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Beneficiaries, Their Physicians, and Supplemental Coverage: Findings from Focus Groups in August and September 2008

Report Submitted to the Medicare Payment Advisory Commission

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EXECUTIVE SUMMARY

In August and September 2008, researchers at NORC and Georgetown University conducted a series of focus groups with Medicare beneficiaries addressing experiences with their physicians and their supplemental insurance arrangements. Nine groups, with a total of 103 beneficiaries, were conducted in three different markets: Richmond, Virginia; Albany, New York; and Albuquerque, New Mexico.

Medical Homes

In its June 2008 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommended the establishment of a medical home pilot program in Medicare. One goal of the focus groups was to learn about beneficiaries' experience with the underlying components of the medical home. Most reported that they had a regular doctor and that their doctors knew them, reminded them about preventive services, and kept track of the drugs they were using (even when prescribed by other doctors). Many also reported reasonably good coordination across the different doctors they visited, but this feeling was not universally held. By contrast, many did not feel they had reliable 24-hour access to their physicians, and few said that electronic medical records were being used. While several of the elements that comprise the medical home concept seem widespread among these beneficiaries, it would take a more extensive look behind the scenes of the medical practices to learn whether medical homes were truly in place. Almost no beneficiaries were aware of the term "medical home," and many disliked the term when introduced to it.

Access to Physicians

Another goal of the focus groups was to explore access to physician services in several markets. Surveys conducted by MedPAC have found few such problems. Similarly, participants in these focus groups mostly did not report major problems with physician access. Many had longstanding relationships with the same doctor and thus had not recently searched for a new doctor. Some had heard about problems from friends and family members – most commonly in Albuquerque and least often in Albany. The few problems that were reported tended to be getting an appointment with a new specialist. Even these could often be overcome with intervention of their primary care physician.

INTRODUCTION

For this project conducted under contract with the Medicare Payment Advisory Commission (MedPAC), researchers at NORC and Georgetown University conducted a series of focus groups with Medicare beneficiaries addressing experiences with their physicians and their supplemental insurance plans. The topics discussed related to three current policy issues:

- **Medical homes.** The concept of the medical home has been explored by MedPAC as a model that might improve primary care and care coordination for Medicare beneficiaries. Beneficiaries shared their experiences with various components of the medical home model, as well as their thoughts on the term "medical home."

- **Access to physicians.** As part of its annual analysis to support recommendations on fee schedule updates, MedPAC examines beneficiary access to physician services. To help MedPAC explore this issue, researchers asked beneficiaries to share their experiences regarding finding a new physician to see them, as well as getting an appointment with physicians with whom they had an existing relationship.

- **Supplemental insurance and Medicare Advantage.** Recent experiences with marketing in the Medicare Advantage program have led Congress and CMS to focus on tightening the rules related to marketing. Beneficiaries shared their experiences with both supplemental insurance and Medicare Advantage plans.

We conducted a total of nine focus groups in August and September 2008, in three markets: Richmond, Virginia; Albany, New York; and Albuquerque, New Mexico.[1] A total of 103 beneficiaries participated in the nine sessions – 34 in Richmond, 33 in Albany, and 36 in Albuquerque. The three locations were selected to provide a diversity of physician supply and Medicare Advantage enrollment. We limited the number of Medicare Advantage (MA) enrollees in each group to be roughly proportionate to the percentage of the local Medicare population enrolled in Medicare Advantage. Questions on demographic characteristics were also asked during the screenings to ensure a mix of beneficiaries. In Albany, the groups included some beneficiaries whose primary physician was part of a practice that some experts have identified as a medical home.

Each focus group lasted for approximately 90 minutes. All participants received an honorarium for participating. The discussions were facilitated by researchers from NORC and Georgetown University, with two moderators leading each group. Discussion protocols were used as guides, but the discussions were also free-flowing, built on participants' responses. Each discussion was recorded and transcribed. Quotes included in this report are taken verbatim from those transcriptions. All procedures and protocols for the focus groups were approved by the Institutional Review Boards (IRBs) at both NORC and Georgetown, and participants were promised that their names and other identifying information would be protected.

