higher. Furthermore, those who received a paper questionnaire had time to look among their belongings to see if they did, in fact, have a copy of the handbook. Consequently, 59 percent of those who responded by mail are aware of the handbook compared with 43 percent of those who responded by telephone (not shown).[1]

Awareness of the handbook, which was mailed to every Medicare beneficiary, did not exceed 55 percent among any of the subgroups most likely to remember receiving it—those who are younger, those with more formal education, those with higher levels of income, or those who are high users of health care services.

One way to increase beneficiary awareness of NMEP information sources is to promote the sources more aggressively in the places where beneficiaries are most likely to look for information—on television (40 percent) and in newspapers (36 percent). To a lesser extent, beneficiaries obtain information in general from books or magazines (13 percent) and from the radio (13 percent) (Table IV.3). Compared with FFS enrollees, a higher percentage of new enrollees gets general information from a spouse or from the Internet, while a higher percentage of switchers gets information from a spouse or from other family members and friends. Again,

[1]This difference is statistically significant at the 0.01 level based on a chi-square test.

TABLE IV.3

BENEFICIARY PREFERENCES FOR GENERAL INFORMATION SOURCES, BY ENROLLMENT AND AGE GROUP
(in percentage of beneficiaries)

Source Used "Very Often"	Enrollment Group			Age Group		
	Switchers	New Enrollees	FFS	65-74	75-84	85+
Television	44.1	43.0	39.8	35.9*	44.6	44.4
Newspaper	37.5	39.0	36.4	35.3	37.6	39.0
Spouse	29.7**	28.0*	23.0	26.7	22.4	6.3**
Books/Magazines	14.2	13.8	12.6	12.3	14.4	7.2*
Family or Friends	19.3*	17.5	14.8	14.0	15.9	15.4
Radio	12.4	14.8	12.9	12.1	13.2	15.8
Experts	3.3	4.6	2.9	2.9	3.2	2.3
Internet	2.3	4.2**	1.9	3.0**	0.8	0.02
Lectures	1.2	1.0	1.0	0.7	1.3	1.2

Source: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Differences between switchers (or new enrollees) and FFS is statistically significant at the 0.05 level, chi-square test.
**Differences between switchers (or new enrollees) and FFS is statistically significant at the 0.01 level, chi-square test.

the younger age of most new enrollees is likely to be associated with the fact that they are more attuned to the Internet and more likely to still have a spouse to consult.

B. FORTY-FOUR PERCENT OF ALL SWITCHERS AND NEW ENROLLEES USED A NMEP SOURCE TO FIND OUT ABOUT MEDICARE

Most switchers and new enrollees are *aware* of at least one NMEP information source, and approximately 44 percent have actually *used* one or more of these sources to find out about Medicare (Table IV.4 and Appendix B, Table B.2). Switchers and new enrollees have most often used the handbook (33 percent) and the toll-free telephone number (12 percent). Four percent attended a federally funded state insurance counseling program, 1 percent used the Medicare website, and less than 1 percent attended a Medicare-sponsored health fair or lecture (Table IV.4). Partly because of their younger age, switchers and new enrollees have used the Medicare website more than FFS enrollees. New enrollees are also more likely to have used the handbook and the insurance counseling services than are FFS beneficiaries.

Although attendance at Medicare-sponsored insurance counseling programs, fairs, and lectures has been low, many beneficiaries have attended similar programs sponsored by their health plan, a senior citizens' organization, or another organization. For example, although only 0.4 percent of switchers and new enrollees attended a Medicare-sponsored health fair, 6 percent attended a health fair sponsored by another organization. When Medicare and non–Medicare sponsored events are combined, approximately 7 percent of switchers and new enrollees have attended a health fair, 7 percent a meeting or lecture about the Medicare program, and 4 percent an insurance counseling program (Appendix B, Table B.3).

TABLE IV.4

USE OF NMEP INFORMATION SOURCES

NMEP Source Used	Percentage of Beneficiaries Using Each Source, by Enrollment Group		
	Switchers	New Enrollees	FFS
Medicare & You 2000	32.4	34.6*	28.9
Toll-Free Telephone Number	10.7	13.4	11.2
State Health Insurance Assistance Program	3.6	3.9*	2.2
Medicare-Sponsored Health Fair	0.4	0.5	0.4
Medicare-Sponsored Meeting or Lecture	0.4	0.8	0.5
Medicare Website	0.8*	1.6*	0.1
Used at Least One Source	43.0	45.3	38.6

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Difference between switchers (or new enrollees) and FFS is statistically significant at the 0.05 level, chi-square test.
**Difference between switchers (or new enrollees) and FFS is statistically significant at the 0.01 level, chi-square test.

C. SWITCHERS AND NEW ENROLLEES WHO ARE AGE 65-74 OR WHO HAVE A HIGH PROPENSITY TO USE INFORMATION ARE MORE LIKELY TO USE NMEP INFORMATION SOURCES

To learn more about the types of beneficiaries who use the NMEP information sources versus those who do not, we performed descriptive and regression analyses. The descriptive analysis presents the mean proportion of beneficiaries with certain characteristics (such as those age 65 to 74 or those with an annual income of $40,000 or more) that are associated with use of NMEP information sources. The mean values do not have a causal interpretation, but indicate the magnitude of use of NMEP sources by various beneficiary characteristics.

The descriptive analysis indicates that beneficiaries with more formal education are more likely to use the handbook and toll-free telephone number than those with less formal education (Table IV.5). The analysis also shows that higher-income beneficiaries are more likely than lower-income beneficiaries to use the handbook or the website. Beneficiaries who have had a heart attack, cancer, or stroke or who have supplemental insurance are more likely to use the toll-free telephone number. Beneficiaries with cognitive difficulties or a hospital admission are less likely to use the handbook. Beneficiaries age 85 and older are less likely to attend health fairs or meetings—possibly because they are generally less able to travel to these events due to frail health or lack of transportation. Beneficiaries with the highest percentage of users of any single NMEP source are those with an income of $40,000 or more. Thirty-eight percent of beneficiaries in this subgroup read the handbook.

We estimated weighted logit regression equations to learn more about beneficiaries who used the handbook or the toll-free telephone number, the two most frequently used sources. The first outcome variable is a binary variable indicating whether or not each beneficiary read the handbook. The second outcome variable indicates whether or not each beneficiary used the toll-free telephone number. The independent variables included demographic characteristics,

TABLE IV.5

BENEFICIARY CHARACTERISTICS ASSOCIATED WITH
USE OF NMEP INFORMATION SOURCES

	Percentage of Beneficiaries who Used an NMEP Information Channel					
Beneficiary Characteristic	Handbook	Toll-Free Telephone Number	Website	Health Fairs	Meetings or Lectures	Insurance Counseling
Overall	29.0	11.2	0.1	4.2	3.6	2.3
Age						
65-74	32.1	11.1	0.2	4.2	3.1	2.6
75-84 (R)	27.2	12.4	0.0	4.9	5.0	1.3
85+	18.6	7.0	0.0	0.8**	1.1*	4.3
Education						
High school or less	26.7*	9.4*	0.0	3.0*	2.7	2.2
More than high school	33.9	15.0	0.3	6.3	5.3	2.3
Income						
Less than $40,000	27.3*	10.6	0.01**	3.6	3.4	2.5
$40,000+	37.6	16.3	0.05	6.0	5.0	1.3
Has a chronic condition						
Yes	28.0	11.2	0.2	4.1	3.7	2.4
No	31.1	11.5	0.03	4.8	3.7	2.2
Had heart attack, cancer, or stroke						
Yes	25.6	13.9*	0.3	4.1	3.6	2.5
No	30.3	9.5	0.03	4.3	3.5	2.2
Purchases Medigap on own						
Yes	32.2	14.1*	0.3	3.0	3.8	1.7
No	27.2	9.7	0.03	4.7	3.4	2.3
Has employer-based supplemental coverage						
Yes	31.5	14.2*	0.01	6.9**	4.7	2.3
No	27.4	9.8	0.2	2.7	3.0	2.0
Has cognitive difficulties						
Yes	22.1**	10.1	0.02	2.4	2.9	3.0
No	31.1	11.5	0.2	4.6	3.8	2.0

TABLE IV.5 (*continued*)

Beneficiary Characteristic	Percentage of Beneficiaries who Used an NMEP Information Channel					
	Handbook	Toll-Free Telephone Number	Website	Health Fairs	Meetings or Lectures	Insurance Counseling
Doctor visits during the past 3 months						
4 or more	32.9	15.9	0.04	7.0	6.8	5.3*
Less than 4	28.2	10.3	0.14	3.7	3.0	1.8
Hospital admissions during the past year						
One or more	22.8*	9.9	0.0	4.9	3.6	4.0
None	30.5	11.6	0.1	4.0	3.6	1.9
HMO penetration rate						
0 – 0.14	28.6	10.4	0.0	3.7	3.0	1.8
0.15 – 0.29 (R)	27.7	12.6	0.5	5.4	5.8	4.5
0.30 or more	33.0	12.9	0.1	4.2	2.9	0.8*

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: (R) refers to the reference group, and it is indicated when a beneficiary characteristic (such as age and HMO penetration rate) is divided into three categories.

*Difference is statistically significant at the 0.05 level, chi-square test.
**Difference is statistically significant at the 0.01 level, chi-square test.

physical and cognitive health status, health insurance experiences, enrollment group (switcher and new enrollee binary variables), a cohort indicator (whether or not in cohort 2), propensity to use general information sources such as newspapers, the Medicare HMO penetration rate, a binary variable indicating whether an HMO dropped out of the county effective January 2000, and a binary variable indicating whether the sample member responded by mail (Appendix B, Table B.4).[2] Using the same set of independent variables, we also estimated logit regression equations to identify the characteristics associated with beneficiaries who have not used any of the NMEP information sources. These are the beneficiaries the NMEP would like to reach.

For each of these outcome variables, we estimated four regression equations. The first equation was estimated for switchers. The second and third equations were estimated for new enrollees and FFS beneficiaries, respectively. We estimated separate regression equations for each beneficiary enrollment group to see if there are any differences in the beneficiary characteristics across beneficiary subgroup associated with use of NMEP information sources. The fourth equation was estimated for switchers, new enrollees and FFS beneficiaries combined. We estimated a regression equation with all beneficiary subgroups combined to see if switchers or new enrollees were more likely to use NMEP information sources compared with FFS beneficiaries. The enrollee group (switcher or new enrollee) binary variables appear only in the regression equations that were estimated with all enrollees combined.

[2]We did not include a measure of beneficiary awareness of the recent changes in Medicare to explore the use of NMEP sources because we did not have a measure of beneficiary awareness *before* the NMEP education campaign began. All our measures of beneficiary awareness apply to the time of the interview, which occurred after the NMEP campaign began. We did conduct a descriptive analysis to examine the relationship between beneficiary self-reported awareness of the changes in Medicare at the time of the interview and the number of NMEP information sources beneficiaries used. We found that beneficiaries who used one or more information sources are more aware of the changes in Medicare at the time of the interview. We do not know whether there is a *difference* in the level of beneficiaries' awareness of the changes in Medicare *before* the NMEP campaign versus *after* it.

1. Factors Associated with Use of the NMEP Handbook or Medicare Toll-Free Telephone Number

The factors associated with the use of the NMEP handbook and Medicare toll-free telephone number are indicated in Table IV.6. Three factors are significant in two or more regression equations: frequent use of three or more general information sources (such as television or newspapers), younger age (age 65-74), and response to the survey by mail instead of by telephone.

In half of the regression equations we estimated, beneficiaries who frequently use three or more general information sources are more likely to use the NMEP handbook or toll-free telephone number than beneficiaries who do not (Table IV.6). It makes sense that those who use many general information sources in the course of their daily lives would be more likely to use NMEP information sources. Specifically, new enrollees who frequently use three or more general information sources are more likely to read the handbook, but this factor does not affect handbook use among switchers and FFS beneficiaries. On the other hand, switchers and FFS beneficiaries who frequently use three or more general information sources are more likely to use the toll-free telephone number; this factor is not associated with use by new enrollees.

Among switchers and new enrollees, those who are younger (age 65-74) are more likely to have read the handbook than those who are age 75 to 84. But among FFS beneficiaries, age has no bearing on handbook use (Table IV.6). This may be because younger switchers and new enrollees are relatively new to Medicare managed care and decided to read the handbook to learn more about Medicare managed care. Age is not a factor in the use of the toll-free telephone number.

Switchers and FFS beneficiaries who responded to the survey by mail were more likely to use the handbook and toll-free telephone number than those who responded by telephone. This may be due in part due to the higher level of awareness of the handbook by beneficiaries who

TABLE IV.6

SIGNIFICANT EXPLANATORY VARIABLES IN MULTIVARIATE LOGIT MODELS THAT EXAMINE THE USE OF NMEP INFORMATION SOURCES

Explanatory Variable	Used NMEP Handbook			Used Toll-Free Telephone Number			Did Not Use an NMEP Information Source		
	Switchers	New Enrollees	FFS	Switchers	New Enrollees	FFS	Switchers	New Enrollees	FFS
Used 3 or more general information sources		+		+		+	–		–
Age 65-74	+	+					–	–	
Responded by mail survey	+	+	+	+		+	–		–
Non-white	–								
Income greater than $40,000 per year							–		
Had less than high school education								+	
HMO dropout or service area reduction in 2000								–	
HMO Penetration rate				–					
Female						+		–	
Had four or more doctor visits during past 3 months									–
Had cognitive difficulties		–							
Resided in urban county				+					
In managed care before Medicare					+				
Had employer-sponsored Medigap						+			
Purchased Medigap on own						+			

NOTES: As indicated, the explanatory variables are significantly different from zero at the 0.5 level or less, two-tailed test. The explanatory variables that are not significant are: Whether in cohort 2; Whether participates in insurance decision; Whether age greater than 85 years; and Whether Hispanic ethnicity.

responded by mail; in addition, beneficiaries who responded by mail had more time to think about whether in fact they did use these NMEP sources.

Two additional beneficiary characteristics are negatively associated with use of the NMEP handbook: non-white race (for switchers), and cognitive difficulties (for new enrollees). Several additional factors are positively associated with use of the toll-free telephone number. These are: residence in an urban county or in a county that has a low HMO penetration rate (for switchers); experience with managed care before enrolling in Medicare (for new enrollees); and female gender or enrollment in an employer-sponsored Medigap plan or individual Medigap plan (for FFS beneficiaries).

2. Characteristics of Beneficiaries Who Did Not Use an NMEP Information Channel

It is also important to identify some of the characteristics of the beneficiaries who used none of the NMEP sources, as they are the beneficiaries CMS may want to target in its future education campaigns. The factors that are most often *negatively* associated with beneficiaries who do not use NMEP information sources are: frequent use of three or more general information sources, younger age (age 65-74), and response to the survey by mail. As discussed above, these are the same factors are most often *positively* associated with beneficiaries who use the handbook or the toll-free telephone number.

Other factors that are *negatively* associated with beneficiaries who do not use NMEP information sources are: high income (for switchers); female gender, some college education, or residence in a county where there was an HMO withdrawal (for new enrollees); and high service use (four or more visits to the doctor during the previous three months) for FFS beneficiaries.

3. Factors that are Not Associated with Use of NMEP Information Channels

Five beneficiary characteristics are not associated with use of NMEP information channels in any of our regression specifications: beneficiary cohort, age greater than 85 years (relative to those who are age 75 to 84), Hispanic ethnicity, whether the beneficiary participates in the insurance decision, and beneficiary enrollment group (new enrollee or switcher).

The likely reason why beneficiary cohort is not significant is that there is only a three-month difference in the survey interview period between the two cohorts, and nothing happened during this short period of time to affect beneficiary use of NMEP information sources.

Our regression results also indicate that once we control for key beneficiary characteristics, switchers and new enrollees are not more likely to use NMEP information sources than FFS beneficiaries. This makes sense, since NMEP information sources contain general information about Medicare that should be useful to all beneficiaries. Given that the NMEP sources are developed for all Medicare beneficiaries, and are not targeted specifically to new enrollees or switchers, we would not necessarily expect new enrollees or switchers to use them at a higher rate than FFS beneficiaries.

Beneficiaries who are age 85 and older or of Hispanic ethnicity are sometimes classified as "vulnerable" populations. Some studies conduct separate analyses of these subgroups to see if, for example, their access to health care is the same as younger or non-Hispanic populations. When our regression models control for factors such as service use, cognitive ability, income, and education, we find that beneficiaries who are 85 years and older are just as likely to use NMEP information sources as beneficiaries who are 75 to 84 years old, and Hispanic beneficiaries are just as likely to use these sources as non-Hispanic beneficiaries.

4. Summary

In summary, we find that two beneficiary characteristics are most often associated with use of NMEP sources by switchers and new enrollees: a younger age and a high propensity to use general information sources. Beneficiaries who are least likely to use a NMEP information source are those who are age 75 and older and those who have a low propensity to use general information sources. Our regression analysis also indicates that switchers with annual household incomes that are less than $40,000 and new enrollees who have no more than a high school education are less likely to use NMEP information sources. If CMS wishes to target its education campaign on beneficiaries who are not using NMEP information sources, these are the types of beneficiaries that NMEP needs to reach.

D. MOST SWITCHERS AND NEW ENROLLEES USE NON–NMEP SOURCES TO OBTAIN HEALTH INSURANCE INFORMATION

In addition to the NMEP information sources, beneficiaries rely on other sources of information about Medicare, such as health care providers, family and friends, and former employers. Many of these sources have always been available to beneficiaries, and all beneficiaries have used at least one of these information sources at some point in time.

Beneficiaries probably use these other sources more frequently than NMEP sources because they have more exposure to them. About 73 percent of switchers and new enrollees used at least one of the non–NMEP sources to obtain information about Medicare, compared with 44 percent who used an NMEP source (Table IV.7 and Appendix B, Table B.5). Health plans (46 percent), family or friends (41 percent), and doctors (35 percent) are the non–NMEP information sources that switchers and new enrollees use most frequently to help them choose a plan. To a lesser extent, they rely on newspapers and former employers. They rarely rely on religious or ethnic organizations. Compared with FFS enrollees, switchers are more likely to use their health plan,

TABLE IV.7

OTHER INFORMATION SOURCES BENEFICIARIES
USED TO MAKE HEALTH INSURANCE DECISIONS

NonNMEP Information Source	Percentage of Beneficiaries by Enrollment Group		
	Switchers	New Enrollees	FFS
Doctor	38.2**	31.6	32.1
Family or Friends	40.4**	42.2**	29.0
Senior Citizens Organization	31.8	32.5	29.4
Health Plan	45.2**	47.1**	29.2
Library or Newspapers	20.1*	18.2	16.0
Hospital or Clinic	13.0	12.5*	15.9
Former Employer	7.3	17.5**	9.6
Internet	1.5	3.3**	0.7
Religious Organization	1.7	1.9	1.5
Ethnic/Racial Organization	0.5	2.0	1.3
Used at Least One Source	71.6	73.9	61.0

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Difference between the enrollment group examined and FFS is statistically significant at the 0.05 level, chi-square test.
**Difference between the enrollment group examined and FFS is statistically significant at the 0.01 level, chi-square test.

family or friends, doctors, or library/newspapers. New enrollees are also more likely than FFS enrollees to use their health plans, family or friends, former employer, hospital, or the Internet. More new enrollees and switchers named their health plan as the non-NMEP source of information they used the most. Thus, it appears that once beneficiaries are in managed care, many of them consider their plans to be a good source of information.

E. MOST SWITCHERS AND NEW ENROLLEES LOOK FOR INFORMATION ON BENEFITS, COST, OR QUALITY

Given that switchers and new enrollees decided to enroll in a Medicare+Choice plan shortly before we interviewed them, they had the strongest incentive to obtain information about plan benefits, cost, and quality of care. Switchers and new enrollees are more likely to look for information on benefits, cost, and quality of care than are FFS enrollees. Approximately 58 percent of switchers and new enrollees have looked for this information, while less then half of the FFS enrollees did so. But switchers and new enrollees as a group do not aggressively seek information about plan benefits, cost, and quality of care--4 out of 10 beneficiaries who enrolled in a Medicare+Choice plan did *not* seek this information.

When switchers and new enrollees look for information, they are most interested in the following: benefits to look for or avoid in a Medicare managed care plan (39 percent), the differences between Medicare FFS and Medicare managed care plans (38 percent), and Medicare coverage of specific services (37 percent). They are somewhat less likely to seek information on premiums (30 percent) or quality of care ratings (24 percent) (Table IV.8). FFS enrollees, on the other hand, are more likely to look for information on Medicare coverage of specific services (25 percent) than on any of the other plan or care-related topics.

Beneficiaries with more formal education and higher levels of income are the two subgroups that are most likely to look for information. Beneficiaries with more formal education are more

TABLE IV.8

HEALTH INSURANCE TOPICS ON WHICH BENEFICIARIES HAVE EVER SOUGHT INFORMATION

Health Insurance Topic	Percentage of Beneficiaries by Enrollment Group		
	Switchers	New Enrollees	FFS
Medicare coverage of specific services, such as prescription drugs	37.0**	37.5**	25.0
What benefits to look for or avoid in a Medicare managed care plan	41.6**	35.8**	16.3
Differences between Medicare FFS and Medicare managed care plans	40.2**	35.8**	13.2
Premiums for Medicare managed care plans	33.1**	27.8**	7.9
Quality-of-care ratings for Medicare managed care plans	25.5**	23.0**	6.4
Any of these topics	59.8	55.8	35.7

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: For some of the information topics above, a significant number of sample members indicated that they did not know if they searched for that topic. For example, 8 percent of sample members did not know if they looked for information on benefits, and 8 percent of sample members did not know if they looked for information on the differences between FFS and HMOs.

**Difference between the enrollment group examined and FFS is statistically significant at the 0.01 level, chi-square test.

likely to look for information on coverage of specific services, which benefits to look for, differences between FFS and managed care, and premiums (Appendix B, Table B7). Beneficiaries with higher incomes are more likely to look for information on the coverage of specific services, differences between FFS and managed care, and premiums. Beneficiaries who indicated that they have "little or no knowledge" about recent changes in the Medicare program are less likely to look for information on coverage of specific services, which benefits to look for, and premiums. Beneficiaries who have had four or more doctor visits during the previous three months are more likely to look for information on the coverage of specific services. Beneficiaries who have had a hospital admission during the past year are more likely to look for information on premiums.

F. BENEFICIARIES IN COHORT 2 ARE MORE LIKELY TO USE INFORMATION FROM FORMER EMPLOYERS

There is only one difference in the awareness and use of NMEP information sources among switchers and new enrollees in cohort 1 versus cohort 2. This difference is that switchers in cohort 2 are less aware of health fairs or meetings than those in cohort 1 (Appendix E, Table IV.1). We have no explanation for this finding. There are no reliable sources of data on the total number of health fairs during any time period,[3] so we cannot attribute the difference in awareness to a decline in the number of health fairs available to sample members in cohort 2.

There were no statistically significant differences between the cohorts with respect to their awareness or use of the NMEP handbook or toll-free telephone number. Perhaps this is due to the fact that there was only a three-month difference in time between the cohort 1 and cohort 2 interview periods, and three months is not enough time to observe any significant differences in the awareness or use of these information sources.

[3]Personal communications with Michael Adelberg, Center for Beneficiary Services, CMS.

One difference we do observe in the information-seeking behavior between beneficiaries in cohort 1 and cohort 2 is that beneficiaries in cohort 2 are more likely to use information from their former employers. In cohort 2, 9 percent of switchers used information from a former employer compared with 4 percent in cohort 1 (Appendix E, Table IV.6). Twenty percent of new enrollees and 12 percent of FFS beneficiaries used information from a former employer in cohort 2, compared with 13 and 8 percent, respectively, in cohort 1. One might hypothesize that the NMEP efforts to engage the participation of employers more fully in Medicare education has created this effect, but we cannot document this as a definite factor.

V. BENEFICIARY UNDERSTANDING

A Medicare education effort can succeed only if beneficiaries receive and understand the basic messages presented to them. In this section, we look at how well new enrollees and switchers understand key Medicare and M+C program characteristics central to the basic messages disseminated through the National Medicare Education Program. We also compare their level of understanding with Medicare beneficiaries in the FFS program.

As expected, switchers and new enrollees know more about Medicare managed care than do FFS enrollees. Moreover, new enrollees and switchers who have read the *Medicare & You 2000* handbook know more about the M+C program than those who did not read the handbook. This is also true for FFS beneficiaries. While this result is consistent with the handbook helping to increase beneficiary knowledge, it is also the case that some of this difference in the program knowledge could be explained by factors other than the handbook. For example, those who read the handbook might have also been more informed than other beneficiaries about Medicare and Medicare managed care before the NMEP program began.

A much larger proportion of switchers and new enrollees understand basic aspects of the M+C program than do FFS beneficiaries. For example, 75 percent of switchers and 70 percent of new enrollees know that if they were to leave a Medicare HMO, Medicare would still cover them. This is true for only 41 percent of FFS beneficiaries. Still, 25 percent of switchers and 30 percent of new enrollees do not understand that Medicare will still cover them if they were to leave their HMO. Overall, then, there is still educational work that has to be done to raise the levels of knowledge about the rules governing the M+C program and its interface with traditional Medicare for switchers, new enrollees, and FFS beneficiaries.

A. BENEFICIARIES FEEL THEY NEED TO KNOW MORE ABOUT RECENT CHANGES TO MEDICARE

Fifty percent of switchers and FFS beneficiaries, and 45 percent of new enrollees reported that they remember hearing about the changes that Congress made to the Medicare program a few years ago. However, most beneficiaries do not feel that they know all they need to know about the changes. Only 23 percent of new enrollees, and 26 percent of switchers and those in FFS reported that they know just about everything or most of what they need to know (Table V.1). Almost half of the individuals in each group reported knowing some or a little of what they needed to know, and about one-quarter of each group reported knowing almost nothing.[1] Therefore, most beneficiaries are aware that they need to know more; in fact, many lack an understanding of major aspects of the M+C program.[2]

B. SWITCHERS AND NEW ENROLLEES DEMONSTRATE MORE KNOWLEDGE ABOUT MEDICARE MANAGED CARE THAN DO FFS BENEFICIARIES

As Medicare beneficiaries decide whether to join an M+C plan, it is critical that they understand key pieces of information. For example, beneficiaries should know that their Medicare coverage continues even if they disenroll from their M+C plan. Similarly, they should understand that their choice of doctors is limited in a managed care plan and that any complaints

[1]None of the differences in self-reported knowledge between cohort 1 and cohort 2 are statistically significant (Appendix E Table V.1).

[2]Those in FFS Medicare did not have lower self-reported knowledge of the changes in the Medicare program as compared with switchers and new enrollees. It should be noted, however, that the question asking whether the respondent knew all they needed to know about these changes may have a slightly different interpretation for those in the FFS program. Some respondents in that group may have had no interest in joining a managed care plan and could therefore have felt that they did not need to know much about the changes to the program. Forty-four percent of FFS beneficiaries in cohort 1 and 38 percent of FFS beneficiaries in cohort 2 had no M+C plan in their county. That could partly explain why those in FFS Medicare who demonstrated less knowledge about the M+C program were still as likely as new enrollees to report that they knew most of what they needed to know.

TABLE V.1

BENEFICIARIES' SELF-REPORTED KNOWLEDGE
ABOUT RECENT CHANGES TO MEDICARE

Self-Reported Knowledge about Recent Changes to Medicare[a]	Percentage of Beneficiaries by Enrollment Status:		
	Switchers[b]	New Enrollees[b]	Fee-for-Service(R)
Knew most or just about everything	26.1	23.2	25.8
Knew some or a little	48.3	49.3	48.6
Knew almost nothing or responded "don't know"	25.6	27.6	25.6
Sample Size	1,083	1,055	987

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

[a]This survey question asked, "How much do you feel you know about the changes in the Medicare program? Do you feel you know just about everything you need to know, most of everything you need to know, some of what you need to know, a little of what you need to know, or almost none of what you need to know?"

[b]The percentage distribution of responses across the three categories did not differ with statistical significance between switchers and FFS beneficiaries or between new enrollees and FFS beneficiaries.

(R) Reference group

can be reported to Medicare. These important pieces of information are among the six true-false questions we asked to assess beneficiaries' knowledge of Medicare and the M+C program.

Overall, as expected, switchers and new enrollees understand the M+C program better than FFS beneficiaries do. Sixty-one percent of switchers and 56 percent of new enrollees answered at least five of the six true-false questions correctly (Table V.2); only one-third of the FFS respondents did so. Switchers performed slightly better than new enrollees.[3] One might expect switchers to demonstrate a higher level of knowledge about Medicare managed care than demonstrated by new enrollees because switchers have experience with Medicare managed care. In addition, the decision to switch plans to begin with may have been based on new (and additional) information obtained by beneficiaries. Thus, by virtue of having made a decision to change, switchers may be more likely to have certain characteristics that predispose them to taking in more information—in other words, they may be better informed.

Many of the FFS beneficiaries do not understand that a Medicare managed care plan limits their choice of doctors—only 62 percent responded correctly to this question (Table V.3). By contrast, 85 percent of switchers and 79 percent of new enrollees understand that their choice of doctors is limited. Furthermore, 87 percent of switchers and 79 percent of new enrollees understand that they can switch to another primary care physician.

Switchers and new enrollees know more about traditional Medicare and its interface with the M+C program than do FFS beneficiaries. That is, a higher proportion of switchers and new enrollees responded correctly to questions in this area than did FFS beneficiaries. The differences are statistically significant.

[3]The distribution of the number of correctly answered questions differs with statistical significance at the .01 level between switchers and those in FFS, and between new enrollees and those in FFS (using a chi-square test). None of the differences between cohort 1 and cohort 2 are statistically significant (see Appendix E Table V.2).

TABLE V.2

BENEFICIARIES' PERFORMANCE ON TRUE-FALSE QUESTIONS
RELATED TO MEDICARE AND MEDICARE MANAGED CARE

Number of Correctly Answered Questions	Percentage of Beneficiaries by Enrollment Status:		
	Switchers**	New Enrollees**	Fee-for-Service (R)
0	0.5	1.8	1.6
1 - 2	5.9	8.4	20.8
3 - 4	33.0	33.9	44.6
5 - 6	60.6	55.9	32.9

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

**The distribution of the number of correctly answered questions differs with statistical significance at the .01 level between switchers and FFS beneficiaries and between new enrollees and FFS beneficiaries.

TABLE V.3

BENEFICIARIES' DEMONSTRATED UNDERSTANDING
OF THE M+C PROGRAM AND MEDICARE

True-False Questions	Percentage Responding Correctly		
	Switchers	New Enrollees	FFS (R)
General Knowledge about Medicare			
Medicare pays for all health care expenses	83.3	83.7	86.2
Can report complaints to Medicare	67.4	67.8	64.2
Interface of Traditional Medicare with M+C			
Can select among health plan options within Medicare	66.3**	61.7**	52.5
If leave a Medicare HMO, would still be covered by Medicare	75.4**	70.2**	40.7
Knowledge about Medicare Managed Care			
Medicare HMOs offer limited choice of doctors	85.1**	79.1**	62.2
Can switch to another primary care physician	86.7**	79.3**	64.2

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

**Indicates a difference with statistical significance at the .01 level from the FFS group (chi-square test).

(R) Reference Group

Perhaps most striking is the finding that most FFS beneficiaries do not understand that their Medicare coverage would continue were they to disenroll from a managed care plan. Only 41 percent of beneficiaries in FFS Medicare answered this question correctly, suggesting that some beneficiaries may not join an M+C plan because they incorrectly assume that they cannot return to FFS Medicare if they are dissatisfied with their plan. With respect to those already enrolled in an M+C plan, 70 percent of new enrollees and 75 percent of switchers understand that Medicare would still cover them if they were to leave their M+C plan. Given that they might otherwise remain in an M+C plan even if they are dissatisfied, enrollees need to understand that their Medicare coverage will continue even if they were to leave an M+C plan. These results further suggest that educating beneficiaries about the most basic aspects of the relationship between M+C and Medicare is critical to their ability to make better-informed, appropriate health coverage decisions.

Across all three enrollment groups, we found that older beneficiaries, less educated beneficiaries, and those with lower incomes were less likely than their counterparts to answer some of the true-false questions correctly (Appendix C, Tables C.1 through C.4). However, the differences in how the questions were answered by age group are statistically significant in only a few cases.[4] Beneficiaries with an education beyond high school demonstrate a higher level of understanding of certain aspects of traditional Medicare and the M+C program. Across all enrollment groups, those with an education beyond high school are more likely to understand that Medicare does not pay for all health services and that Medicare coverage continues after

[4]Among new enrollees, those age 85 and older are less likely to know that complaints can be reported to Medicare and that HMOs offer a limited choice of doctors; these differences are statistically significant. Switchers age 65 to 74 compared with switchers age 75 to 84 are more likely to know that Medicare HMOs offer a limited choice of doctors. Other than these cases, none of the differences in the proportion who answered the questions correctly are statistically significant across age groups.

they leave a Medicare HMO, and the differences are statistically significant. More educated switchers and FFS beneficiaries are also more likely to understand that Medicare HMOs offer a limited choice of doctors, and the differences are statistically significant. Across all three enrollment groups, those with an income below $20,000 are less likely than those with an income of $40,000 or more to understand that Medicare does not pay for all health care expenses, or that Medicare coverage continues after they leave a Medicare HMO. These differences are statistically significant.

C. SURVEY RESULTS ARE CONSISTENT WITH THE HANDBOOK CONTRIBUTING TO KNOWLEDGE ABOUT TRADITIONAL MEDICARE AND M+C

Across almost all of the questions pertaining to beneficiary knowledge of Medicare and the M+C program, a higher proportion of beneficiaries who read the handbook answered the questions correctly as compared with those who had not. For the question addressing the key issue of whether one can disenroll from an M+C plan and still retain Medicare coverage, the proportion of beneficiaries answering correctly was 12 percentage points higher for switchers who had read the handbook as compared to those who had not. This difference was about 19 percentage points for new enrollees and 15 percentage points for those in FFS (Table V.4).[5]

While the descriptive comparisons reveal that enrollees who read the handbook demonstrate a better understanding than those who did not, we cannot conclude for certain that the handbook helped to increase beneficiary knowledge. Another contributing factor could be greater knowledge a priori on the part of people who read the handbook compared to those who did not. Therefore, our results are consistent with the hypothesis that reading the handbook increases

[5]The differences between cohort 1 and 2 are not statistically significant, with one exception. For switchers, the proportion who understand that complaints can be reported to Medicare is somewhat higher for cohort 2 than for cohort 1 (66 percent compared to 59 percent), and the difference is statistically significant at the .05 level (Appendix E Table V.4).

TABLE V.4

BENEFICIARIES' UNDERSTANDING—FOR THOSE WHO READ THE HANDBOOK AND THOSE WHO DID NOT

True-False Questions	Percentage Responding Correctly					
	Switchers		New Enrollees		FFS	
	Did Not Read or Recall Handbook	Read Handbook (R)	Did Not Read or Recall Handbook	Read Handbook (R)	Did Not Read or Recall Handbook	Read Handbook (R)
General Knowledge About Medicare						
Medicare pays for all health care expenses	83.7	86.8	83.0	86.1	83.6**	93.5
Can report complaints to Medicare	63.1**	77.6	64.7**	75.6	61.1**	72.6
Interface of Traditional Medicare with M+C						
Can select among health plan options within Medicare	58.3**	80.1	54.2**	76.5	48.5**	63.1
If leave a Medicare HMO, would still be covered by Medicare	71.4**	83.1	63.8**	82.8	37.1**	52.1
Knowledge About Medicare Managed Care						
Medicare HMOs offer limited choice of doctors	84.4	86.2	76.8*	83.2	58.4**	70.9
Can switch to another primary care physician	82.8**	93.0	76.6**	86.4	65.4	65.0

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Indicates that within that enrollment group, the difference between those who read the Handbook and those who did not is significant at the .05 level.

