Monetary Medicare+Choice

NEW ORLEANS Profile

April 2001

Medicare Beneficiaries and Choice in the New Orleans Metropolitan Area, 2000

by Marsha Gold, Jessica Mittler, and Beth Stevens

NEW ORLEANS AT A GLANCE: In 2000, 14 percent of Medicare beneficiaries in the New Orleans metropolitan area had no source of supplemental coverage to pay costs not covered by the Medicare benefits package. Medicare health maintenance organizations (HMOs) are a historically important source of coverage, particularly for those who do not receive supplemental coverage through an employer group. In New Orleans, 32 percent of Medicare beneficiaries are in Medicare HMOs, almost twice as many as those who receive coverage through Medigap policies. Though the Medicare HMOs in New Orleans seem well established, withdrawals elsewhere in the state where payment rates are lower have created uncertainty about and concern over the future availability of Medicare HMOs in the market. This Profile provides new data on New Orleans’s Medicare beneficiaries to help local policymakers better respond to beneficiaries’ concerns and questions about their choices under Medicare.

Medicare is a national program, but the people it serves—the elderly and many persons with disabilities—live in states and local communities. Despite substantial and high-profile concern about the choices that Medicare offers beneficiaries, there is very little information to describe how Medicare+Choice is working at the local level where beneficiaries make decisions based on the physicians, hospitals, and health plans available to them. Under Medicare+Choice, beneficiaries in New Orleans have had two options: stay in traditional Medicare and decide whether and how to obtain supplemental coverage, or join a coordinated care plan such as an HMO. It is important to understand how beneficiaries see their choices to determine how to make the program work better for them where they live.

This Profile highlights how beneficiaries are dealing with Medicare and Medicare+Choice in the New Orleans metropolitan statistical area (MSA). We describe the demographic characteristics, supplemental coverage, relevance of choice, and information sources used to support choice by beneficiaries. Data come from a week-long visit to New Orleans in winter 2000 and a survey of Medicare beneficiaries in spring 2000, conducted as part of the Monitoring Medicare+Choice Project funded by The Robert Wood Johnson Foundation. The Appendix summarizes the findings from the New Orleans site visit, including insights from the field on beneficiary concerns and needs.

Table 1

Medicare Beneficiaries, 2000

<table>
<thead>
<tr>
<th></th>
<th>New Orleans</th>
<th>U.S. Counties with Medicare+Choice</th>
<th>All United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 years</td>
<td>16%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>65-84 years</td>
<td>75</td>
<td>77</td>
<td>77</td>
</tr>
<tr>
<td>85 and over</td>
<td>8</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>White</td>
<td>66%</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td>African American</td>
<td>28</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Language other than English</td>
<td>3%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Less than high school</td>
<td>31%</td>
<td>27%</td>
<td>26%</td>
</tr>
<tr>
<td>High school graduate</td>
<td>37%</td>
<td>38</td>
<td>39</td>
</tr>
<tr>
<td>Some college or more</td>
<td>32%</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>$10,000 or less</td>
<td>30%</td>
<td>24%</td>
<td>27%</td>
</tr>
<tr>
<td>$10,001-$20,000</td>
<td>33</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>$20,001-$35,000</td>
<td>21</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>$35,001 or more</td>
<td>16</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Married</td>
<td>53%</td>
<td>46%</td>
<td>48%</td>
</tr>
<tr>
<td>Widowed</td>
<td>31%</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Divorced/separated/never married</td>
<td>17</td>
<td>14</td>
<td>13</td>
</tr>
</tbody>
</table>

Number of beneficiaries: 159,814

SOURCE: MPR Survey of Medicare Beneficiaries, 2000

The Monitoring Medicare+Choice Project of Mathematica Policy Research, Inc., seeks to provide credible and timely information on insurance decisions made by Medicare beneficiaries. It is funded by The Robert Wood Johnson Foundation.
qualify for Medicare because of a disability or other condition, which is higher than in the nation overall. The rest are over age 65 (see Table 1). The main minority group among New Orleans's Medicare beneficiaries is African Americans, who comprise 28 percent of beneficiaries in the MSA and a majority in Orleans Parish, which is the city of New Orleans. The New Orleans metropolitan area also has smaller subgroups of Vietnamese and Hispanic beneficiaries.