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[1] The Richmond focus groups were held in a suburban location but drew participants from throughout the metropolitan area. The Albany focus groups were held in a nearby town (Clifton Park) and drew participants from a variety of locations near Albany, Troy, and Schenectady.

MEDICAL HOMES

A medical home is a health care environment that provides continuity, integration and coordination of health care. It furnishes primary care to patients and conducts care management—coordinating with specialists, hospitalists, and pharmacists; reminding patients about preventive care; providing 24-hour patient communication and rapid access; and serving as the patient's first point of contact for medical care or questions. Various types of health information technology, such as electronic medical records (EMRs), are often considered a key component of a medical home.

In its June 2008 report to the Congress, MedPAC describes the potential role for the medical home in Medicare as part of a broader set of initiatives to promote the use of primary care. In particular, the Commission recommended the establishment of a medical home pilot program in Medicare. It suggested that this pilot should be on a scale that allows testing of "the hypothesis that medical homes can improve the quality and efficiency of care for patients with multiple chronic conditions."[2]

One goal of the focus groups was to learn about beneficiaries' experience with the various components of the medical home in their normal course of receiving medical care. In addition, we sought to learn whether they were aware of the term or how they reacted when introduced to it. This section details what we heard from beneficiaries on this topic.

Regardless of whether beneficiaries received care from practices that are more or less involved with the medical home concept, most of the beneficiaries in the focus groups had received care consistent with some of the major elements of a medical home. In particular, most participants had a regular doctor and reported that their doctors provided them reminders about preventive services and maintained good knowledge of prescriptions used. Many also indicated a sense that their various doctors communicated about their care and that their primary physicians played a role in coordinating their care, but this sense was not universally held. By contrast, many participants did not feel that they had reliable 24-hour access to their physicians, and few reported that electronic medical records were used by their physicians.

Evidence of the medical home environment varied across the three communities in which the focus groups were conducted. Participants in Albany and Albuquerque were more likely to report the presence of key elements than those in Richmond. In Albuquerque, Medicare managed care plans played a large role in creating medical home systems for beneficiaries.

Evidence that beneficiaries were experiencing some of the elements of the medical home does not necessarily mean that their physicians' practices would meet all or most of the requirements of a medical home. While some of their physicians may be incorporating the key elements in their practices, others may simply be providing good medical care to these patients, many of whom had relatively long personal relationships with their doctors. And some of these participants reported taking an active role themselves in making sure that their doctors were

[2] Medicare Payment Advisory Commission, *Report to the Congress: Reforming the Delivery System*, Chapter 2, June 2008.

communicating or that changes in prescriptions were being tracked regularly. It would take a more extensive look behind the scenes of the medical practices to determine whether these patients were experiencing all the benefits promised by the medical home model.

Physician Relationships

Almost all of the beneficiaries reported that they had a regular doctor. This doctor was usually a primary care physician, but sometimes a specialist, such as a cardiologist or oncologist, functioned as a primary doctor. Some beneficiaries had developed close relationships with their doctors for more than a decade, and most felt their doctors knew them well. Several also had ongoing relationships with staff at the doctors' offices. However, some struggled to find doctors with whom they could connect. One woman had chosen to see a nurse practitioner on a regular basis for primary care and was pleased with her choice. A few beneficiaries did not have regular doctors, in some cases by choice.

In general, beneficiaries characterized their doctors as busy individuals. Most beneficiaries said they got adequate time with their doctors, though some beneficiaries expressed concern about their short appointments. Appointment length varied depending on the reason for the visit. Physicals tended to last longer, up to an hour for some beneficiaries, though as little as twenty minutes for others. Appointments made for specific reasons or for follow up were shorter in duration. Fifteen minutes appeared to be the average appointment time. In Albuquerque beneficiaries were particularly cognizant of doctor's busy schedules – they were especially appreciative of the time their doctors spent with them.