**Indicates that within that enrollment group, the difference between those who read the Handbook and those who did not is significant at the .01 level.

(R) Reference Group

enrollees' knowledge, but they do not provide final proof that this is so, nor evidence on the magnitude of this effect.

To learn more about the effect of reading the handbook on beneficiary understanding, we estimated a weighted logit regression equation for each of the true-false questions. The outcome variable was a binary variable taking a value of one if the question was correctly answered and zero otherwise. The independent variables included demographic characteristics, physical and cognitive health status, health insurance experiences, a dummy variable for respondents in cohort 2, a binary variable indicating whether the handbook had been read, and a count variable for the number of information sources used (other than the handbook). We ran these regressions separately for switchers, new enrollees and FFS beneficiaries.

After controlling for differences in socioeconomic characteristics and health status, we observed that enrollees who have read the handbook demonstrate better knowledge than those who did not, with the difference being statistically significant for four of the six true-false questions for each enrollment subgroup (Table V.5a and Table V.5b). However, the questions for which the handbook contributed to beneficiary knowledge differed slightly for switchers and new enrollees as compared to FFS beneficiaries. For all three subgroups, we found that those who read the handbook are more likely to know that they can select among health plan options; that if they leave a Medicare MCO, they will still be covered by Medicare; and that they can report complaints to Medicare. With respect to the two questions pertaining to how physician networks function in Medicare HMOs, FFS beneficiaries do not appear to have increased their knowledge by reading the handbook. However for switchers and new enrollees, reading the handbook increases the likelihood that they understand that it is possible to switch between

TABLE V.5A

CHARACTERISTICS ASSOCIATED WITH BENEFICIARY UNDERSTANDING
OF THE M+C PROGRAM AND MEDICARE

Beneficiary Characteristics	Can Select Among Health Plan Options			If Leave a Medicare HMO, Medicare Coverage Continues			Medicare Does Not Pay All Health Expenses		
	Switcher	New Enrollee	FFS	Switcher	New Enrollee	FFS	Switcher	New Enrollee	FFS
Intercept				+		–	+	+	++
Read the handbook	++	++	++	+ (a)	++	++			+
Number of information sources collected on Medicare	++	++	+	++	+	+		+	++
Nonwhite				—	—		–	—	
Hispanic							—	—	–
Has high school education or less				–				–	–
Income is more than $40,000 per year									
Age 65–74									
Age 85 or above									
Has cognitive difficulties				–	—				
Has employer sponsored Medigap coverage	—	–		–					++
Has purchased own Medigap coverage		—							++
Participates in insurance decision									
Was member of managed care before Medicare				–	+				
Used 3 or more general information sources						+			++
Female				–					
Resides in urban area			+						
Medicare HMO county penetration rate									—
Responded by mail questionnaire	—		—						

NOTE: Explanatory variables that were not significant in any of the regressions are: Whether respondent was in cohort 2; Whether the respondent had 4 or more doctor visits; Whether there was an HMO dropout or service area reduction in the respondent's county of residence in 2000. Based on results from our multivariate logit model analyzing responses to the six true-false questions about Medicare and the M+C program.

++ Indicates the explanatory variable is positively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .01 level.
+ Indicates the explanatory variable is positively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .05 level.
— Indicates the explanatory variable is negatively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .01 level.
– Indicates the explanatory variable is negatively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .05 level.

[a]This coefficient was significantly different from zero at the .0503 level.

TABLE V.5B

CHARACTERISTICS ASSOCIATED WITH BENEFICIARY UNDERSTANDING
OF THE M+C PROGRAM AND MEDICARE

	Can Report Complains to Medicare				Medicare HMOs Offer Limited Choice of Doctors				Can Switch to Another Primary Care Physician		
Beneficiary Characteristics	Switcher	New Enrollee	FFS		Switcher	New Enrollee	FFS		Switcher	New Enrollee	FFS
Intercept					+	+			++		
Read the handbook	++	+	++						+	++	
Number of information sources collected on Medicare		+	+		+		+				
Nonwhite					—						
Hispanic					–						
Has high school education or less									–		
Income is more than $40,000 per year											+
Age 65–74					+						
Age 85 or above						—					
Has cognitive difficulties									–		+
Has employer sponsored Medigap coverage											
Has purchased own Medigap coverage		–									
Participates in insurance decision			+							+	
Was member of managed care before Medicare											
Used 3 or more general information sources											+
Female		–	—								
Resides in urban area											
Medicare HMO county penetration rate											
Responded by mail questionnaire	—		—								—

NOTE: Explanatory variables that were not significant in any of the regressions are: Whether respondent was in cohort 2; Whether the respondent had 4 or more doctor visits; Whether there was an HMO dropout or service area reduction in the respondent's county of residence in 2000. Based on results from our multivariate logit model analyzing responses to the six true–false questions about Medicare and the M+C program.

++ Indicates the explanatory variable is positively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .01 level.
+ Indicates the explanatory variable is positively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .05 level.
— Indicates the explanatory variable is negatively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .01 level.
– Indicates the explanatory variable is negatively associated with beneficiary understanding, and coefficient is significantly different from zero, at the .05 level.

[a]This coefficient was significantly different from zero at the .0503 level.

primary care physicians. Perhaps the interest level in this fact is greater for switchers and new enrollees than for FFS beneficiaries since they decided to join an M+C plan.[6]

For FFS beneficiaries, those who read the handbook were more likely to understand that Medicare does not pay for all health expenses. However there was no such discernable affect for switchers and new enrollees. Perhaps FFS beneficiaries may have greater interest in general facts about Medicare than switchers and new enrollees.

The number of NMEP information sources (other than the handbook) from which beneficiaries gather information about Medicare is also statistically significant and positively related to answering some of the true-false questions correctly. For questions related to general knowledge about Medicare, the number of NMEP information sources collected was associated with greater understanding for new enrollees and FFS beneficiaries, but not for switchers. This result could also be driven by beneficiary interest level in that switchers may have the less interest in general information about Medicare since they were previously enrolled in a managed care plan. For questions related to the interface of traditional Medicare with the M+C program, the number of NMEP information sources used was positively and significantly associated with understanding across all three enrollment groups.

In interpreting the impact of using these information sources on beneficiary knowledge, readers should note that our regression analysis may not have controlled for important unobserved differences between those who read the handbook and those who did not. Our

[6]The handbook did not contribute to beneficiaries' understanding that their choice of doctors is limited in a Medicare HMO. That was the only true-false question for which the handbook did not contribute significantly to beneficiary knowledge for any of the three enrollment groups.

regression analysis may therefore tend to overstate the effect of the handbook and other information sources on beneficiary understanding.[7]

The best way to determine the effect of the handbook would be through a randomized study design, in which enrollees would be randomly assigned to a treatment group (those who would receive the handbook) and a control group (those who would not receive the handbook). Such an analysis was done by McCormack and others (2000) in Kansas City. A control group of Medicare beneficiaries received no information, whereas three treatment groups received NMEP information sources. One treatment group received the handbook only, another received an abbreviated version of the handbook, and a third received the handbook in addition to the Consumer Assessment of Health Plans (CAHPS) survey report comparing the quality of health care provided by Medicare HMOs. The study team found that Medicare beneficiaries who were in one of the three treatment groups answered more questions about Medicare and Medicare managed care correctly than those who had not received any information. The higher demonstrated level of understanding was modest and statistically significant.

The study by McCormack (2000) also included a separate analysis of two groups: those age 64 and therefore becoming newly eligible for Medicare and "experienced" beneficiaries who already had both Medicare Parts A and B. Modest and statistically significant increases in knowledge were observed for both groups, but the effects were somewhat greater for those becoming newly eligible for Medicare. The study did not account for the levels of knowledge of experienced beneficiaries that differed depending upon whether they were in traditional

[7]It would have been helpful to have had baseline data on enrollees' knowledge level before introduction of NMEP. Our regression analysis provides an upper-bound estimate of the effect.

Medicare or a Medicare HMO.[8] The authors of the study point out that their sample consisted of respondents who agreed to look at the materials and were able to participate in the study, and may therefore be healthier and perhaps more educated than the average Medicare beneficiary.

In order to compare the level of understanding of switchers and new enrollees to FFS beneficiaries, we also ran the regression across all three groups combined, and included a dummy variable for switchers and new enrollees. Our results from this analysis show that compared with FFS beneficiaries, switchers and new enrollees are more likely to answer correctly the three questions pertaining to the M+C program. Switchers and new enrollees are more likely to understand that coverage continues after one disenrolls, their network of doctors is limited in M+C, and that one can switch to another primary care physician. (The binary variables for switchers and new enrollees are significant at the .01 level for these questions).

Through our regression analysis, we found that levels of education and income are associated with beneficiary understanding in only a few cases. FFS beneficiaries and new enrollees who had not received education beyond high school are less likely to understand that Medicare does not pay for all health expenses (the coefficients are statistically significant at the 5 percent level, see Table V.5 and Appendix Table C-6). And switchers who did not receive an education beyond high school are less likely to understand that if they were to leave a Medicare HMO, their Medicare coverage would continue, or that they can switch between primary care physicians. FFS beneficiaries with incomes of $40,000 or more are more likely to understand that they can switch between primary care physicians. For the remaining questions, the coefficients on education and income are not statistically significant for any of the enrollment

[8]It appears that both FFS beneficiaries and Medicare managed care enrollees were included in the sample of experienced beneficiaries, but that is not made clear in the report. Beneficiaries who are enrolled in a Medicare HMO may have a higher level of understanding of Medicare managed care to begin with (before having received the handbook).

groups. In addition, age was a statistically significant factor in only one of the regressions—switchers between the ages of 65 and 74 were more likely to understand that their doctor choice is limited than their older counterparts.[9]

Minorities (both nonwhites and hispanics) were less likely to understand that Medicare does not pay for all health expenses. And of some concern, minorities who were switchers or new enrollees were less likely to understand that if they were to leave a Medicare HMO, they would still be covered by Medicare. Switchers who were also in a minority group were less likely to understand that their doctor choice is limited. These results suggest that minorities have less understanding of some key aspects of Medicare and Medicare managed care and may need educational efforts that target them specifically.

Having employer sponsored coverage was positively associated with understanding for FFS beneficiaries in one instance—those with employer based coverage were more likely to understand that Medicare does not pay for all health expenses. This was also true for FFS beneficiaries that had purchased Medigap coverage themselves. However, for switchers and new enrollees, employer based coverage was negatively associated with beneficiary understanding. Those switchers and new enrollees with employer based coverage were less likely to understand that they could select among health plan options within the M+C program. This makes sense, given that for these enrollees, it is likely that their employer may have selected the M+C plan on their behalf.

[9]The results are consistent with our descriptive tables, C.1 through C.5, discussed earlier. In the descriptive tables, differences across age groups were rarely statistically significant. And where the regression results are statistically significant for income and education levels, the descriptive tables also show differences across education and income subgroups that are statistically significant. The regression analysis provides a more robust test of when these demographic characteristics are associated with greater beneficiary understanding.

Switchers and new enrollees with cognitive difficulties were less likely to understand that if they leave a Medicare HMO, they would still be covered by Medicare. Switchers with cognitive difficulties were also less likely to understand that they can switch between primary care physicians.[10] These results show that those with cognitive difficulties may be at a particular disadvantage for understanding key aspects of the M+C program and its interface with Medicare.

In our regression analysis on beneficiary understanding, the differences between cohorts 1 and 2 are not statistically significant. (We included a dummy variable for respondents who were in cohort 2 in each of the 6 regressions.) This result is consistent with our descriptive comparison of cohorts 1 and 2 in terms of beneficiary understanding. With one exception, none of the differences between cohorts 1 and 2 shown in Appendix E Table V.3 are statistically significant. Sixty-three percent of switchers in cohort 1, and 70 percent of switchers in cohort 2 understand that they can report complaints to Medicare. (This difference is statistically significant at the .05 level.)

An important event that occurred in the brief interval between the interview dates of the two cohorts was that a number of Medicare HMOs announced that they were dropping out of the M+C program for 2001. Such an event could increase publicity about the program and motivate beneficiaries to seek more information. However, our regression results do not indicate that cohort 2 understands the Medicare program and its relationship with with Medicare managed care better than cohort 1.

We also examined whether beneficiaries were more likely to answer the true false questions correctly in markets with a higher Medicare managed care penetration rate. Our regression results show that higher penetration rates are associated with a statistically significant effect on

[10]FFS beneficiaries with cognitive difficulties were more likely to understand that they can switch between primary care physicians in a Medicare HMO. We cannot explain this counter-intuitive result.

correctly answering one question for FFS beneficiaries only: that Medicare does not cover all health care expenses; and the effect on beneficiary understanding in this one case is negative. That is, FFS beneficiaries living in areas with a higher M+C penetration rate are somewhat less likely to understand that Medicare does not cover all health expenses. If advertising by M+C plans tends to be greater in markets with higher penetration rates, then one might expect FFS beneficiaries in higher penetration rate areas to be somewhat more aware that Medicare does not cover all expenses and that M+C plans offer additional benefits beyond Medicare. The fact that the reverse is true is difficult to explain. Higher M+C penetration rates were not associated with beneficiary understanding for any of the other true-false questions. The proportion of respondents that correctly answered the true-false questions, and how that proportion varies with the Medicare managed care penetration rates are shown for all six true-false questions in Appendix Table C-5.

The analysis of the responses of the FFS group points to some of the most dramatic differences in program-related knowledge between those who have read the handbook and those who have not. For example, only 37 percent of FFS beneficiaries who have not read the handbook know that that Medicare coverage continues after disenrolling from an M+C plan, whereas 52 percent of those who have read the handbook correctly answered this question (Table V.4). Still, we cannot attribute the entire difference to the effect of the handbook. Nonetheless, the descriptive statistics suggest that the Medicare issues on which managed care enrollees are least informed differ from the issues on which FFS beneficiaries are least informed. The latter group is less informed about the basic characteristics of managed care plans and how those plans interface with Medicare. Still, it should also be noted that FFS beneficiaries who have no intention of joining a managed care plan may feel no need to be further informed about the M+C program.

D. UNDERSTANDING THE SOURCE OF THE INFORMATION

Many Medicare beneficiaries are not able to discern which information sources come from the federal government. We analyzed whether beneficiaries who have read the handbook know that the source of the information is the federal government. Previously we found that 32 percent of switchers and 35 percent of new enrollees reported that they had read the handbook. And more than three-quarters of these individuals reported that the handbook was important or somewhat important in their decision to enroll in a managed care plan. However, of those who read the handbook and found it at least somewhat important in their decision-making process, only 30 percent of new enrollees and 20 percent of switchers reported that they had used any information from the federal government when selecting a type of Medicare health insurance. That is, in answer to the questions of whether they had "used any information from the federal government when making decisions about Medicare health insurance," most of these switchers and new enrollees who read the handbook responded "no" or "don't know." In other words, most switchers and new enrollees who have read the booklet and used it in their decision-making process did not demonstrate an understanding that they had used an information source from the federal government. It is also possible that when respondents reached this question about using information provided by the federal government, some interpreted it as pertaining to federal sources other than those already mentioned in previous questions (such as the handbook and toll free number). So our estimate could understate the proportion of beneficiaries who understand that the handbook comes from the federal government.

A higher proportion of beneficiaries who read the handbook understood that it was provided by the Medicare program. Sixty-eight percent of new enrollees, 64 percent of switchers, and 61 percent of those in FFS who read the handbook responded that they received information from

the Medicare program, but they do not seem to be aware that the federal government is in charge of this program.

Some research has indicated that Medicare beneficiaries trust some sources of information more than others (Gibbs, Sangl, and Burris 1996). Still other research has shown that knowing the source of the information is a primary factor in a consumer's belief in the validity and reliability of the information (Hibbard, Slovic, and Jewett 1997). If beneficiaries are unaware of the source of the information that they use most frequently, they are not actively judging different sources of information according to the likely point of view expressed in that information. Such behavior indicates a lack of sophisticated understanding on the part of beneficiaries of their role as consumers and of the types of information that might influence their decision. To the extent that beneficiaries cannot distinguish between federal information and health plan information, they cannot consider how the nature and type of information provided is related to its source. Such lack of understanding prevents beneficiaries from taking full advantage of the useful, but different, information provided by both sources.

VI. USE OF INFORMATION SOURCES IN DECISION MAKING

In this section, we examine the degree to which new enrollees and switchers found value in the sources of information they consulted and whether they used the information in their health coverage decision-making process. The information sources under study include informal networks of family and friends, formal nongovernmental sources such as former employers and health care providers, and NMEP sources.

Previously, we found that 35 percent of new enrollees and 32 percent of switchers read at least part of the handbook. Of those who read it, about three-quarters termed it at least somewhat important in their decision to enroll in a managed care plan. Other NMEP sources of information, such as the toll-free telephone number, also helped answer beneficiaries' questions. In addition, beneficiaries used many non–NMEP sources such as family, friends, medical personnel, and health plans when deciding whether to enroll in a managed care plan.

A. BENEFICIARIES FIND NMEP SOURCES HELPFUL

Overall, about one-third of new enrollees and switchers read the handbook, and most of those who read it find it very helpful. About three-quarters of new enrollees and switchers who read the handbook rate it as "good," "very good," or "excellent" (Table VI.1). The remaining switchers and new enrollees gave the handbook either a fair or poor rating or did not know how to rate it. In addition, across the three enrollment groups, approximately 90 percent of those who read the handbook reported that they still retain a copy (not shown). Twenty-four percent of *all* switchers and new enrollees found the handbook at least somewhat important in their decision to enroll in a managed care plan (Table VI.2). Restricting the analysis to those new enrollees and switchers who read the handbook, over three-quarters reported that it was important or somewhat important in their decision to enroll in a managed care plan. Differences between the two

TABLE VI.1

RATING OF THE HANDBOOK BY THOSE WHO READ IT

Handbook Rating	Percent of Beneficiaries, by Enrollment Status		
	Switchers	New Enrollees	Fee-for-Service
Excellent	7.0	6.4	5.0
Very Good	26.3	21.4	20.4
Good	40.9	47.9	48.4
Fair	19.5	17.3	18.8
Poor	1.0	3.0	1.3
Don't Know	5.2	3.9	6.2

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: Overall, 32 percent of switchers and 35 percent of new enrollees read the handbook. Twenty-nine percent of FFS beneficiaries read the handbook. The distribution of responses did not differ with statistical significance between switchers and FFS beneficiaries or between new enrollees and FFS beneficiaries (chi-square test).

TABLE VI.2

IMPORTANCE OF HANDBOOK IN DECISION TO
JOIN A MEDICARE MANAGED CARE PLAN

	As a Percentage of Those Who Read the Handbook[a]			As a Percentage of the Entire Subgroup	
Handbook Rating	Switchers and New Enrollees Combined	Switchers	New Enrollees	Switchers	New Enrollees
Very Important	41.3	39.4	45.0	12.0	14.3
Somewhat Important	36.8	38.8	32.9	11.8	10.4
Not Important	13.1	12.6	13.9	3.9	4.4
Found No Information	7.4	7.8	6.4	2.4	2.0
Don't Know	1.5	1.3	1.8	0.4	0.6

SOURCE: MPR survey of cohort 1 and cohort 2, Medicare beneficiaries.

[a]Thirty-two percent of switchers and 35 percent of new enrollees read the handbook.

cohorts on the rating of the handbook and the proportion of beneficiaries who found it useful in their decision-making process were not statistically significant (see Appendix E Tables VI.1 and VI.2).

To examine whether demographic and socioeconomic characteristics could partly explain who was more likely to read the handbook and find it helpful in their health care decision-making process, we conducted a regression analysis. The dependent variable was a binary variable taking a value of one if the handbook was read and was important in the decision process (zero otherwise). The regression was conducted for separately for switchers and new enrollees.[1] We controlled for demographic characteristics, health status, insurance experience, and the Medicare managed care penetration rate. We found that for switchers, those aged 65 to 74 were more likely than older beneficiaries to read the booklet and find it helpful in their health care decision-making process. For new enrollees, minorities (nonwhite) and those with no more than a high school education were less likely to have done so (with statistical significance at the .05 level for the last two estimates; see Table VI.3). Other beneficiary characteristics had no discernable effect on whether the handbook was useful to a beneficiary. These findings suggest that the handbook may need to be adapted somewhat to become more useful for minorities and older beneficiaries, and that some attention to what changes would make it more useful to these groups is needed.

Of those who used other NMEP sources, the great majority say they received answers to their questions. The toll-free telephone number was the second most frequently used NMEP information source. Eleven percent of switchers and 13 percent of new enrollees use the toll-free telephone number; among them, 86 percent of switchers and 81 percent of new enrollees have received answers to their questions (Table VI.4). Eleven percent of FFS beneficiaries used the

[1]The question on the importance of the handbook was not asked of FFS beneficiaries.

TABLEVI.3

CHARACTERISTICS ASSOCIATED WITH USE OF HANDBOOK IN DECISION PROCESS FOR SWITCHERS AND NEW ENROLLEES

Explanatory Variable	Switchers	New Enrollees
Intercept	-0.03**	-0.28*
Cohort 2	1.25	-0.97
Has employer sponsored Medigap coverage	-0.6	-0.63
Has purchased own Medigap coverage	1.09	1.06
Has 4 or more doctor visits	1.31	-0.93
Has cognitive difficulties	-0.75	-0.65
Participates in insurance decision	1.69	1.19
Was member of managed care before Medicare	1.28	1.11
Has high school education or less	-0.94	-0.68*
Income is more than $40,000 per year	1.24	-0.79
Medicare HMO dropped out of county in January 2000	1.18	1.28
Age 65-74	1.67*	1.44
Age 85 or above	1.10	1.04
Nonwhite	-0.66	-0.59*
Hispanic	-0.64	-0.52
Responded by mail questionnaire	2.91**	2.01**
Female	1.07	1.38
Resides in urban area	2.47	-0.76
Medicare HMO county penetration rate	2.76	1.24

NOTE: The dependent variables take a value of 1 if the handbook was read and used in the decision process, zero otherwise.

*Statistically significant from zero at the .05 level.
**Statistically significant from zero at the .01 level.

TABLE VI.4

HELPFULNESS OF OTHER NMEP SOURCES

Information Source	Of Those Who Used the Information Source, the Proportion Who Received Answers to Their Questions[a]		
	Switchers	New Enrollees	Fee-for-Service
Toll-Free Telephone Number	86.0	80.9	88.5
Health Fair	91.2	89.0	93.0
Lecture	95.6	88.7	89.1
State-Sponsored Insurance Counseling	90.5	87.2	84.5

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTES: The differences between switchers and FFS beneficiaries were not statistically significant; nor were the differences between new enrollees and FFS beneficiaries.

[a]Calculated as a percent of those who used the information source. See Tables IV.4 and B.3 for the percentage of beneficiaries who used these sources.

toll-free number. Of those FFS beneficiaries who use it, 89 percent have received answers to their questions. A third source of information, the state health insurance assistance programs (SHIPs) is used by only a small portion of those sampled. A mere 4 percent of new enrollees and switchers used a SHIP, and only 2 percent of FFS beneficiaries did likewise (Table IV.3). And across the three groups, 4 to 8 percent attended a health fair that discussed Medicare or attended a meeting or lecture that featured Medicare. Of those relatively few beneficiaries who take advantage of the various information sources, the large majority has received answers to their questions.[2]

B. OTHER HELPFUL SOURCES INCLUDE HEALTH PLANS, DOCTORS, FRIENDS, AND FAMILY

Beneficiaries were asked to indicate the information source other than the handbook that, among those they cited, they found most helpful.[3] Over 45 percent of switchers and new enrollees reported using information they received from their health plan. And for both switchers and new enrollees, the health plan is most frequently the most helpful source (Table VI.5). Twenty-five percent of switchers and 24 percent of new enrollees reported their health plan as the most helpful source. The numbers imply that more than half of the switchers and

[2]With one exception, the proportion of beneficiaries who found these information sources helpful did not differ with statistical significance between cohorts 1 and 2. Only 82 percent of FFS beneficiaries in cohort 2 found that the toll-free number answered their questions, whereas 96 percent of FFS beneficiaries in cohort 1 did so. The difference was statistically significant at the .05 level (see Appendix VI.3).

[3]The handbook was not listed as a separate option in the survey under this question. Some of those who cited the Medicare program as their most helpful source may have been referring to the handbook. Switchers and new enrollees evaluated the handbook when asked whether they found the comparative information in it important in their decision to enroll in a managed care plan (Question 34i).

TABLE VI.5

BENEFICIARIES' MOST HELPFUL INFORMATION SOURCE

Information Source	Proportion of Beneficiaries, by Enrollment Status					
	Switchers		New Enrollees		Fee-for-Service	
	Used the Source	Cited as the Most Helpful Source**	Used the Source	Cited as the Most Helpful Source	Used the Source	Cited as the Most Helpful Source**
Their Health Plan	45.2	25.0	47.1	23.6	29.2	12.0
Doctor or Medical Personnel	38.2	15.2	31.6	10.4	32.1	12.8
Family or Friends	40.4	11.0	42.2	13.1	29.0	7.9
Medicare Program[a]	38.7[c]	8.9	37.9[c]	9.2	39.7[c]	13.1
Senior Citizen Organization	31.8	8.4	32.5	7.5	29.4	11.5
Toll-Free Telephone Number	10.7	2.2	13.4	3.1	11.2	4.2
Meeting/Lecture	7.4	1.6	6.8	0.9	3.5	0.3
Former Employer	7.3	4.0	17.5	8.9	9.6	5.1
Other Organization	3.9[c]	2.5	4.7[c]	2.5	3.9[c]	2.7
Library or Newspaper	20.1	2.4	18.2	2.1	16.0	3.0
Hospital/Clinic/Nursing Home	13.0	1.0	12.5	2.0	15.9	2.6
State Sponsored Insurance Counseling	3.6	0.5	3.9	0.8	2.2	0.3
Website	1.5	0.2	3.3	0.7	0.7	0.0
Health Fair	7.6	0.8	5.7	0.8	4.1	0.2
None[b]	13.6	16.3	11.8	14.4	19.3	24.5

SOURCE: MPR survey of Medicare beneficiaries, cohort 1 and cohort 2.

[a]The handbook was not listed as a separate option for respondents to choose from. However, it would have been one of the sources under the category "Medicare Program."

[b]Two percent of FFS beneficiaries had read the handbook but did not give their most helpful information source (and are included under none). This is also true for 0.8 percent of switchers and 0.9 percent of new enrollees.

[c]Proportion of beneficiaries that received information from this source (rather than used the source). Based on responses to Question 18.

**The percentage distribution of responses across the categories differed with statistical significance at the .01 level between the enrollment group examined and FFS beneficiaries (chi-square test).

new enrollees who used information from their health plan reported the plan as their most helpful information source.[4]

Another frequently used source for switchers and new enrollees was their doctor or medical personnel. Thirty-eight percent of switchers and 32 percent of new enrollees obtained information from that source. Overall, 15 percent of switchers and 10 percent of new enrollees cited their doctor or medical personnel as their most helpful source. Therefore, of those who used this source, a significant proportion found it to be the most helpful—40 percent of switchers and 33 percent of new enrollees reported it as the most helpful.

Over 40 percent of switchers and new enrollees frequently obtained information from their family and friends. And 11 percent of switchers and 13 percent of new enrollees reported family and friends as their most helpful source. Overall, about 31 percent of new enrollees and 25 percent of switchers who obtained information from family and friends reported this source as the most helpful. Therefore, while family and friends serve as a source of information almost as frequently as the health plan and more frequently than doctors, those who rely on family are somewhat less likely to cite them as the most helpful information source.

A much higher proportion of new enrollees cited their employer as their most helpful source—9 percent compared with switchers and FFS beneficiaries (at 4 to 5 percent). This is consistent with the fact that a relatively high percentage of new enrollees used information from their employer—18 percent. It is likely that many new enrollees are also new retirees and have stronger ties to their employers.

Those in FFS cited the Medicare program as the most helpful information source--among 13 percent of beneficiaries--followed by doctor or medical personnel at just under 13 percent and

[4]The calculation takes the following form: for switchers, 25 percent report the plan as the most helpful source divided by 45.2 who used the source = 55 percent. For new enrollees, 23.6 percent report the plan as the most helpful divided by 47.1 who used the source = 50 percent.

then by the health plan at 12 percent.[5] The other frequently cited sources overall for FFS beneficiaries were senior citizen organizations (11 percent) and family or friends (8 percent).

Fourteen percent of new enrollees, 16 percent of switchers, and 25 percent of FFS beneficiaries did not identify their most helpful information source (based on the information sources they reported using); most of these beneficiaries did not report using any information source. Unlike switchers and new enrollees who recently made a decision to join a Medicare managed care plan, many FFS beneficiaries may not have taken a recent interest in reviewing their coverage options. Perhaps for that reason, they were less likely than switchers and new enrollees to name a helpful information source.

The distribution of responses across the most helpful information source differed significantly for switchers and FFS beneficiaries, and for new enrollees and FFS beneficiaries.[6] Among the differences, FFS beneficiaries listed their health plan as the most helpful source much less frequently and the Medicare program and senior citizen organizations more frequently than switchers and new enrollees. FFS beneficiaries perhaps are more likely to turn to Medicare program information sources because they are older, more likely to have been beneficiaries for a longer time, and thus more familiar with Medicare program publications. They are similarly more familiar with senior citizen organizations because of their longer tenure as seniors. Across the three enrollment groups, the distribution of responses listing the most helpful information source was not significantly different for cohorts 1 and 2.

[5]For FFS beneficiaries, their health plan would include a Medigap plan or an employer-sponsored plan that wraps around their Medicare coverage.

[6]Since respondents answered this question by choosing from among a list of information sources, it is appropriate to perform a chi square test across the entire distribution of responses, comparing switchers with FFS beneficiaries and new enrollees with FFS beneficiaries. (See question 27 of the survey instrument.)

C. OVER 60 PERCENT OF SWITCHERS AND NEW ENROLLEES USE THEIR MOST HELPFUL SOURCE TO COMPARE BENEFITS

Plan benefits are an important point of comparison for switchers and new enrollees. Sixty-five percent of switchers and 60 percent of new enrollees who named a most helpful source (either an NMEP or a non–NMEP source) used that source to compare benefits across plans (Table VI.6). About half of switchers and new enrollees who named a helpful information source used it to compare quality or costs across different plans. The results imply that benefits, quality, and cost are major factors that underlie a beneficiary's decision to enroll in a Medicare managed care plan. (See Chapter 7 for a discussion of this point.) Overall, 55 percent of new enrollees and 53 percent of switchers who named their most helpful source report using that source to help them decide to enroll in a managed care plan.

With two exceptions, the responses on how beneficiaries used the most helpful information source generally were not significantly different for cohorts 1 and 2. First, a higher proportion of switchers in cohort 1 used their most helpful source to compare quality than was the case for cohort 2 (62versus 51 percent), and, second, a higher proportion of switchers used their most helpful source to compare costs in cohort 1 as compared with cohort 2 (54 versus 50 percent; see Appendix E Table VI.2).

D. FFS BENEFICIARIES USE THEIR MOST HELPFUL SOURCE TO DRAW COMPARISONS ACROSS PLANS LESS FREQUENTLY THAN SWITCHERS AND NEW ENROLLEES

Fewer FFS beneficiaries used their most helpful source to draw comparisons across health plans as compared with switchers and new enrollees; these differences are statistically

TABLE VI.6

HOW BENEFICIARIES USED THEIR MOST HELPFUL INFORMATION SOURCE

Use of Most Helpful Source	Percentage of Beneficiaries, by Enrollment Status		
	Switchers	New Enrollees	Fee-for-Service (R)
To Draw Comparisons Across Plans			
Compare benefits	64.8**	60.3**	39.0
Compare costs	51.6**	48.5**	26.1
Compare quality	54.6**	48.4**	27.0
To Understand Enrollment/ Disenrollment Process			
Understand how to sign up for a plan	51.7**	48.4**	24.6
Understand how to drop out of plan	43.8**	38.7**	15.2
To Make Health Coverage Decision			
To decide to enroll (or not) in an M+C plan	53.2**	54.6**	42.4

SOURCE: MPR survey of cohort 1 and cohort 2 Medicare beneficiaries (questions 28A through 28E).

**Significantly different at the .01 level from the FFS group (chi-square test).

significant.[7] This finding is not unexpected in that many FFS beneficiaries can be presumed to have had traditional Medicare for a long time and are less likely to have recently made a decision concerning their health coverage. They are therefore thus less likely to compare the various features of health plans.

Overall, only 39 percent of FFS beneficiaries who named their most helpful information source used it to compare benefits across different Medicare health insurance plans (including Medigap plans).[8] And only 26 percent of FFS beneficiaries who named their most helpful source used it to compare costs. Twenty-seven percent of FFS beneficiaries reporting a helpful information source used that source to compare quality across Medicare managed care plans, and 25 percent used their most helpful source to learn how to sign up for a managed care plan.

The fact that almost one-quarter of FFS beneficiaries used their information source to learn about how to sign up also indicates an interest on the part of a substantial portion of FFS beneficiaries in possibly joining an M+C plan. Only 15 percent of FFS beneficiaries who named a helpful source thought far enough ahead to use their information source to learn about how to disenroll from a managed care plan. And it is important to recall that this was a topic area where FFS beneficiaries are not well informed. (That is, most do not understand that they would still be covered by Medicare if they were to disenroll from an M+C plan.) Finally, 42 percent of FFS beneficiaries who named their most helpful source used that source to decide to remain in traditional Medicare. If we include FFS beneficiaries who did not name a helpful source, then about 32 percent of all FFS beneficiaries used an information source to decide whether or not to

[7]Differences between new enrollees and FFS beneficiaries and between switchers and FFS beneficiaries on all estimates reported in table VI.5 are significantly different from zero at the .01 level.

[8]With respect to costs and benefits, FFS beneficiaries were asked if they made comparisons across Medicare health insurance plans (which could include Medigap plans). With respect to quality, beneficiaries were asked if they drew comparisons across Medicare managed care plans.

remain in FFS Medicare. That indicates that a significant minority of FFS beneficiaries appear to have used information to weigh their option of whether to join a Medicare managed care plan.

E. HOW SWITCHERS AND NEW ENROLLEES USED THE TOP FOUR HELPFUL INFORMATION SOURCES

We examined how beneficiaries used the four information sources they most frequently cited as helpful: health plans, doctor or medical personnel, family or friends, and the Medicare program. Switchers and new enrollees obtain many types of information from health plans. Over half of new enrollees and switchers who cited health plans as their most helpful source used it to *draw comparisons* between plans on costs and benefits or to learn how to enroll and disenroll (Table VI.7). Specifically, 69 percent of switchers and new enrollees reporting their health plans as their most helpful source used that source to compare benefits, 59 percent used it to compare costs, and 52 to 56 percent used it to compare quality or to learn how to enroll or disenroll. Many also used that source to make their health coverage decision. Sixty-two percent of switchers and new enrollees, citing their health plan as their most helpful source, used that source to help make their *decision* to enroll in a Medicare managed care plan.