Even more so than in the nation as a whole, New Orleans’s Medicare beneficiaries tend to have low to moderate incomes: 30 percent have annual incomes of $10,000 or less, and another 33 percent have incomes between $10,001 and $20,000. Only 16 percent have incomes of $35,001 or more. The education level of beneficiaries is also relatively low; only 32 percent have some college education, and 31 percent did not graduate from high school. Literacy appears to be a problem for some beneficiaries. In addition, 10 percent have poor vision.

Health status varies (see Figure 1). While 15 percent self-rate their health as excellent, 31 percent say it is only fair or poor. Thirty-eight percent of New Orleans’s beneficiaries report one or more of three functional disabilities asked about in the survey.

Supplemental Coverage in New Orleans

In New Orleans, 14 percent of Medicare beneficiaries had no source of supplemental coverage in 2000 (see Table 2). In 2000, 32 percent of New Orleans’s beneficiaries obtained coverage through a Medicare HMO, with 22 percent having no other additional subsidized source of coverage (e.g., through an employer, Medicaid, or the military). HMOs are more dominant in New Orleans than elsewhere in the state. In the late 1990s, the continued availability of the Medicare HMO option was in some doubt, with withdrawals from elsewhere in the state and some reductions in offerings in the New Orleans market. Federal capitation rates to Medicare HMOs in New Orleans are relatively high, however, and it seems likely that some choice of Medicare HMOs will remain. In 2000, the monthly rate for aged beneficiaries was $651 in Orleans Parish and $674 in Jefferson Parish (compared to the national average payment of $505).

Similar to the nation as a whole, just over a third of New Orleans’s Medicare beneficiaries receive supplemental coverage through an employer. Thirteen percent have Medicaid benefits, and 5 percent have military benefits. The rest rely on the individual market, mainly Medigap coverage or a Medicare HMO. In 2000, Medigap premiums for a 65-year-old male in New Orleans (Plan F, New Orleans) ranged from $1,224 to $2,245 (Quotesmith.com, 2000). Sterling Health Plan, a fee-for-service health insurance plan that combines Medicare and supplemental benefits, has increased its marketing in Louisiana, outside of New Orleans. This plan was approved for offering in 17 states nationwide in 2000 and reportedly has expanded its marketing in areas that benefited from the increase in payment rates authorized by Congress in December 2000. This excludes the core parishes of New Orleans, but includes some of the surrounding ones.
Consideration and Relevance of Choice
The vast majority of Medicare beneficiaries in the New Orleans MSA, like beneficiaries nationally, do not consider their choice of health plan each year. Choice was only “salient” to 19 percent of New Orleans-area beneficiaries for the enrollment period beginning September 15, 1999, through the time of the survey (see Figure 2). This is low, but somewhat higher than elsewhere in the nation, a fact that may be attributed to some changes in offerings in 2000. In this Profile, salience refers to active or serious consideration of choice by beneficiaries, either voluntarily (e.g., a beneficiary wants coverage for pharmacy or lower out-of-pocket costs) or involuntarily (e.g., a new beneficiary must choose, or a beneficiary’s HMO leaves the program). The salient group includes (1) new beneficiaries who must make a choice among Medicare coverage options; (2) current beneficiaries who switch to, from, or among HMOs (switchers); and (3) beneficiaries who report they had considered making a change since September 15, and characterized this consideration as very or somewhat serious, even if they ultimately did not make a change.

In reality, a small proportion of beneficiaries think about choice, and fewer actually make changes. The most common reason given for not considering choice seriously is that beneficiaries are relatively satisfied with their current coverage. This is especially the case for those with group-based coverage. In New Orleans, as in the nation, most beneficiaries are relatively satisfied with their coverage, with only a small minority rating coverage as fair or poor or not willing to recommend their plan to a friend (see Figure 3). This could change in the future, since 41 percent of all beneficiaries in New Orleans say their premiums were higher in 2000 than in the previous year, and cost is an important factor influencing satisfaction (see Table 3). Fifty-two percent reported higher out-of-pocket costs for drugs. As a result, 25 percent of beneficiaries reported worrying more in 2000 than in 1999.