After-Hours Access

Beneficiaries had different experiences with round-the-clock or after-hours access to their doctors. Many beneficiaries had not attempted to contact their doctors after hours and some simply assumed that their doctors would not be available. Among those who have tried to reach a physician after hours, there were some who reported having round-the-clock access to someone from their practice by phone, but some only could reach a physician during office hours.

Beneficiaries whose physician practices had after-hours phone systems generally reported that if they called their doctors after hours they could leave a message and would get a return call from a doctor or triage nurse – someone was always on call. Of our three sites, this was most common in Albuquerque. Further probing with beneficiaries in Albuquerque suggests that after-hours access for some was obtained through their Medicare Advantage plan, not directly from the physician's office. A few beneficiaries whose doctors had an after-hours system expressed frustration at the time-consuming nurse screening process and their inability to talk directly to doctors. One beneficiary said that she had left a message for her doctor, but when she did not receive a call back promptly she had to go to the emergency department.

Some beneficiaries – particularly in Richmond – said there was no on-call system in their doctor's offices. Their doctors' message machines instructed them either to call back during working hours or to go to the emergency room. These beneficiaries opted to wait until business hours, or visit an emergency department or urgent care clinic if they felt they needed care more

immediately. However, they were aware of the potential of very long wait times in emergency facilities. As one beneficiary put it, “I think Sundays are a lost day for medicine frankly, we have had terrible luck. Saturdays are a little bit better.”

Communication and Coordination

Communication among doctors, a vital part of a medical home, was mixed according to focus group participants. While there were reports of some primary doctors and specialists communicating regularly, many beneficiaries felt that they had to take the initiative to ensure their primary care doctor received reports from their specialists. Some beneficiaries expressed concern that their doctors did not communicate with their specialists and were thus not up to date on their care situation. In a few cases, beneficiaries had doctors that were in constant communication, faxing new and important information about their patients or, in Albuquerque, sharing it via an electronic medical records system. Some beneficiaries indicated that they made sure to ask their specialists to send reports back to their primary care physicians. It appears that the best communication among the multiple doctors occurred where doctors used electronic medical records.

Most beneficiaries reported that if nothing else, their physicians monitored their prescriptions by asking them to update the list of drugs that they take each time they come in for a visit. There was more variation in whether specialists shared information about newly prescribed medications with patients’ primary care doctors. Many beneficiaries kept track of their own prescriptions and were aware that this was an important thing to do. In fact, many carried a list of their medications with them at all times. One told us:

> I find that to be very, very helpful in my agenda book that I keep listing them all the time. I have a list of all my medications with milligram and everything, because sometimes you might have to go to the ER or something and they want to know what you’re on, so if you keep that with you, you have it accessible when it’s needed.

We asked beneficiaries whether they had experienced any adverse outcomes related to a lack of communication – repeated tests, harmful drug interactions, or conflicting advice. None had any recent examples of such problems. Many pointed to the potential for these problems as the reason they try to take responsibility for getting reports and other information back to their primary care doctor.

Preventive Care

Many beneficiaries reported receiving preventive medicine reminders from their physicians. In general, these appeared to be reminders during office visits or annual physicals. Most beneficiaries said their doctors reminded them to get flu shots, but only some reported receiving mailed reminders. Many were given standard screenings such as EKGs. A few beneficiaries felt they had to take initiative with their preventive care, requesting tests when they visited their doctors. A number of people in Albuquerque mentioned that their health plans send newsletters with information about the preventive care they need and how to get it.