For those switchers and new enrollees citing family and friends as their most helpful source, over 70 percent used such informal networks to compare the quality of different plans. None of the other three information sources most frequently cited as helpful by switchers and new enrollees (their health plan, doctor or the Medicare Program) had nearly as high a proportion of beneficiaries reporting that they had used that source to compare quality across plans. Family and friends therefore appear to be an important resource for those who are interested in learning more about the quality of different health plans. A high proportion of those reporting family or friends as their most helpful source also used that source to compare benefits (74 percent) or to compare costs (66 percent) of different plans. Those reporting family and friends as their most

TABLE VI.7

HOW NEW ENROLLEES AND SWITCHERS
USED TOP FOUR INFORMATION SOURCES

	Percent Who Used the Information Source to:					
Of Those Citing Their Most Helpful Source As	Compare Benefits	Compare Cost	Compare Quality	Learn How to Enroll	Learn How to Disenroll	Help Make Decision to Enroll in M+C Plan
Their Health Plan	69.0	58.9	52.4	52.1	55.8	61.9
Doctor or Medical Personnel	52.8	29.0	58.4	43.4	24.2	50.7
Family or Friends	73.5	66.1	72.4	52.8	27.6	57.4
Medicare Program[a]	59.5	42.0	47.1	48.0	48.2	44.4

SOURCE: MPR survey of cohort 1 and cohort 2 Medicare beneficiaries.

[a]The handbook was not listed as a separate option for respondents to choose when selecting their most helpful information source. This category would therefore include some of those who found the handbook to be their most helpful information source.

helpful source used this source least frequently to learn how to disenroll from a plan (28 percent). This is not surprising; most beneficiaries would turn to formal sources, such as health plans or the Medicare program, to get specific detailed information on disenrollment.

Those citing their doctor or medical personnel as their most helpful source used that source most frequently to compare quality (58 percent) and to compare benefits (53 percent) across plans. As expected, doctors and medical personnel are another important resource for learning about the quality of health plans. Those citing doctors and medical personnel as their most helpful source used this source least frequently to learn how to disenroll from a plan; only 24 percent used the source for this purpose. Again, this finding is not surprising in that beneficiaries would expect to learn about this type of information from more formal sources, such as the health plan or the Medicare program.

Switchers and new enrollees citing the Medicare program as their most helpful source used that source most frequently to compare benefits across plans—60 percent used the Medicare program for that purpose. Almost half of switchers and new enrollees relying on this source also used it to learn how to enroll or how to disenroll.

Of the four top information sources examined, the health plan captured the highest proportion of switchers and new enrollees reporting that they had used that source in their decision to enroll in a plan, at 62 percent. Family and friends also had a high proportion of switchers and new enrollees reporting that they had used that source in their decision-making process, at 57 percent.

F. HOW FFS BENEFICIARIES USED INFORMATION FROM THE MEDICARE PROGRAM AND THEIR HEALTH PLAN

The most frequently cited helpful source for FFS beneficiaries is the Medicare program. Forty-five percent of those who cited the Medicare program as their most helpful source report that they used it to help them make their decision to remain in FFS Medicare (Table VI.8). One-third reported using that source to compare benefits, and one-fourth reported using it to compare costs. About 20 percent of FFS beneficiaries who relied on the Medicare program as their most helpful source used it to compare quality or for instruction on how to enroll or disenroll from an M+C plan.

FFS beneficiaries citing their health plans as their most helpful information source used that source most frequently to compare benefits across different plans (42 percent). FFS beneficiaries citing their health plans as the most helpful source used that source least frequently to learn how to disenroll from a Medicare managed care plan—only 13 percent reported using it for that purpose. And a high proportion—53 percent—of FFS beneficiaries citing the health plan as their most helpful source reported using that source to help them decide to remain in traditional Medicare.

Thirteen percent of FFS beneficiaries reported that their doctor or other medical personnel was their most helpful information source. Thirty-two percent of FFS beneficiaries citing their doctor as the most helpful source used that source to compare benefits across plans, 28 percent used it to compare quality, and 19 percent used it to learn how to disenroll. Only 10 percent of those citing their doctor or other medical personnel as their most helpful source used that source to compare costs and only 8 percent used it to learn how to disenroll. Thirty percent of those FFS beneficiaries citing their doctor as the most helpful source used that source to help them to decide to remain in FFS Medicare.

TABLE VI.8

HOW FFS BENEFICIARIES USED TOP
FOUR INFORMATION SOURCES

	Percent Who Used the Information to:					
Of Those Citing Their Most Helpful Source As	Compare Benefits	Compare Cost	Compare Quality	Learn How to Enroll	Learn How to Disenroll	Help Make Decision to Remain in FFS Medicare
Their Health Plan	42.4	34.2	25.0	27.7	13.0	52.5
Doctor or Medical Personnel	32.0	9.7	27.9	18.7	7.5	30.0
Family or Friends	50.7	35.5	34.3	32.6	21.4	35.6
Medicare Program[a]	33.5	24.7	21.6	21.5	19.0	44.6

SOURCE: MPR survey of cohort 1 and cohort 2 Medicare beneficiaries.

[a]The handbook was not listed as a separate option for respondents to choose when selecting their most helpful information source. This category would therefore include some of those who found the handbook to be their most helpful information source.

Family and friends were the most helpful source for 8 percent of FFS beneficiaries. Fifty-one percent of FFS beneficiaries who cited family and friends as their most helpful source used that source to compare benefits across plans; just over one-third used it to compare cost or quality or to learn how to enroll. Overall, FFS beneficiaries are much less likely to use their most helpful source to draw comparisons across plans as compared with switchers and new enrollees.

VII. MAKING A HEALTH COVERAGE DECISION

The purpose of NMEP is to provide Medicare beneficiaries with information they can use to make decisions about Medicare coverage. This information is particularly relevant for switchers and new enrollees because they may decide to select a Medicare managed care plan as an alternative to staying with the Medicare FFS system. If information about Medicare insurance coverage is to be helpful, then those who design NMEP must know which factors switchers and new enrollees actually consider in their decision-making. This section presents our findings on these factors.

The three most important factors switchers and new enrollees consider when selecting a health plan are: the medical services (benefits) covered by each option, the quality of care offered by the providers under each option, and whether current providers can continue to be used under each option. Surprisingly, recommendations from family and friends as to various options are much less important to switchers and new enrollees than indicated by earlier research. Instead, switchers and new enrollees appear to rely on criteria used in formal sources to describe and/or "rate" plans.

In addition to identifying which factors are important to switchers and new enrollees when they choose a plan, our analysis also showed that these factors are different for users and nonusers of NMEP materials. Switchers and new enrollees who have read *Medicare & You 2000* are more likely than those who have not to consider benefits or quality of care as "very important" in their health care decision. Eighty-eight percent of switchers and 83 percent of new enrollees who read the handbook consider benefits and quality of care as "very important." Switchers and new enrollees who consider the cost of the premium, the amount of paperwork, or patient satisfaction as very important are also more likely to have read the handbook than are

those who do not consider such factors as very important. In sharp contrast, only 35 percent of switchers and new enrollees who read the handbook rely heavily on the recommendations of family and friends (Table VII.1).

A. COVERED BENEFITS, QUALITY, AND MAINTAINING PROVIDER RELATIONSHIPS ARE MORE IMPORTANT THAN COST OF PREMIUM IN CHOOSING A HEALTH PLAN

Conventional wisdom and some research asserts that beneficiaries focus on just a small set of health plan characteristics, such as cost, choice of physician, and covered benefits when making a health plan decision. Few appear to consider other characteristics such as quality of care and member satisfaction (Gibbs et al. 1996; MedPAC 1998; Sofaer and Fox 1998; Stevens and Mittler 2000). However, the switchers and new enrollees in our study in both cohorts combined ranked these factors somewhat differently. Although they ranked covered benefits and choice of physician very highly, they told us that health plan quality is more important than cost of the premium.

More specifically, we asked switchers and new enrollees to evaluate the importance of several factors that they may have considered when they made their decision to enroll in a Medicare managed care plan: premiums, benefits covered, patient satisfaction, quality of care, the ability to stay with current providers, the amount of paperwork, the recommendations of family and friends, and the fact that an employer offered to pay for managed care insurance. Respondents were asked to indicate whether the factor was very important, somewhat important, or not important at all in their decision to enroll in a Medicare HMO.[1]

The three factors that are most important to switchers and new enrollees are, in descending order: benefits covered, quality of care, and the ability to remain with their current physicians.

[1]See question 34 in the survey instrument, which appears in Appendix F.

TABLE VII.1

FACTORS CONSIDERED BY SWITCHERS AND NEW ENROLLEES WHEN MAKING A HEALTH PLAN DECISION

Factor	Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Benefits Covered	82.4	12.9	3.4	1.0	0.3
Quality of Care	78.6	14.6	2.9	3.0	0.8
Staying with Current Physicians	71.4	13.1	10.3	4.2	1.0
Cost of Premium	64.6	19.7	11.0	4.2	0.6
Amount of Paperwork	54.0	18.1	14.8	12.8	0.1
Satisfaction of Plan Members	45.8	22.9	12.3	15.3	3.7
Recommendations of Family and Friends	34.8	25.9	21.8	17.6	0.0
Employer Offered to Pay for Insurance	15.0	3.7	8.5	71.5	1.3
HMO Drop-Outs	17.7		38.1	44.2	

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

NOTE: When asked if HMO withdrawals affected their health insurance decision, respondents replied, “Yes,” “No,” “Didn’t think about it,” or “Don’t know.” The “Yes” responses are recorded in the “very important” category.

Over 80 percent of switchers and new enrollees in both cohorts combined ranked covered benefits as "very important" (Table VII.1). Quality of care and the ability to stay with their current physicians are also very important factors for at least 70 percent of switchers and new enrollees.

Although 82 percent of switchers and new enrollees indicate that the benefits covered are very important, a much lower percentage of them ever looked for information on Medicare coverage of specific services, such as prescription drugs (37 percent) or on what benefits to look for or avoid in a Medicare managed care plan (39 percent), as indicated in Table IV.8 in Section IV. If benefits are so important to the vast majority of switchers and new enrollees, why did not more of them look for information on Medicare benefits?

Much psychological research demonstrates that beliefs can be good predictors of behavior in some situations and poor predictors of behavior in other situations. According to the theory of planned behavior, this is because an individual's behavior depends jointly on his or her intentions (which includes beliefs) and perceived ability to undertake the action. Thus, many people may believe that benefits coverage is important to them, but that does not necessarily mean that they will undertake a search for information because of that belief.

Ajzen (1991) discusses several empirical studies that examine the theory of planned behavior. These studies show that for some types of behavior—such as voting—intentions are very highly correlated with actual behavior. People's *intentions* with regard to how they plan to vote in an upcoming election are highly correlated with their actual voting choice (the correlation is 0.75 to 0.80). For other types of behavior, intentions are not highly correlated with actual behavior. For example, one study found that people's intentions with respect to losing weight are not highly correlated with actual weight loss (the correlation is 0.25). Instead, their perception of the ease or difficulty of losing weight matters more (the correlation is 0.41).

Our survey data indicate that the belief that benefits are very important is not a good predictor of whether a switcher or new enrollee will actually look for information about benefits. According to the theory of planned behavior, this could be because switchers and new enrollees felt that identifying and using information sources to learn about benefits would be very difficult, so they did not try to do so.[2] In addition, it is also possible that some switchers and new enrollees did not look for information on benefits because they were able to obtain the information they needed incidentally, through information offered to them by friends, family members, health plans, or other sources of information.

Covered benefits are relatively more important to switchers and new enrollees who are age 65 to 74, who have read *Medicare & You*, and who used their most helpful information source to compare benefits (Table VII.2).[3] It is possible that the reading of the handbook has alerted these beneficiaries to the fact that different Medicare insurance options treat various benefits in different ways (in terms of limits on access, co-payments, or timing of treatment), so they value information on benefits more highly.

Quality of care is relatively more important to switchers and new enrollees who seek information from several sources. Switchers and new enrollees who rank quality of care "very important" are more likely to have read *Medicare & You 2000*, used their most helpful source of

[2]We can only speculate as to why switchers and new enrollees did not look for this information, since the survey did not ask them to explain why.

[3]For each factor that switchers and new enrollees may consider when making a health plan decision, we examined beneficiary characteristics that we thought would affect the relative importance of that factor to beneficiaries. For example, we thought that beneficiaries with serious illnesses would consider covered benefits as more important than would beneficiaries who do not have a serious illness (Table VII.2). A different set of beneficiary characteristics is likely to affect the relative importance of each factor. Consequently, the list of beneficiary characteristics we considered in Tables VII.2 through VII.5 is different for each table.

TABLE VII.2

IMPORTANCE OF BENEFITS IN MAKING HEALTH PLAN DECISIONS BY BENEFICIARY CHARACTERISTICS

Beneficiary Characteristic	Benefits Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	82.9	12.3	3.5	0.9	0.4
New enrollee	81.3	14.0	3.2	1.3	0.3
Age					
65-74	84.5*	11.7	2.5	1.2	0.1
75-84 (R)	78.8	15.8	4.2	0.6	0.6
85+	76.7	11.4	9.2	1.2	1.4
Income					
< $20,000	80.4	13.6	4.4	1.2	0.4
$20,000 - $40,000 (R)	85.3	11.3	2.7	0.6	0.1
> $40,000	79.8	15.1	3.5	1.2	0.4
Race					
White	83.1	12.3	3.4	1.0	0.2
Nonwhite	75.6	18.6	3.5	1.5	0.8
Read *Medicare & You 2000*					
Yes	87.5**	9.3	2.4	0.8	0.1
No	79.8	14.7	3.9	1.2	0.4
Used the Medicare toll-free telephone number					
Yes	82.6	11.5	4.6	0.8	0.5
No	82.1	13.2	3.3	1.1	0.3
Used most helpful source to compare benefits					
Yes	88.4**	9.5	1.3	0.8	0.0
No	76.4	16.1	5.5	1.4	0.6
Had heart disease, cancer, or stroke					
Yes	84.3	10.4	4.3	0.8	0.2
No	81.4	14.2	2.9	1.1	0.4
Had chronic condition					
Yes	82.8	12.6	3.4	0.9	0.3
No	83.4	11.7	3.1	1.2	0.5

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

*Difference in the distribution across responses is statistically significant at the 0.05 level, chi-square test.

**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.

(R) refers to reference group

TABLE VII.3

IMPORTANCE OF QUALITY OF CARE IN MAKING HEALTH PLAN DECISIONS, BY BENEFICIARY CHARACTERISTICS

	Quality of Care Ranking (Percentage of Beneficiaries)				
Beneficiary Characteristic	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	78.6	14.8	2.9	3.1	0.6
New enrollee	78.7	14.2	3.0	3.0	1.2
Age					
65-74	79.9	14.0	2.5	2.8	0.8
75-84 (R)	77.1	15.2	3.6	3.4	0.7
85+	72.8	17.7	4.4	3.9	1.2
Income					
< $20,000	75.7*	17.1	2.7	3.4	1.0
$20,000 - $40,000 (R)	80.6	13.8	4.0	1.1	0.5
> $40,000	78.3*	12.4	2.6	5.5	1.3
Race					
White	79.9*	13.3	2.9	3.1	0.9
Nonwhite	67.3	25.0	3.5	3.8	0.5
Read *Medicare & You 2000*					
Yes	83.1*	12.4	1.3	2.6	0.7
No	76.4	15.7	3.8	3.3	0.9
Used the Medicare toll-free telephone number					
Yes	77.3	17.3	2.1	2.7	0.5
No	78.4	14.5	3.1	3.2	0.9
Used most helpful source to obtain information on quality of care					
Yes	84.7**	11.7	1.8	1.3	0.6
No	74.3	16.5	3.9	4.4	0.9
Obtained information from health plan					
Yes	84.5**	10.2	2.1	2.2	1.0
No	73.5	18.4	3.6	3.8	0.7

TABLE VII.3 (*continued*)

Beneficiary Characteristic	Quality of Care Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Obtained information from family or friends					
Yes	82.1*	12.9	2.1	2.0	0.9
No	76.2	15.7	3.6	3.8	0.8
Importance of insurance option					
Very important	82.1**	12.8	1.9	2.5	0.6
Somewhat important (R)	57.2	29.8	5.3	5.4	2.4
Not very important	54.3*	13.0	22.6	9.2	0.9
Education					
High school or less	77.8	16.4	2.8	2.2	0.8
More than high school	80.1	12.0	3.0	3.9	1.0

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

*Difference in the distribution across responses is statistically significant at the 0.05 level, chi-square test.

**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.

(R) refers to the reference group.

information to learn more about quality of care, or obtained information from their health plan or from their family and friends (Table VII.3). In addition, beneficiaries who rank quality of care very important tend to be white, have an annual income between $20,000 to $40,000, and believe that their insurance option is also very important. This increased exposure to information (such as the handbook and publications from health plans, which often emphasize quality) is likely to drive home the importance of factors like quality of care, thereby helping beneficiaries to use such factors as criteria for choosing a health plan.

Maintaining relationships with the same providers is more important to switchers and new enrollees who have a high school education or less compared with those with more formal education (Table VII.4). This outcome is somewhat unexpected, since we thought this factor would matter more to the elderly and to those with serious illnesses because such beneficiaries, who presumably have stronger and more long-standing ties to their physicians, would be more reluctant to change providers.

Surprisingly, only 65 percent of switchers and new enrollees said that the cost of the premium is a very important factor in their decision, while 4 percent said they do not consider the premium at all. The beneficiary subgroups that ranked cost as "very important" at a higher rate compared with their reference subgroups are new enrollees, those who read the handbook, those who used the Medicare toll-free number, and those who used their most helpful source to compare costs. Those who purchased Medigap on their own also said that cost is important. That finding is not surprising, since Medigap insurance is expensive, ranging from hundreds to thousands of dollars annually depending on the health risk and geographic location of the beneficiary (Stevens and Mittler 2000). Those who purchase it are likely to be more aware of its cost (Table VII.5). In contrast, beneficiaries who had a hospital admission during the previous

TABLE VII.4

IMPORTANCE OF MAINTAINING PROVIDER RELATIONSHIPS IN MAKING HEALTH PLAN DECISIONS, BY BENEFICIARY CHARACTERISTICS

Beneficiary Characteristic	Provider Relationships Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	72.4	12.5	9.7	4.3	1.1
New enrollee	69.5	14.3	11.4	4.2	0.6
Age					
65-74	71.6	13.2	10.4	3.7	1.0
75-84 (R)	71.8	11.8	9.7	5.6	1.0
85+	67.4	17.7	11.7	3.2	0.0
Income					
< $20,000	73.2	11.8	9.4	5.0	0.6
$20,000 - $40,000 (R)	69.5	13.4	12.4	3.9	0.8
> $40,000	70.2	15.4	11.0	3.2	0.2
Race					
White	71.3	13.1	10.8	4.1	0.7
Nonwhite	72.1	14.9	6.2	6.0	0.8
Read *Medicare & You 2000*					
Yes	72.0	12.3	11.1	3.4	1.3
No	71.1	13.6	9.9	4.7	0.8
Used the Medicare toll-free telephone number					
Yes	72.8	12.5	10.4	4.0	0.3
No	71.4	13.0	10.5	4.4	0.8
Had heart disease, cancer, or stroke					
Yes	71.4	13.9	10.3	3.5	0.8
No	71.0	12.7	10.5	4.7	1.1
Had a chronic condition					
Yes	71.6	13.1	10.2	4.1	0.9
No	70.6	13.2	10.4	4.6	1.1
Education					
High school or less	74.8**	12.4	8.4	3.6	0.8
More than high school	66.1	14.5	13.7	5.1	0.6

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

(R) refers to the reference group

TABLE VII.5

IMPORTANCE OF THE COST OF THE PREMIUM IN MAKING HEALTH PLAN DECISIONS, BY BENEFICIARY CHARACTERISTICS

	Cost of Premium Ranking (Percentage of Beneficiaries)				
Beneficiary Characteristic	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	63.1*	21.0	10.7	5.0	0.3
New enrollee	67.6	17.0	11.4	2.7	1.2
Age					
Age 65-74	65.0	20.5	9.9	4.1	0.6
Age 75-84 (R)	64.4	17.1	13.4	4.6	0.5
Age 85+	60.8	23.2	10.8	4.5	0.6
Income					
< $20,000	70.3	15.4	10.0	4.2	0.1
$20,000 - $40,000 (R)	64.4	20.7	10.4	4.3	0.3
> $40,000	53.6	27.4	14.6	3.1	1.3
Read *Medicare & You 2000*					
Yes	68.4**	20.6	9.0	1.8	0.2
No	62.7	19.1	12.0	5.5	0.7
Used the Medicare toll-free telephone number					
Yes	71.8**	14.5	11.6	1.7	0.5
No	63.4	20.3	11.1	4.7	0.6
Used most helpful source to compare costs					
Yes	72.2**	19.5	6.4	1.8	0.0
No	59.0	20.0	14.3	5.9	0.8
Purchased Medigap on own					
Yes	66.2*	22.4	8.8	1.7	1.0
No	64.1	19.1	11.5	4.9	0.4
Had heart disease, cancer, or stroke					
Yes	66.8	19.6	10.3	2.8	0.5
No	63.1	20.0	11.3	5.1	0.6

TABLE VII.5 (*continued*)

Beneficiary Characteristic	Cost of Premium Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Had a hospital admission					
Yes	64.8*	14.4	14.4	6.1	0.4
No	64.4	20.9	10.3	3.9	0.6
Had supplemental insurance					
Yes	62.5	21.5	12.1	3.3	0.7
No	65.4	19.0	10.5	4.6	0.5

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

*Difference in the distribution across responses is statistically significant at the 0.05 level, chi-square test.

**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.

(R) refers to the reference group.

year are less likely to view premiums as important or to consider them at all. Switchers and new enrollees who are hospitalized in network hospitals typically pay little or no out-of-pocket costs for their hospital stay, so they do not directly incur the costs of a hospital admission. Surprisingly absent from the list of beneficiaries who might see cost as important are lower-income switchers and new enrollees, and those who have no supplemental insurance. We expected to find that lower-income beneficiaries would consider cost more than beneficiaries with higher incomes, but this was not the case. The ranking of the cost of the premium did not vary significantly according to income level.

B. THE AMOUNT OF PAPERWORK AND THE DEGREE OF PATIENT SATISFACTION ARE IMPORTANT TO SWITCHERS AND NEW ENROLLEES

Managed care plans often promote the fact that they do not require much paperwork. New enrollees and switchers appear to have heard this message, with 54 percent citing its importance to their decision (Table VII.1). A slightly lower proportion (46 percent) focused on the satisfaction of plan members in their decision.

The amount of paperwork is relatively more important to switchers and new enrollees who read *Medicare & You 2000.* It is also relatively more important to beneficiaries who have an annual income of $20,000 to $40,000 than it is to beneficiaries who have an annual income of less than $20,000 (Appendix D, Table D.1). Like the amount of paperwork, the satisfaction of other health plan members is also relatively more important to switchers and new enrollees who have read *Medicare & You* than to those who have not (Appendix D, Table D.2). Switcher and new enrollee rankings of paperwork and satisfaction do not differ with respect to the other characteristics we examined, which included age and enrollment group.

C. RECOMMENDATIONS FROM FRIENDS, AN OFFER OF EMPLOYER COVERAGE, AND HMO WITHDRAWALS ARE LEAST IMPORTANT

The recommendations of family and friends, the fact that an employer offered to pay for managed care insurance, and Medicare HMO withdrawals are not very important to most switchers and new enrollees when they are choosing a health plan (Table VII.1). Among the switchers and new enrollees who read *Medicare & You 2000,* a relatively low percentage—only 35 percent—relies heavily on the recommendations of family and friends (Appendix D, Table D.3). Switchers and new enrollees who have an annual income below $20,000 are more likely to see these recommendations as very important than are a reference group of switchers and new enrollees who have an annual income in the range of $20,000 to $40,000.

Only 15 percent of switchers and new enrollees stated that the fact that their employer offered to pay for managed care insurance is very important or somewhat important (Appendix D, Table D.4). One reason this factor was ranked low is that most switchers and new enrollees do not have employer-based supplemental coverage; in fact, only 8 percent of switchers and 20 percent of new enrollees have such insurance (Table III.2 in Section III). An employer's offer to pay for managed care insurance is relatively more important to switchers and new enrollees who have employer-based coverage than to those who do not (Appendix D, Table D.4). It is also relatively more important to new enrollees and switchers who have read the handbook than to those who have not.

Medicare HMO withdrawals are not an important factor in health plan decisions—it was cited as important by only about 18 percent of switchers and new enrollees.[4] This low ranking is largely due to the fact that about 42 percent of switchers and new enrollees did not know at the time of the interview that HMOs had withdrawn from the Medicare program (see Section III,

[4]Question 35A in the survey instrument asked beneficiaries whether HMO withdrawals affected their health insurance decision.

Table III.2). Among those who are aware of plan withdrawals, the drop-outs are more important to white switchers and new enrollees than to other racial/ethnic groups. HMO drop-outs are also less important among switchers and new enrollees with an annual income of less than $20,000 (Appendix D, Table D.5). That response could be related to the fact that for beneficiaries with low incomes, HMO options are more affordable than Medigap insurance, so they ignore the instability in the Medicare managed care market.

D. HMO WITHDRAWALS ARE MORE LIKELY TO AFFECT DECISIONS MADE BY BENEFICIARIES IN COHORT 2

With one exception, the distribution of the importance of the rankings that switchers and new enrollees give to factors such as the benefits covered, quality of care, and ability to stay with their current provider does not differ significantly among beneficiaries in cohort 1 and cohort 2. However, the distribution of the importance of HMO withdrawals is different for beneficiaries in cohort 2 compared with those in cohort 1. Nineteen percent of beneficiaries in cohort 2 replied that HMO withdrawals affect their health insurance decisions, compared with 16 percent in cohort 1 (Appendix E, Table VII.1). Fewer beneficiaries in cohort 2 (40 percent) replied that they do not think about or do not know if they think about HMO withdrawals, compared with beneficiaries in cohort 1 (54 percent). However, 42 percent of beneficiaries in cohort 2 said that HMO withdrawals do not affect their decisions, compared with 30 percent in cohort 1.

We interviewed beneficiaries in cohort 1 only three months before we interviewed beneficiaries in cohort 2. Given this relatively small difference in the time of the interview, we did not expect to see very many differences between the two cohorts in terms of the factors that beneficiaries consider when they make health insurance decisions. The intervening three months, however, include January, which is when Medicare managed care plans formally withdraw from the program or reduce the areas they serve. It is likely that the publicity given to

these events made cohort 2 more aware than cohort 1 of the withdrawals, thereby making them more likely to consider withdrawals in their insurance decisions. The fact that we observed a difference with respect to the importance of HMO withdrawals in decisions fits logically with the finding that switchers, new enrollees, and FFS beneficiaries in cohort 2 are much more aware of HMO withdrawals than are those in cohort 1 (see Section III).

VIII. NMEP'S ROLE FOR NEW M+C ENROLLEES AND SWITCHERS IN SEEKING INFORMATION, LEARNING, AND MAKING DECISIONS

One of the biggest challenges facing the Medicare program in recent years is to effectively educate Medicare beneficiaries about their benefits and health plan options so that they can make truly informed decisions. To meet this challenge, CMS must induce a wide range of beneficiaries to seek and use information on the Medicare program. The agency must also design the information in a way that is helpful to beneficiaries. Our survey of new Medicare HMO enrollees, beneficiaries who switched from one HMO to another, and FFS beneficiaries indicates that most beneficiaries are aware that NMEP information is available. Forty-four percent of new enrollees and switchers, and 39 percent of FFS beneficiaries have used an NMEP information source. Most of these individuals have found the sources to be helpful in learning about Medicare and getting answers to their specific questions.

A. SUMMARY OF FINDINGS

Most switchers, new enrollees, and FFS beneficiaries are aware of information from the NMEP campaign. NMEP efforts have begun to have an impact. Seventy-one percent of switchers, 75 percent of new enrollees, and 73 percent of FFS beneficiaries are aware of at least one NMEP source. For new enrollees and switchers, the handbook is the most recognized source; for FFS beneficiaries, it is the toll-free number. The Medicare website is the source least recalled across all three groups of beneficiaries, although new enrollees have a significantly greater awareness of the website than do those in traditional Medicare.

Forty-four percent of all switchers and new enrollees actually use NMEP information sources to learn about Medicare. Although a large majority of beneficiaries are aware of NMEP information, 44 percent of new enrollees and switchers actually *use* one or more of the sources of information. Even fewer FFS beneficiaries use them (39 percent). The two sources

used most often by new enrollees and switchers are the *Medicare & You* handbook (33 percent) and the toll-free telephone number (12 percent).

Switchers and new enrollees least likely to use NMEP information sources are those who are age 75 and older and those who have a low propensity to use general information sources such as newspapers and television. Our multivariate regression analysis also indicates that switchers with annual household incomes that are less than $40,000 and new enrollees who have no more than a high school education are less likely to use NMEP information sources. If CMS wishes to target its education campaign on beneficiaries who are not using NMEP information sources, these are the types of beneficiaries that NMEP needs to reach.

Switchers and new enrollees are not more likely to use NMEP information sources than FFS beneficiaries. The NMEP information channels disseminate general information about Medicare that should be useful to all beneficiaries. Regression models that control for key beneficiary characteristics such as age, education, income, race, health status, and enrollment group, indicate that switchers and new enrollees are not more likely to use NMEP information materials than FFS beneficiaries. In addition, beneficiary cohort, age greater than 85 years (relative to those who are age 75 to 84), and Hispanic ethnicity were not significantly associated with more or less use of NMEP materials.

New enrollees and switchers have a better understanding of their Medicare options than do FFS beneficiaries. The plans that beneficiaries choose are likely to be related to their understanding of their Medicare options. New enrollees and switchers demonstrate a greater knowledge of the basic aspects of the Medicare and M+C programs than do FFS beneficiaries. Sixty-one percent of switchers and 56 percent of new enrollees answered at least 5 of the 6 true-false questions about Medicare and the M+C program correctly, compared with 33 percent of FFS beneficiaries. For example, compared with only 41 percent of FFS beneficiaries, 75 percent

of switchers and 70 percent of new enrollees know that if they were to disenroll from an M+C managed care plan, Medicare would still cover them. Less educated and lower income beneficiaries are also less likely to be aware of this crucial fact.

Greater knowledge of Medicare and M+C is associated with reading the *Medicare&You 2000* handbook. New enrollees, switchers, and FFS beneficiaries who read the handbook are more likely to understand that they can select among health plan options within Medicare, that Medicare coverage continues after disenrolling from an M+C plan, and that complaints can be reported to Medicare. In some cases, the association between having read the handbook and beneficiary knowledge differs across FFS beneficiares, switchers and new enrollees. FFS beneficiaries who read the handbook are more likely to know that Medicare does not cover all health expenses (this is not true for switchers and new enrollees). Switchers and new enrollees who read the handbook are more likely to know that they can switch between primary care physicians (this is not true for FFS beneficiaries). These differential affects may be due in part to the varied interests that each group has in the type of knowledge they are seeking.

The number of NMEP sources used (other than the handbook) is related to a greater understanding of certain key aspects of the Medicare and M+C program across all three enrollment groups. For example, switchers, new enrollees and FFS beneficiaries who had used additional NMEP sources were more likely to know that Medicare coverage continues after disenrollment, and that they can choose among health plan options within Medicare. While these results are consistent with the hypothesis that the handbook and other NMEP sources increase the knowledge of beneficiaries who use it, the effect is also consistent with the idea that users of the handbook and other NMEP sources have greater knowledge a priori.

Unfortunately, many beneficiaries do not appear to know that the federal government is the source of the handbook or that the handbook is produced by the Medicare program. Of new

enrollees and switchers who read the handbook and said that it played a role in their decision to join a managed care plan, only 30 percent of new enrollees and 20 percent of switchers indicated later in the interview that they relied on a federal source of information to make that decision.

Some ethnic and racial minorities are less likely to understand key aspects of the Medicare and M+C program. Across all three enrollee groups, Hispanics were less likely to understand that Medicare does not pay for all health care expenses. This was also true for switchers and new enrollees who are nonwhite. Switchers and new enrollees who are nonwhite are also less likely to understand that if they were to disenroll from and M+C plan, Medicare coverage would continue. And switchers who are Hispanic or nonwhite are less likely to understand that their doctor choice is limited in a Medicare HMO. These results suggest that minorities may need educational efforts that target them specifically.

NMEP and other information sources have been helpful to those who use them. Beneficiaries who use NMEP information find it to be helpful. Among the 33 percent of new enrollees and switchers who read the handbook, 75 percent rated it good to excellent. Three-quarters of the 29 percent of FFS beneficiaries who read it rated it as good to excellent. Eighty-four percent of switchers and new enrollees, and 88 percent of FFS beneficiaries who used the toll-free line received answers to their questions.

Medicare beneficiaries obtain information on the Medicare program from a variety of sources *other* than NMEP. Switchers and new enrollees reported that their health plan is the most helpful source of information (24 percent). Thirteen percent of switchers and new enrollees cite their doctor as their next most helpful source. They rank Medicare fourth (9 percent). The three most helpful information sources for FFS beneficiaries are the Medicare program (13 percent), doctors (13 percent), and health plans (12 percent). For switchers and new enrollees, family and friends were also frequently cited as the most helpful information source (11 percent

and 13 percent, respectively). Eight percent of FFS beneficiaries cited family or friends as their most helpful source.

Beneficiaries who use health insurance information are most interested in learning about benefits covered, quality of care, ability to keep their providers, and premiums. The NMEP educational campaign will be most helpful to beneficiaries if the information addresses the factors that beneficiaries rank as the most important to their health insurance decisions. Overall, 55 percent of new enrollees and 53 percent of switchers who named a most useful source of information reported using that information to decide whether or not to enroll in an M+C plan. Among the FFS beneficiaries who named a most helpful source (76 percent), 43 percent reported using that information when they decided not to enroll in an M+C plan.

Most of the new enrollees and switchers who use any information in making health plan decisions are most likely to use it to compare the benefits covered by the various plans. A smaller proportion uses the information to compare quality across plans, and about half use it to compare costs. FFS beneficiaries use formal sources of information to compare plans less often than their counterparts in managed care. Only 39 percent of those FFS beneficiaries who name a most helpful NMEP or non-NMEP information source have used it to compare benefits, (including Medigap benefits), in contrast to 65 percent of switchers and 60 percent of new enrollees. Still, the fact that many FFS beneficiaries use information to learn about their options, and a substantial minority used their most helpful source to decide to remain in traditional Medicare, indicates that there is a broad audience for the NMEP educational campaign.

The switchers and new enrollees we interviewed indicated that cost of the premium is somewhat less important than other factors when they make a health plan decision. Although they rank covered benefits and choice of physician very highly (82 and 71 percent, respectively), quality of care is more important to them than the cost of the premium (79 and 65 percent,

respectively). Switchers and new enrollees should therefore find NMEP information on availability of benefits, quality of care, cost of premiums, and the ability to remain with current providers useful.