Table 3
Trends in Cost of Coverage, 2000

<table>
<thead>
<tr>
<th></th>
<th>New Orleans</th>
<th>U.S. Counties with Medicare+Choice</th>
<th>All United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insurance Premium, Compared to Last Year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher</td>
<td>41%</td>
<td>57%</td>
<td>54%</td>
</tr>
<tr>
<td>Same</td>
<td>51</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>Lower</td>
<td>8</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Costs for Drugs, Compared to Last Year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher</td>
<td>52%</td>
<td>55%</td>
<td>52%</td>
</tr>
<tr>
<td>Same</td>
<td>37</td>
<td>39</td>
<td>41</td>
</tr>
<tr>
<td>Lower</td>
<td>11</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td><strong>Worry About Ability to Pay Bills, Compared to Last Year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More</td>
<td>25%</td>
<td>28%</td>
<td>30%</td>
</tr>
<tr>
<td>Same</td>
<td>62</td>
<td>62</td>
<td>61</td>
</tr>
<tr>
<td>Less</td>
<td>13</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

SOURCE: MPR Survey of Medicare Beneficiaries, 2000
about their ability to pay bills; only about half as many—13 percent—reported worrying less. This means that choice could become more important to beneficiaries in the future as they balance cost and coverage with other competing needs. Nationally, those who lack a source of supplemental coverage were substantially more likely to be dissatisfied with their current coverage than others.

Beneficiaries are markedly similar across communities and subgroups on the factors they would consider very important if they were choosing a plan today. By far, the dominant concern is whether they can get health care when they are sick (see Figure 4). Nearly two-thirds of beneficiaries in the New Orleans MSA say this would be extremely important if they were choosing a health plan today. Otherwise, beneficiaries appear to be about equally concerned with benefits and costs (e.g., inclusion of prescription drug coverage, keeping premiums down, having low out-of-pocket costs) and the ability to access the provider they wish (e.g., having a choice of personal doctor, the ability to self-refer to a specialist).

**Process of Choice for Those Making or Considering It**

Beneficiaries in New Orleans who make a change or seriously consider doing so have mixed experiences, just like beneficiaries across the nation. For the most part, beneficiaries say they are very confident or at least somewhat confident of their ultimate decision (see Figure 5). Some reach this endpoint with relatively little effort, but others seem to find the decision-making process more difficult. Over half say their decision was relatively easy to make, yet almost as many (46 percent) report that the decision was hard. Twenty-nine percent say they spent no time making a decision, and another 23 percent spent a day or less. At the same time, 24 percent spent four days or more, and 25 percent spent two to three days. Presumably, reaching the subgroup for whom decision making is more difficult is an important function of the Health Care Financing Administration’s (HCFA’s) Medicare National Education Program and the community organizations that educate and counsel Medicare beneficiaries.

The number of beneficiaries and the different subgroups of beneficiaries that both national programs and community organizations reach to educate and support is less than optimal, in large part because the resources available are limited.

Beneficiaries in New Orleans, as elsewhere, rely for the most part on informal sources to provide them with important information to support their choice of provider (see Figure 6). In New Orleans, 23 percent say their spouse, other family, or friends are the most important source of information; 20 percent rely on their personal physicians (which is less than beneficiaries nationally do). A current health plan or employer sponsoring the plan is the main source of information for 23 percent. Eight percent rely most on Medicare, and 26 percent on various other sources. Local hospitals are more important sources of information in New Orleans than elsewhere, with several institutions
sponsoring programs directed at the elderly and Medicare. The media (TV/radio) also are used here somewhat more than elsewhere.

In New Orleans, 12 percent of Medicare beneficiaries for whom choice was salient at the time of the study say that they used information from seniors’ organizations (Table 4); 2 percent of them said it was their most important source of information. In New Orleans, the State Health Insurance Information Program (SHIIP), based in the Insurance Commissioner’s office in the state capital of Baton Rouge, is the main organization for Medicare education and conducts most of the education efforts, especially outside New Orleans. The SHIIP works closely with three other organizations—the Part B educator (BCBS of Arkansas), the Louisiana Health Care Review (the state peer review organization), and the local Social Security Administration (SSA) office—to conduct joint education seminars titled, “Medicare 101.” SHIIP also trains local staff and volunteers, including the New Orleans Council on Aging, the Jefferson Council on Aging, Seniors with Power United for Rights, and the Catholic Archdiocese. Some not-for-profit hospitals run seniors programs that provide information, billing assistance, and counseling. However, resources in all these programs are generally very limited.