Information Technology

The integration of technology in health care for Medicare beneficiaries differed substantially by location. Electronic medical records were common for participants in the Albuquerque focus groups.[3] Many beneficiaries in Albany also said their doctors used electronic records. Patients familiar with electronic medical records said they worked quite well. However, beneficiaries who had not experienced EMRs did not agree about whether they would like their doctors to use such a system. Some had concerns about confidentiality and security issues, such as identity theft. For example one beneficiary told us, "I don't want my business on the computer." Others agreed that having information on a centralized computer system would be helpful and efficient:

> I think it would be beneficial for doctors to do it because of the time involved, it's amazing what they could find out in a couple of seconds that goes on a fax machine or making phone calls, and you're sitting in the office waiting for all of that stuff to happen it could be hours. If it was computerized, I think it would be beneficial financially, in time, everything.

Email was rarely used to communicate with doctors, and most beneficiaries did not seem interested in pursuing this as an option. One man did say that he communicated with his doctor via email.

The Term "Medical Home"

Very few beneficiaries had ever heard the term "medical home." When presented with the term, most said they disliked it. Many said they felt it connoted a nursing home or a service for disabled persons.

One participant in Albuquerque said that the term medical home could symbolize a positive idea of a family environment that is concerned about the broader context of one's health, and several others agreed with that sentiment. But others in that group responded that this notion could also be construed as suggesting an overly protective parent.

Some others responded positively, such as a participant who suggested:

> I like the idea that it is somehow focused on my medical. So something like a personal medical plan or personal medical program. It attaches both personal and medical together somehow.

Focusing on the concept of having all of their health information available in one centralized location, one Richmond focus group concluded that it would be good to use the term "repository" to describe medical home services. Some said a medical home sounded like a general awareness of health:

[3] Among beneficiaries who reported that their doctors used EMRs, some may have witnessed simply the use of a computer for basic information or computer-printed prescriptions rather than full EMRs. However, we confirmed with these patients that they no longer see nurses or physicians reading or entering information into paper charts.

> The key word that comes to me in this medical home concept is awareness, like medical awareness, life awareness, something like that would mean more to me then medical home.

Focus group participants had mixed feelings about where the responsibility of health care coordination fell. Many beneficiaries noted that their doctors already coordinate care, and this was something they expected of their doctors. On the other hand, some were sensitive to doctors' schedules and expressed doubt that doctors would ever have time to provide a medical home environment.

Other beneficiaries argued that it should be up to the patient to coordinate his or her care, and some told us of many things they did to keep records and remind their doctors to share tests and reports with each other. However, many recognized that it can become difficult with illness, age, and lack of resources to maintain this role. A few beneficiaries specifically mentioned that individuals with Alzheimer's disease can be difficult to care for and would benefit from a medical home environment:

> I hear other people being [advocates] for themselves, the one thing that I get concerned about is if I can't be my own advocate. I don't know whether the care would be the same or not. I'm pretty confident in my care group but I've been in situations before where I'm thinking, "Gee if I were older or addled because it was a real emergency, would I be able to have that kind of advocacy?"

Most beneficiaries said that doctors should not be paid more to provide a medical home because they felt that it should be expected as part of the role of a primary care physician. Some were comfortable with doctors being paid to establish medical homes, recognizing the time burden associated with providing extra services. A few beneficiaries said that they themselves would pay a little more for quality care coordination and other services of medical homes.

ACCESS TO PHYSICIANS

Another goal of the focus groups was to learn more about beneficiaries' experiences with physician access. Prior research conducted by MedPAC has found that beneficiaries have few problems finding or seeing a physician. In a 2007 survey, most beneficiaries (75 percent) reported that they never had to wait longer than they wanted for a doctor's appointment. A sizeable proportion (82 percent) reported that they "never" had to wait for an appointment if they were ill or injured. Among the 10 percent of beneficiaries that had to find a new doctor, most reported that they had no problems finding a new primary care physician (70 percent) or specialist (85 percent).[4] Yet despite this survey evidence, there continue to be regular anecdotal reports in the news media that physicians are becoming less likely to take Medicare patients.