Beneficiaries in cohort 2 are more aware of Medicare HMO withdrawals. Switchers, new enrollees, and FFS beneficiaries in cohort 2 are more aware of HMO withdrawals than are their cohort 1 counterparts. During the three-month period between interviews with cohort 1 and cohort 2, awareness among switchers increased from 53 percent to 65 percent, awareness among new enrollees increased from 43 percent to 58 percent, and awareness among FFS beneficiaries increased from 31 percent to 44 percent. This increase in awareness is most likely due to the fact that many HMO withdrawals for 2001 were announced in the interval between interviews, and that the withdrawals were widely publicized. Switchers and new enrollees in cohort 2 are also more likely than their counterparts in cohort 1 to use information about HMO withdrawals in their decision about whether to enroll in a Medicare HMO than their counterparts in cohort 1.

B. DISCUSSION

The National Medicare Education Program serves a valuable function for many Medicare beneficiaries, enabling them get answers to many of the questions that they have about their Medicare coverage. Our findings show that there are substantial numbers of beneficiaries who are knowledgeable about the Medicare program, search out information on the program when they feel they need it, and use information to help them make their health insurance decisions. Our analysis also reveals a sub-population of Medicare beneficiaries--new enrollees and switchers--who are more knowledgeable about the Medicare program.

There is room for the NMEP to build upon its strengths and address the challenges we identified in this study. First, many beneficiaries lack knowledge of some of the basic facts about the Medicare program. These facts, such as whether one can return to FFS Medicare after

disenrolling from a Medicare managed care plan, are crucial to understanding Medicare HMO options. Second, a substantial minority of beneficiaries are not aware of any NMEP information channels. Third, many beneficiaries who used NMEP information (and found the information to be helpful) do not seem to realize that the information came from the Medicare program. Fourth, minorities were less likely to understand key aspects of Medicare and the M+C program. Finally, there are segments within the beneficiary population that are less likely to use NMEP information sources. This is especially true for beneficiaries who are age 75 and older and beneficiaries who are not active users of general information sources (for example, beneficiaries who do not read newspapers, listen to the radio, or watch television on a regular basis). If CMS wishes to target beneficiaries who are not using NMEP sources, these are the sub-populations that NMEP needs to reach.

This research continues to remind us that the Medicare population is quite varied and requires a multi-faceted approach to education. Our analysis suggests that CMS should keep the multiple sources and formats of information on Medicare because those sources reach different segments of the beneficiary population. CMS might, however, consider producing more specialized information products in addition to the current offerings. The current NMEP materials seek to provide general information on all aspects of the Medicare program to all beneficiaries. To enhance consumption, CMS might choose to produce materials that key in on the concerns of particular segments of beneficiaries, such as switchers and new enrollees. NMEP materials also need to be more visibly authored by the Medicare program, so that beneficiaries can better identify the source of the information that they say they find helpful. Finally, since beneficiaries, particularly new enrollees and switchers, find health plans, physicians, and family members to be helpful sources of information in addition to the NMEP, NMEP designers could use these other sources as channels for clearly identified NMEP materials

or perhaps design joint communications campaigns that could capitalize on beneficiaries' greater familiarity with and use of these alternative sources.

REFERENCES

Ajzen, Icek. "The Theory of Planned Behavior." *Organizational Behavior and Human Decision Processes*, vol. 50, pp. 179-211, 1991.

Alliance for Health Reform. "Medicare and Medicaid Dual Eligibles." *Managed Care and Vulnerable Americans*. Washington, DC: Alliance for Health Reform, 1997.

Blendon, R., et al. "The Public's View of the Future of Medicare." *Journal of the American Medical Association*, vol. 274, no. 20, 1995, pp. 1645-1648.

Chollet, Deborah, Kosali Simon, and Adele Kirk. "What Impact HIPAA? State Regulation and Private Health Insurance Coverage Among Adults." Washington, DC: Mathematica Policy Research, Inc., October 2000.

Chromy, James R. "Sequential Sample Selection Methods." In *Proceedings of the American Statistical Association Survey Research Section*, 1979, pp. 401-406.

Cronin, C. "Communicating to Beneficiaries about Medicare+Choice: Opportunities and Pitfalls," presented at the National Health Policy Forum. *Issue Brief No.723.* Washington, DC: The Forum, 1998.

David, M., Roderick Little, Michael Samuhel, and Robert Triest. "Nonrandon Nonresponse Models Based on the Propensity to Respond." In *Proceedings of the Business Economic Statistical Section of the American Statistical Association*, 1983, pp. 168-173.

Eppig, F.J., and J.A. Poisal. "Medicare Beneficiary Information Needs: 1994." *Health Care Financing Review*, vol. 18, no.3, 1996, pp.247-252.

Federal Register, vol. 48, no. 227, November 1983.

Fowler, F., et al. "Comparing Telephone and Mail Responses to the CAHPS Survey Instrument, Consumer Assessment of Health Plans Study." *Medical Care*, vol. 37, no. 3, 1997, pp. 41-49.

Gibbs, Deborah., Judith Sangl, and Barri Burrus. "Consumer Perspectives on Information Needs for Health Plan Choice." *Health Care Financing Review*, vol. 18, no. 1, Fall 1996, pp. 55-73.

Hash, M. "Statement on Medicare+Choice and Consumer Education." Before the Senate Special Committee on Aging, U.S. Senate, May 6, 1998. [www.hcfa.gov/testimony/1998/98_0506.htm].

Hibbard, J., and J. Jewett. "An Assessment of Medicare Beneficiaries' Understanding of the Differences between the Traditional Medicare Program and HMOs." Public Policy Institute #9805. Washington, DC: American Association of Retired Persons, June 1998.

Hibbard, J., J. Jewett, S. Englemann, and M. Tusler. "Can Medicare Beneficiaries Make Informed Choices?" *Health Affairs*, vol. 17, no. 6, 1998, pp. 181-193.

Hibbard, J.H., P. Slovic, and J.J. Jewett. "Informing Consumer Decisions in Health Care: Implications from Decision-Making Research." *Milbank Quarterly*, vol. 75, no. 3, 1997, pp. 395-414.

Huffman, Catherine, and D. Rice. "Estimates Based on the 1987 National Medicare Expenditure Survey." San Francisco: University of California and Institute for Health and Aging. Cited in *Chronic Care in America: A 21st Century Challenge*, Princeton, NJ: The Robert Wood Johnson Foundation, 1995.

Huffman, Catherine, D. Rice, and H.Y. Sung. "Persons with Chronic Conditions: Their Prevalence and Costs." *Journal of the American Medical Association*, vol. 276, no.18, 1996, pp. 1473-1479.

Institute of Medicine. *Improving the Medicare Market: Adding Choice and Protections*. Washington, DC: IOM, 1996.

Kaiser Family Foundation. "Medicare at a Glance." Washington, DC: KFF, 1999.

Kalton, G., and D. Kasprzyk. "The Treatment of Missing Survey Data." *Survey Methodology*, vol. 12, no. 1, 1986, pp. 1-16.

Kirsch, I., A. Jungeblut, L. Jenkins, and A. Kolstad. *Adult Literacy in American: A First Look at the FIndings of the National Adult Literacy Survey.* Washington, D.C.: National Center for Education Statistics, 1993.

Kleinman, S. "Inundated by Information." Testimony before the Senate Special Committee on Aging, U.S. Senate, May 6, 1998.

McCormack, Lauren A., Steven Garfinkel, Judith Hibbard, et al. "Health Insurance Knowledge among Medicare Beneficiaries." Research Triangle Park, NC: Research Triangle Institute, August 2000.

Medicare Payment Advisory Commission (MedPac). *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPac, March 2000.

Murray, Lauren, and A. Shatto. "Beneficiary Knowledge of the Medicare Program." *Health Affairs*, vol. 20, no. 1, 1998, pp.127-131.

National Center for Educational Statistics (NCES). *Literacy of Older Adults in America: Results from the National Adult Literacy Survey.* Washington, DC: U.S. Department of Education, 1996.

Nelson, Lyle et al. "1996 Access to Care in Medicare Managed Care, Results from a 1996 Survey of Enrollees and Disenrollees." Washington, DC: Physician Payment Review Commission, 1996.

Neuman, P., and K. Langwell. "Medicare's Choice Explosion? Implications for Beneficiaries." *Health Affairs*, vol. 18, no. 1, 1999, pp. 150-160.

Potter, F.J., V.G. Iannacchione, W.D. Mosher, et al. "Sample Design, Sample Weights, Imputation and Variance Estimation in the 1995 National Survey of Family Growth." U.S. Department of Health and Human Resources, Series 2 Report 124, DHHS Publication PHS 98-1398, 1998.

Rosenbaum, P.R., and D.B. Rubin. "Reducing Bias in Observational Studies Using Subclassification on the Propensity Score." *Journal of the American Statistical Association*, vol. 79, no. 387, 1984, pp. 516-524.

Sainfort, F., and B.C. Booske. "Role of Information in Consumer Selection of Health Plans." *Health Care Financing Review*, vol. 18, no.1, 1996, pp. 31-54.

Schwarz, N., D. Park, B. Knauper, and S. Sudman, eds. *Cognition, Aging and Self-Reports*. Philadelphia: Psych Press, 1998.

Sing, Merrile, Beth Stevens, Anna Cook, Michael Sinclair, and Julie Ingels. "Educating New Members of Medicare+Choice Plans About their Health Insurance Options: Does the National Medicare Education Program Make a Difference? Cohort 2. Draft report submitted to HCFA. Washington, DC: Mathematica Policy Research, Inc., January 2001.

Sing, Merrile, Beth Stevens, Anna Cook, Michael Sinclair, and Julie Ingels. "Educating New Members of Medicare+Choice Plans About their Health Insurance Options: Does the National Medicare Education Program Make a Difference? Cohort 1. Draft report submitted to HCFA. Washington, DC: Mathematica Policy Research, Inc., November 2000.

Sing, Merrile, Beth Stevens, and Michael Sinclair. "Evaluation of New Medicare Members of Medicare+Choice Plans: Analysis Plan." Washington, DC: Mathematica Policy Research, Inc., January 2000.

Sofaer, Shoshanna, and Kimberly Fox. "Providing Medicare Beneficiaries with Useful Quality Information to Compare HMOs." Report submitted to the Commonwealth Fund, New York, December 1998.

Stevens, Beth, and Jessica Mittler. "Making Medicare+Choice Real: Understanding and Meeting the Information Needs of Beneficiaries at the Local Level." Princeton, NJ: Mathematica Policy Research, Inc., November 2000.

Sofaer, Shoshanna, and K. Fox. "Providing Medicare Beneficiaries with Useful Quality Information to Compare HMOs: Literature Review." New York: The Commonwealth Fund, December 1998.

Terrell, S. "Evaluation of CAHPS and the 1999 Medicare and You Handbook in Kansas City." Presentation to the Coordinating Committee of the National Medicare Education Program, May 12, 1999, Washington, DC.

U.S. Bureau of the Census (U.S. Census). *Educational Attainment in the United States: March 1997.* P20-505. Washington, DC, 1998.

Williams, M.V. R.M. Parket, and D.W. Baker. "Inadequate Functional Health Literacy Among Patients at Two Public Hospitals." *Journal of the American Medical Association,* vol. 274, pp. 1677-1682, 1995.

APPENDIX A

THE SAMPLE DESIGN AND SURVEY WEIGHTING PROCEDURES FOR THE EVALUATION OF NEW MEDICARE MEMBERS OF MEDICARE+CHOICE PLANS

I. THE SAMPLE DESIGN

This appendix describes the sample design and survey weighting procedures for cohort 1 of the Evaluation of New Medicare Members of Medicare+Choice Plans. We used the same procedures for cohort 2.

The sampling design for this study consisted of a stratified selection procedure. For cohort 1, CMS prepared a sampling frame from the Enrollment Data Base (EDB) that consisted of all eligible beneficiaries age 65 or older who did not have end-stage renal disease (ESRD), who were not in hospice or institutional care, and who were members of three enrollment groups defined below. For the first cohort, the enrollment groups were defined based on whether the beneficiary made a particular type of change in their enrollment on the first of each month for October, November, and December, 1999 as reflected in the EDB extracted on January 22, 2000. We stratified the sampling frame into nine sampling strata based on a combination of membership in the three enrollment groups and three age categories: 65 to 74 years; 75 to 84 years; and 85 years and older.

A. THE TARGET POPULATION

The target population for our study included three groups of beneficiaries as follows:

- ***Switchers*** were enrolled in one Medicare HMO and switched to a different HMO on October 1, November 1, or December 1, 1999.
- ***New enrollees*** were in Medicare FFS and enrolled in an HMO on October 1, November 1, or December 1, 1999, or became eligible for Medicare during this time period and decided to enroll in an HMO.
- ***FFS enrollees*** were in Medicare FFS as of October 1, 1999, and remained in FFS through December 1, 1999.

Table A.1 summarizes the number of eligible beneficiaries in the sampling frame in each of the nine sampling strata, and the number of beneficiaries selected for the study sample from each

stratum. Table A.1 also provides the corresponding counts for each of the three target groups and the three age categories as a whole. As the Table A.1 indicates, CMS and MPR designed the sample allocation procedures so that the sample selection procedures would yield an approximately equal number of completed interviews in each of the three target groups to support analytical comparisons. Within each of the target groups, we allocated the sample by age in proportion to the population profile.

TABLE A.1 TARGET POPULATION AND SAMPLE PROFILE BY SAMPLING STRATA MEMBERSHIP

Stratum Number	*Enrollment Group*	*Age*	*Population*	*Population Percent*	*Percent Within Each Enrollment Group*	*Sample Selected*	*Target Number of Interviews*	*Sample Percent*	*Sample Percent Within Each Enrollment Group*
1	Switcher	65-74	106,772	0.4%	56.8%	540	284	18.9%	56.8%
2	Switcher	75 -84	65,271	0.3%	34.7%	330	174	11.6%	34.7%
3	Switcher	85+	15,931	0.1%	8.5%	81	42	2.8%	8.5%
4	New Enrollee	65-74	86,995	0.4%	74.0%	703	370	24.7%	74.0%
5	New Enrollee	75-84	23,147	0.1%	19.7%	187	98	6.6%	19.7%
6	New Enrollee	85+	7,418	0.0%	6.3%	60	32	2.1%	6.3%
7	Reference Group	65-74	11,978,987	49.1%	49.7%	472	249	16.6%	49.7%
8	Reference Group	75-84	8,899,663	36.5%	36.9%	351	185	12.3%	36.9%
9	Reference Group	85+	3,207,458	13.1%	13.3%	127	67	4.4%	13.3%
	Total		24,391,642	100.0%		2,851	1,500	100.0%	
Subtotals									
	Switcher		187,974	0.8%		950	500	33.3%	
	New Enrollee		117,560	0.5%		950	500	33.3%	
	Reference		24,086,108	98.7%		950	500	33.3%	
	Age 65-74		12,172,754	49.9%		1,715	903	60.2%	
	75-84		8,988,081	36.8%		868	457	30.5%	
	85+		3,230,807	13.2%		267	141	9.4%	
Total			24,391,642	100.0%		2,850	1,500	100.0%	

Based on an anticipated response rate of 70 percent and a survey eligibility rate of about 85 percent, we determined we needed a base sample of about 2,500 beneficiaries to yield a total of

1,500 cohort 1 completed interviews. To ensure that we had a sufficient sample, we selected a total of 2,851 beneficiaries. We then divided this sample into random replicates or waves for a potential staged released. Our initial release of 2,356 cases proved to be sufficient to obtain a total of 1,462 interviews at a 71.1 percent response rate.

To select the samples from each stratum we utilized a sequential probability-proportionate-to-size (PPS) sample selection procedure based on the procedures outlined by Chromy (1979). We used a specified sorting procedure in conjunction with the sequential selection methodology to impose a deeper level of implicit stratification based on the actual age, gender and the first three digits of the beneficiary's postal ZIP code. Furthermore, we utilized 1990 Census data on the prevalence of Hispanic persons in each five-digit ZIP code in combination with the CMS reported racial category to slightly oversample minorities to compensate for an anticipated lower response rate (which was realized, as noted in section II of the report).

To oversample the minorities, we assigned them a measure-of-size (MOS) between 1 and 1.5 to give them a slightly larger probability of selection. (Whites received a MOS value of 1). We determined the MOS value to assign based on the product of three factors assigned to each beneficiary. If the beneficiary had a non-white CMS racial membership, he or she received a value for the first factor of 1.2; it was 1.0 otherwise. If the beneficiary record indicated a preference for a Spanish translation (using the variable BENE_LANG_PREFNC_CD), we set the second factor value to 1.2; it was 1.0 otherwise. The third factor value was based on the prevalence of Hispanic persons in the beneficiary's ZIP code as of the 1990 Census. The third factor ranged from a 1 to 1.3 depending on the ZIP code profile. (For example, beneficiaries in ZIP Codes for which 10 to 15 percent of its residents are Hispanic received a factor value of 1.2. Beneficiaries in ZIP codes for which 95 to 100 percent of its residents are Hispanic received a value of 1.3). From the product of these three factors each beneficiary received a final MOS

value for use in the PPS selection procedures. To prevent a large variation in the sampling rates, we capped the MOS values at 1.5.

We designed the above procedures to sample minorities at a relative rate of about 1.1 (10 percent higher) compared with their white non-Hispanic counterparts. While we were not able to fully evaluate the impact of these procedures due to the burden on the CMS mainframe system, we did conduct a test on the new enrollment target group. The test on this group showed that the oversampling process increased the expected relative rate of Hispanic persons in the sample by 8 percent (from an estimated 12 percent in the new enrollment population to 13 percent in the sample). Likewise, the oversampling process increased the rate of Blacks in the sample from 11.3 percent to 12.3 percent and other races from 8.7 to 10.4 percent for the new enrollment target group. In contrast, the oversampling procedures had little impact on the sampling precision in the estimates. For the 2,851 cases sampled, the oversampling process only introduced a design effect[1] of 1.01 or less in each of the nine sampling strata.

The final processing of the sample included the standardization of the CMS beneficiary address information and processing to detect miss-spelled street names and out-of-range street numbers. We conducted an address parsing procedure to split and re-combine the multiple address fields provided by CMS into a standardized format that includes street number, street prefix, street name, street suffix, city, state and ZIP code address. We also separated the contact name information (such as Jane Smith for John Smith) from the address data. After standardizing the addresses, we processed the resulting address data using the Mailers+4 software package.

[1]The design effect represents the relative increase or decrease in the sampling precision in the estimates that is associated with the proposed design compared to what would be obtained using a simple random sampling methodology with equal size survey weights. Dividing the actual sample size obtained by the design effect provides the effective sample size that is associated with an estimate.

This package uses a current database of all street names and street name number ranges to identify addresses with unmailable addresses. The software package also provides suggested corrections. MPR staff evaluated the proposed correction options and selected one for the final address for each of the identified problem cases.

We sent the final list of sampled addresses to Pacific East Research Corporation (formally called Executive Marketing Services) for electronic and directory assistance telephone look-up procedures. Finally, cases with remaining unknown telephone numbers or telephone numbers that were found to be incorrect during the interviewing process were researched by our telephone look-up staff. If a telephone number could not be determined, the sample member is sent a questionnaire in the mail.

II. THE SURVEY WEIGHTING PROCEDURES

A. OVERVIEW

MPR prepared survey weights for the completed interviews for cohort 1 to account for differences in the selection probabilities and for potential demographic and social-economical differences between the survey respondents and the study's targeted population of Medicare beneficiaries. The survey weights, referred to as projection weights, are based on the probabilities of selecting each individual for the survey, and as such, provide for unbiased estimation of various population attributes including totals, mean values and percentages among the sampled individuals.

We computed the survey weights for cohort 1 in stages that correspond to various outcomes of the sampling and data collection process. Specifically, we computed the survey weights using a five-step process. These five steps produced a set of weights that are composed of the product of four components coupled with an adjustment procedure to obtain the desired results. For the

first step, we prepared the first component in the weights to account for the differential probabilities of selection among the beneficiaries based on the sample design implemented.

This first component provided a weight for the full set of sampled beneficiaries. If we had attempted and completed interviews for the entire sample, this component would have been sufficient; however, as in most surveys, only a portion of the sample actually completes the interview. In this study, we selected a larger sample than was needed to be adaptable to various response rates. Since we were able to achieve the 70 percent targeted response rate for cohort 1, we did not interview the entire sample. The second component in the weight compensates for using only a subset of the full sample selected. The third component compensates for survey nonresponse among the released sample.

We prepared the three weight components and their resulting product to provide an initial weight for all of the beneficiaries who completed the survey or were found to be ineligible (referred to as respondents). To finalize the weights we made two adjustments. For the first adjustment, we conducted a "calibration" step to ensure the weighted counts from the respondents matched the original population totals across various domains. Second, using the data from the ineligible cases, we adjusted the weights via a fourth component so that the weighted count from the completed interviews would represent the study population that was still eligible at the time of the cohort data collection.

We prepared the nonresponse adjustments using a multi-step procedure that began with a careful evaluation of the differences between the respondents and the sample selected based on the beneficiary characteristics available on the sampling frame. A summary of the characteristics that were found to be related to response is presented in section II of the main report. Using the results of these procedures we used a combination of a modeling procedure to predict response status and a cell-based weighting adjustment to compensate for the observed differences. A

detailed summary of the nonresponse adjustment methodology is presented in section II.C.3 of this appendix.

Given that the sampling frame did not provide phone numbers, response depended primarily on whether we were able to locate a phone number for the sampled beneficiary. In cohort 1, 71 percent of the phone locatable beneficiaries completed the survey in comparison to only a 31 percent completion rate among the non-phone locatable beneficiaries. This finding in conjunction with the fact that that persons without locatable phone numbers (including persons with unlisted numbers or without phone service) tend to be demographically, social-economically, or situational different from their phone locatable counterparts, lead us to conduct a separate nonresponse adjustment on these two groups. While the separate adjustment process increased the range in the survey weights, we felt that this procedure was necessary to minimize the potential for nonresponse bias in the analytical results. Furthermore, we mention that without the use of a telephone-mail strategy, such an adjustment would not have been possible. In a mail-telephone follow-up approach such as that used for the Consumer Assessment Health Plan Survey, the ability to locate a telephone number is confounded with mail vs. phone completion, and as such the weighting procedures are less able to compensate for the potential bias.

For the phone and non-located phone cases we also needed to consider that the eligibility information was not equivalent. As mentioned above, we designed the weights (using the calibrated product of the three components) to weight the respondents (completes and known ineligible cases) to represent the population at the time the sample was selected. Therefore, by eliminating the ineligible cases from the analytical data set and their corresponding contribution to the total weighted count, the weighted count among the completed interviews reflects an estimate of the study population that is still eligible at the time of data collection. Unfortunately, in mail surveys beneficiaries typically do not return the questionnaire if they are ineligible, so

response status is confounded with eligibility. As a result, we do not have a representative sample of identified ineligible cases from the non-located phone beneficiaries. If fact, we did not identify any ineligibles among the non-located phone cases. Therefore, we decide to deflate the weights for the non-located phone completed interviews to take into account the unobserved eligibility rate among this group. To do this, we assumed that for a specific age and enrollment group category that the eligibility rate among the phone located cases would be same as that for the non-located phone cases. Then, to prepare the final weights, we deflated the non-located phone complete case weights, via a fourth component that was equal to the estimated eligibility rate for the case's age and enrollment membership category. By eliminating the ineligible cases from the phone located respondents and adjusting the weights for the completed non-located phone cases, the final weighted count among the combined completed interviews reflects an estimate of the study population that was eligible at the time the survey cohort was conducted.

The final weights among the completed interviews sum to an estimated eligible population at the cohort 1 data collection period of 21,501,908. Given that the initial sampling frame contained 24,391,642 beneficiaries, this reflects a weighted estimated eligibility rate of 88.2 percent. The weighted survey data reflects an overall design effect of 3.23 with design effects among the three major analytical groups ranging from 1.10 to 1.14, yielding a range in the effective sample sizes for these groups from 456 to 498 (see section II.D) .

Section B of this appendix provides an overall summary of the outcome of the data collection operation for each cohort as it relates to the weighting procedures. The unweighted survey response rate for cohort 1 was 71.1 percent. For cohort 1, this value is calculated by dividing the 1,557 completed interviews by the estimated portion of the 2,356 released cases that were eligible. Based on the cases with known eligibility status (1,574 phone located cases), 1,462 people were eligible and completed the survey (112 or 7.1 percent were ineligible).

Assuming this eligibility rate of 92.9 percent (1,462/1,574) holds for the entire sample released, we estimate that 2,188 cases were eligible, yielding a response rate of 1,557/2,188= .711 or 71.1 percent. As a weighted response rate, the initial weights based on the product of factors 1 and 2 for the completed interviews (1,557) total to 15,061,624 which divided by the estimated eligible population 21,501,908 produces a weighted response rate of 70.0 percent. The weighted response is the proportion of the total population that is represented by the population of respondents. In contrast, the unweighted response rate represents the proportion of the *sample* represented by the respondents. The weighted response rate is a better measure of the survey's quality and the potential for nonresponse bias. In this case, both measures produce a very similar response rate.

B. OUTCOME OF THE DATA COLLECTION PROCESS AND THE DIVISION OF THE SAMPLE

Whether we obtain a completed survey questionnaire for a sampled beneficiary depends on a variety of both operational and individual factors. For the computation of the survey weights we divided the sampled cases for each cohort into six groups:

1. Released, could not locate a phone number, completed the survey by mail or call-in
2. Released, could not locate a phone number, did not respond
3. Released, located a phone number, completed the survey by CATI, call-in or mail
4. Released, located a phone number, found during CATI interview that they were ineligible for the survey (deceased or institutionalized)
5. Released, located a phone number, refused survey or no contact made.
6. Sampled, but not released

For each case, our CATI and mail questionnaire tracking system maintains a history of the outcomes of each attempt to reach the beneficiary including the results of the phone look-up

procedures. From this history, we prepared a final result of call code for each case when the interviewing was terminated. Table A.2 provides a breakdown of the sampled cases in each of the six categories listed above and within these categories by the result of call classes used to define the category. We note that we assumed eligibility status was unknown for all cases in group 5.

The results in Table A.2 indicate that the telephone-mail mode of data collection was influential in maximizing the response rates. For cohort 1, that we were unable to obtain a phone number for 310 (13.2 percent) of the 2,356 attempted cases. Of these 310 cases, 95 completed the survey (30.6 percent) as a result of the mailing procedures or called-in on the 1-800 number (85 by mail, 10 by phone). Without the mail follow up we would have not received the 85 mail completes which would have reduced the response rate to 67.3 percent for cohort 1. The mail procedures also helped to elicit response among the cases with a phone number. Of the 2,046 cases for which we found a phone number, 214 cases (10.5 percent) returned a survey by mail as a result of the initial mailing operation. Hence, we suspect that without the mail follow-up, some portion of these would have failed to respond via CATI which would have lowered the response rate further. A total of 48 cases (2 percent of the 2,356 attempted) completed the survey by calling in as a result of the letter we sent sample members with the study's toll-free telephone number. As suspected, response rates were much higher for the phone located cases than the non-located phone cases at 76.6 and 32.8 percent, respectively, for cohort 1.

C. COMPUTATION OF THE WEIGHTING COMPONENTS

This section describes the methodology we used to compute the weighting components and includes, as appropriate, either a table of values for these components if these values were computed on a cell basis, or the distributional properties of the values, if the component was computed on an individual beneficiary basis.

TABLE A.2 RESULTS OF DATA COLLECTION PROCEDURES

Weighting Category	Call Outcome Category	Cohort 1 Number	Cohort 1 Percent
1. No Phone Complete	02 complete (hard copy mail in)	85	3.6%
	03 complete (CATI call in)	10	0.4%
2. No Phone Nonrespondent	55 Unpublished number = no address	33	1.4%
	59 Final unlocated/no contact	182	7.7%
	Subtotal No Phone	310	13.2%
			0.0%
3. With Phone Complete	01 complete (CATI call out)	1,210	51.4%
	02 complete (hard copy mail in)	214	9.1%
	03 complete (CATI call in)	38	1.6%
4. With Phone Ineligible	40 Deceased	26	1.1%
	44 Institutionalized	86	3.7%
5. With Phone Nonrespondent	20 Hung up during intro (never spoke with)	3	0.1%
	21 Refusal by respondent	288	12.2%
	22 Refusal by proxy / other	27	1.1%
	23 requested questionnaire never returned refusal	24	1.0%
	30 language barrier (language other than English)	20	0.8%
	31 mental / physical impairment (confirmed, no proxy)	10	0.4%
	32 Speech / hearing problem (confirmed, no proxy)	4	0.2%
	33 Unavailable during field period	4	0.2%
	65 Max calls/No respondent contact	55	2.3%
	66 Max calls/R contact	37	1.6%
Total Attempted		2,356	100%
6. Not Released		495	
Total Sampled		2,851	

1. Factor 1: Inverse Probability of Selection

This factor give a weight to each respondent to account for the number of beneficiaries they represent in the sampling frame based on the sample selection procedures. The sampling frame consisted of an extract from the CMS database of beneficiary records entitled to Medicare as of December 28, 1999, for cohort 1. For cohort 1, we used a stratified sample design to select the final sample from this extract based plan enrollment history and age. Within each sampling stratum we used a probability-proportionate-to-size (PPS) selection procedure to oversample minorities. We allocated the sample disproportionately across the stratum per CMS's specification to support separate enrollment group analysis.

Each beneficiary's probability of selection, can be expressed by the formula given in (1).

$$(1) \qquad p_{h,i} = \frac{n_h \times MOS_{h,i}}{\sum_{i=1}^{N_h} MOS_{h,i}}$$

where,

h indexes the sampling strata. We created a total of nine sampling strata based on a combination of three enrollment categories and three age ranges.

i indexes the beneficiaries in each stratum for the cohort.

N_h defines the number of beneficiaries in the sampling frame in stratum h for the cohort.

n_h defines the number of beneficiaries sampled from stratum h from the CMS sampling frame.

$MOS_{h,i}$ defines the measure of size (MOS) associated with each beneficiary, which ranged from a value of 1 to 1.5 depending on the beneficiary's racial status.

The first weighting factor was set to the inverse value of the probability of selection as given in (2). As such, these factors are applied at the beneficiary level in each stratum.

$$(2) \qquad F1_{h,i} = \left(p_{h,i}\right)^{-1}$$

We present the distribution of the values of F1 by stratum for cohort 1 in Table A.3

TABLE A.3 DISTRIBUTION OF THE F1 WEIGHTING FACTORS

COHORT 1

Stratum	Population Total	Initial Sample Size	Distribution of Initial Sampling Weights (Factor F1)				
			Mean	Minimum	Maximum	Sum	CV
Switcher 65-74	106,772	540	196.62	151.80	227.71	106,175	10.50
Switcher 75 –84	65,271	330	198.75	151.26	226.90	65,588	9.63
Switcher 85+	15,931	81	193.77	151.35	225.22	15,695	9.97
New Enrollee 65-74	86,995	703	123.51	94.88	142.32	86,827	11.29
New Enrollee 75-84	23,147	187	123.07	94.05	141.08	23,013	11.69
New Enrollee 85+	7,418	60	121.45	93.65	140.47	7,287	11.15
Reference Group 65-74	11,978,987	472	25,457.16	18,493.95	27,740.92	12,015,780	9.55
Reference Group 75-84	8,899,663	351	25,441.32	18,429.62	27,644.42	8,929,903	8.84
Reference Group 85+	3,207,458	127	25,264.43	18,366.19	27,549.29	3,208,582	9.28
Total	24,391,642	2,851				24,458,852	139.74

2. Adjustment for Partial Use of the Full Sample

The second factor accounts for the partial release of the sample. Since we anticipated that we would not need all of these sample cases to reach the interview targets, we divided the sample in random replicates or waves on a stratum basis. This process allowed us to create an initial random and representative subset of the full sample that would be sufficient to meet the study interviewing targets at a specified 70 percent response rate, with the remaining portion to act as a reserve sample if response rates were lower than expected. For cohort 1, in each stratum, we created 23 waves. The first 19 waves served as the main sample and the 4 remaining waves were a reserve sample.

For cohort 1, since we were able to obtain a 71.1 percent response rate, we only released the first 19 waves among the 23 created. Therefore the second factor was set equal to 23/19 = 1.21 for all of the released cases.

3. The Nonresponse Adjustments

One common approach for adjusting for differences in the respondents and nonrespondents in the weighting procedures is to divide the attempted sample cases into a set of mutually

exclusive groups (see Kalton and Kasprzyk 1986) so that within each group, the respondents and nonrespondents have similar characteristics for the characteristics that affect response status. As a result, by adjusting the respondent's weights to sum to the weighted total among the respondents and nonrespondents on a cell basis, we eliminate the bias associated with the differential response patterns across these cells and the related cell defining characteristics. For this study we decided to apply a similar strategy. But we enhanced the creation of the cells using a modeling procedure to better account for a wider variety of characteristics. Specifically, we decided to create the cells based on two of the factors that had the greatest impact on the response rates—whether we could identify the telephone number and stratum membership. We then used the results of a weighted (by the product of factors 1 and 2) logistic regression analysis to further divide these cells into groups that had a similar propensity to respond based on the remaining characteristics (Kalton and Kasprzyk 1986 and Rosenbaum and Rubin 1983). [2]

The weighted logistic regression analysis provided us with a methodology for ascertaining the likelihood that a beneficiary would respond based on their demographic profile while controlling for stratum membership and whether we could identify the telephone number. Ideally, given our goal to subdivide the respondents and nonrespondents by their propensity to respond within the stratum and telephone identification status classes, we would create a separate model for each stratum and phone identification status combination. Since the sample sizes in these groups were small, the model results would be subject to high level of sampling variability. As a result, we decided to use a two-step procedure using aggregate models to develop the propensity scores for the cell definitions.

[2]The propensity to respond is obtained from the inverse of the estimated predicted probability of responding as obtained from the logistic regression model. Large values correspond to units that were less likely to complete the survey.

Whether or not we were able to find a sample member's telephone number had the largest impact on the response rates. Therefore, we began the process by preparing two models, one model for the phone located cases and another for the non-phone located cases. Since these models represented an aggregation of these two groups across sampling stratum, to help control for any relationships between stratum membership and the other characteristics, we included strata membership in the set of predictors in the models. Unfortunately, since the non-phone located sample was small, the propensity scores from the non-located phone model were quite variable. Therefore, we decided to develop a final overall model for the combined phone located and non-located phone cases using the characteristics that were significant predictors of response status in either of the two separate models. This process ensured that we captured the items that predicted response among the two telephone-located status groups while stabilizing the model and the resulting propensity scores from the use of the combined sample.

To prepare the data for the models, we transformed the categorical responses into a series of indicator variables. We collapsed some of the categories if the number of cases in the category was small (that is, less than 10 cases). For example, since the sample size in stratum 6, new enrollees, 85 years and older, was small, and had a similar response rate to stratum 5, new enrollees, age 75 to 84, we combined these two strata for the modeling process. We also considered the fact that some of the variables had missing information (e.g., race and entitlement reason and urbanicity). Given that the number of missing cases was either few or by definition was related to one of the other categories (missing entitlement reason was assumed to be based on age), we collapsed the missing cases with one of the other categories as needed.