In New Orleans, as in the nation, the Internet is used rarely by Medicare beneficiaries seeking to make a choice, even though the HCFA’s beneficiary-oriented Web site (www.medicare.gov) contains extensive information. In New Orleans, only 6 percent said the Internet was a source of information for them. Use is so low probably because the vast majority of beneficiaries, at least in early 2000, do not use the Internet. Only 16 percent of beneficiaries in the New Orleans MSA say they have ever used the Internet or Web for any purpose. Medicare information provided on the Internet is indirectly available to beneficiaries through other sources, of course, such as family members or counselors.

Lessons for the Future

Findings from both New Orleans and the national study highlight ways in which decision-making support for beneficiaries can be enhanced.

First, improve the availability of one-on-one sources of unbiased information. Only 16 percent of all New Orleans beneficiaries said they knew of a local, free, and unbiased source of counseling about Medicare and choosing a health plan, and 52 percent more were uncertain about the availability of such a source. Yet there seems to be a demand for such sources. In New Orleans, 38 percent of beneficiaries said they very likely would use such a source if it were available and they needed help; another 27 percent said they would be somewhat likely to use it. Demand is similar elsewhere in the country.

Second, tailor information better to the diverse needs of beneficiaries at the local level, which is hard to do in New Orleans because of the limited resources available. The national study found substantial differences in the information strategies used by different subgroups of beneficiaries. Given the characteristics of the New Orleans population, the following national findings are particularly relevant:

- **Under-age-65 disabled population:** These individuals do not relate to aging organizations, even though they are a major source of information for Medicare beneficiaries. Because advertising—and even product names in New Orleans—focuses on the elderly, disabled individuals may be unaware they are eligible to enroll in a Medicare HMO. Despite the fact that a high share of the under-age-65 disabled subgroup lacks supplemental coverage, few...
Though experience may increase their familiarity with and awareness
handbook. Among those who did know, only about a third used it.
Medicare beneficiaries know whether they received the Medicare
Like beneficiaries nationally, only about half of New Orleans
develop and promote other opportunities to support informed choice.
• Some minorities and ethnic groups: People in these subgroups
often look within their own communities for organizations whose
information they trust. This is an important consideration in New
Orleans. Though some efforts are underway to reach Hispanic
communities, there are few organizations based in that community,
or in the Vietnamese community, that focus on elderly issues or on
Medicare-related concerns, which makes education difficult.
There also may be some lingering distrust of government agencies
among African American communities, which means that special
efforts to reach African Americans are needed. National findings
confirm the importance of strengthening and expanding efforts to
reach and work with community groups.
• Lower-income and less-educated beneficiaries: These individuals
are not reached as effectively with written material. Instead, one-
on-one counseling appears to be more effective. Low literacy or
cognitive impairment was viewed as a particular concern in New
Orleans, restricting the value of written materials. Many people in
this subgroup nationally ask their physicians for information,
although this is less the case among minorities and in New
Orleans than elsewhere. Outreach through physicians, together
with general outreach directing individuals to sources of
personalized assistance, may be of considerable value in better
meeting the needs of these lower-income and less-educated ben-
eficiaries. In addition to general outreach, developing materials
that physicians can give to patients referring them to sources of
support may be valuable.
• Beneficiaries with poor health or disabilities: These individuals
are more likely to be socially isolated and unable to access existing
information. Reaching them probably requires working with
physicians (because those in poor health see physicians more
than do beneficiaries in good health) and addressing the access
barriers that make it harder for them to use available sources of
unbiased counseling (e.g., mobility problems for the homebound).

Third, make written material more accessible to beneficiaries and
develop and promote other opportunities to support informed choice.
Like beneficiaries nationally, only about half of New Orleans’s
Medicare beneficiaries know whether they received the Medicare
handbook. Among those who did know, only about a third used it.
Though experience may increase their familiarity with and awareness
of the handbook, it is important to continue developing other forms of
written material to make information more accessible to beneficiaries
so that they will refer to it. The national study found that significant
emphasis was placed on developing, improving, or distributing written
materials. However, written materials are not enough, even when they
are of high quality and appropriately targeted and disseminated to
beneficiaries. One-on-one counseling and other targeted efforts are
crucial to addressing the needs of all Medicare beneficiaries as they
consider choice.