The experiences of the beneficiaries in this round of focus groups were largely similar to what MedPAC reported in its 2007 survey. Overall, focus group participants did not report major

[4] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Chapter 2, Section 2B, March 2008.

problems with physician access. Some beneficiaries had established relationships with the same doctor or practice over many years, and most had not recently had to search for a new doctor. In both Richmond and Albany, at least one beneficiary said that he or she had been transferred to another doctor in the practice after their original physician retired or died, which ensured some continuity.

There is variation across the markets in which focus groups were held. Although none of our groups was having widespread issues with access to physicians, we heard about the greatest number of problems in Albuquerque and the fewest in Albany. These differences may reflect underlying differences in the health care systems of each region. Enrollment in managed care plans was most common in Albuquerque and least common in Richmond. Focus group participants were aware that changes in one of the dominant health systems in Albuquerque had recently caused some physicians to leave that system. A general physician shortage in New Mexico was also a factor that likely influenced some responses in Albuquerque; beneficiaries in Albuquerque had heard that factors such as changes to the state's tax code had prompted doctors to leave or quit practicing. A few beneficiaries in Albuquerque noted that friends or family in more rural areas of New Mexico seemed to have more trouble with access to physicians.

Finding Doctors Who Will Take New Medicare Patients

Most of the beneficiaries who participated in the focus groups had not recently had to look for a new primary care physician or specialist. Of those who had, at least one beneficiary in each market had difficulty finding a new doctor who would accept Medicare – an access issue that was probably not unique to Medicare beneficiaries. A more common complaint was that it was more difficult to get in to see specialists (e.g., dermatologists) than primary care doctors, as discussed below.

In Albuquerque, beneficiaries noted that there were broader access problems or doctor shortages that affected both Medicare and non-Medicare patients. One beneficiary was told that a doctor's practice was only accepting patients ages 40 or younger. Others had been told that doctors were no longer accepting new patients, regardless of their insurance carrier. Beneficiaries in Albany and Richmond reported less acute problems with physician access. The evidence in these areas was mostly second-hand – "I haven't been told personally, but I heard recently of a group that was threatening to take no Medicare" – rather than based on personal experience.

One particular concern was unique to Albuquerque. One beneficiary indicated that a friend had contacted physicians listed on a health plan's network and was told by several offices that they were not accepting new Medicare patients. Others observed that the network listing they received from the plan included notations for some doctors that they were not taking new patients or new Medicare patients.

Because most beneficiaries reported long-standing relationships with a specific doctor or practice, they had not noticed differences in access over time. Some beneficiaries, particularly in Albuquerque, thought that it had become more difficult to find a new doctor or make an appointment with an existing doctor in the past few years.

Primary Care Physicians and Appointments

Most beneficiaries with a usual doctor said that they could get an appointment within a day or two. In both Albuquerque and Albany, a few beneficiaries said that their doctor would make time to see them that day if they were experiencing a serious health problem. A few beneficiaries in Albany said that they would see another doctor in the practice, a physician's assistant, or a nurse practitioner to get an appointment more quickly. They felt that this was an acceptable alternative to seeing their regular physician. One beneficiary in Richmond reported a less positive experience. When he had the flu and bronchitis, he called his doctor and was told that they were "booked up for two months." Overall, however, beneficiaries with an existing relationship with a practice felt that they could get timely appointments when they needed them.

Specialists and Appointments

Beneficiaries had more difficulty in getting an appointment with a specialist within a reasonable amount of time, particularly if the patient was new to the practice. Beneficiaries in both Richmond and Albuquerque brought up dermatology as a specialty where it was particularly hard to get an appointment. Beneficiaries suggested that a call by one's regular doctor may help with specialist appointments. In Richmond, one woman explained her approach:

> I had a problem about two months ago and I called my doctor to go in to see him. I was four months away, like you said. So what I did is I called my regular doctor and told him the problem. He called the doctor and I went in the next day.

Another Richmond beneficiary had to make an appointment with a specialist six months in advance. Having to wait that long for an appointment, however, was unusual among the beneficiaries in these focus groups.