We used a multi-step process to develop the two initial models—one model for the phone located cases and the other for non-located phone cases. These steps reduced the predictor variables to those that had at least some observed impact on the response rates in each group to

help further reduce the variability in the propensity score values. First, we prepared a full model using all the variables via the SUDAAN logistic regression procedures to account for the design effects in measuring the significance of each variable. From the full model results, we eliminated variables with a Chi-square test of significance p-value of 0.50 or higher. We then reviewed the results and in an iterative fashion deleted and added variables, to reach a minimum significance level among all the items included in each final model. We decided to use a relatively large minimum significance for variable inclusion of .25 to .30 to eliminate only those variables that had a negligible impact on the prediction. We based this decision on the purpose of preparing a set of homogeneous weight classes which would smooth out any extraneous variability in the predictions.

Table A.4 presents the definitions and usage of the variables included in the full response models for the phone located and non-located phone cases. For each variable, Table A.4 indicates whether the variables were significant predictors at the .25 significance level. We used these significant variables in the final model to produce the propensity scores. Table A.5 presents the results of the final modeling procedures. For the final model, we decided not to include the Pacific East Research Corporation's telephone number status as one of the predictors given its somewhat direct relationship to the outcome variable. For cohort 1 the Hosmer Lemeshow goodness of fit test (Hosmer and Lemeshow 1989) had a test statistic value of 6.93 with 8 degrees of freedom and a p-value of .5439, indicating the model was a good fit.

As indicated above, from the final model we prepared a set of weighting class based on stratum, phone locateability status and the propensity scores. A profile of the final classes is presented in Table A.6. To create these classes we collapsed some of the starting categories by either combining stratum or collapsing the ranges in the propensity scores to maintain a

TABLE A.4: SUMMARY OF THE TWO INITIAL LOCATABLITY STATUS MODELS

Characteristics Examined	Variable Indicators Created	Cohort 1	
		Significance Status for Non-Located Phone Model	Significance Status for Non-Located Phone Model
Sampling Strata Membership reflecting Age and History and County Choice Status and their interactions	One variable for each of the unique stratum categories (stratum 5 and 6 combined)	√ For Stratum 1, 3 and 4	√ For Stratum 2, 4 and 5
Race and Race/Gender Interaction	One indicator for White, Black, (both excluding missing) and combination of non-white (White=0) and male gender		√ For black membership only
Census Division	One indicator for each unique division		√ (All divisions)
Urbanicity	One indicator if Urban	√	√
Gender	One indicator if Male		
Representative Payer	One indictor = 1if Yes, 0 otherwise (including missing)	√	√
Dual Eligibility	One indicator =1 if Part A or Part B primary payer code =1, state paid, 0 otherwise (including missing)		
Entitlement Reason	One indicator =1 if entitlement was not based on age, 0 otherwise (including missing)		
Pacific Telephone Number Status	One indicator =1 if Pacific initially found a phone number, 0 otherwise	√	
Claimant Type (BENE_IDENT_CD)	One indicator =1 if beneficiary is primary claimant	√	

TABLE A.5 SUMMARY OF THE FINAL RESPONSE MODEL

COHORT 1

Variable	Coefficient	SE of Coefficient	T-Test B=0	P-Value	Design Effect	Odds Ratio	Odds Ratio 95 Percent Confidence Level Lower Limit	Odds Ratio 95 Percent Confidence Level Upper Limit
Intercept	-0.333	1.236	-0.270	0.788	2.450	0.72	0.060	7.98
Switcher 65-74	0.197	0.152	1.290	0.196	0.050	1.22	0.910	1.64
Switcher 75-84	0.252	0.175	1.440	0.151	0.040	1.29	0.910	1.81
Switcher 85+	0.415	0.307	1.350	0.177	0.030	1.51	0.830	2.76
New 65-74	0.215	0.133	1.610	0.108	0.030	1.24	0.960	1.61
New 75 +	-0.102	0.171	-0.590	0.552	0.020	0.90	0.650	1.26
Census Division 1	1.622	1.270	1.280	0.202	2.480	5.06	0.430	60.2
Census Division 2	1.759	1.238	1.420	0.156	2.450	5.80	0.520	64.84
Census Division 3	1.590	1.236	1.290	0.198	2.450	4.90	0.440	54.56
Census Division 4	1.748	1.259	1.390	0.165	2.470	5.74	0.490	66.91
Census Division 5	1.628	1.235	1.320	0.188	2.450	5.09	0.460	56.62
Census Division 6	1.677	1.258	1.330	0.183	2.470	5.35	0.460	62.21
Census Division 7	1.586	1.247	1.270	0.204	2.450	4.89	0.430	55.61
Census Division 8	1.666	1.273	1.310	0.191	2.470	5.29	0.440	63.34
Census Division 9	1.655	1.246	1.330	0.184	2.450	5.23	0.460	59.37
Urban Status								
Urban Status=1	-0.498	0.195	-2.550	0.011	3.010	0.61	0.420	0.89
BENE_IDENT_CD=1 IF Not "A"	-0.327	0.174	-1.880	0.060	2.970	0.72	0.510	1.01
1=Black Race 0=Non Black	-0.125	0.279	-0.450	0.654	2.500	0.88	0.510	1.52
Representative Payer=1	0.608	0.650	0.940	0.350	2.980	1.84	0.52	6.53
R-Square (Cox and Snell)	0.018242							
H&L test statistic	6.9329 with 8 DF (p=0.5439)							

TABLE A.6 NONRESPONSE WEIGHTING CLASS CELLS AND ADJUSTMENTS COHORT 1

Cell	Phone Status	Stratum	Propensity Range	A Sum of Weights Attempted Cases Using Factors 1 and 2)	B Sum of Weights Completed + Ineligible Cases	Number of Attempted Cases	Number of Completes + Ineligibles	Mean Propensity Score	Adjustment (A / B) Factor 3
1	Located	1	1	55,253	44,080	229	183	1.3548	1.25346
2		1	2	23,785	18,449	102	79	1.4158	1.28921
3		1	3	10,095	8,779	43	37	1.5651	1.14988
4		2	1	59,030	44,483	245	184	1.3669	1.32703
5		3	1	10,714	9,247	45	39	1.2987	1.15869
6		3	2	3,383	2,283	15	10	1.5946	1.48153
7		4	1	74,659	58,912	494	389	1.3783	1.26729
8		5	1	15,143	11,953	99	78	1.4783	1.26688
9		5	2	4,767	3,373	33	23	1.7327	1.41347
10		6	1	5,807	4,176	39	28	1.5260	1.39063
11		7	1	10,640,242	7,989,558	341	256	1.4348	1.33177
12		8	1	4,040,614	3,075,678	129	98	1.3495	1.31373
13		8	2	3,137,322	2,277,391	103	75	1.4807	1.37760
14		8	3	1,003,048	694,900	33	23	1.6811	1.44344
15		9	1	2,206,919	1,682,467	71	54	1.3661	1.31172
16		9	2	750,327	530,502	25	18	1.5974	1.41437
17	Not Located	1	1	12,548	3,780	52	15	1.3584	3.31996
18		1	2	4,225	1,172	18	5	1.4901	3.60378
19		2	1	8,285	3,889	35	16	1.3682	2.13054
20		4	1	7,198	2,647	51	18	1.3436	2.71977
21		4, 5 and 6	2	9,693	2,200	70	16	1.5069	4.40541
22		7	1	979,400	320,426	34	11	1.4071	3.05656
23		7	2	445,303	137,095	16	5	1.7249	3.24814
24		8 and 9	1	999,106	267,738	34	9	1.4712	3.73165
Total				24,506,867	17,195,177	2,356	1,669		

minimum number of respondents in each cell. We set the third component of the weight equal to the ratio of the sum of the weights using factors 1 and 2 for the attempted cases in the cell divided to the sum of the weights using factors 1 and 2 for the complete and ineligible cases in the cell. For cohort 1, the third weighting component values ranged from 1.14 to 4.40.

4. Calibration Step

After creating the weights from the first three components for the complete and ineligible cases, we adjusted the weights via a raking or calibration step. This procedure aligned the sum of the weights to reproduce the population totals marginally on a stratum, race membership (white, black and other) and geographical (for the four census regions) basis. We conducted a weighted least-squares raking procedure that finds a set of new weights that meet the specified constraints while minimizing the difference between the new weight and the pre-raked weight. The procedure differs from the standard least-squares approach (see Deville and Carl-Erik Sarndal, 1992 and 1993) by minimizing the relative squared difference, rather than the actual difference between the pre-raked weights and the new weights. As such, the square differences are minimized relative to the starting weights, which gives this process its name. This procedure prevents the process from making a larger relative change in a small weight value compared with a large weight in meeting the constraints and can reduce the variability in the survey weights that results from the calibration process. The constraints are specified in terms of the desired weighted counts for a set of categories.

The adjustment process produced the desired results with relatively little impact the on final weight distributions. For cohort 1, the raking procedure increased the overall coefficient of variation in the weights from 148.5 to 148.7 with differences in the CV of the weights of less than 1.0 for each of the nine sampling strata.

5. Eligibility Rate Adjustments for the Non-Located Phone

As indicated in section II.A, we did not have any identified ineligible cases among the non-located phone cases. As a result, the weights for the completed interviews in the non-located phone cases overstated this size of the population. Therefore, we deflated the weights for the non-located phone cases to reflect our best estimate of the eligibility rate among these cases from the phone located beneficiaries. While we suspected that the eligibility rates overall for the non-located phone cases might be different from those for the phone-located cases, the rates would be similar if not the same when confined to a specific stratum. Therefore, for each of the nine sampling stratum we computed a weighted eligibility rate for the phone-located cases and applied this rate as a fourth factor in the weights for the non-located phone cases. The weighted eligibility rates from the phone located cases are presented in Table A.7.

TABLE A.7 ESTIMATED ELIGIBILITY RATES BY STRATUM FOR PHONE LOCATED CASES COHORT 1

Stratum	Population Total	Completes + Ineligibles	Total Eligible Completed Phone Cases	Rake Weighted Count Completes + Ineligibles	Rake Weighted Count Completes	Rake Weighted Count Ineligibles	Weighted Eligibility Rate (Factor 4)
Switcher 65-74	106,772	299	293	89,934	88,152	1,782	0.980
Switcher 75 –84	65,271	184	173	57,725	54,238	3,487	0.940
Switcher 85+	15,931	49	45	15,399	14,061	1,338	0.913
New Enrollee 65-74	86,995	389	386	72,771	72,253	518	0.993
New Enrollee 75-84	23,147	101	86	20,610	17,448	3,162	0.847
New Enrollee 85+	7,418	28	18	7,418	4,709	2,709	0.635
Reference Group 65-74	11,978,987	256	242	10,540,358	9,967,561	572,797	0.946
Reference Group 75-84	8,899,663	196	172	8,108,545	7,129,398	979,147	0.879
Reference Group 85+	3,207,458	72	47	2,996,610	1,922,245	1,074,365	0.641
Total	24,391,642	1,574	1,462	21,909,371	19,270,065	2,639,305	0.880

D. SUMMARY OF DISTRIBUTION OF SURVEY WEIGHTS AND RELATED PRECISION LEVELS IN THE SURVEY ESTIMATES

Table A.8 presents the distribution of the final survey weights for the three enrollment groups as a whole and for each enrollment group and age group separately for the completed interviews. Table A.8 also presents the estimated design effects due to sampling procedures and

the weighting adjustments based on the CV of the weights and the effective sample sizes associated with these categories. Based on the effective sample sizes, the sampling precision for a binary variable with a 50 percent mean, as reflected by a 95 percent confidence interval, is plus or minus 4.53 percentage points overall. By enrollment category, the confidence intervals range from plus or minus 4.4 to 4.6 percentage points. For cohort 1, the survey weights for the 1,557 completed interviews total to an estimated eligible study population of 21,501,908.

Table A.9 presents means and confidence intervals for several of the study's key outcome variables for cohort 1, cohort 2, and both cohorts combined.

TABLE A.8 DISTRIBUTION OF SURVEY WEIGHTS

COHORT 1

Group	Total Completed Cases	Mean	Minimum	Maximum	Sum (Estimated Population)	CV of Weights	Design Effect	Effective Sample Size	95 Percent Confidence Half Interval 50 Percent Binary Variable
Total	1,557	13,810	143	110,877	21,501,908	152.42	3.323	469	4.53%
Switcher	547	330	231	940	180,531	32.17	1.103	496	4.40%
New Enrollee	524	211	143	684	110,683	37.67	1.142	459	4.57%
Reference	486	43,643	32,918	110,877	21,210,694	25.60	1.066	456	4.59%
Age 65-74	987	11,671	143	96,012	11,519,535	171.63	3.946	250	6.20%
Age 75-84	457	17,299	151	110,877	7,905,720	130.09	2.692	170	7.52%
Age 85+	113	18,377	233	70,298	2,076,653	115.38	2.331	48	14.08%

TABLE A.9. MEANS AND CONFIDENCE INTERVALS
FOR SOME KEY OUTCOME VARIABLES

	Both Cohorts Combined			Cohort 1			Cohort 2		
	Switchers	New Enrollees	FFS	Switchers	New Enrollees	FFS	Switchers	New Enrollees	FFS
Whether aware of the handbook									
Mean	.473	.503	.462	.449	.505	.480	.484	.501	.444
95% confidence interval	.440-.507	.469-.536	.430-.495	.405-.494	.459-.551	.434-.526	.440-.529	.454-.548	.398-.490
Number of respondents	1078	1050	982	546	522	484	532	528	498
Whether aware of the toll-free telephone number									
Mean	.422	.478	.466	.397	.453	.451	.433	.493	.482
95% confidence interval	.389-.455	.444-.512	.434-.499	.354-.440	.408-.499	.405-.497	.389-.477	.446-.540	.435-.528
Number of respondents	1076	1050	981	546	522	485	530	528	496
Whether used the handbook									
Mean	.324	.346	.289	.292	.356	.292	.338	.339	.285
95% confidence interval	.292-.356	.313-.378	.258-.319	.250-.333	.312-.400	.249-.335	.296-.381	.294-.385	.243-.327
Number of respondents	1079	1053	986	525	524	486	534	529	500
Whether used the toll-free telephone number									
Mean	.107	.134	.112	.109	.130	.104	.106	.137	.120
95% confidence interval	.086-.128	.111-.158	.092-.131	.080-.137	.098-.161	.077-.131	.078-.134	.104-.171	.092-.148
Number of respondents	1071	1047	978	544	522	483	527	525	495
Understood that coverage continues after disenrolling from M+C plan									
Mean	.754	.702	.407	.776	.694	.412	.744	.707	.403
95% confidence interval	.725-.783	.672-.733	.375-.439	.739-.812	.652-.737	.366-.457	.705-.783	.666-.749	.358-.448
Number of respondents	1079	1053	978	546	523	481	533	530	497
Total Number of Respondents	1083	1055	987	547	524	486	536	531	501

REFERENCES

Claude Deville and Carl-Erik Sarndal (1993) "Generalized Raking Procedures in Survey Sampling." *Journal of the American Statistical Association*, vol. 88, no. 423, pp. 1013-1020.

Claude Deville and Carl-Erik Sarndal (1992), "Calibration Estimators in Survey Sampling." *Journal of the American Statistical Association*, vol. 87, no. 418, pp. 376-382.

Chromy, James R. "Sequential Sample Selection Methods," In *Proceedings of the American Statistical Association Survey Research Section*, 1979, pp. 401-406.

Hosmer, David, W. and Stanley Lemeshow. *Applied Logistic Regression*, New York: John Wiley and Sons, 1989.

Kalton, Graham and Daniel Kasprzyk. "The treatment of missing survey data." *Survey Methodology*, vol. 12, no. 1, 1986, pp. 1-16.

Rosenbaum, Paul and Donald Rubin. "The Central Role of the Propensity Score in Observation Studies for Casual Effect." *Biometrika*, vol. 70, no.1, 1983, pp. 41-55.

APPENDIX B

ADDITIONAL TABLES FOR SECTION IV

TABLE B.1

AWARENESS LEVEL OF NMEP INFORMATION CHANNELS

Number of NMEP Sources Beneficiaries Are Aware of	Percentage of Beneficiaries, by Enrollment Group		
	Switchers	New Enrollees	FFS
0	28.7	24.9	27.3
1	25.4	24.9	26.5
2	20.6	21.9	23.4
3	12.1	14.9	14.4
4	10.7	9.2	6.6
5	2.4	4.1	1.5
Don't know	0.0	0.1	0.2

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: Survey respondents were asked if they were aware of the *Medicare & You 2000* handbook; the Medicare toll-free telephone number, the Medicare website, health fairs, town meetings, or educational events about the changes in Medicare, and about one-to-one information services (that is, state-sponsored health insurance counseling programs.) See questions 3 through 7 in the survey instrument. Question 6 asks about two NMEP information channels, which in this table are counted as one.

TABLE B.2

NUMBER OF NMEP SOURCES USED

Number of Sources	Percentage of Beneficiaries, by Enrollment Group		
	Switchers	New Enrollees	FFS
0	57.0	54.7	61.4
1	28.6	30.6	29.4
2	10.0	10.7	7.4
3	3.5	2.7	1.6
4	0.8	0.8	0.3
5	0.1	0.5	0.0
6	0.0	0.0	0.0

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: The NMEP information sources that survey respondents were asked about were the *Medicare & You 2000* handbook, the Medicare toll-free telephone number, the Medicare website, health fairs, meetings or lectures about Medicare, and one-to-one information services (that is, state-sponsored health insurance counseling programs.) See questions 8 through 13 in the survey instrument.

TABLE B.3

USE OF HEALTH FAIRS, MEETINGS, AND STATE INSURANCE COUNSELING SERVICES, BY SPONSOR

Type Of Sponsorship	Percentage of Beneficiaries, by Enrollment Group		
	Switchers	New Enrollees	FFS
Health Fairs			
Other senior citizens organization	2.6	1.6	1.8
Another organization	1.8	1.6	1.8
Medicare program	0.4	0.5	0.4
Health plan	3.0**	2.2**	0.2
Did not attend health fair	92.4	94.3	95.9
Meeting/Lecture			
Other senior citizens organization	2.1	1.3	1.3
Another organization	1.6	1.4	1.2
Medicare program	0.4	0.8	0.5
Health plan	3.6**	3.3**	0.6
Did not attend health fair	92.6	93.2	96.5
State Insurance Counseling Services			
Medicare	2.2	2.2	1.1
Another source or don't know	1.5	1.7	1.1
Did not use this service	96.4	96.1	97.7

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: The sum of the percentages may exceed 100 percent in some cases because some beneficiaries attended two or more events sponsored by two or more different organizations.

**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.

TABLE B.4

USERS AND NONUSERS OF NMEP SOURCES:
ESTIMATED ODDS RATIOS--SWITCHERS

Independent Variable	Used the Handbook	Used the Toll-Free Telephone Number	Did Not Use Any NMEP Sources
Intercept	-0.22	0.00	3.47
Cohort 2	1.30	1.07	-0.85
Age 65-74	1.60*	1.04	-0.67*
Age $\geq$ 85	1.09	1.64	-0.87
Has high school education or less	-0.82	1.11	1.12
Income is more than $40,000 per year	1.38	1.73	-0.59*
Nonwhite	-0.56*	-0.98	1.58
Hispanic	-0.59	-0.94	1.49
Female	1.05	-0.89	-0.89
Has 4 or more doctor visits	1.26	1.01	-0.89
Has cognitive difficulties	-0.76	1.26	1.15
Has employer-sponsored Medigap	1.04	-0.55	1.25
Purchases Medigap on own	1.09	1.55	-0.70
Participates in insurance decision	-0.86	3.48	-0.82
Used 3 or more general information sources "very often"	1.25	1.99**	-0.56**
Was member of managed care before in Medicare	1.02	-0.71	-0.90
Medicare HMO dropped out of county effective January 1, 2000	-1.00	1.48	1.04
Medicare HMO penetration rate in county	1.85	-0.11*	1.67
Responded by mail questionnaire	2.43**	1.82*	-0.44**
Resides in urban area	1.15	62.12**	-0.76

SOURCE: Weighted logit regression equations estimated with data from cohort 1 and cohort 2 beneficiary survey.

NOTES: *Statistically significant at the 0.05 level.
**Statistically significant at the 0.01 level.
General information sources include television, newspapers, radio, and books (see Table IV.3).
Medicare HMO drop-outs include contract withdrawals and service area reductions.
The Medicare HMO penetration rate for a county is the number of M+C plan enrollees in that county divided by the total number of beneficiaries in that county.

TABLE B.5

NUMBER OF NON-NMEP SOURCES USED

Number of Sources	Percentage of Beneficiaries, by Enrollment Group		
	Switchers	New Enrollees	FFS
0	28.4	26.1	39.0
1	16.1	16.4	19.3
2-3	34.0	35.3	24.1
4-5	18.3	18.6	13.2
6-7	3.2	3.5	4.5

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTES: Other sources include the library or newspapers, the internet, a former employer or union, a current health plan or insurance company, a hospital, clinic, or nursing home, senior citizen organizations such as AARP, a religious institution such as a church, an ethnic organization, family or friends, and a doctor or other medical personnel. See question 26 in the survey instrument.

TABLE B.6

NUMBER OF TOPICS FOR WHICH BENEFICIARIES
EVER SOUGHT INFORMATION

	Percentage of Beneficiaries, by Enrollment Group		
Number of Topics	Switchers	New Enrollees	FFS
0	40.2	44.2	64.3
1	16.2	16.4	19.8
2	10.0	9.8	7.1
3	7.6	6.6	2.9
4	12.5	11.1	3.7
5	13.6	11.9	2.2

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTES: The information topics include Medicare coverage of specific services, which benefits to look for in a Medicare managed care plan, differences between Medicare FFS and HMOs, quality-of-care ratings for Medicare plans, and premiums for Medicare plans. See question 25 in the survey instrument.

TABLE B.7

RELATIONSHIP BETWEEN TOPICS ON WHICH BENEFICIARIES SOUGHT INFORMATION AND BENEFICIARY CHARACTERISTICS

Beneficiary Characteristic	Topics (Percentage of Beneficiaries)				
	Coverage of Specific Services	Which Benefits to Look For	Differences between FFS and Managed Care	Premiums	Quality of Care
Age					
65-74	27.2	19.2	15.9	10.4*	8.0*
75-84 (R)	24.0	14.2	11.6	6.5	5.4
85+	18.7*	12.7	10.1	3.9	5.0
Education					
High school or less	19.0**	13.4**	10.1**	5.2**	5.6
More than high school	34.7	22.5	19.5	13.6	8.4
Income					
Less than $40,000	22.4**	15.8	11.5*	6.3*	5.8
$40,000 +	36.0	21.2	20.8	13.4	10.6
Self-assessed knowledge about changes in Medicare					
Very knowledgeable	28.8	23.0	20.1**	14.0	10.0
Some knowledge (R)	28.9	18.6	14.4	8.7	6.9
Little or no knowledge	17.5**	10.2**	8.9	4.5*	4.6
Visits to doctor during the past 3 months					
4 or more	32.8*	17.4	14.7	9.4	8.2
Fewer than 4	23.9	16.8	13.3	8.0	6.0
Inpatient hospital admission during past year					
1 or more	22.6	17.6	12.5	7.8*	6.5
None	25.8	16.5	13.5	6.0	8.6

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries

NOTE: (R) indicates the reference group.
*Difference is statistically significant at the .05 level, chi-square test.
**Difference is statistically significant at the .01 level, chi-square test.

APPENDIX C

ADDITIONAL TABLES FOR SECTION V

TABLE C.1

BENEFICIARIES' DEMONSTRATED UNDERSTANDING OF
THE M+C PROGRAM AND MEDICARE, BY AGE GROUP

	Percent Responding Correctly								
	Switchers			New Enrollees			Fee-for-Service		
True False Questions	65 - 74	75 – 84 (R)	85+	65 - 74	75 – 84 (R)	85+	65 - 74	75 – 84 (R)	85+
General Knowledge About Medicare									
Medicare pays for all health care expenses	82.3	85.5	81.2	84.4	81.7	79.2	88.5	85.5	76.2
Can report complaints to Medicare	68.4	67.1	60.7	68.2	70.6	47.7*	65.4	62.9	63.1
Interface of Medicare with M+C									
Can select among health plan options within Medicare	67.1	65.8	62.5	63.4	56.9	49.2	54.0	52.7	43.5
If leave a Medicare HMO, would still be covered by Medicare	77.9	73.4	64.5	71.5	67.0	60.0	42.7	39.8	33.6
Knowledge About Medicare Managed Care									
Medicare HMOs offer limited choice of doctors	87.9*	82.6	74.4	80.8	77.9	49.8**	65.8	60.2	49.8
Can switch to another primary care physician	88.2	85.6	79.5	80.3	78.3	64.5	63.6	64.6	66.1
Sample Size	631	368	84	834	182	39	527	361	99

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Indicates that within that enrollment group, the difference between the age subgroup and the reference group of those aged 75-84 is significant at the .05 level.
**Indicates that within that enrollment group, the difference between the age subgroup and the reference group of those aged 75-84 is significant at the (.01) level.
(R) indicates the Reference Group

TABLE C.2

BENEFICIARIES' DEMONSTRATED UNDERSTANDING OF THE
M+C PROGRAM AND MEDICARE, BY EDUCATION LEVEL

True False Questions	Percent Responding Correctly					
	Switchers		New Enrollees		FFS	
	Up to High School	Beyond High School (R)	Up to High School	Beyond High School (R)	Up to High School	Beyond High School (R)
General Knowledge About Medicare						
Medicare pays for all health care expenses	81.7*	87.0	80.4**	89.5	82.5**	94.2
Can report complaints to Medicare	67.8	66.3	68.8	67.2	64.2	65.4
Interface of Medicare with M+C						
Can select among health plan options within Medicare	66.5	67.3	59.5	66.0	50.9	57.2
If leave a Medicare HMO, would still be covered by Medicare	70.9**	82.0	67.5**	76.0	35.8**	49.3
Knowledge About Medicare Managed Care						
Medicare HMOs offer limited choice of doctors	84.0**	88.1	76.9	81.9	58.9**	70.9
Can switch to another primary care physician	85.2*	90.0	79.5	80.7	63.6	65.7
Sample Size	646	403	605	420	614	347

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Indicates that within that enrollment group, the difference between those who went beyond high school and those who did not is significant at the .05 level.
**Indicates that within that enrollment group, the difference between those who went beyond high school and those who did not is significant at the .01 level.
(R) indicates the reference group

TABLE C.3

BENEFICIARIES' DEMONSTRATED UNDERSTANDING OF
THE M+C PROGRAM AND MEDICARE, BY INCOME LEVEL

	Percent Responding Correctly							
	Switchers				New Enrollees			
True False Questions	< $20,000	$20,000 - $30,000	$30,000 - $40,000	$40,000+ (R)	< $20,000	$20,000 - $30,000	$30,000 - $40,000	$40,000+ (R)
General Knowledge About Medicare								
Medicare pays for all health care expenses	76.4**	87.4	95.4*	88.2	76.0**	83.9	93.9	92.3
Can report complaints to Medicare	65.7	65.9	68.0	75.1	69.2	62.9	69.2	70.6
Interface of Medicare with M+C								
Can select among health plan options within Medicare	63.1*	65.1	65.2	74.5	57.1**	62.7	54.7*	69.9
If leave a Medicare HMO, would still be covered by Medicare	70.5**	80.4	83.8	84.0	65.6**	64.5**	72.3	80.0
Knowledge About Medicare Managed Care								
Medicare HMOs offer limited choice of doctors	80.7	87.0	89.6	88.0	78.0	75.6	80.9	83.2
Can switch to another primary care physician	82.2	89.1	92.2	89.1	76.6**	74.5*	80.0	86.2
Sample Size	456	185	122	132	390	200	108	209

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Indicates that within that enrollment group, the difference between the income group and the reference group of those with incomes of $40,000 or more is significant at the .05 level.
*Indicates that within that enrollment group, the difference between the income group and the reference group of those with incomes of $40,000 or more is significant at the .01 level.

(R) indicates the reference group

TABLE C.4

BENEFICIARIES' DEMONSTRATED UNDERSTANDING OF
THE M+C PROGRAM AND MEDICARE, BY INCOME LEVEL

True False Questions	Percent Responding Correctly			
	FFS			
	< $20,000	$20,000 - $30,000	$30,000 - $40,000	$40,000+ (R)
General Knowledge About Medicare				
Medicare pays for all health care expenses	79.6**	90.1*	92.4	96.5
Can report complaints to Medicare	62.6	66.8	72.7	61.6
Interface of Medicare with M+C				
Can select among health plan options within Medicare	50.7	55.6	55.3	55.2
If leave a Medicare HMO, would still be covered by Medicare	39.6**	35.4**	39.5*	53.2
Knowledge About Medicare Managed Care				
Medicare HMOs offer limited choice of doctors	56.5**	64.7	64.5	73.0
Can switch to another primary care physician	63.1	63.6	70.6	69.1
Sample Size	382	168	82	173

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

*Indicates that within that enrollment group, the difference between the income group and the reference group of those with incomes of $40,000 or more is significant at the .05 level.
*Indicates that within that enrollment group, the difference between the income group and the reference group of those with incomes of $40,000 or more is significant at the .01 level.
(R) indicates the reference group

TABLE C.5

BENEFICIARIES' DEMONSTRATED UNDERSTANDING OF THE M+C PROGRAM AND MEDICARE, BY MEDICARE MANAGED CARE PENETRATION RATE

	Switchers			New Enrollees			FFS			
	Medicare MCO Penetration Rate			Medicare MCO Penetration Rate			Medicare MCO Penetration Rate:			
True False Questions	Up to .14	.15 to .29	30+ (R)	Up to .14	.15 to .29	30+ (R)	0	Up to .14	.15 to .29	30+ (R)
General Knowledge About Medicare										
Medicare Pays for all health care expenses	86.7	84.3	81.7	84.4	86.6	80.7	88.7	86.9	82.6	83.4
Can report complaints to Medicare	72.7	64.3	67.6	70.5	65.7	69.2	66.1	60.9	63.8	66.1
Interface of Medicare with M+C										
Can select among health plan options	64	67	66.8	59.1	62.5	64.9	49.3	51.6	59.0	53.2
If leave a Medicare HMO, would still be covered	71.3	80.7*	73.2	73.1	69.9	70.7	37.4	40.1	44.4	47.2
Knowledge About Medicare Managed Care										
Medicare HMOs offer limited choice of doctors	86.9	85.3	84.5	81.1	83.2*	75.0	57.7*	64.5*	60.0*	77.0
Can switch to another primary care physician	87.2	85.7	87.1	77.1	81.6	79.2	64.8	65.1	63.9	61.7

(R) Reference group

*Difference from reference group is statistically significant at the .05 level

TABLE C.6

CHARACTERISTICS ASSOCIATED WITH SWITCHERS' UNDERSTANDING OF THE M+C PROGRAM AND MEDICARE ODDS RATIO FROM THE MULTIVARIATE LOGISTIC REGRESSIONS FOR SWITCHERS

	Interface of Traditional Medicare with M+C		General Knowledge About Medicare		Knowledge About Medicare Managed Care	
Explanatory Variable	Can Select Among Plan Options	If Leave MCO, Still Covered	Medicare Pays All Expenses	Can Report Complaints to Medicare	Doctor Choice Limited	Can Switch PCPs
Intercept	1.41	6.27*	8.03*	1.38	20.66*	16.08**
Cohort 2	-0.96	-0.85	-0.85	1.22	1.12	1.05
Has employer sponsored Medigap coverage	-0.42**	-0.48*	2.82	1.39	-0.92	1.24
Has purchased own Medigap coverage'	1.39	-0.95	1.68	1.13	-0.65	-0.6
Has 4 or more doctor visits	-0.76	-0.81	-0.81	1.17	1.06	1.21
Has cognitive difficulties	-0.83	-0.56*	-0.99	1.01	1.73	-0.53*
Participates in insurance decision	1.03	-0.83	-0.73	-0.74	1.31	-0.35
Was member of managed care before Medicare	-0.92	-0.63*	1.09	1.12	0.86	1.07
Used 3 or more general information sources	-0.92	-0.94	1.15	1.01	1.07	-0.79
Has high school education or less	1.26	-0.62*	-0.93	1.16	-0.80	-0.57*
Income is more than $40,000 per year	1.40	1.14	1.10	1.46	-0.86	-0.81
Medicare HMO dropped out of county in January 2000	1.18	1.32	1.06	1.00	1.11	-0.87
Age 65-74	-0.99	1.22	-0.70	-0.96	1.6*	1.0
Age 85 or above	-0.99	-0.79	-0.62	-0.70	-0.56	-0.81

TABLE C.6 (*continued*)

Explanatory Variable	Interface of Traditional Medicare with M+C		General Knowledge About Medicare		Knowledge About Medicare Managed Care	
	Can Select Among Plan Options	If Leave MCO, Still Covered	Medicare Pays All Expenses	Can Report Complaints to Medicare	Doctor Choice Limited	Can Switch PCPs
Nonwhite	-0.64	-0.53**	-0.47*	1.04	-0.45**	-0.99
Hispanic	-0.78	-0.72	-0.26**	-0.98	-0.44*	-0.71
Responded by mail questionnaire	-0.40**	-0.94	-0.93	-0.53**	-0.79	-0.61
Female	-0.81	-0.67*	-0.87	-1.00	-0.83	1.24
Resides in urban area	-0.93	-0.90	1.53	1.28	-0.24	1.64
Medicare HMO county penetration rate	1.52	-0.92	-0.49	1.04	-0.50	1.36
Read the handbook	2.86**	1.57[a]	1.14	2.17**	-0.80	2.19*
Number of information sources collected on Medicare	1.22**	1.36**	1.15	1.00	1.29*	1.09

NOTE: The dependent variables take a value of 1 of the true-false question was answered correctly, zero otherwise.

*Statistically significant from zero at the .05 level.
**Statistically significant from zero at the .01 level.

[a]Statistically significant from zero at the .0503 level

APPENDIX D

ADDITIONAL TABLES FOR SECTION VII

TABLE D.1

IMPORTANCE OF THE AMOUNT OF PAPERWORK NEEDED TO FILE A CLAIM IN MAKING HEALTH PLAN DECISIONS, BY BENEFICIARY CHARACTERISTICS

Beneficiary Characteristic	Paperwork Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	53.6	17.8	15.1	13.2	0.2
New enrollee	54.9	18.8	14.3	12.1	0.0
Age					
65-74	55.0	18.7	14.3	11.9	0.1
75-84 (R)	52.1	16.7	15.9	15.2	0.0
85+	52.7	18.8	15.7	12.1	0.8
Income					
< $20,000	52.8**	15.0	16.3	15.8	0.1
$20,000 - $40,000 (R)	56.6	19.9	15.1	8.3	0.1
> $40,000	49.7	23.3	15.7	11.2	0.0
Had employer-based Medigap					
Yes	57.1	16.5	15.1	11.4	0.0
No	53.6	18.4	14.8	13.1	0.2
Read *Medicare & You 2000*					
Yes	58.9**	19.5	12.4	9.1	0.1
No	51.7	17.3	16.1	14.8	0.1
Used the Medicare toll-free telephone number					
Yes	60.1	16.1	14.4	9.4	0.0
No	52.8	18.2	15.2	13.6	0.2

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and enrollees.