Fourth, be realistic about the role of education about choice for
Medicare beneficiaries. The findings of this project highlight the
current limits of the infrastructure available to support choice for
Medicare beneficiaries in communities. In most or all communities, a
small group of organizations with few resources is trying to educate
many beneficiaries with varying needs about an extremely complicated
program. Improving education should help many beneficiaries make
informed choices, but there also are constraints. Medicare beneficiaries
are diverse, with many having characteristics—for example, low
income, poor health or functional disability, and difficulties with
language, cognition, or reading—that complicate choice and heighten
cost concerns. In addition, the complexity of the Medicare supple-
mental market means that the choices Medicare beneficiaries face
vary with their circumstances, yet another complication. All of this
makes choice in Medicare substantially harder to support than in the
more traditional employment-based market.

THE SURVEY ESTIMATES
This Profile is based on a survey of Medicare beneficiaries age 18
and older with both Part A and Part B benefits on December 28,
1999. Nationally, 6,620 people responded, a 64 percent response
rate. Interviews were conducted by telephone over a 15-week period
starting March 2, 2000. The results are weighted to provide unbiased
estimates for Medicare beneficiaries nationally, in six communities
sampled separately, and selected subgroups of beneficiaries. The six
communities are Albuquerque, Baltimore, Detroit, New Orleans,
Orlando, and Orange County (CA).

Estimates for the New Orleans MSA are based on Medicare benefici-
aries sampled from eight parishes: Jefferson, Orleans, Plaquemines,
St. Bernard, St. Charles, St. James, St. John the Baptist, and St.
Tammany. There were 889 interviews completed, representing a 72
percent response rate. The 95 percent confidence half-interval for
these estimates is 5.5 percent.
APPENDIX

Community Characteristics

Community Definition
The New Orleans MSA is composed of eight parishes: Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, and St. Tammany. The focus of our visit was Jefferson and Orleans parishes, the two core urban parishes. The boundaries of Orleans Parish are also the boundaries for the city of New Orleans. Both Jefferson and Orleans parishes are divided into east and west banks by the Mississippi River.

Demographics
The New Orleans MSA contains 1.3 million people, of whom 14 percent receive Medicare benefits, and 17 percent receive Medicaid (InterStudy, 1999). Compared with the other parishes, Orleans and Jefferson have larger and older populations, and Orleans Parish has more low-income households. These two parishes account for 74 percent of the MSA population. Thirteen percent of the residents of Orleans Parish are age 65 or older, as are 10 percent of Jefferson Parish residents. Between 5 and 7 percent of the residents of the six other parishes are age 65 or older. Twenty percent of Orleans and Jefferson seniors are below the poverty line. Orleans Parish is mostly African American (62 percent), and Jefferson Parish is primarily white (78 percent). Less than 6 percent of the residents of either parish are Hispanic (1990).

Labor Market
According to the Louisiana Department of Economic Development, the largest employer in Jefferson and Orleans parishes is a construction firm with 14,600 employees. The other major employers in the two parishes have between 1,300 and 6,000 employees and are primarily in banking, medical, groceries, and oil. The market consists mainly of small employers and is not heavily unionized. Employers generally do not offer retiree health benefits, and those that do have not been particularly interested in Medicare managed care options.

Political Infrastructure
The parishes of Orleans and Jefferson have a collegial relationship, but few regional organizations officially link the two. Both parishes have health insurance programs for seniors through their Councils on Aging. Jefferson’s is considerably older and was a primary resource of such insurance for residents of both parishes before the Orleans program started in January 2000. We did not get a sense that there is an active, well-organized community infrastructure of neighborhood and voluntary organizations in the area.

Provider Organizations

Hospitals
Twenty-eight hospitals operate in the MSA (NIHCM, 1999). The hospitals are divided between public institutions owned by the state (the Charity system) and those run by private firms. Private hospitals are divided further between local, not-for-profit hospitals (Columbia) and for-profit hospitals (Tenet). There
are no dominant multihospital systems in the area. Residents tend to have strong loyalties to particular hospitals, and much of the market is driven by geography. It is unusual for residents, especially the elderly, to cross the Mississippi River to receive care.