SUPPLEMENTAL INSURANCE AND MEDICARE ADVANTAGE

In previous focus groups conducted for MedPAC, we heard complaints from beneficiaries about how Medicare Advantage plans were sold to them. Although steps have been taken recently to reduce marketing abuses, the Commission was interested in additional information about the marketing of Medicare Advantage plans.

In each of the nine focus groups, we asked beneficiaries to tell us whether they had coverage to supplement their basic Medicare coverage. In all three markets, most beneficiaries had supplemental coverage through private Medigap policies or were enrolled in Medicare Advantage plans. A few were dual eligibles whose supplemental coverage is provided by Medicaid. In Albuquerque, most beneficiaries were enrolled in Medicare Advantage plans. Beneficiaries in Richmond were more likely to have traditional fee-for-service Medicare and some form of supplemental coverage. Participants in the Albany focus groups fell in between, with some in Medicare Advantage plans and some in traditional Medicare.

We were interested in learning about how supplemental insurers and Medicare Advantage plans marketed their products. In response to concerns about the marketing of Medicare Advantage and supplemental insurance policies, a provision in the Medicare Improvements for Patients and Providers Act (MIPPA), passed by Congress in July 2008, placed new prohibitions on the marketing activities of Medicare Advantage and supplemental plans.[5] CMS issued new regulations on marketing in September 2008, shortly before the 2009 enrollment period.[6] The Richmond and Albany focus groups took place in between the passage of MIPPA and the effective date of the September CMS regulations (September 18, 2008). The Albuquerque focus groups were conducted a week after the regulations took effect.

Nearly all of the focus group participants reported that they had received mail and seen advertisements for insurance plans related to Medicare. Many had also attended seminars. Few beneficiaries said they had had problems related to marketing. Of the problems reported, most were minor, but there were a few cases where marketing activities apparently led to some confusion about their options or incomplete information about the plan they ultimately selected.

Mass Marketing: Mail and Other Advertising

Beneficiaries in all three regions received a considerable amount of marketing mail and saw various types of advertisements.[7] One beneficiary in Albuquerque described herself as "bombarded with mail." These advertisements are specifically targeted to their audience; a beneficiary in Albany said that she was "inundated when I turned 65. I was invited to every kind of dinner and thing that I could possibly go to."

Group Marketing: Plan Seminars

A significant number of beneficiaries had gone to marketing seminars sponsored by insurance plans. Many found them informative and thought that they had received good information from plan representatives. A few beneficiaries reported that they found plan seminars confusing, and one woman felt that she was given inaccurate information at a seminar in Albuquerque. Other beneficiaries said the plan seminars were not helpful. Whether beneficiaries found seminars useful seemed to depend on their approach and size; one man attended a large meeting and described it as "a dog and pony show. They spent all the time telling how wonderful they are." A woman in the same focus group attended a seminar in which there were only "six people in my session. And there was a lot of give and take." Beneficiaries tended to prefer smaller meetings where they had the opportunity to ask specific questions.

[5] "Medicare Issues New Rules to Enforce Marketing Requirements During Upcoming Health and Drug Plan Enrollment Period." Press release, Centers for Medicaid and Medicare Services, September 15, 2008.
[6] Centers for Medicare and Medicaid Services, memorandum, "Guidance for Regulations in CMS 4131-F and CMS 4138-IFC," September 15, 2008.
[7] Some marketing materials reported by beneficiaries were undoubtedly for Medicare Part D plans as well as for Medicare Advantage plans. Participants often fail to appreciate the differences among different segments of the program.

Individual Marketing: Phone Calls and Home Visits

We were particularly interested in one-on-one marketing efforts to beneficiaries. The regulations released by CMS in September 2008 prohibit unsolicited phone calls and visits by plan representatives.[8] Beneficiaries in the focus groups discussed their experiences prior to these regulations taking effect.