**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.
(R) refers to the references group.

TABLE D.2

IMPORTANCE OF PATIENT SATISFACTION IN MAKING HEALTH PLAN DECISIONS, BY BENEFICIARY CHARACTERISTICS

	Satisfaction Ranking (Percentage of Beneficiaries)				
Beneficiary Characteristics	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	44.6	23.0	12.0	16.6	3.8
New enrollee	48.4	22.7	12.9	12.6	3.5
Age					
65-74	47.9	22.6	11.8	14.0	3.6
75-84 (R)	43.0	22.8	12.0	18.6	3.6
85+	36.3	26.6	18.8	13.3	5.0
Income					
< $20,000	45.6	24.7	11.5	15.0	3.2
$20,000 - $40,000 (R)	47.1	21.2	13.3	13.9	4.5
> $40,000	40.0	25.9	12.7	18.1	3.3
Had employer-based Medigap					
Yes	37.1	24.9	12.2	22.9	2.8
No	47.0	22.7	12.4	14.3	3.7
Read *Medicare & You 2000*					
Yes	48.6**	25.5	8.6	12.6	4.7
No	44.5	21.6	14.2	16.7	3.0
Used the Medicare toll-free telephone number					
Yes	48.5	20.4	16.6	11.4	3.1
No	45.3	23.3	12.0	16.1	3.3

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.
(R) refers to the reference group.

TABLE D.3

IMPORTANCE OF THE RECOMMENDATIONS OF FAMILY AND FRIENDS IN MAKING HEALTH PLAN DECISIONS, BY BENEFICIARY CHARACTERISTICS

Beneficiary Characteristic	Recommendations Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	34.0	25.5	22.4	18.2	0.0
New enrollee	36.5	26.7	20.6	16.2	0.0
Age					
65-74	34.3	25.9	21.5	18.2	0.0
75-84 (R)	36.0	26.2	21.3	16.5	0.0
85+	34.1	23.7	27.0	15.2	0.0
Income					
< $20,000	39.9**	21.1	22.4	16.6	0.0
$20,000 - $40,000 (R)	30.8	30.5	21.8	16.9	0.0
> $40,000	31.6	24.3	24.2	19.9	0.0
Race					
White	33.9	26.1	22.2	17.7	0.0
Nonwhite	42.0	25.8	18.6	13.6	0.0
Read *Medicare & You 2000*					
Yes	34.9	28.0	20.7	16.5	0.0
No	34.7	24.8	22.4	18.1	0.0
Used the Medicare toll-free telephone number					
Yes	42.2	26.1	19.0	12.7	0.0
No	33.9	25.8	22.1	18.2	0.0

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

(R) refers to the reference group.
**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.

TABLE D.4

IMPORTANCE OF EMPLOYER OFFER TO PAY FOR MANAGED CARE INSURANCE IN MAKING A HEALTH PLAN DECISION, BY BENEFICIARY CHARACTERISTICS

	Employer Offer Ranking (Percentage of Beneficiaries)				
Beneficiary Characteristic	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Enrollment group					
Switcher	10.9**	3.4	8.7	76.0	1.0
New enrollee	23.6	4.4	8.1	61.9	1.9
Age					
65-74	16.4	3.2	8.5	70.6	1.2
75-84 (R)	12.3	4.6	8.9	72.8	1.3
85+	12.2	3.9	6.7	75.6	1.6
Income					
< $20,000	9.9	3.3	8.8	76.6	1.3
$20,000 - $40,000 (R)	17.2	3.2	8.3	70.1	1.1
> $40,000	26.9	3.6	10.7	58.4	0.4
Had employer-based Medigap					
Yes	58.2**	9.1	5.8	26.7	0.2
No	8.6	2.9	8.9	78.1	1.4
Read *Medicare & You 2000*					
Yes	16.3*	2.2	7.0	74.1	0.4
No	14.3	4.4	9.3	70.2	1.8
Used the Medicare toll-free telephone number					
Yes	14.2	2.5	8.0	75.0	0.3
No	15.0	3.6	8.8	71.5	1.1

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

*Difference in the distribution across responses is statistically significant at the 0.05 level, chi-square test.
**Difference in the distribution across responses is statistically significant at the 0.01 level, chi-square test.
(R) refers to the reference group.

TABLE D.5

IMPORTANCE OF MEDICARE HMO WITHDRAWALS IN MAKING HEALTH PLAN DECISIONS, BY BENEFICIARY CHARACTERISTICS

Beneficiary Characteristic	Whether HMO Withdrawals Affected the Enrollment Decision (Percentage of Beneficiaries)		
	Yes	No	Not an Issue
Enrollment group			
Switcher	19.8	38.0	42.2
New enrollee	13.8	34.6	51.6
Age			
65-74	18.5	37.5	44.0
75-84 (R)	16.4	36.8	46.8
85+	17.4	30.0	52.6
Education			
More than high school	19.3	41.8	38.8
High school or less	16.6	34.6	48.8
Income			
< $20,000	15.4*	32.0	52.5
$20,000 - $40,000 (R)	18.5	39.2	42.3
> $40,000	19.2	46.8	34.0
Race			
White	18.5*	38.3	43.1
Nonwhite	9.0	30.7	60.4

SOURCE: MPR survey of cohort 1 and cohort 2 switchers and new enrollees.

*Difference is statistically significant at the .05 level, chi-square test.
(R) refers to the reference group.

APPENDIX E

TABLES COMPARING ENROLLEE SUBGROUP OUTCOMES FOR COHORT 1 AND COHORT 2

NOTES FOR APPENDIX TABLES

*Difference in the distribution of responses between an enrollment group (switcher, new enrollee, or FFS) in cohort 1 compared with that same enrollment group in cohort 2 is statistically significant at the 0.05 level, chi-square test.

**Difference in the distribution of responses between an enrollment group (switcher, new enrollee, or FFS) in cohort 1 compared with that same enrollment group in cohort 2 is statistically significant at the 0.01 level, chi-square test.

†Difference in the distribution of responses between the enrollment group examined and FFS beneficiaries in cohort 1 is statistically significant at the 0.05 level, chi-square test.

††Difference in the distribution of responses between the enrollment group examined and FFS beneficiaries in cohort 1 is statistically significant at the 0.01 level, chi-square test.

§Difference in the distribution of responses between the enrollment group examined and FFS beneficiaries in cohort 2 is statistically significant at the 0.05 level, chi-square test.

§§Difference in the distribution of responses between the enrollment group examined and FFS beneficiaries in cohort 2 is statistically significant at the 0.01 level, chi-square test.

€Indicates that within that enrollment group and cohort, the difference between those who read the booklet and those who did not is significant at the .05 level.

€€Indicates that within that enrollment group and cohort, the difference between those who read the booklet and those who did not is significant at the .01 level.

TABLE III.1

COMPARISON OF COHORT 1 AND COHORT 2
ENROLLMENT GROUPS

Characteristic	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Demographic Characteristics						
Age	††	§§	††	§§		
65-69	28.5	31.9	59.7	61.6	26.6	26.1
70-74	29.5	26.9	18.3	17.4	26.8	26.8
75-79	22.8	22.7	12.5	11.3	23.0	23.2
80-84	11.2	11.2	5.2	5.7	13.9	13.7
> 85	8.1	7.3	4.2	4.0	9.7	10.2
Sex						
Female	59.2	58.0	57.5	55.7	59.2	59.7
Race			†			
White	88.7	92.1	82.6	89.3	89.4	90.4
African-American or Black	9.0	6.2	11.9	8.0	7.6	7.9
Native American, Alaskan Native, Native Hawaiian, or other Pacific Islander	1.2	0.5	2.6	1.0	1.7	0.6
Asian	1.1	1.2	2.8	1.8	1.3	1.2
Ethnicity	††	§	††	§§		
Hispanic	8.8	7.7	8.1	9.2	3.9	3.8
Income	††					
< $20,000	52.8	48.2	46.7	40.3	49.7	46.0
$20,000 to $30,000	21.5	21.1	23.7	21.7	18.2	23.8
$30,000 to $40,000	12.9	14.1	10.1	12.6	9.5	10.2
≥ $40,000	12.8	16.6	19.5	25.5	22.6	20.1
Marital status			††	§§		
Married	60.7	58.1	58.7	63.5	57.2	55.3
Widowed	29.8	30.2	25.8	23.8	34.0	32.6
Divorced or separated	7.4	8.6	11.7	8.9	5.7	6.8
Never married	2.2	3.1	3.8	3.8	3.0	5.3
Education	††			§		
High school graduate or less	62.3	61.6	58.7	59.3	61.3	67.2
Some college	26.4	23.2	24.6	25.2	20.1	17.3
College graduate	5.4	7.3	9.8	9.2	9.7	7.0
Graduate studies	5.9	8.0	6.9	6.4	9.0	8.4

TABLE III.1 (*continued*)

Characteristic	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Health and Functional Status						
Percent with a history of the following health conditions:						
Hypertension	54.2	52.9	54.6	52.7	52.0	54.3
Hardening of the arteries	8.5	7.2	8.5	8.2	10.6	9.8
Heart disease	25.0	21.2	18.7†	19.8	25.8	25.2
Stroke	9.5	9.1	5.3	7.1	8.5	7.7
Cancer	14.6	17.7	11.8	13.2	15.1	15.7
Diabetes or high blood sugar	18.8	20.6§	21.2	17.0	16.3	15.0
Rheumatoid arthritis	14.7	13.8	15.0	17.0	17.9	17.8
Percent with one or more of the above health conditions						
One condition	30.0	35.8	31.2	30.7	35.6	30.0
Two conditions	23.0	19.8	22.0	22.0	22.1	22.7
Three conditions	13.4	12.1	10.8	9.5	11.8	10.8
Four or more conditions	6.8	6.5	6.4	5.8	7.2	7.8
Percent needing help with						
Handling finances	9.5	10.8	10.8	8.8*	13.0	12.0
Filling out forms	13.8†	18.2	15.8	17.7	19.9	20.1
Participating in games or hobbies	5.2	9.8*	5.1	6.7	9.0	9.6
Number of physician office visits in past three months						
0	22.3	22.8	24.8	26.2	27.8	21.3
1-2	46.3	46.0	43.9	46.4	42.4	45.1
3-5	23.0	24.0	24.3	19.6	21.8	26.6
6-9	6.8	4.3	3.3	4.9	5.6	4.4
≥ 10	1.6	2.9	3.6	2.9	2.4	2.7
Number of visits to the emergency room				§		
0	86.4	89.3	89.2	91.7	87.3	86.2
1	11.2	7.9	8.0	6.7	10.1	11.1
≥ 2	2.4	2.8	2.9	1.6	2.7	2.7
Number of hospitalizations		*	†	§		
0	77.3	83.5	86.2	85.0	78.9	80.1
1	16.2	12.5	9.4	12.0	14.7	12.7
2-4	5.8	4.0	3.7	3.0	5.5	6.6
≥ 5	0.7	0.0	0.7	0.0	1.0	0.5

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE III.2A

HEALTH INSURANCE EXPERIENCE AND AWARENESS
OF HMO WITHDRAWALS, BY ENROLLMENT GROUP

	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Enrolled in HMO before becoming eligible for Medicare	20.1††	25.7§§**	32.0††	36.7§§	11.4	9.7
Had employer-based supplemental insurance at time of interview	3.0††	9.6§§**	16.7††	21.6§§	35.6	33.2
Lives in a county where a Medicare HMO dropped out in 2000	72.9††	64.9§§**	47.7††	51.8§§	35.7	35.7
Aware of HMO drop-outs	53.4††	64.8§§**	43.4††	57.6§§**	31.2	43.5**
Does not have supplemental insurance	20.5	24.4	42.0	39.1	69.0	65.1
Average HMO penetration rate	31.0	30.0	25.0	25.0	11.0	12.0

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: Medicare HMO drop-outs refer to HMO contract withdrawals and service area reductions in a county.

TABLE III.2B

HEALTH INSURANCE EXPERIENCE AND AWARENESS
OF HMO WITHDRAWALS, BY AGE GROUP

	65 – 74		75 - 84		85 +	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Enrolled in HMO before becoming eligible for Medicare	18.3††	14.4§§	4.7	6.4	0.1††	1.8
Had employer-based supplemental insurance at time of interview	37.8	38.6	37.2	29.4	13.2††	11.8§§
Lives in a county where a Medicare HMO dropped out in 2000	32.9	37.0	39.9	37.5	39.0	29.0
Aware of HMO drop-outs	34.1	46.1	34.0	41.7	6.4††	41.5

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: Medicare HMO drop-outs refer to HMO contract withdrawals and service area reductions in a county.

TABLE IV.1

BENEFICIARY AWARENESS OF NMEP INFORMATION CHANNELS

Information Channel	Percentage of Beneficiaries Aware of Each NMEP Channel, by Enrollment Subgroup					
	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Saw *Medicare & You 2000*						
Yes	45.0	48.4	50.5	50.1	48.0	44.4
No	45.7	41.6	41.0	39.0	41.0	45.6
Don't know	9.3	10.0	8.6	10.8	11.0	9.9
Aware of toll-free telephone number						
Yes	39.7††	43.3	45.3	49.3	45.1	48.2
No	52.3	47.6	46.4	43.0	42.8	44.1
Don't know	7.9	9.1	8.2	7.6	12.0	7.7
Aware of insurance counseling service						
Yes	27.2	31.4	31.1††	31.1	25.0	30.7
No	48.9	50.3	50.9	49.7	49.5	46.3
Don't know	24.0	18.3	18.0	19.2	25.4	23.0
Aware of health fairs or meetings						
Yes	30.8††	23.1*	24.7†	22.5	18.9	20.6
No	66.9	72.7	72.8	72.9	76.9	75.9
Don't know	2.3	4.3	2.5	4.7	4.2	3.6
Aware of website						
Yes	12.8	13.8	17.9†	18.2§§	10.6	11.3
No	81.4	83.0	77.3	76.6	84.7	85.4
Don't Know	5.8	3.2	4.8	5.2	4.7	3.4
Awareness of at least one information source	72.6	70.7	75.6	74.8	71.4	73.9

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE IV.3A

BENEFICIARY PREFERENCES FOR GENERAL INFORMATION SOURCES, BY ENROLLMENT GROUP

	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Television	48.2†	42.2	37.9	46.2§*	40.4	39.2
Newspaper	36.9	37.8	36.3	40.7	36.8	36.1
Spouse	31.0†	29.0§§	27.2	28.6§	24.7	21.3
Books/Magazines	12.5	14.9§	15.1	13.0	15.3	9.8*
Family or Friends	18.8†	19.6	19.1†	16.4	13.7	15.8
Radio	10.7	13.2	16.6	13.7	13.1	12.7
Experts	3.1	3.4	4.6	4.6	2.5	3.3
Internet	3.5	1.7	2.7	5.1§§	1.9	1.9
Lectures	0.5	1.4	0.8	1.2	0.6	1.4

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE IV.3B

BENEFICIARY PREFERENCES FOR GENERAL INFORMATION SOURCES, BY AGE GROUP

	65 - 74		75 - 84		85+	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Television	34.3††	37.5	50.0	39.2*	39.0	49.5
Newspaper	34.0	36.5	40.2	34.9	39.0	39.0
Spouse	28.6	24.8	24.6	20.1	3.9††	8.6§
Books/Magazines	15.8	8.9*	17.0	11.9	6.4†	8.0
Family or Friends	14.3	13.7	13.0	18.9	14.2	16.5
Radio	11.7	12.5	14.9	11.6	13.4	18.1
Experts	2.5	3.4	3.3	3.0	0.01†	4.5
Internet	3.2†	2.8	0.4	1.1	0.02	0.03
Lectures	0.3	1.1	1.0	1.6	0.0	2.3

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE IV.4

USE OF NMEP INFORMATION SOURCES

	Percentage of Beneficiaries Using Each Source, by Enrollment Group					
	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Medicare & You 2000	29.2	33.8	35.6†	34.0	29.2	28.5
Toll-Free Telephone Number	10.9	10.6	13.0	13.8	10.4	12.0
State Health Insurance Assistance Program	3.3†	3.8	4.4††	3.6	1.1	3.4*
Medicare-Sponsored Health Fair	0.5	0.4	0.4	0.5	0.6	0.2
Medicare-Sponsored Meeting or Lecture	0.5	0.4	1.5	0.4	0.6	0.4
Medicare Website	1.0	0.8	0.9	2.0§§	0.2	0.0
Used at Least One Source	41.6	43.6	46.7	44.5	38.3	38.9

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE IV.6

OTHER INFORMATION SOURCES BENEFICIARIES USED TO MAKE HEALTH INSURANCE DECISIONS, BY ENROLLMENT GROUP

	Percentage of Beneficiaries, by Enrollment Group					
	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Doctor	42.1†	36.4§	32.7	31.0	34.9	29.2
Family or Friends	41.9††	39.7§§	41.7††	42.4§§	31.2	26.7
Senior Citizens Organization	30.0	32.6	33.3	32.0	30.5	28.2
Health Plan	47.1††	44.4§§	46.8††	47.3§§	30.0	28.5
Library or Newspapers	18.7	20.8§§	18.0	18.3	17.7	14.3
Hospital or Clinic	13.3	12.9	15.1	10.9§	15.9	15.9
Former Employer	4.1†	8.7**	13.0†	20.3§§**	7.7	11.6*
Internet	2.1	1.3	2.1	4.1§§	1.0	0.4
Religious Organization	1.0	2.1	1.9†	1.8	0.6	2.5*
Ethnic/Racial Organization	0.3	0.5	1.4	2.4	0.4	2.2*
Used at Least One Source	75.4	69.9	75.0	73.2	62.6	59.3

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE IV.7

HEALTH INSURANCE TOPICS ON WHICH BENEFICIARIES HAVE EVER SOUGHT INFORMATION

	Percentage of Beneficiaries, by Enrollment Group					
	Switchers		New Enrollees		FFS	
Health Insurance Topic	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Medicare coverage of specific services, such as prescription drugs	38.3††	36.4§§	41.1††	35.2§§	24.3	25.6
What benefits to look for or avoid in a Medicare managed care plan	45.4††	40.0§§	37.0††	35.1§§	14.8	17.8
Differences between Medicare FFS and Medicare managed care plans	42.4††	39.2§§*	36.7††	35.3§§	11.4	15.0
Premiums for Medicare managed care plans	34.2††	32.6§§	29.7††	26.7§§	6.6	9.2
Quality-of-care ratings for Medicare managed care plans	28.9††	23.9§§	25.7††	21.3§§	4.4	8.3*
Any of these topics	63.3	58.2	58.0	54.3	35.2	36.3

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTE: For some topics, a significant number of sample members indicated that they did not know if they searched for that topic. For example, in cohort 1, 9 percent of sample members did not know if they looked for information on benefits, and 8.7 percent of sample members did not know if they looked for information on the differences between Medicare FFS and HMOs.

TABLE V.1

BENEFICIARIES' SELF-REPORTED KNOWLEDGE
ABOUT RECENT CHANGES TO MEDICARE

Self-Reported Knowledge about Recent Changes to Medicare[a]	Percent of Beneficiaries by Enrollment Status:					
	Switchers[b]		New Enrollees[b]		FFS[b]	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Knew most or just about everything	27.1	25.7	23.2	23.1	23.4	28.3
Knew some or a little	47.3	48.8	49.4	49.2	49.6	47.6
Knew almost nothing or responded "don't know"	25.6	25.6	27.4	27.7	27.1	24.2

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

[a]This survey question asked, "How much do you feel you know about the changes in the Medicare program? Do you feel you know just about everything you need to know, most of everything you need to know, some of what you need to know, a little of what you need to know, or almost none of what you need to know?"

[b]Within both cohorts 1 and 2 the percentage distribution of responses across the three response categories did not differ with statistical significance between switchers and FFS beneficiaries or between new enrollees and FFS beneficiaries. And the distribution of responses within each enrollment group did not differ with statistical significance between cohort 1 and cohort 2.

TABLE V.2

BENEFICIARIES' PERFORMANCE ON TRUE-FALSE QUESTIONS
RELATED TO MEDICARE AND MEDICARE MANAGED CARE

Number of Correctly Answered Questions	Switchers		New Enrollees		FFS	
	Cohort 1 ††	Cohort 2 §§	Cohort 1 ††	Cohort 2 §§	Cohort 1	Cohort 2
0	0.6	0.4	0.7	2.5	1.8	1.4
1 - 2	5.3	6.2	9.6	7.7	22.2	19.5
3 - 4	35.6	31.8	32.3	34.9	42.8	46.5
5 - 6	58.4	61.6	57.5	54.9	33.3	32.6

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE V.3

BENEFICIARIES' DEMONSTRATED UNDERSTANDING
OF THE M+C PROGRAM AND MEDICARE

True-False Questions	Percentage Responding Correctly					
	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
General Knowledge about Medicare						
Medicare pays for all health care expenses	83.8	83.1	82.7	84.3	87.5	84.9
Can report complaints to Medicare	62.7*	69.5	69.9	66.5	63.5	64.9
Interface of Traditional Medicare with M+C						
Can select among health plan options within Medicare	65.7††	66.5§§	62.6††	61.2§§	52.6	52.4
If leave a Medicare HMO, would still be covered by Medicare	77.6††	74.4§§	69.4††	70.7§§	41.2	40.3
Knowledge about Medicare Managed Care						
Medicare HMOs offer limited choice of doctors	83.7††	85.7§§	77.5††	80.0§§	62.6	61.8
Can switch to another primary care physician	86.8††	86.6§§	82.6	77.3§§	62.2	66.2

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE V.4A

BENEFICIARIES UNDERSTANDING—FOR THOSE WHO READ THE HANDBOOK AND THOSE WHO DID NOT

True-False Questions	Percentage Responding Correctly							
	Switchers				New Enrollees			
	Did Not Read Or Recall Handbook		Read Handbook (R)		Did Not Read Or Recall Handbook		Read Handbook (R)	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
General Knowledge About Medicare								
Medicare pays for all health care expenses	82.1€	84.4	89.2	85.9	79.2€	85.4	88.3	84.6
Can report complaints to Medicare[a]	58.5€*	65.5€	71.1*	80.2	67.9	62.7€€	75.8	75.4
Interface of Traditional Medicare with M+C								
Can select among health plan options within Medicare	60.0€€	57.5€€	77.3	81.2	55.1€€	53.6€€	75.3	77.2
If leave a Medicare HMO, would still be covered by Medicare	73.1€€	70.6	86.1	82.0	65.4€€	62.8€€	77.7	86.1
Knowledge About Medicare Managed Care								
Medicare HMOs offer limited choice of doctors	82.0	85.6	87.0	85.9	76.7	76.8	80.7	84.9
Can switch to another primary care physician	83.3€€	82.6€€	93.4	92.8	80.3	74.3€€	84.7	87.5

SOURCE: MPR Cohort 1 and Cohort 2 survey of beneficiaries.

[a]Estimates from cohort 1 did not differ with statistical significance from those for cohort 2 with one exception. For switchers the proportion who correctly answered "can report complaints to Medicare" differed with statistical significance at the .05 level between cohort 1 and cohort 2 for those who had read the Handbook and for those who had not.

€Indicates that within that enrollment group and cohort, the difference between those who read the Handbook and those who did not is significant at the .05 level.

€€Indicates that within that enrollment group and cohort, the difference between those who read the Handbook and those who did not is significant at the .01 level.

TABLE V.4B

BENEFICIARIES UNDERSTANDING—FOR THOSE WHO READ THE HANDBOOK AND THOSE WHO DID NOT

True-False Questions	Percentage Responding Correctly			
	FFS			
	Did Not Read Or Recall Handbook		Read Handbook (R)	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2
General Knowledge About Medicare				
Medicare pays for all health care expenses	85.1€	82.1€€	94.2	92.8
Can report complaints to Medicare	59.6€€	62.5	73.2	71.9
Interface of Traditional Medicare with M+C				
Can select among health plan options within Medicare	51.8	45.3€€	56.2	70.4
If leave a Medicare HMO, would still be covered by Medicare	37.4€€	36.8	52.6	51.5
Knowledge About Medicare Managed Care				
Medicare HMOs offer limited choice of doctors	56.3€€	60.4	76.7	65.0
Can switch to another primary care physician	63.3	67.4	63.7	66.3

SOURCE: MPR survey of Cohort 1 and Cohort 2 beneficiaries.

€Indicates that within that enrollment group and cohort, the difference between those who read the Handbook and those who did not is significant at the .05 level.

€€Indicates that within that enrollment group and cohort, the difference between those who read the Handbook and those who did not is significant at the .01 level.

TABLE VI.1

RATING OF THE HANDBOOK BY THOSE WHO READ IT

Handbook Rating	Percent of Beneficiaries, by Enrollment Status					
	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Excellent	5.4	7.6	5.3	7.2	7.4	2.5
Very Good	24.9	26.9	21.4	21.4	18.9	22.0
Good	43.9	39.8	46.6	48.8	48.6	48.2
Fair	20.1	19.3	21.8	14.3	17.3	20.3
Poor	0.6	1.2	2.5	3.4	0.7	1.9
Don't Know	5.1	5.3	2.5	4.9	7.1	5.2

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

TABLE VI.2

IMPORTANCE OF HANDBOOK IN DECISION TO JOIN
A MEDICARE MANAGED CARE PLAN

	As a Percent of Those Who Read the Handbook						As a Percentage of the Entire Subgroup[a]			
	Switchers and New Enrollees Combined		Switchers		New Enrollees		Switchers		New Enrollees	
Ratings	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Very Important	42.1	40.9	40.0	39.2	45.2	44.9	11.7	12.5	16.1	13.9
Somewhat Important	38.4	36.1	43.6	36.9	31.1	34.1	12.7	11.8	11.1	10.6
Not Important	14.0	12.6	10.8	13.3	18.4	11.0	3.2	4.2	6.6	3.4
Found No Information	4.9	8.5	5.6	8.7	3.8	8.1	1.6	2.8	1.4	2.5
Don't Know	0.6	1.9	0.0	1.9	1.5	1.9	0.0	0.6	0.5	0.6

SOURCE: MPR survey of cohort 1 and cohort 2 Medicare beneficiaries.

[a]Thirty-two percent of switchers and 35 percent of new enrollees read the handbook.

TABLE VI.3

HELPFULNESS OF OTHER NMEP SOURCES

Information Source	Of Those Who Used the Information Source, the Proportion Who Received Answers to Their Questions[a]					
	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Toll-Free Telephone Number	90.9	83.8	78.6	82.2	96.4*	81.6
Health Fair	92.3	90.2	89.0	89.1	100.0	86.6
Lecture	93.0	97.4	84.4	92.2	79.2	95.0
State-Sponsored Insurance Counseling	94.3	89.0	81.0	91.8	[b]	90.9

SOURCE: MPR survey of cohort 1 and cohort 2 beneficiaries.

NOTES: [a]Calculated as a percent of those who used the information source

[b]Only six FFS respondents reported that they had attended a state health insurance assistance program, and only four of those answered the question pertaining to whether their questions were answered (12B); therefore, this estimate is not reliable.

TABLE VI.4

BENEFICIARIES' MOST HELPFUL INFORMATION SOURCE

Information Source	Switchers		New Enrollees		FFS	
	Cohort 1††	Cohort 2§§	Cohort 1††	Cohort 2§§	Cohort 1	Cohort 2
Their Health Plan	25.4	24.8	23.9	23.5	13.4	10.5
Doctor or Medical Personnel	19.7	13.0	10.4	10.4	13.9	11.8
Family or Friends	12.9	10.1	14.1	12.4	8.4	7.4
Medicare Program[a]	8.2	9.3	9.7	8.9	15.1	11.0
Senior Citizen Organization	6.5	9.3	8.3	6.7	10.9	12.2
Toll-free Telephone Number	2.1	2.2	2.6	3.4	4.3	4.1
Meeting/Lecture	2.4	1.2	1.1	0.8	0.4	0.2
Employer	1.5	5.3	6.2	10.8	4.4	5.9
Other Organization	2.0	2.8	3.0	2.1	1.1	3.8
Library or Newspaper	2.8	2.2	3.1	1.4	3.0	2.9
Hospital/clinic/Nursing Home	1.0	1.0	2.1	1.9	2.4	2.7
State Sponsored Insurance Counseling	0.4	0.5	1.2	0.4	0.2	0.4
Website	0.5	0.0	0.7	0.6	0.0	0.0
Health Fair	0.7	0.8	0.5	1.0	0.4	0.0
None	14.1	17.4	12.8	15.6	22.1	27.2

SOURCE: MPR survey of Medicare beneficiaries, cohort 1 and cohort 2.

NOTES: [a]The handbook was not listed as a separate option for respondents to choose from. However, it would have been one of the sources under the category "Medicare Program."

TABLE VI.5

HOW BENEFICIARIES USED THEIR MOST HELPFUL INFORMATION SOURCE

Use of Most Helpful Source	Switchers		New Enrollees		FFS	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
To Draw Comparisons Across Plans						
Compare benefits	65.0††	64.7§§	61.0††	59.8§§	39.9	38.0
Compare costs	54.3††*	50.2§§	48.4††	48.6§§	23.5	29.1
Compare quality	61.9††**	50.9§§	50.5††	48.6§§	25.6	28.6
To Understand Enrollment/ Disenrollment Process						
Understand how to sign up for a plan	52.7††	51.2§§	47.8††	48.8§§	24.9	24.2
Understand how to drop out of plan	48.6††	41.3§§	36.6††	40.2§§	14.5	16.0
To Make Health Coverage Decision						
To decide to enroll (or not) in an M+C plan	57.2††	51.2§	56.0††	53.7§	40.2	44.9

SOURCE: MPR survey of Medicare beneficiaries, cohort 1 and cohort 2 (questions 28A through 28E).

TABLE VII.1

FACTORS CONSIDERED BY SWITCHERS AND NEW ENROLLEES
WHEN MAKING A HEALTH PLAN DECISION

Factor	Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
Benefits covered					
Cohort 1	82.6	11.6	3.8	1.2	0.8
Cohort 2	82.3	13.5	3.2	1.0	0.1
Quality of care					
Cohort 1	79.2	13.0	3.6	2.7	1.5
Cohort 2	78.4	15.4	2.6	3.2	0.5
Staying with current physicians					
Cohort 1	71.7	11.9	10.6	4.7	1.0
Cohort 2	71.3	13.7	10.1	4.0	0.9
Cost of premium					
Cohort 1	62.0	19.4	12.9	5.1	0.7
Cohort 2	65.9	19.9	10.0	3.8	0.5
Amount of paperwork					
Cohort 1	54.9	19.9	15.4	9.4	0.4
Cohort 2	53.6	17.3	14.5	14.6	0.0
Satisfaction of plan members					
Cohort 1	49.6	22.2	14.0	9.6	4.6
Cohort 2	43.9	23.3	11.5	18.1	3.2
Recommendations of family and friends					
Cohort 1	35.2	24.8	22.0	18.1	0.0
Cohort 2	34.6	26.4	21.7	17.3	0.0
Employer offered to pay for insurance					
Cohort 1	11.5	4.2	8.6	73.8	1.9
Cohort 2	16.2	3.5	8.5	70.7	1.1

TABLE VII.1 (*continued*)

Factor	Ranking (Percentage of Beneficiaries)				
	Very Important	Somewhat Important	Not Important	Did Not Consider	Found No Information
HMO drop-outs					
Cohort 1	15.8**		30.0	54.1	
Cohort 2	18.7		41.6	39.7	

SOURCE: MPR survey of cohort 1 and cohort 2 new enrollees and switchers.

NOTE: When asked if HMO withdrawals affected their health insurance decision, respondents could reply: "Yes," "No," "Didn't think about it," or "Don't know." The "Yes" responses are recorded in the "very important" category above.

APPENDIX F

EVALUATION OF NEW MEDICARE MEMBERS OF MEDICARE+CHOICE PLANS: QUESTIONNAIRE (ENGLISH VERSION)

SCREENER

Screener text was taken from the Medicare+Choices New Enrollee Survey, conducted for HCFA by Mathematica Policy Research, Inc. (MPR). Screener question S17 was taken from the PPRC survey.

MAIN SURVEY QUESTION SOURCES

The main survey instrument has taken standard questions from previously OMB approved questionnaires. Two questionnaire sources did not undergo OMB approval: FAQ and PPRC. Where no previous questionnaire covered the necessary domains of interest, MPR developed and pretested additional questions. The source of each question is marked.

FAQ: Functional Activities Questionnaire[1]. (No OMB approval.)

MAY1: Survey of Medicare Beneficiaries for the *National Medicare and You Handbook: 2000* Evaluation - short version. Conducted for HCFA by RTI (OMB No. 0938-0771).

MAY2: Survey of Medicare Beneficiaries for the *National Medicare and You Handbook: 2000* Evaluation - expanded version. Conducted for HCFA by RTI (OMB No. 0938-0771).

MCBS: Medicare Current Beneficiary Study, Rounds 16, 23 and 24. Conducted for HCFA by Westat (OMB No. 0938-0751).

M+C New Enrollee: Medicare+Choices New Enrollee Survey. Conducted for HCFA by MPR (OMB No. pending).

M+C Non-enrollee. Medicare+Choices Disenrollee Survey. Conducted for HCFA by MPR (OMB No. pending).

MPR: Question developed for HCFA's Evaluation of New Medicare Members of Medicare+Choice Plans questionnaire by MPR (this survey).

OMB: OMB regulation questions on race and ethnicity.

PPRC: Survey for the Physicians' Payment Review Commission. Conducted by MPR for the Physician's Payment Review Commission. (No OMB approval.)

---

[1]Pfeffer et al. "Measurement of Functional Activities in Older Adults in the Community." Journal of Gerontology, vol. 37, 1982, pp. 323-329.

Screener (M+C New Enrollee/ Screener)

S1. Hello, my name is [INTERVIEWER'S FULL NAME] from Mathematica - a research company in Princeton, New Jersey. May I please speak to [SP]?

SPEAKING TO SP ⇒ **GO TO S4**

PERSON WHO ANSWERED WANTS TO KNOW WHAT CALL IS ABOUT ⇒ **GO TO S2**

WHEN SP COMES TO PHONE ⇒ **GO TO S3**

SP HAS HEARING/SPEECH DIFFICULTIES ⇒ **GO TO S9**

SP UNABLE TO RESPOND ON PHONE ⇒ **GO TO S7**

SP BUSY, UNAVAILABLE, NOT HOME, NOT FEELING WELL, TEMPORARILY OUT OF THE AREA ⇒ ASK FOR BEST DAY AND TIME TO REACH SP AND SKIP TO CALL BACK

NEVER HEARD OF SP ⇒ SEND CASE TO TRACKING

SP DECEASED ⇒ **GO TO S10**

SP INSTITUTIONALIZED, IN HOSPICE, HAS ESRD ⇒ **GO TO S11**

SP MOVED ⇒ **GO TO S12**

PERSON REFUSES FOR SP ⇒ SKIP TO CALL BACK

LANGUAGE BARRIER ⇒

IF SPOKEN LANGUAGE IS SPANISH ⇒ TRANSFER CALL TO SPANISH SPEAKING INTERVIEWER

IF SPOKEN LANGUAGE IS OTHER, ATTEMPT TO REACH PROXY ⇒ **GO TO S9**

IF NO PROXY AVAILABLE ⇒ SKIP TO SUPERVISOR REVIEW

S2. We recently mailed [SP] a letter about a study we are conducting for the Medicare program. The study is about the information [he/she] used to help pick a Medicare health insurance plan. We are calling people on Medicare to interview them over the telephone. When is a good time to call [SP]?