Physicians

The physician market is dominated by independent practice associations (IPAs). There is one large, multigroup practice (Ochsner). Although some physicians do not participate in Medicare managed care, many are in all of the plans’ networks. The exception is the Ochsner Foundation Hospital and its affiliated physicians, who participate only in the Medicare managed care product offered by Ochsner Health Plan (OHP).

Managed Care

Total managed care penetration in the New Orleans MSA reached 27 percent in January 1999. Commercial managed care entered the market in 1984, with Medicare following 10 years later. Medicare managed care penetration was 32 percent in the MSA in March 2000. In general, local managed care firms dominate the market, led by OHP, a provider-sponsored plan affiliated with a tertiary care hospital and multigroup and specialty practices.

### Medicare Insurance Options

**Medicare + Choice MCOs**
The New Orleans market is dominated by local firms, including two Medicare + Choice managed care organizations (MCOs) that are provider-sponsored. OHP has almost 40 percent of the Medicare + Choice enrollees in the MSA, and the Tenet-sponsored Choices Demonstration product has another 20 percent (March 2000). Competition is based on premium and pharmacy benefits. Several of the other MCOs in the market are experiencing administrative turmoil, which affects both their commercial and Medicare businesses. In 2000, seven Medicare + Choice MCOs were in the New Orleans market: (1) Aetna U.S. Healthcare, (2) Gulf South, (3) HMO Louisiana (BCBS), (4) Maxicare, (5) OHP, (6) SMA, and (7) Tenet Choices. (In 2001 both Aetna and HMO Louisiana exited the market.) None of the MCOs serves all of the parishes in the MSA, but all of them serve both Jefferson and Orleans parishes. HMO Louisiana and Maxicare entered the New Orleans market in 1999, and United Healthcare withdrew from New Orleans and the rest of the parishes it served in Louisiana as of December 31, 1999. Although it remains in New Orleans, OHP withdrew from several other markets in the state at the end of 1999; in many of these areas, its product had been the only Medicare + Choice option available. New Orleans also experienced one withdrawal at the end of 1998, when Advantage Health Plan did not renew its contract.

**Medicare + Choice Products**
The nine Medicare products offered in the New Orleans area are typically HMO models with some supplemental benefits, including prescription drugs. In 2000, only Aetna offered more than one product with different levels of premiums, benefits, and copayments (although the single Tenet Choices product is a triple-option product). Most products have a zero premium, and all but one Medicare + Choice MCO retained this feature in 2000. Aetna introduced premiums on all its products, ranging from $29 to $59 in 2000. (Aetna subsequently withdrew in 2001.) All products include a prescription drug benefit, with coverage ranging from $500 for both generic and brand-name drugs to an unlimited generic drug benefit and as much as $1,200 in brand-name coverage. In 2000, MCOs seemed to be considering whether to add a premium in the future and expected the Medicare + Choice market to remain active.

**Medicare + Choice Capitation**
The capitation for Medicare, at an average $671 for the MSA in 1999, weighted by the Medicare population in each parish, is well above the national average (33 percent greater).
Medigap

The primary Medigap carriers in the market are BCBS of Louisiana and Physicians. Medigap premiums seem to be increasing in recent years, but it is unclear by how much. The most popular plans are F and C. BCBS also offers a Medicare Select product.

Information Infrastructure

Key Organizations

The four key actors in Medicare education are (1) the SHIIP, (2) the Part B educator (BCBS of Arkansas), (3) Louisiana Health Care Review, and (4) the local SSA. These organizations are based primarily in the state capital, Baton Rouge, and conduct joint education seminars titled, “Medicare 101.” In Louisiana, the SHIIP is dominant and leads most education efforts, especially outside New Orleans. It also trains counselors with the local Councils on Aging and other groups and leads presentations on Medicare. In the New Orleans area, the SHIIP has trained staffs and volunteers of the New Orleans Council on Aging, the Jefferson Council on Aging, Seniors with Power United for Rights (SPUR), and the Catholic Archdiocese. Some not-for-profit hospitals run seniors’ programs that provide information, billing assistance, and counseling.

Topical Focus

Education focuses on the Medicare program as a whole, only one part of which is Medicare+Choice. Most education starts with basic concepts but covers the gamut of Medicare topics, including programs for low-income beneficiaries and dual eligibles. Although they initially presented all the Medicare+Choice options that could be offered, most educators have refined their efforts to mention only currently available ones. Information on managed care structure and terminology was presented when Medicare managed care MCOs first entered the market several years ago. Currently, the greatest demand for information is in response to withdrawals and changes in benefits.