Telemarketing calls seem fairly common. In groups where we asked for a show of hands, about one in four had received marketing calls, although there was no way to be sure that these were totally unsolicited. One beneficiary in Albany expressed frustration with the number of calls she received from plans: "You get a lot of phone calls from everybody… I've got a caller ID so I can see those unavailables, and I get so frustrated because they just bug you."

Home visits were less frequent than phone calls, although one man in Albuquerque did receive a phone call from a plan to confirm an appointment that he had not made. He accepted the appointment and then enrolled with the new plan saying he "wanted to try another one just to see how it works."

Visits from plan representatives were more common in Richmond than in Albuquerque or Albany. In previous focus groups for MedPAC, we found that lower-income beneficiaries were more likely to receive phone calls or visits at home from plan representatives, but in these groups the sample of low-income beneficiaries was too limited to draw a clear conclusion.

A small number of beneficiaries believed that they were actively misled about the provisions of their coverage during individual marketing efforts. No beneficiaries in these groups reported that they had been enrolled in a plan without their knowledge or consent, though there were examples of beneficiaries who had signed up for plans without a full understanding of what they covered. For example, one woman in Richmond said:

> I was paying $189 for my primary insurance and I had that and Medicare. So this lady came along and she sold me the idea. I only paid $94, or was it $96? But there's a catch in that too. When I got my first bill, I owed a thousand dollars. I had to pay that thousand dollars off. Then everything else was free.

Even at the time of the focus group, she remained unsure of whether the deductible was a one-time or yearly expense.

Other Sources of Information

Beneficiaries turned to a number of other sources of information when choosing a Medicare Advantage or supplemental plan. In Richmond, we heard more about the use of agents than in other markets. Beneficiaries were generally satisfied with the help they had received from their insurance agents. Beneficiaries in Albany and Albuquerque were less likely to have used insurance agents, and some were skeptical of the idea. Family members and friends were

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[8] Centers for Medicare and Medicaid Services, memorandum, "Guidance for Regulations in CMS 4131-F and CMS 4138-IFC," September 15, 2008. See pages 16-17.

common resources. Some beneficiaries switched plans after a friend told them about the benefits or premium of another plan. Others asked their doctor or pharmacist for assistance in choosing a plan that would cover their medications or that included their providers.

Participants were generally unfamiliar with the State Health Insurance Assistance Programs. One beneficiary in Albany said of receiving help from the Area Agencies on Aging, “I never thought of it. I probably would have done it, had I known.” A couple of beneficiaries did receive assistance with the enrollment process through a local senior center or agency.

Fewer than half of beneficiaries reported turning to Medicare for information about health plans or supplemental insurance. Those who had called 1-800-Medicare generally reported positive experiences "when you can get through." One beneficiary in Albany liked the helpline better than the website:

> The phone wasn’t too bad, but the internet wasn’t helpful. It didn’t give me much information. It was too difficult to find answers for the questions that I had. Everything about that – I think I would rather just talk to people. It didn’t take too long to get through to a person.

Relatively few beneficiaries had used the Medicare website, although most who had used the site to gather plan information liked it. In Albuquerque, one beneficiary who had used the website thought that it was the most objective source of information, more so than plan presentations or insurance brokers.

Program Complexity

In all three geographic areas, beneficiaries were unhappy about the complexity of the Medicare program. While they seemed to appreciate having a choice of plans, many beneficiaries felt that there were too many options from which to choose. A woman in Albuquerque thought that the number of plans offered made her choice “more personal,” but also “more confusing.” A woman in Richmond described the problem more succinctly: “too much is as bad as not enough.” Some beneficiaries thought that they might not have the best supplemental coverage, but were unable or unwilling to try to sort through all the information they receive. As a man in Richmond said,

> You just get tons of mail, you know, offering all these different plans and I really personally don’t know that I have the best plan for me. But so far I’ve had good experience with them. They’ve taken care of everything that I needed taking care of. I hesitate to wade through that mountain of stuff to try to find out just which plan would be better.