WHEN SP COMES TO THE PHONE ⇒ **GO TO S3**

SP BUSY, UNAVAILABLE, NOT HOME, NOT FEELING WELL, TEMPORARILY OUT OF THE AREA ⇒ ASK FOR BEST DAY AND TIME TO REACH SP AND SKIP TO CALL BACK

PERSON REFUSES FOR SP ⇒ SKIP TO CALL BACK

SP HAS HEARING/SPEECH DIFFICULTIES ⇒ **GO TO S9**

SP BUSY, UNAVAILABLE, NOT HOME, NOT FEELING WELL, TEMPORARILY OUT OF THE AREA ⇒ ASK FOR BEST DAY AND TIME TO REACH SP AND SKIP TO CALL BACK

SP UNABLE TO RESPOND ON PHONE ⇒ **GO TO S7**

SP DECEASED ⇒ **GO TO S10**

SP INSTITUTIONALIZED, IN HOSPICE, HAS ESRD ⇒ **GO TO S11**

SP MOVED ⇒ **GO TO S12**

S3. Hello, my name is [INTERVIEWER'S FULL NAME] from Mathematica - a research company in Princeton, New Jersey.

S4. We recently mailed you a letter about a study we are conducting for the Medicare program. The study is about the information you used to help pick a Medicare health insurance plan. We are calling people on Medicare to interview them over the telephone. Your participation is voluntary and all of your answers will be confidential. Could we begin the survey now?

YES ⇒ **GO TO S18**

NOT A GOOD TIME ⇒ SCHEDULE APPOINTMENT AND SKIP TO CALL BACK

SP REFUSES ⇒ SKIP TO CALL BACK

DID NOT RECEIVE LETTER

S5. The letter explained the study and explained that you were picked at random from a list of people on Medicare. The letter also explained that we would be calling to interview you. May we begin the interview?

YES ⇒ **GO TO S18**
NOT A GOOD TIME ⇒ SCHEDULE APPOINTMENT SKIP TO CALL BACK
SP REFUSES ⇒ SKIP TO CALL BACK
NO, WANTS ANOTHER LETTER

S6. Maybe we have the wrong address. VERIFY SP'S ADDRESS. IF NECESSARY ASK: May I have your current address so that I can mail you another letter? May I begin the interview now?

YES ⇒ RECORD NEW ADDRESS AND **GO TO S18**
NO, WANTS ANOTHER LETTER FIRST ⇒ SKIP TO CALL BACK

NO, WANTS TO SEE QUESTIONNAIRE FIRST/PREFERS TO SELF-COMPLETE ⇒ MAIL QUESTIONNAIRE AND SKIP TO CALL BACK

S7. We recently mailed a letter to [SP] explaining a study we are conducting for the Medicare program. The study is about the information [SP] used to help pick a Medicare health insurance plan. [SP's] participation is voluntary and all of [his/her] answers will be confidential. The interview takes about 20 minutes.

Will [SP] be able to talk on the telephone if I call back in a week or two?

YES
NO ⇒ **GO TO S9**
NOT SURE

S8. When would be a good time to call to see if [he/she] is up to it?

ENTER DATE AND TIME, SKIP TO CALL BACK AND END INTERVIEW.

S9. Is there a family member or friend who would be able to answer questions about information [SP] used to pick a Medicare health plan?

YES, SPEAKING TO PROXY ⇒ **GO TO S17**

YES, BUT PROXY NOT AVAILABLE ⇒ SCHEDULE APPOINTMENT, SKIP TO CALL BACK

NO PROXY AVAILABLE ⇒ SKIP TO CALL BACK

PROXY REFUSAL ⇒ SKIP TO CALL BACK

S10 I am very sorry to hear that [he/she] passed away. I was calling about a study we are conducting for the Medicare program but since [he/she] passed away, we won't be requesting any information. Thank you for your assistance. Please accept my condolences.

END OF INTERVIEW

S11 I am very sorry to hear that [he/she] [is institutionalized/is in a hospice/has ESRD]. I was calling about a study we are conducting for the Medicare program but since [he/she] [is institutionalized/is in a hospice/has ESRD] we won't be requesting any information. Thank you for your assistance.

END OF INTERVIEW

S12 We recently sent a letter to [SP] explaining the study we are conducting for the Medicare program. The study is about the information [SP] used to help choose a Medicare health insurance plan. Do you know how we can reach [SP]?

YES
NO ⇒ SEND TO TRACKING

S13 May I have [his/her] telephone number?

YES
NO/DON'T KNOW ⇒ **GO TO S15**

S14 INTERVIEWER: RECORD TELEPHONE NUMBER

|__|__|__| |__|__|__|-|__|__|__|__|
AREA CODE TELEPHONE NUMBER

S15 May I please have [her/his] address so that I can send [him/her] a letter about the study?

PROBE: Is there an apartment number?

STREET: _____ APT. NO. _____

CITY: _____

STATE: _____

ZIP CODE: |__|__|__|__|__| - |__|__|__|__|

S16 Thank you for your time. MAIL OUT LETTER

S17 Did [SP] discuss with you [his/her] reasons for picking a Medicare health plan - either original Medicare or a Medicare managed care plan? Did you help [him/her] make the decision to join the plan, did you make the decision for [him/her], or were you not involved at all? **PPRC-c1**

<1> SP DISCUSSED DECISION WITH PROXY
<2> PROXY PARTICIPATED IN DECISION
<3> PROXY MADE DECISION FOR SAMPLE MEMBER
<9> PROXY REFUSED ⇒ SKIP TO CALL BACK AND END INTERVIEW

S18 Before we begin I need to verify [your/SP's] date of birth. Is [your/SP's] date of birth [READ DATE OF BIRTH]?

YES ⇒ **GO TO Q1**
NO ⇒ **SEND TO SUPERVISOR REVIEW AND SAY:**
DON'T KNOW ⇒ **SEND TO SUPERVISOR REVIEW AND SAY:**
REFUSED ⇒ **SEND TO SUPERVISOR REVIEW AND SAY:**

I'm sorry but I'm having a problem with your birthdate. I need to check with my supervisor. One of us will get back to you.

QUESTION TEXT WILL DIFFER IF INTERVIEWER IS SPEAKING WITH SP (S5=YES), SPEAKING TO THE PROXY WHO KNOWS HOW SP MADE DECISIONS (S17 = <1> or <2>) OR TO THE PROXY WHO MADE THE DECISIONS FOR SP (S17=<3>).

1. A few years ago Congress made changes in the Medicare program to offer people on Medicare more health insurance options. [Do you/ Does SP] remember hearing about these changes? **MPR**

   YES
   NO
   DON'T REMEMBER
   REFUSED

2. How much do you feel [you know/SP knows] about the changes in the Medicare program? [Do you/does SP] feel [you know /he/she knows] just about everything [you need/he/she needs] to know, most of everything [you need/he/she needs] to know, some of what [you need/he/she needs], a little of what [you need/he/she needs], or almost none of what [you need/he/she needs] to know? **MAY1-17**

   JUST ABOUT EVERYTHING YOU NEED TO KNOW
   MOST OF WHAT YOU NEED TO KNOW
   SOME OF WHAT YOU NEED TO KNOW
   A LITTLE OF WHAT YOU NEED TO KNOW
   ALMOST NONE OF WHAT YOU NEED TO KNOW
   DON'T KNOW
   REFUSED

3. Since September, 1999, [have you/has SP] seen a booklet called *Medicare and You: 2000*? **MAY2-30**
   [PROBE: This is about a 57 page soft-cover, stapled booklet with a picture of the American flag on the cover. There is a dark red band across the bottom of the cover, with the words "Health Care Financing Administration, the Federal Medicare Agency."]

   YES
   NO
   DON'T KNOW
   REFUSED

4. Since September, 1999, [have you/has SP] heard of a toll-free (1-800) telephone number to answer any questions about Medicare? **MAY1-53**

   YES
   NO
   DON'T KNOW
   REFUSED

5. [Are you/Is SP] aware of any Internet Website providing information on Medicare? **MAY2-35**

   YES
   NO
   DON'T KNOW
   REFUSED

6. [Have you/Has SP] heard of any local health fairs, town meetings, or educational events about the changes in Medicare? **MPR**

   YES
   NO
   DON'T KNOW
   REFUSED

7. As far as [you know/SP knows], is there a one-on-one information service that people on Medicare can use to get help understanding and comparing health insurance options? **MCBS-27**

   YES
   NO
   DON'T KNOW
   REFUSED

8. [Have you/Has SP] ever called the toll-free 1-800 MEDICARE number to get information about Medicare or Medicare managed care? **MCBS-QBK55**

   PROBE: When I say managed care I mean a health plan that requires you to use doctors on their lists. Managed care plans are sometimes called HMOs. **Medicare+Choice, Nonenrollee. QB6.**

   YES
   NO ⇒ **GO TO Q9**
   DON'T KNOW ⇒ **GO TO Q9**
   REFUSED ⇒ **GO TO Q9**

   8a. [Were your/Was SP's] questions answered by the information you received from the toll-free number? **MCBS-QBK6 (Round 23)**

   YES
   NO
   DON'T KNOW
   REFUSED

9. **[IF Q5= NO, GO TO Q10]**
[Have you/has SP] ever used the official Medicare Website (www.Medicare.gov) to get information on Medicare or Medicare managed care? **MAY1-37**

YES
NO ⇒ **GO TO Q10**
DON'T KNOW ⇒ **GO TO Q10**
REFUSED ⇒ **GO TO Q10**

9a. [Were your/SP's] questions answered by the information you received? **MCBS-QBK6 (Round 23)**

YES
NO
DON'T KNOW
REFUSED

10. **[IF Q6= NO, GO TO Q11]**
[Have you/Has SP] ever gone to a health fair that discussed Medicare or Medicare managed care? **MPR**

YES
NO ⇒ **GO TO Q11**
DON'T KNOW ⇒ **GO TO Q11**
REFUSED ⇒ **GO TO Q11**

10a Was the health fair sponsored by [your own/SP's own] health plan, the Medicare program, an independent organization serving senior citizens or some other organization? CODE ALL THAT APPLY **MPR**

OWN HEATH PLAN
MEDICARE PROGRAM
INDEPENDENT ORGANIZATION SERVING SENIORS
ANOTHER ORGANIZATION
DON'T KNOW
REFUSED

10b [Were your/Were SP's] questions answered by the information [you/he/she] received at the health fair? **MCBS-QBK6 (Round 23)**

YES
NO
DON'T KNOW
REFUSED

11. [Have you/Has SP] ever gone to any meetings or lectures about Medicare or Medicare managed care? **MPR**

YES
NO ⇒ **GO TO Q12**
DON'T KNOW ⇒ **GO TO Q12**
REFUSED ⇒ **GO TO Q12**

11a Was the meeting or lecture sponsored by [your own/SP's own] health plan, the Medicare program, an independent organization serving senior citizens or some other organization? CODE ALL THAT APPLY **MPR**

OWN HEATH PLAN
MEDICARE PROGRAM
INDEPENDENT ORGANIZATION SERVING SENIORS
ANOTHER ORGANIZATION
DON'T KNOW
REFUSED

11b [Were your/Were SP's] questions answered by the information you received at the meeting or lecture? **MCBS-QBK6 (Round 23)**

YES
NO
DON'T KNOW
REFUSED

12. [Have you/Has SP] ever called or gone to a state-government sponsored one-to-one Medicare information program in [your/his/her] area to get help in understanding Medicare or Medicare managed care plans? **MPR**

YES
NO ⇒ **GO TO Q13**
DON'T KNOW ⇒ **GO TO Q13**
REFUSED ⇒ **GO TO Q13**

12a [Did you/SP] find out about the state information service from official Medicare materials? **MPR**

YES
NO
DON'T KNOW
REFUSED

12b [Were your/SP's] questions answered by the information [you/he/she] received? **MCBS-QBK6 (Round 23)**

YES
NO
DON'T KNOW
REFUSED

13. **[IF Q3= NO ⇒ GO TO Q17]**
Since September, 1999, [did you/SP] receive [your/his/her] own copy of a booklet called *Medicare and You: 2000* in the mail? **MCBS-BK28**

YES
NO ⇒ **GO TO Q17**
DON'T KNOW ⇒ **GO TO Q17**
REFUSED ⇒ **GO TO Q17**

14. Would you say [you have/SP has] read the booklet thoroughly, that [you/he/she] have read parts of it, or that [you/he/she] haven't read it at all? **MCBS-BK30**

READ IT THOROUGHLY
READ PARTS OF IT
HAVEN'T READ IT AT ALL ⇒ **GO TO Q17**
DON'T KNOW ⇒ **GO TO Q17**
REFUSED ⇒ **GO TO Q17**

15. How would [you/SP] rate the information in the booklet at helping [you/him/her] understand the advantages and disadvantages of each type of Medicare health insurance option? Would [you/he/she] rate the information as poor, fair, good, very good or excellent? **MAY1-82**

POOR
FAIR
GOOD
VERY GOOD
EXCELLENT
DON'T KNOW
REFUSED

16. [Do you/Does SP] still have a copy of the *Medicare and You: 2000* booklet? **MCBS-BK40**

YES
NO
DON'T KNOW
REFUSED

17. [Have you/Has SP] used any information from the federal government when making decisions about Medicare health insurance? **MPR**

    YES
    NO
    DON'T KNOW
    REFUSED

18. Now, I am going to read the names of some information sources about Medicare or Medicare managed care. When I read each one, please tell me "Yes" if [you/SP] got information from it, "No" if you didn't, or "Don't Know" if that is the case. **MPR**

    Did [you/SP] get information on Medicare or Medicare managed care from...

18a. The Medicare program	YES	NO	DK	REF
18b. [Your/SP's] health plan	YES	NO	DK	REF
18c. An employer or former employer?	YES	NO	DK	REF
18d. An organization serving senior citizens?	YES	NO	DK	REF
18e. Another organization?	YES	NO	DK	REF

Recently, Congress passed a law authorizing a program called Medicare+Choice, making many changes to the Medicare program. We're interested in what people covered by Medicare understand about the Medicare program. I'm going to read a series of statements about Medicare. For each one, please tell me whether [you think/SP thinks] it is true or false, or whether [you aren't/he/she isn't] sure. **MCBS BK43INT**

19. Most people covered by Medicare can select among different kinds of health plan options **within** Medicare.
    [PROBE: [Do you/Does SP] think this is true or false?] **MCBS BK43**

    TRUE
    FALSE
    NOT SURE
    REFUSED

20. Medicare **without** a supplemental insurance policy pays for all of your health care expenses.
    [PROBE: [Do you/Does SP] think this is true or false?] **MCBS BK44**

    TRUE
    FALSE
    NOT SURE
    REFUSED

21. People can report complaints to Medicare about their Medicare managed care plans (HMOs) or supplemental plans if they are not satisfied with them.
[PROBE: [Do you/Does SP] think this is true or false?] **MCBS BK47**

TRUE
FALSE
NOT SURE
REFUSED

22. If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they have limited choices about which doctors they can see and be covered under their HMO. [PROBE: [Do you/Does SP] think this is true or false?] **MCBS BK48**

TRUE
FALSE
NOT SURE
REFUSED

23. If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they can change or drop the plan and still be covered by Medicare.
[PROBE: [Do you/Does he/she] think this is true or false?] **MCBS BK49**

TRUE
FALSE
NOT SURE
REFUSED

24. If someone is not happy with their primary care physician they can switch to another physician. **MPR**

TRUE
FALSE
NOT SURE
REFUSED

25. The next questions are about the kinds of information [you/SP] might have looked for to help decide about Medicare health insurance. For each kind of information, please tell me "Yes" if [you have/SP has] ever tried to find it, "No" if [you haven't/SP hasn't], or "Don't know" if that is the case. **MPR**

Did [you/SP] ever try to find information about ...

25a. The Medicare coverage of specific medical services, like prescription drugs?	YES	NO	DK	REF
25b. What benefits to look for or to avoid in a Medicare managed care plan?	YES	NO	DK	REF
25c. The differences between original Medicare and Medicare managed care plans (HMOs)? **IF NO, GO TO Q26**.	YES	NO	DK	REF
25d. The quality of care ratings for Medicare managed care plans you were comparing?	YES	NO	DK	REF
25e. The cost of the premiums for Medicare managed care plans you were comparing?	YES	NO	DK	REF

26. Earlier you told me some Medicare information sources [you/SP] had looked at. Now, I'll read the names of some ***other*** sources. For each one, tell me "Yes" if [you've/SP has] looked for information from the source, "No" if [you haven't/SP hasn't], or "Don't Know" if that is the case. **MPR**.

Did [you/SP] ever look for information in or from...

26a. The library or newspapers?	YES	NO	DK	REF
26b. (**IF Q5=NO, GO TO 26c**) The Internet	YES	NO	DK	REF
26c. A former employer or union	YES	NO	DK	REF
26d. Your current health plan or insurance company	YES	NO	DK	REF
26e. Your local hospital, clinic or nursing home	YES	NO	DK	REF
26f. Organizations like AARP or other senior citizen organizations	YES	NO	DK	REF
26g. Your church, synagogue or mosque	YES	NO	DK	REF
26h. An organization that represents your ethnic or racial community	YES	NO	DK	REF
26i. Your family or friends	YES	NO	DK	REF
26j. Your doctor or other medical personnel	YES	NO	DK	REF

IF NO SOURCE USED ⇒ **GO TO Q30**
IF ONLY ONE SOURCE USED ⇒ **GO TO Q28**

27. You told me [you/SP] used information from [READ SOURCE/S]**. MPR**

27a. Which of these sources was the most helpful to [you/SP]? [PROBE: READ SOURCE/S AGAIN] MPR

CODE MOST HELPFUL SOURCE

27b. Which of these sources was the next most helpful to [you/SP]? [PROBE: READ SOURCE/S AGAIN] MPR

CODE NEXT MOST HELPFUL SOURCE

28. **IF ONE SOURCE NAMED**: You said [you/SP] used [SOURCE] as a source of information when making decisions about your health care.

IF MORE THAN ONE SOURCE WAS NAMED: You said [your/SP's] most helpful source was [MOST HELPFUL SOURCE].

28a. Did [you/SP] use [SOURCE/MOST HELPFUL SOURCE] to help the compare costs of different Medicare health insurance plans? **MPR**

YES
NO
DIDN'T FIND INFORMATION ON COSTS
DON'T REMEMBER
REFUSED

28b. Did [you/SP] use [SOURCE/MOST HELPFUL SOURCE] to help compare the benefits covered by Medicare health insurance plans? **MPR**

YES
NO
DIDN'T FIND INFORMATION ON BENEFITS
DON'T REMEMBER
REFUSED

28c. Did [you/SP] use [SOURCE/MOST HELPFUL SOURCE] to compare the quality of care given by Medicare managed care plans (HMOs)? MPR

[PROBE IF NEEDED: When I say managed care I mean a health plan that requires you to use doctors on their list. These plans are sometimes called HMOs. **Medicare+Choice, Nonenrollee. QB6.**

YES
NO
DIDN'T FIND INFORMATION ON QUALITY OF CARE
DON'T REMEMBER
REFUSED

28d. Did [you/SP] use [SOURCE/MOST HELPFUL SOURCE] to help understand how to sign up for different Medicare managed care plans (HMOs) if [you/he/she] wanted to? **MPR**

YES
NO
DIDN'T FIND ANY INFORMATION ON HOW TO SIGN UP
DON'T REMEMBER
REFUSED

28e. Did [you/SP] use [SOURCE/MOST HELPFUL SOURCE] to help understand how to drop out of a Medicare managed care plan (HMO) if [you/he/she] wanted to? **MPR**

YES
NO
DIDN'T FIND INFORMATION ON HOW TO DISENROLL
DON'T REMEMBER
REFUSED

29. Did [SOURCE/MOST HELPFUL SOURCE] help [you/SP] in making the decision to [stay in original Medicare/enroll in a Medicare managed care plan]? **MPR**

YES
NO
[PROXY/SP] SAYS SP WAS NEVER ENROLLED IN MANAGED CARE PLAN
[PROXY/SP] SAYS SP IS IN MANAGED CARE PLAN
DON'T REMEMBER
REFUSED

30. Some people have insurance policies that cover the health care costs that are not fully paid for by Medicare. These policies are called Medicare supplemental or Medigap policies. [Do you/Does SP] receive supplemental Medicare insurance or Medigap insurance through an employer? The employer could be [your/his/her] former or present employer or [your/his/her] spouse's former or present employer. **MPR**

    Do not count other types of policies that pay so many dollars per day for incidental expenses while [you are/SP is] in the hospital. **Medicare+Choice, Non-enrollee Questionnaire, I8**

    YES
    NO ⇒ **GO TO Q33**

31. Does this employer offer a choice of several health insurance plans or only one plan? **MPR**

    OFFER ONLY ONE PLAN
    OFFER A CHOICE OF PLANS ⇒ **GO TO Q33**

32. Is the employer's health insurance plan a Medicare managed care plan or a Medicare supplement or Medigap policy? **MPR**

    <1> MEDICARE MANAGED CARE PLAN
    <2> MEDICARE SUPPLEMENT OR MEDIGAP
    <8> DON'T KNOW
    <9> REFUSED

33. [Do you/Does SP] purchase any supplemental insurance on [your/his/her]own? [IF Q32=<2> or Q30=NO ⇒ DO NOT READ REST OF QUESTION]. Don't include the employer Medicare supplemental or Medigap insurance you just told me about. **MPR**

    YES
    NO
    DON'T KNOW
    REFUSED

34. IF SP SAMPLE TYPE = CONTROL ⇒ **GO TO Q35**
    The next questions are about the factors [you/SP] thought about when [you/he/she] decided to enroll in [NAME OF MANAGED CARE PLAN]. For each factor, tell me if it was very important, somewhat important or not at all important to [you/him/her] in making [your/his/her] decision. **MPR**

    IF PROXY OR SP INDICATES SP WAS NEVER IN MANAGED CARE PLAN ⇒ **GO TO Q35**.

How important to [your/SP's] decision to enroll in a managed care plan (HMO) was...
[PROBE: Was it very important, somewhat important or not important at all?]

34a. The cost of the premium?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER COST 5-FOUND NO INFORMATION	DK	REF
34b. The benefits covered?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3-NOT IMPORTANT AT ALL 4-DID NOT CONSIDER BENEFITS 5-FOUND NO INFORMATION	DK	REF
34c. The satisfaction of other members of the plan?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER OTHERS' SATISFACTION 5-FOUND NO INFORMATION	DK	REF
34d. The quality of care offered by the health plan?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER QUALITY 5-FOUND NO INFORMATION	DK	REF
34e. Being able to stay with your current doctors or other health care providers?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER STAYING WITH USUAL PROVIDERS 5-FOUND NO INFORMATION	DK	REF
34f. The amount of paperwork you would need to do to file a claim?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER PAPERWORK 5-FOUND NO INFORMATION	DK	REF
34g. The recommendations of family and friends?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER RECOMMENDATIONS	DK	REF
34h. **IF Q30=NO ⇒ GO TO Q34i** The fact that your employer offered to pay for managed care insurance?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-FOUND NO INFORMATION 5-NEVER WORKED	DK	REF
34i. The comparative information from the Medicare & You Handbook about the managed care plans available to you?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3-NOT IMPORTANT AT ALL 4-FOUND NO INFORMATION 5-NEVER WORKED	DK	REF

35. [Have you/Has SP] heard that some HMOs have stopped enrolling Medicare beneficiaries in their managed care plans? **MPR**

YES
NO ⇒ **GO TO Q36**
DON'T KNOW ⇒ **GO TO Q36**
REFUSED ⇒ **GO TO Q36**

35a. Did this information affect your decision to [stay in original Medicare/enroll in an HMO]? **MPR**

YES
NO
DIDN'T THINK ABOUT IT
DON'T KNOW
REFUSED

The next questions ask about [your/SP's] health.

36. In the past three months, how many times did [you/SP] go to a doctor's office or clinic? Please do not include any visits [you/SP] made to an emergency room. **Medicare+Choice, Enrollee Questionnaire, E5**

RECORD NUMBER OF DOCTOR/CLINIC VISITS: |__|__|

37. In the past three months, how many times did [you/SP] go to an emergency room? **MPR**

RECORD NUMBER OF EMERGENCY ROOM VISITS: |__|__|

38. In the past year, how many times [were you/was SP] hospitalized for one or more nights? **Medicare+Choice, Enrollee Questionnaire, E1**

RECORD NUMBER OF OVERNIGHT HOSPITAL STAYS: |__|__|

39. Now, I'm going to read a list of medical conditions. Please tell me if a doctor ever told [you/SP] that [you/SP] had any of these conditions. **MCBS HS23 (R16)**

Has a doctor ever told [you/SP] that [you/he/she] had...

39a. Hypertension, sometimes called high blood pressure? **MCBS HS23b (R16)**	YES	NO	DK	REF
39b. Hardening of the arteries or arteriosclerosis? **MCBS HS23a (R16)**	YES	NO	DK	REF
39c. A heart attack or heart disease of any kind? **MCBS HS23c,d (R16)**	YES	NO	DK	REF
39d. A stroke or brain hemorrhage? **MCBS HS 23f (R16)**	YES	NO	DK	REF
39e. Any kind of cancer, malignancy, or tumor other than skin cancer? **MCBS HS 23h (R16)**	YES	NO	DK	REF
39f. Diabetes, high blood sugar or sugar in your urine? **MCBS HS 23i (R16)**	YES	NO	DK	REF
39g. Rheumatoid arthritis? **MCBS HS 23k (R16)**	YES	NO	DK	REF

Now, I'm going to ask about some everyday activities and whether [you have/SP has]]had any difficulty doing them by [yourself/himself/herself]. **MPR**

40. Because of a health or physical problem [do you/does SP] have difficulty writing checks, paying bills, balancing a checkbook, or keeping financial records? **MCBS HS R16, Q5**

YES
NO
DOESN'T DO FOR OTHER REASONS
DON'T KNOW
REFUSED

41. [Do you/Does SP] have trouble filling out insurance or social security forms or assembling tax records? **FAQ 2**

SP HAS NEVER TAKEN CARE OF THIS
SP HAS SOME TROUBLE NOW
SP HAS SOME TROUBLE BUT SOMEONE HELPS
SP HAS NO TROUBLE WITH THIS
DON'T KNOW
REFUSED

42. [Do you/Does SP] have trouble playing games like bingo, bridge, or other card games, or working on a hobby like stamp collecting? **FAQ 8**

NEVER DID THESE THINGS
HAS SOME TROUBLE NOW
HAS SOME TROUBLE BUT SOMEONE HELPS
HAS NO TROUBLE WITH THIS
DON'T KNOW
REFUSED

43. IF S17= <3> ⇒ **GO TO Q44.**
Sometimes people make decisions about health insurance alone and sometimes with others. Who makes the decision about which Medicare health insurance plan [you/SP] will get? **[READ LIST IF NECESSARY] MAY1-65.**

SP ALONE MAKES THE DECISION
SP AND [HIS/HER] SPOUSE ALWAYS MAKE DECISIONS TOGETHER
SP AND A FAMILY MEMBER OR FRIEND
SP AND INSURANCE ADVISOR MAKE THE DECISION TOGETHER
SOMEONE ELSE MAKES THE DECISION FOR SP
DON'T KNOW
REFUSED

44. [Were you/Was SP] ever a member of a managed care plan (HMO) before [you/he/she] became eligible for Medicare? **PPRC-D2**.

YES
NO
DON'T KNOW
REFUSED

45. For some people, choosing a health insurance option is a very big or important decision and for others it is not as important. If [you/SP] were choosing a Medicare health insurance option today, how important would the choice be? Would it be very important, somewhat important, or not very important at all? **MAY2-44**

VERY IMPORTANT
SOMEWHAT IMPORTANT
NOT VERY IMPORTANT AT ALL
DON'T KNOW
REFUSED

46. What kinds of sources do [you/SP] prefer to go to for general information like local news, weather, or financial advice? I'll read a short list. Please tell me "Yes" or "No" for each. FOR EACH YES, How often do you use that source? **MPR**

SOURCE	**USED?**	**IF YES, HOW OFTEN USED?**
46a. Newspapers	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46b. Radio	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46c. Television	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46d. The Internet	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46e. Lectures	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46f. Published materials like books or magazine articles	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46g. Talk to an expert	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46h. Talk to [my/his/her] spouse	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46i. Talk to friends and other family members	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN

47. What is the highest grade or year of school [you have/SP has] completed? **MCBS-D13**

[1 - 12]
1 YEAR COLLEGE
2 YEARS COLLEGE (ASSOCIATE'S DEGREE)
3 YEARS COLLEGE
4 YEARS COLLEGE (BACHELORS DEGREE)
5 YEARS OF COLLEGE
6 YEARS OR MORE OF COLLEGE (MASTERS DEGREE, JD, MD, DOCTORATE)

48. What is [your/SP's] race? [Are you/is he/she] ... **OMB**

White
Black or African American
American Indian or Alaskan Native
Asian
Native Hawaiian or Other Pacific Islander
DON'T KNOW
REFUSED

49. What is [your/SP's] ethnicity? [Are you/Is he/she]... **OMB**

Hispanic or Latino
Not Hispanic or Latino
DON'T KNOW
REFUSED

50. [Are you/Is SP] currently married, widowed, divorced, separated, or never married? **Medicare+Choice, Enrollee Questionnaire, I2**

MARRIED
WIDOWED
DIVORCED
SEPARATED
NEVER MARRIED
DON'T KNOW
REFUSED

51. In studies like this, people are sometimes grouped together according to income. My next questions are about [your/SP's] household's income. By household I mean people who live together and share living expenses. **Medicare+Choice, Enrollee Questionnaire, I8**

    Is [your/SP's] yearly household income before taxes more than $20,000? Please count all sources of income, including Social Security, pension, retirement benefits, insurance dividends and any other income [you/SP] may have.

    YES ⇒ **GO TO Q54**
    NO ⇒ **GO TO Q56**
    DON'T KNOW
    REFUSED

52. Can you tell me [your/SP's] **monthly** household income? **Medicare+Choice, Enrollee Questionnaire, I9**

    YES
    NO ⇒ **GO TO Q56**
    DON'T KNOW ⇒ **GO TO Q56**
    REFUSED ⇒ **GO TO Q56**

53. What is [your/SP's] monthly income before taxes? Please count all sources of income, including Social Security, pension, retirement benefits, insurance dividends and any other income [you/SP] may have. **Medicare+Choice, Enrollee Questionnaire, I10**

    RECORD AMOUNT THEN ⇒ **GO TO Q56**
    DON'T KNOW ⇒ **GO TO Q56**
    REFUSED ⇒ **GO TO Q56**

54. Is [your/SP's] yearly household income before taxes more than $30,000? **Medicare+Choice, Enrollee Questionnaire, I11**

    YES ⇒ **GO TO Q55**
    NO ⇒ **GO TO Q56**
    DON'T KNOW ⇒ **GO TO Q56**
    REFUSED ⇒ **GO TO Q56**

55. Is [your/SP's] yearly household income before taxes more than $40,000? **Medicare+Choice, Enrollee Questionnaire, I12**

    YES
    NO
    DON'T KNOW
    REFUSED

    My last questions ask about your telephone.

56. During the past 12 months, was there any time when you did not have a working telephone in your household for two weeks or more? **MPR**

    YES
    NO
    DON'T KNOW
    REFUSED

57. For how many of the past 12 months did you not have a working telephone? **MPR**

    <0-12> MONTHS
    DON'T KNOW
    REFUSED

    Those are all the questions we have for you today. Thank you very much for participating.

EVALUATION OF NEW MEDICARE MEMBERS OF MEDICARE+CHOICE PLANS QUESTIONNAIRE

(SPANISH VERSION)

Screener (M+C New Enrollee/ Screener)

S1. (Buenos días/Buenas tardes). Mi nombre es [INTERVIEWER'S FULL NAME], y estoy llamando de Mathematica – una compañía de estudios en Princeton, New Jersey. ¿ Puedo hablar con [SP], por favor?

SPEAKING TO SP ⇒ **GO TO S4**

PERSON WHO ANSWERED WANTS TO KNOW WHAT CALL IS ABOUT ⇒ **GO TO S2**

WHEN SP COMES TO PHONE ⇒ **GO TO S3**

SP HAS HEARING/SPEECH DIFFICULTIES ⇒ **GO TO S9**

SP UNABLE TO RESPOND ON PHONE ⇒ **GO TO S7**

SP BUSY, UNAVAILABLE, NOT HOME, NOT FEELING WELL, TEMPORARILY OUT OF THE AREA ⇒ ASK FOR BEST DAY AND TIME TO REACH SP AND SKIP TO CALL BACK

NEVER HEARD OF SP ⇒ SEND CASE TO TRACKING

SP DECEASED ⇒ **GO TO S10**

SP INSTITUTIONALIZED, IN HOSPICE, HAS ESRD ⇒ **GO TO S11**

SP MOVED ⇒ **GO TO S12**

PERSON REFUSES FOR SP ⇒ SKIP TO CALL BACK

LANGUAGE BARRIER ⇒

IF SPOKEN LANGUAGE IS SPANISH ⇒ TRANSFER CALL TO SPANISH SPEAKING INTERVIEWER

IF SPOKEN LANGUAGE IS OTHER, ATTEMPT TO REACH PROXY ⇒ **GO TO S9**

IF NO PROXY AVAILABLE ⇒ SKIP TO SUPERVISOR REVIEW

S2. Recientemente le enviamos a [SP] una carta acerca de un estudio que estamos conduciendo para el programa de Medicare. El estudio es acerca de la información que (él/ella) usó para ayudarle(a) a escoger a un plan de seguro de salud de Medicare. Estamos llamando a gente registrada en Medicare, para conducir una entrevista por teléfono. ¿ Cuándo sería conveniente llamar a [SP]?

WHEN SP COMES TO THE PHONE ⇒ **GO TO S3**

SP BUSY, UNAVAILABLE, NOT HOME, NOT FEELING WELL, TEMPORARILY OUT OF THE AREA ⇒ ASK FOR BEST DAY AND TIME TO REACH SP AND SKIP TO CALL BACK

PERSON REFUSES FOR SP ⇒ SKIP TO CALL BACK

SP HAS HEARING/SPEECH DIFFICULTIES ⇒ **GO TO S9**

SP UNABLE TO RESPOND ON PHONE ⇒ **GO TO S7**

SP DECEASED ⇒ **GO TO S10**

SP INSTITUTIONALIZED, IN HOSPICE, HAS ESRD ⇒ **GO TO S11**

SP MOVED ⇒ **GO TO S12**

S3. (Buenos días/Buenas tardes). Mi nombre es [INTERVIEWER'S FULL NAME], y estoy llamando de Mathematica – una compañía de estudios en Princeton, New Jersey.

S4. Recientemente le enviamos a Ud. una carta acerca de un estudio que estamos conduciendo para el programa de Medicare. El estudio es acerca de la información que Ud. usó para ayudarle(a) a escoger a un plan de seguro de salud de Medicare. Estamos llamando a gente registrada en Medicare, para conducir una entrevista por teléfono. Su participación es voluntaria, y todas sus respuestas serán confidenciales. ¿ Podríamos comenzar la encuesta ahora?