Education Activities

The dominant activities in New Orleans are seminars or presentations by the four key actors and one-on-one counseling by other groups.

Outreach

The Councils on Aging perform outreach in senior centers, meal sites, and housing projects to make seniors aware of their services, including health insurance counseling and information and assistance. Educators publicize their activities in newspapers (including a weekly senior issues column) and newsletters, on the radio, through direct mail, and at health fairs and senior centers. The Councils on Aging are developing methods to reach Hispanic seniors, but neither the Hispanic nor the large Vietnamese community focuses on elderly issues or Medicare-related concerns.

Essential Questions

Medicare advisors say that Medicare beneficiaries in New Orleans seem to understand the concept of managed care, but do not comprehend the interaction between Medicare and Medicare+Choice MCOs, and are confused about the basics of the Medicare program. In considering enrollment in a Medicare+Choice MCO, beneficiaries are most concerned about whether their physician participates in the plan and the plan’s costs. An issue running a close third is the generosity of the plan’s prescription drug benefit. Most education groups are also asked questions about eligibility and specific billing issues. Disabled individuals are concerned primarily with becoming eligible to participate in the Medicare program and obtaining prescription drug coverage. Because advertising—and even product names—focus on the over-65 population, disabled beneficiaries may be unaware that Medicare+Choice MCO options are available to them, and that these options are not restricted to the elderly population.
Availability and Quality of Medicare Information

Educators felt that reliable resources were available for those who were interested, but that most people generally do not seek information until after a problem has arisen. The educators also are concerned that much of the printed material on Medicare is not accessible to individuals with low literacy or cognitive impairments (a particular problem in New Orleans), and they believe that additional methods of reaching these people must be developed. One educator also thought that some minority communities, especially African American ones, were less trusting of government agencies and, therefore, less likely to request information from those groups.

Resource Adequacy

The organizations we talked with are small. Other than the SHIIP, most had only one or two staff members devoted to education. Many had diverted resources from other services to develop insurance information programs or to respond to information about senior health insurance. Louisiana was affected by Medicare+Choice MCO withdrawals at the end of both 1998 and 1999, although the impact was not as great in New Orleans. Organizations were more prepared to respond to withdrawal announcements in 1999, but this response often took over senior health insurance activity, diverting it from broader outreach tasks.

Unique Efforts

The four key actors in Medicare education have developed a presentation, “Medicare 101,” that discusses issues ranging from Medicare’s basic structure to eligibility and enrollment requirements to Medicare insurance options. The program is presented across the state and is often sponsored and publicized by other aging groups.

The coordinator of community services for the New Orleans Council on Aging writes a weekly column on elder issues for the neighborhood section of the area’s large daily paper. This column, “Gray Matters,” covers a range of topics related to the senior community, including health care and health insurance.

Recommendations from the Field

Beneficiaries need education about a range of Medicare topics. Beneficiaries are unfamiliar with many aspects of traditional Medicare and are unaware of programs for dual eligibles. They also need information about Medigap plans and on how Medigap and Medicare+Choice MCOs interact with the Medicare program.

Medicare & You has limitations. Many educators noted that the handbook does not appear to be widely used; one noted that, “it’s too much” for the elderly to understand. Formatting issues caused some confusion, and the “local” information still does not apply to many individuals. Most educators noted that beneficiaries consider more basic cost factors and access to specific providers and do not use quality indicators in making decisions about Medicare+Choice plans. Several of the groups with which we spoke had not received the handbook, or had received only a limited number of copies.

Do not educate about choices that do not exist. Beneficiaries are confused by presentations about options that are not currently available. Restrict discussion to options that are offered, and do not mention items that are only possibilities.
Lessons

Beneficiaries are intimidated by change and often do not consider their insurance options until a crisis (often financial) exists. Information intermediaries are helping beneficiaries who have identified a need for more knowledge about Medicare and know whom to contact. Other beneficiaries may not be getting this information. This is especially true for disabled beneficiaries, because advocates for people with disabilities seem less knowledgeable about the Medicare insurance options available and do not perceive this issue to be a priority with the disabled population.
References


Related Publications