YES ⇒ **GO TO S18**

NOT A GOOD TIME ⇒ SCHEDULE APPOINTMENT AND SKIP TO CALL BACK

SP REFUSES ⇒ SKIP TO CALL BACK

DID NOT RECEIVE LETTER

S5. La carta explicaba el estudio, y que Ud. fue escogido(a) al azar de una lista de gente registrada en Medicare. La carta también explicaba que ibamos a llamar para entrevistarlo(a). ¿ Podemos empezar la entrevista?

YES ⇒ **GO TO S18**

NOT A GOOD TIME ⇒ SCHEDULE APPOINTMENT SKIP TO CALL BACK

SP REFUSES ⇒ SKIP TO CALL BACK

NO, WANTS ANOTHER LETTER

S6. Quizás tenemos una dirección equivocada. VERIFY SP'S ADDRESS. IF NECESSARY ASK: ¿ Me puede dar su dirección actual para que le pueda enviar otra carta? ¿ Puedo empezar la entrevista ahora?

YES ⇒ RECORD NEW ADDRESS AND ⇒ **GO TO S18**

NO, WANTS ANOTHER LETTER FIRST SKIP TO CALL BACK

NO, WANTS TO SEE QUESTIONNAIRE FIRST/PREFERS TO SELF-COMPLETE ⇒ MAIL QUESTIONNAIRE AND SKIP TO CALL BACK

S7. Recientemente le enviamos a [SP] una carta explicando un estudio que estamos conduciendo para el programa de Medicare. El estudio es acerca de la información que [SP] usó para ayudarle(a) a escoger a un plan de seguro de salud de Medicare. La participación de [SP] es voluntaria, y todas sus respuestas serán confidenciales. La entrevista toma unos 20 minutos.

¿ Podrá [SP] hablar por teléfono, si vuelvo a llamar en una o dos semanas?

YES
NO ⇒ **GO TO S9**
NOT SURE

S8. ¿ Cuándo sería conveniente volver a llamar para ver si [él/ella] puede hablar?

ENTER DATE AND TIME, SKIP TO CALL BACK AND END INTERVIEW.

S9. ¿ Hay algún miembro de la familia o una amistad que podría contestar a preguntas acerca de la información que [SP] usó para escoger a un plan de seguro de salud de Medicare?

YES, SPEAKING TO PROXY ⇒ **GO TO S17**

YES, BUT PROXY NOT AVAILABLE ⇒ SCHEDULE APPOINTMENT, SKIP TO CALL BACK

NO PROXY AVAILABLE ⇒ SKIP TO CALL BACK

PROXY REFUSAL ⇒ SKIP TO CALL BACK

S10 Me apena mucho escuchar que [él/ella] falleció. Yo estaba llamando acerca de un estudio que estamos conduciendo para el programa de Medicare, pero como [él/ella] falleció, no vamos a pedir ninguna información. Le agradezco mucho por su asistencia. Y por favor acepte mi pésame.

END OF INTERVIEW

S11 Me apena mucho escuchar que [él/ella] [está en una institución/está en un hospicio/tiene una enfermedad de los riñones en su última etapa (ESRD – End Stage Renal Disease)]. Yo estaba llamando acerca de un estudio que estamos conduciendo para el programa de Medicare, pero como [él/ella] [está en una institución/está en un hospicio/tiene una enfermedad de los riñones en su última etapa (ESRD – End Stage Renal Disease)], no vamos a pedir ninguna información. Le agradezco mucho por su asistencia.

END OF INTERVIEW

S12 Recientemente le enviamos a [SP] una carta explicando un estudio que estamos conduciendo para el programa de Medicare. El estudio es acerca de la información que [SP] usó para ayudarle(a) a escoger a un plan de seguro de salud de Medicare. ¿ Sabe Ud. cómo nos podemos comunicar con [SP]?

YES
NO ⇒ SEND TO TRACKING

S13 ¿ Me puede dar su número de teléfono?

YES
NO/DON'T KNOW ⇒ **GO TO S15**

S14 INTERVIEWER: RECORD TELEPHONE NUMBER

|__|__|__| |__|__|__|-|__|__|__|__|
AREA CODE TELEPHONE NUMBER

S15 ¿ Me puede dar su dirección para que [le/la] pueda enviar una carta acerca del estudio?

PROBE: ¿ Hay un número de apartamento?

STREET: _____ APT. NO. _____

CITY: _____

STATE: _____

ZIP CODE: |__|__|__|__|__| - |__|__|__|__|

S16 Le agradezco por el tiempo que nos brindó. MAIL OUT LETTER

S17 ¿ Discutió [SP] con Ud. acerca de sus razones para escoger un plan de salud de Medicare – sea el Plan Original de Medicare, o un Plan Medicare de Salud Administrada (managed care)? ¿ Ud. [lo/la] ayudó a tomar la decisión de registrarse en el plan; Ud. tomó la decisión para [él/ella]; o Ud. no estuvo involucrado(a) en la decisión?

<1> SP DISCUSSED DECISION WITH PROXY

<2> PROXY PARTICIPATED IN DECISION

<3> PROXY MADE DECISION FOR SAMPLE MEMBER

<9> PROXY REFUSED ⇒ SKIP TO CALL BACK AND END INTERVIEW

S18 Antes de empezar, necesito verificar [su/la] fecha de nacimiento (de [SP])? ¿ Es [su/la] fecha de nacimiento (de [SP]) el [READ DATE OF BIRTH]?

YES ⇒ **GO TO Q1**

NO ⇒ **SEND TO SUPERVISOR REVIEW AND SAY:**

DON'T KNOW ⇒ **SEND TO SUPERVISOR REVIEW AND SAY:**

REFUSED ⇒ **SEND TO SUPERVISOR REVIEW AND SAY:**

Discúlpeme, pero tengo un problema con su fecha de nacimiento. Necesito hablar con mi supervisor(a). Le volveremos a llamar.

1. Hace unos años, el Congreso hizo cambios en el programa de Medicare, para ofrecer más opciones de seguro de salud a la gente registrada en Medicare. ¿ Se acuerda [usted/SP] si escuchó acerca de estos cambios?

   YES
   NO
   DON'T REMEMBER
   REFUSED

2. ¿ Cuánto cree Ud. que [usted/SP] sabe acerca de los cambios en el programa de Medicare? ¿ Cree [usted/SP] que [usted/él/ella] sabe casi todo lo que [usted/él/ella] necesita saber; la mayoría de todo lo que [usted/él/ella] necesita saber; algo de lo que [usted/él/ella] necesita saber; un poco de lo que [usted/él/ella] necesita saber; o casi nada de lo que [usted/él/ella] necesita saber?

   JUST ABOUT EVERYTHING YOU NEED TO KNOW
   MOST OF WHAT YOU NEED TO KNOW
   SOME OF WHAT YOU NEED TO KNOW
   A LITTLE OF WHAT YOU NEED TO KNOW
   ALMOST NONE OF WHAT YOU NEED TO KNOW
   DON'T KNOW
   REFUSED

3. Desde Septiembre de 1999, ¿ ha visto [usted/SP] un manual llamado *Medicare y Usted: 2000*?

   [PROBE: Este es un manual de unas 57 páginas con una portada con un dibujo de la bandera de los Estados Unidos. Hay una franja de color rojo oscuro en la parte de abajo de la portada, en la que está escrito: "Health Care Financing Administration, the Federal Medicare Agency."]

   YES
   NO
   DON'T KNOW
   REFUSED

4. Desde Septiembre de 1999, ¿ ha oído [usted/SP] de un número de teléfono para llamadas gratis (toll-free o del 1-800), donde contestan cualquier pregunta acerca de Medicare?

   YES
   NO
   DON'T KNOW
   REFUSED

5. ¿ Sabe [usted/SP] si hay algún sitio Web (Website) en el Internet que proporciona información acerca de Medicare?

   YES
   NO
   DON'T KNOW
   REFUSED

6. ¿ Ha escuchado [usted/SP] de alguna "feria de salud" local, de asambleas, o de eventos educacionales acerca de los cambios de Medicare?

   YES
   NO
   DON'T KNOW
   REFUSED

7. Según lo que [usted/SP] sabe, ¿ hay algún servicio de información individual que gente registrada en Medicare puede usar para recibir ayuda en comprender y en comparar opciones de seguro de salud

   YES
   NO
   DON'T KNOW
   REFUSED

8. ¿ Alguna vez ha llamado [usted/SP] al número para llamadas de teléfono gratis (toll-free): 1-800 MEDICARE, para recibir información acerca de Medicare o salud administrada (managed care) de Medicare?

PROBE: Cuando digo salud administrada, quiero decir un plan de salud que requiere que uno use a los doctores en sus listas. A veces les llaman a los planes de salud administrada Organizaciones de Mantenimiento de Salud o HMO.

YES
NO ⇒ **GO TO Q9**
DON'T KNOW ⇒ **GO TO Q9**
REFUSED ⇒ **GO TO Q9**

8a.¿ Fueron contestadas las preguntas que [usted/SP] tenía, por la información que recibió del número de teléfono gratis (toll-free)?

YES
NO
DON'T KNOW
REFUSED

9. **[IF Q5= NO, GO TO Q10]**
¿ Alguna vez ha usado [usted/SP] el "Website" oficial de Medicare (www.Medicare.gov) para recibir información acerca de un plan de Medicare o acerca de un plan de salud administrada de Medicare?

YES
NO ⇒ **GO TO Q10**
DON'T KNOW ⇒ **GO TO Q10**
REFUSED ⇒ **GO TO Q10**

9a.¿ Fueron contestadas las preguntas que [usted/SP] tenía, por la información que recibió?

YES
NO
DON'T KNOW
REFUSED

10. **[IF Q6= NO, GO TO Q11]**
¿ Alguna vez ha ido [usted/SP] a una “feria de salud” en la cual se discutió acerca de un plan de Medicare o de un plan de salud administrada de Medicare?

YES
NO ⇒ **GO TO Q11**
DON’T KNOW ⇒ **GO TO Q11**
REFUSED ⇒ **GO TO Q11**

10a ¿ Fue la “feria de salud” patrocinada por [su plan de salud/el plan de salud de SP]; por el programa de Medicare; por una organización independiente que sirve a personas mayores; o por alguna otra organización? CODE ALL THAT APPLY **MPR**

OWN HEATH PLAN
MEDICARE PROGRAM
INDEPENDENT ORGANIZATION SERVING SENIORS
ANOTHER ORGANIZATION
DON’T KNOW
REFUSED

10b¿ Fueron contestadas las preguntas que [usted/SP] tenía, por la información que recibió en la “feria de salud”? **MCBS-QBK6 (Round 23)**

YES
NO
DON’T KNOW
REFUSED

11. ¿ Alguna vez ha ido [usted/SP] a una reunion o una clase o conferencia (lecture) en la cual se discutió acerca de un plan de Medicare o de un plan de salud administrada de Medicare?

YES
NO ⇒ **GO TO Q12**
DON’T KNOW ⇒ **GO TO Q12**
REFUSED ⇒ **GO TO Q12**

11a ¿ Fue la reunion o la clase o conferencia (lecture) patrocinada por [su plan de salud/el plan de salud de SP]; por el programa de Medicare; por una organización independiente que sirve a personas mayores; o por alguna otra organización? CODE

ALL THAT APPLY
OWN HEATH PLAN
MEDICARE PROGRAM
INDEPENDENT ORGANIZATION SERVING SENIORS
ANOTHER ORGANIZATION
DON'T KNOW
REFUSED

11b ¿ Fueron contestadas las preguntas que [usted/SP] tenía, por la información que recibió en la reunion o la clase o conferencia (lecture)?

YES
NO
DON'T KNOW
REFUSED

12. ¿ Alguna vez llamó, o fue, [usted/SP] a un programa de información acerca de Medicare, patrocinada por el gobierno estatal en el área donde [usted/él/ella] vive, para recibir ayuda en comprender a un plan de Medicare o un plan de salud administrada de Medicare?

YES
NO ⇒ **GO TO Q13**
DON'T KNOW ⇒ **GO TO Q13**
REFUSED ⇒ **GO TO Q13**

12a ¿ Aprendió [usted/SP] acerca del servicio de información del estado, de materiales oficiales de Medicare? **MPR**

YES
NO
DON'T KNOW
REFUSED

12b ¿ Fueron contestadas las preguntas que [usted/SP] tenía, por la información que [usted/él/ella] recibió?

YES
NO
DON'T KNOW
REFUSED

13. **[IF Q3= NO ⇒ GO TO Q17]**
Desde Septiembre de 1999, ¿ recibió [usted/SP] en el correo, su propia copia de un manual llamado *Medicare y Usted: 2000* ?

YES
NO ⇒ **GO TO Q17**
DON'T KNOW ⇒ **GO TO Q17**
REFUSED ⇒ **GO TO Q17**

14. ¿ Diría Ud. que [usted/SP] lo ha leído a fondo, que [usted/él/ella] tan sólo ha leído en parte, que [usted/él/ella] no lo ha leído?

READ IT THOROUGHLY
READ PARTS OF IT
HAVEN'T READ IT AT ALL ⇒ **GO TO Q17**
DON'T KNOW ⇒ **GO TO Q17**
REFUSED ⇒ **GO TO Q17**

15. ¿ Cómo clasificaría [usted/SP] la información en el manual, en ayudarle(a) a [usted/él/ella] a entender las ventajas y las desventajas de cada tipo de opcion de seguro de salud de Medicare? ¿ Clasificaría [usted/él/ella] a la información como pobre, regular, buena, muy buena, o excelente?

POOR
FAIR
GOOD
VERY GOOD
EXCELLENT
DON'T KNOW
REFUSED

16. ¿ Aún tiene [usted/SP] una copia del manual *Medicare y Usted: 2000* ?

YES
NO
DON'T KNOW
REFUSED

17.¿ Ha usado [usted/SP] alguna información del gobierno federal cuando tomó decisiones acerca de seguro de salud de Medicare?

YES
NO
DON'T KNOW
REFUSED

18. Ahora, le voy a leer los nombres de algunas fuentes de información acerca de Medicare o de salud administrada de Medicare. Cuando yo le lea cada una, por favor diga "Sí", si [usted/SP] recibió información de esta fuente, "No", si no recibió, o "No sé", si ese es el caso.

18a. El programa de Medicare	YES	NO	DK	REF
18b. El plan de salud que [usted/SP] tiene	YES	NO	DK	REF
18c. Un lugar de empleo actual o anterior?	YES	NO	DK	REF
18d. Una organización que sirve a personas mayores?	YES	NO	DK	REF
18e. Alguna otra organización?	YES	NO	DK	REF

Recientemente, el Congreso pasó una ley autorizando un programa llamado Medicare + Choice (Medicare + Opción en español), que hace muchos cambios en el programa de Medicare. Estamos interesados en lo que la gente registrada en Medicare entiende acerca del programa de Medicare. Le voy a leer una serie de frases acerca de Medicare. Para cada una, por favor dígame si [usted/SP] piensa que es cierto o falso, o si [usted/él/ella] no está seguro.

19. La mayoría de la gente cubierta por Medicare puede hacer una selección entre varios tipos diferentes de opciones de planes de salud **dentro** de Medicare.
[PROBE: ¿ Piensa [usted/SP] que esto es cierto, o falso?]

TRUE
FALSE
NOT SURE
REFUSED

20. Medicare **sin** una póliza de seguro suplementario, paga por todos sus gastos de servicios de salud (health care).
[PROBE: ¿ Piensa [usted/SP] que esto es cierto, o falso?]

TRUE
FALSE
NOT SURE
REFUSED

21. La gente puede reportar quejas a Medicare acerca de sus planes de salud administrada de Medicare (HMOs) o planes suplementarios, si no está satisfecha con el plan.
[PROBE: ¿ Piensa [usted/SP] que esto es cierto, o falso?]

TRUE
FALSE
NOT SURE
REFUSED

22. Si alguien se registra en un plan de salud administrada de Medicare (HMO) que cubre a gente registrada en Medicare, tiene una selección limitada de doctores a los que puede ver y ser cubierto por su HMO.
[PROBE: ¿ Piensa [usted/SP] que esto es cierto, o falso?]

TRUE
FALSE
NOT SURE
REFUSED

23. Si alguien se registra en un plan de salud administrada de Medicare (HMO) que cubre a gente registrada en Medicare, puede cambiar o salir del plan, y permanece cubierto por Medicare.

[PROBE: ¿ Piensa [usted/SP] que esto es cierto, o falso?]

TRUE
FALSE
NOT SURE
REFUSED

24. Si alguien no está contento con su médico de atención primaria (primary care physician), puede hacer un cambio a otro doctor.

TRUE
FALSE
NOT SURE
REFUSED

25. Las próximas preguntas son acerca de los tipos de información que [usted/SP] quizás buscó para ayudar a decidir acerca de seguro de salud de Medicare. Para cada tipo de información, por favor díga "Sí", si alguna vez [usted/SP] trató de encontrarla, "No", si [usted/SP] no lo hizo, o "No sé", si ese es el caso.

¿ Alguna vez trató [usted/SP] de encontrar información acerca de . . . .

25a. La cobertura de Medicare para servicios médicos específicos, tales como drogas (o medicinas) recetadas?	YES	NO	DK	REF
25b. A cuales beneficios buscar o evitar en un plan de salud administrada de Medicare?	YES	NO	DK	REF
25c. Las diferencias entre el plan original de Medicare y planes de salud administrada de Medicare (HMOs)? **IF NO, GO TO Q26**.	YES	NO	DK	REF
25d. Los grados de calidad del cuidado (quality of care ratings) de salud administrada de Medicare que Ud. estaba comparando?	YES	NO	DK	REF
25e. El costo de las premias de los planes salud administrada de Medicare que Ud. estaba comparando?	YES	NO	DK	REF

26. Anteriormente Ud. me contó acerca de algunas fuentes de información de Medicare que [usted/SP] había visto. Ahora, le voy a leer los nombres de algunas ***otras*** fuentes. Para cada una, por favor díga "Sí", si alguna vez [usted/SP] buscó información de la fuente, "No", si [usted/SP] no lo hizo, o "No sé", si ese es el caso. **MPR**

¿ Alguna vez trató [usted/SP] de buscar información en (o de). . . .

26a. La biblioteca o en periódicos?	YES	NO	DK	REF
26b. (**IF Q5=NO, GO TO 26c**) El Internet?	YES	NO	DK	REF
26c. Un empleador anterior o un sindicato (union)?	YES	NO	DK	REF
26d. Su plan de salud o compañía de seguros actual?	YES	NO	DK	REF
26e. Su hospital, clínica o asilo de ancianos local?	YES	NO	DK	REF
26f. Organizaciones tales como el AARP u otras organizaciones de personas mayores?	YES	NO	DK	REF
26g. Su iglesia, sinagoga o mezquita?	YES	NO	DK	REF
26h. Una organización que representa a su comunidad racial o étnica?	YES	NO	DK	REF
26i. Su familia o amistades?	YES	NO	DK	REF
26j. Su doctor u otro personal médico?	YES	NO	DK	REF

IF NO SOURCE USED ⇒ **GO TO Q30**
IF ONLY ONE SOURCE USED ⇒ **GO TO Q28**

27. Ud. me dijo que [usted/SP] usó información de [READ SOURCE/S]**.**

27a. ¿ Cuál de estas fuentes fue la de más ayuda para [usted/SP]? [PROBE: READ SOURCE/S AGAIN] MPR

CODE MOST HELPFUL SOURCE

27b. ¿ Cuál de estas fuentes fue la segunda de más ayuda para [usted/SP]? [PROBE: READ SOURCE/S AGAIN] MPR

CODE NEXT MOST HELPFUL SOURCE

28. **IF ONE SOURCE NAMED**: Ud. dijo que [usted/SP] usó a [SOURCE] como una fuente de información cuando tomó decisiones acerca de sus servicios de salud (health care).

IF MORE THAN ONE SOURCE WAS NAMED: Ud. dijo que la fuente de más ayuda para [usted/SP] fue [MOST HELPFUL SOURCE].

28a. ¿ Usó [usted/SP] a [SOURCE/MOST HELPFUL SOURCE] para ayudar a comparar los costos de diferentes planes de salud de Medicare?

YES
NO
DIDN'T FIND INFORMATION ON COSTS
DON'T REMEMBER
REFUSED

28b. ¿ Usó [usted/SP] a [SOURCE/MOST HELPFUL SOURCE] para ayudar a comparar los beneficios cubiertos por diferentes planes de salud de Medicare?

YES
NO
DIDN'T FIND INFORMATION ON BENEFITS
DON'T REMEMBER
REFUSED

28c. ¿ Usó [usted/SP] a [SOURCE/MOST HELPFUL SOURCE] para comparar la calidad de los servicios o cuidado que dan planes de salud administrada (managed care) de Medicare (HMOs)?

[PROBE IF NEEDED: Cuando digo salud administrada, me refiero a un plan de salud que requiere usar a los doctores en su lista. A veces los llaman a estos planes HMOs.

YES
NO
DIDN'T FIND INFORMATION ON QUALITY OF CARE
DON'T REMEMBER
REFUSED

28d. ¿ Usó [usted/SP] a [SOURCE/MOST HELPFUL SOURCE] para ayudarle(a) a entender cómo enrolarse para diferentes planes de salud administrada de Medicare (HMOs), si [usted/él/ella] lo quería?

YES
NO
DIDN'T FIND ANY INFORMATION ON HOW TO SIGN UP
DON'T REMEMBER
REFUSED

28e. ¿ Usó [usted/SP] a [SOURCE/MOST HELPFUL SOURCE] para ayudarle(a) a entender cómo salir de un plan de salud administrada de Medicare (HMO), si [usted/él/ella] lo quería?

YES
NO
DIDN'T FIND INFORMATION ON HOW TO DISENROLL
DON'T REMEMBER
REFUSED

29. ¿ Le ayudó [SOURCE/MOST HELPFUL SOURCE] a [usted/SP] en tomar la decisión de [permanecer en el plan original de Medicare/enrolarse en un plan de salud administrada de Medicare]?

YES
NO
[PROXY/SP] SAYS SP WAS NEVER ENROLLED IN MANAGED CARE PLAN
[PROXY/SP] SAYS SP IS IN MANAGED CARE PLAN
DON'T REMEMBER
REFUSED

30. Algunas personas tienen pólizas de seguro que cubren los gastos de servicios de salud que no son completamente pagados por Medicare. Estas son llamadas pólizas de Seguro Suplemental de Medicare o Medigap. ¿ Recibe [usted/SP] Seguro Suplemental de Medicare o Medigap por medio de un empleador? El empleador podría ser su empleador anterior o actual, o el empleador anterior o actual de su esposa(o).

    Por favor no cuente otros tipos de pólizas que pagan cierto número de dólares por día para gastos incidentales mientras que [usted/SP] está en el hospital.

    YES
    NO ⇒ **GO TO Q33**

31. ¿ Ofrece este empleador una selección de varios planes de seguro de salud, o sólo ofrece un plan?

    OFFER ONLY ONE PLAN
    OFFER A CHOICE OF PLANS ⇒ **GO TO Q33**

32. ¿ Es el plan de seguro de salud del empleador un plan de salud administrada de Medicare, o una póliza suplemental de Medicare o Medigap?

    <1> MEDICARE MANAGED CARE PLAN
    <2> MEDICARE SUPPLEMENT OR MEDIGAP
    <8> DON'T KNOW
    <9> REFUSED

33. ¿Compra [usted/SP] algún seguro suplemental por sí mismo(a)? [IF Q32=<2> or Q30=NO ⇒ DO NOT READ REST OF QUESTION]. Por favor no incluya al seguro suplemental de Medicare o Medigap del empleador, del cual me acaba de contar.

    YES
    NO
    DON'T KNOW
    REFUSED

34. IF SP SAMPLE TYPE = CONTROL ⇒ **GO TO Q35**
    Las próximas preguntas son acerca de las cosas o los factores en los que [usted/SP] pensó, cuando [usted/él/ella] decidió enrolarse en [NAME OF MANAGED CARE PLAN]. Para cada factor, por favor dígame si esto fue muy importante, algo importante o no fue en nada importante para [usted/él/ella], en tomar su decisión.

IF PROXY OR SP INDICATES SP WAS NEVER IN MANAGED CARE PLAN ⇒ **GO TO Q35**.
¿ Cuán importante para [su decisión/la decisión de SP] de enrolarse en un plan de salud administrada (HMO) fue(ron) . . .
[PROBE: ¿ Fue muy importante, fue algo importante o no fue en nada importante?]

34a. El costo de la premia?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER COST 5-FOUND NO INFORMATION	DK	REF
34b. Los beneficios cubiertos?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3-NOT IMPORTANT AT ALL 4-DID NOT CONSIDER BENEFITS 5-FOUND NO INFORMATION	DK	REF
34c. La satisfacción de otros miembros del plan?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER OTHERS' SATISFACTION 5-FOUND NO INFORMATION	DK	REF
34d. La calidad de los servicios ofrecidos por el plan de salud?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER QUALITY 5-FOUND NO INFORMATION	DK	REF
34e. Poder quedarse con sus actuales doctores u otros proveedores de servicios de salud?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER STAYING WITH USUAL PROVIDERS 5-FOUND NO INFORMATION	DK	REF
34f. La cantidad de papeleo que tendría que hacer para hacer un reclamo?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER PAPERWORK 5-FOUND NO INFORMATION	DK	REF
34g. Las recomendaciones de su familia y sus amistades?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-DID NOT CONSIDER RECOMMENDATIONS	DK	REF
34h. **IF Q30=NO ⇒ GO TO Q34i** El hecho que su empleador ofreció pagar por seguro de salud administrada?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-FOUND NO INFORMATION 5-NEVER WORKED	DK	REF
34i. La información de comparación en el Manual Medicare y Usted, acerca de los planes de salud administradad que están a su disposición?	1-VERY IMPORTANT 2-SOMEWHAT IMPORTANT 3- NOT IMPORTANT AT ALL 4-FOUND NO INFORMATION 5-NEVER WORKED	DK	REF

35. ¿ Ha [usted/SP] oído que algunos HMOs han parado de enrolar a beneficiarios de Medicare en sus planes de salud administrada?

YES
NO ⇒ **GO TO Q36**
DON'T KNOW ⇒ **GO TO Q36**
REFUSED ⇒ **GO TO Q36**

35a. ¿ Afectó esta información a su decisión de [permanecer en Medicare original/enrolarse en un HMO]?

YES
NO
DIDN'T THINK ABOUT IT
DON'T KNOW
REFUSED

Las próximas preguntas son acerca de [su salud/la salud de SP].

36. En los últimos tres meses, ¿ cuántas veces fue [usted/SP] al consultorio de algún doctor o a una clínica? Por favor no incluya cualquier visita que [usted/SP] hizo a una sala de emergencia.

RECORD NUMBER OF DOCTOR/CLINIC VISITS: |__|__|

37. En los últimos tres meses, ¿ cuántas veces fue [usted/SP] a una sala de emergencia?

RECORD NUMBER OF EMERGENCY ROOM VISITS: |__|__|

38. En el último año, ¿ cuántas veces estuvo [usted/SP] internado(a) en un hospital por una noche o más?

RECORD NUMBER OF OVERNIGHT HOSPITAL STAYS: |__|__|

39. Ahora le voy a leer una lista de condiciones de salud (médicas). Por favor dígame si un doctor alguna vez le dijo a [usted/SP] que [usted/SP] tenía o sufría de cualquiera de estas condiciones.

¿ Alguna vez le dijo a [usted/SP] un doctor que [usted/él/ella] tenía (o tuvo) . . .

39a. Hipertensión, que a veces es llamada presión arterial alta?	YES	NO	DK	REF
39b. Arterioesclerosis, o calcificación de las arterias?	YES	NO	DK	REF
39c. Un ataque o infarto del corazón, o cualquier tipo de enfermedad del corazón?	YES	NO	DK	REF
39d. Un infarto o hemorragia cerebral?	YES	NO	DK	REF
39e. Cualquier tipo de cáncer, malignidad, o tumor, fuera de cáncer cutáneo (de la piel)?	YES	NO	DK	REF
39f. Diabetes, alto nivel de azúcar en la sangre, o azúcar en su orina?	YES	NO	DK	REF
39g. Artritis reumatoide?	YES	NO	DK	REF

Ahora le voy a preguntar acerca de algunas actividades cotidianas, y si [usted/SP] ha tenido alguna dificultad en hacerlos por sí mismo(a).

40. Por causa de un problema físico o de salud, ¿ tiene [usted/SP] alguna dificultad en escribir cheques, en pagar cuentas, en hacer el balance de su talonario de cheques (checkbook) o en mantener sus archivos financieros?

YES
NO
DOESN'T DO FOR OTHER REASONS
DON'T KNOW
REFUSED

41. ¿ Tiene [usted/SP] algún problema en llenar formularios de seguros o del Social Security (Seguro Social), o en reunir su archivo de impuestos?

SP HAS NEVER TAKEN CARE OF THIS
SP HAS SOME TROUBLE NOW
SP HAS SOME TROUBLE BUT SOMEONE HELPS
SP HAS NO TROUBLE WITH THIS
DON'T KNOW
REFUSED

42. ¿ Tiene [usted/SP] algún problema en jugar Bingo o en juegos de cartas o naipes, o en ocuparse en una afición (hobby) tal como una colección de estampillas?

NEVER DID THESE THINGS
HAS SOME TROUBLE NOW
HAS SOME TROUBLE BUT SOMEONE HELPS
HAS NO TROUBLE WITH THIS
DON'T KNOW
REFUSED

43. IF S17= <3> ⇒ **GO TO Q44.**
A veces uno toma decisiones acerca de seguro de salud sólo, y a veces se hace esto con otros. ¿ Quién toma la decisión acerca de cual plan de seguro de salud de Medicare [usted/SP] obtendrá? **[READ LIST IF NECESSARY]**

SP ALONE MAKES THE DECISION
SP AND [HIS/HER] SPOUSE ALWAYS MAKE DECISIONS TOGETHER
SP AND A FAMILY MEMBER OR FRIEND
SP AND INSURANCE ADVISOR MAKE THE DECISION TOGETHER
SOMEONE ELSE MAKES THE DECISION FOR SP
DON'T KNOW
REFUSED

44. ¿ Fue [usted/SP] alguna vez miembro de un plan de salud administrada (HMO), antes de que [usted/él/ella] fue elegible para Medicare?

YES
NO
DON'T KNOW
REFUSED

45. Para alguna gente, escoger una opción de seguro de salud es una decisión muy grande o importante, para otros no es tan importante. Si [usted/SP] estaría escogiendo una opción de seguro de salud de Medicare hoy, ¿ cuán importante sería esta selección? ¿ Sería muy importante, algo importante, o no sería muy importante?

VERY IMPORTANT
SOMEWHAT IMPORTANT
NOT VERY IMPORTANT AT ALL
DON'T KNOW
REFUSED

46. ¿ Qué tipos de fuentes prefiere [usted/SP] para recibir información general tal como sus noticias locales, el clima, o consejo financiero? Le voy a leer una corta lista. Por favor dígame "Sí" o "No", para cada una. FOR EACH YES: ¿ Con qué frecuencia usa esa fuente?

SOURCE	USED?	IF YES, HOW OFTEN USED?
46a. Periódicos	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46b. Radio	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46c. Televisión	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46d. El Internet	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46e. Conferencias o clases	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46f. Materiales publicados, tales como libros o artículos en revistas	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46g. Habla con un experto	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46h. Habla con [mi/su] esposo(a)	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN
46i. Habla con amistades y otros miembros de la familia	YES ⇒ NO DK REF	VERY OFTEN OFTEN NOT VERY OFTEN

47. ¿ Cuál es el grado o año de escuela más alto que [usted/SP] ha completado?

    [1 - 12]
    1 YEAR COLLEGE
    2 YEARS COLLEGE (ASSOCIATE'S DEGREE)
    3 YEARS COLLEGE
    4 YEARS COLLEGE (BACHELORS DEGREE)
    5 YEARS OF COLLEGE
    6 YEARS OR MORE OF COLLEGE (MASTERS DEGREE, JD, MD, DOCTORATE)

48. ¿ Cuál es [su raza/la raza de SP]? ¿ Es [usted/él/ella] . . .

    Blanco(a)
    Negro(a) o africano(a)-americano(a)
    Amerindio(a), indígena, o nativo(a) de Alaska
    Asiático(a)
    Nativo(a) de Hawaii o de las islas del Pacífico
    DON'T KNOW
    REFUSED

49. ¿ Cuál es su etnicidad? ¿ Es [usted/él/ella] . . .

    Hispano(a) o latino(a)
    No es hispano(a) o latino(a)
    DON'T KNOW
    REFUSED

50. Actualmente, ¿ está [usted/SP] casado(a), es viudo(a), divorciado(a), separado(a) o nunca se ha casado?

    MARRIED
    WIDOWED
    DIVORCED
    SEPARATED
    NEVER MARRIED
    DON'T KNOW
    REFUSED

51. En estudios como este, a veces se agrupa a la gente según sus ingresos. Mis próximas preguntas son acerca de los ingresos del hogar [suyo/de SP]. Por su hogar, me refiero a personas que viven juntas y comparten gastos de subsistencia.

    ¿ Son los ingresos anuales [de su hogar/del hogar de SP], antes de impuestos, más de $20,000? Por favor cuente todas las fuentes de ingreso, incluyendo Social Security (Seguro Social), pensión, beneficios de jubilación, dividendos de seguros, o cualquier otro ingreso que [usted/SP] tiene.

    YES ⇒ **GO TO Q54**
    NO ⇒ **GO TO Q56**
    DON'T KNOW
    REFUSED

52. ¿ Me puede decir cuál es el ingreso **mensual** de [su hogar/el hogar de SP]?

    YES
    NO ⇒ **GO TO Q56**
    DON'T KNOW ⇒ **GO TO Q56**
    REFUSED ⇒ **GO TO Q56**

53. ¿ Cuál es [su ingreso mensual/el ingreso mensual de SP], antes de impuestos? Por favor cuente todas las fuentes de ingreso, incluyendo Social Security (Seguro Social), pensión, beneficios de jubilación, dividendos de seguros, o cualquier otro ingreso que [usted/SP] tiene.

    RECORD AMOUNT THEN ⇒ **GO TO Q56**
    DON'T KNOW ⇒ **GO TO Q56**
    REFUSED ⇒ **GO TO Q56**

54. ¿ Son los ingresos anuales [de su hogar/del hogar de SP], antes de impuestos, más de $30,000?

    YES ⇒ **GO TO Q55**
    NO ⇒ **GO TO Q56**
    DON'T KNOW ⇒ **GO TO Q56**
    REFUSED ⇒ **GO TO Q56**

55. ¿ Son los ingresos anuales [de su hogar/del hogar de SP], antes de impuestos, más de $40,000?

    YES
    NO
    DON'T KNOW
    REFUSED

Mis últimas preguntas son acerca de su teléfono.

56. Durante los últimos 12 meses, ¿ hubo algún tiempo cuando no tenía en su hogar un teléfono que funcionaba, por dos semanas o más?

    YES
    NO
    DON'T KNOW
    REFUSED

57. ¿ Por cuántos de los últimos 12 meses no ha tenido Ud. un teléfono que funciona?
    <0-12> MONTHS
    DON'T KNOW
    REFUSED

Esas son todas las preguntas que tenemos para Ud. hoy. Muchas gracias por haber participado.