



How are Seniors Choosing and Changing Health Insurance Plans?

Findings from Focus Groups with Medicare Beneficiaries

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Prepared by:

Gretchen Jacobson and Christina Swoope
Kaiser Family Foundation

and

Michael Perry and Mary C. Slosar
PerryUndem Research and Communication

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Executive Summary

For many seniors, selecting an initial Medicare plan is an unexpectedly daunting task. The plan environment in Medicare today is quite unlike that of 10 or 20 years ago, when the vast majority of seniors were enrolled in traditional Medicare and may only have had to decide whether or not to purchase a Medigap supplemental policy. In recent years, the Medicare plan landscape has been transformed, with dozens of private Medicare Advantage and Part D drug plans available to most people on Medicare. With so many plans and options to review, many beneficiaries find the process of comparing and selecting plans overwhelming and look for ways to simplify the task. If they choose traditional Medicare, they often need to choose a specific stand-alone Part D prescription drug plan (PDP), and perhaps a supplemental Medigap plan if they are not otherwise receiving supplemental coverage under a retiree health plan or Medicaid. If instead they choose coverage under Medicare Advantage, they often face a myriad of plan choices, including HMOs and PPOs, with different provider networks, benefits, and premiums. Each year, plans may change their premiums, benefits, and other features and beneficiaries have the opportunity to assess these changes and, if deemed necessary, switch plans during the annual open enrollment period. Yet, many studies show that few beneficiaries revisit their coverage decisions each year to determine which option is best for them based on their individual needs and the specific features of the plans available to them.¹

This report summarizes first-hand accounts of seniors' decision making strategies for choosing and changing Medicare private plans, based on 9 focus groups of 6 to 8 seniors in 4 cities. To explore the diverse methods and thought processes employed by seniors in their plan decision making, focus groups were conducted in cities reflecting variations in Medicare marketplace features: Baltimore, Maryland; Seattle, Washington; Memphis, Tennessee; and Tampa, Florida.

KEY FINDINGS:

- Seniors cited a number of factors that were important in choosing a plan when they first enrolled in Medicare, including: premiums and out-of-pocket costs, access to desired providers, familiarity with the name of the company offering the plan (such as AARP), favorable experience with a plan representative, and adequate coverage for their health care needs. Some also said they enrolled in a particular Part D or Medicare Advantage plan in order to have the same coverage as their spouse. Star quality ratings of plans did not play a role in seniors' plan choices. In the case of seniors choosing among Part D plans, some wanted to be sure the specific drug they were taking was covered by the plan before signing up.
- Seniors say they found it frustrating and difficult to compare plans due to the volume of information they receive in the mail and through media (television and radio) and their inability to organize the information to determine which plan is best for them. Most seniors did not use the "Medicare Compare" tool available on the medicare.gov website, and many of those who did said they found it confusing, lacking information, and poorly constructed for comparisons on their desired factors. For this reason, many rely on insurance agents as trusted advisors or receive suggestions from friends, family, doctors' offices and/or pharmacists to help them narrow down their options.

- Many senior Medicare beneficiaries said they did not want to switch plans because the process of their initial plan selection was so frustrating. They believed they did their homework the first time and most did not want to revisit the decision. In general, they did not view the annual open enrollment period as a time to review their health plan options and confirm they were still in the plan most likely to meet their needs. Instead, they feared that a change in plan may disrupt their care or lead to an unforeseen increase in out-of-pocket costs, and require them to learn a daunting new set of rules and requirements. To many senior beneficiaries, the grass was not necessarily greener in other plans, and other plans could be worse. They were skeptical that any other plan would be much better, even if they were less than satisfied with their coverage or costs. Most viewed premium increases as inevitable, and were reluctant to switch plans unless premiums rose considerably. For these reasons, many will go to considerable lengths to make their existing plan work.
- Among the relatively small number of seniors in the focus groups who said they did switch plans, some cited a desire to stay with a particular health care provider. Seniors would consider switching plans in response to a significant change in their personal health care needs, a major modification to their coverage or provider network, or, in the case of Part D plans, a big increase in the cost of a particular drug that they take, or a change in their plan's formulary or utilization management requirements.

Seniors in our focus groups said they appreciated being able to choose among many plans, and did not want their number of choices to be limited; however, they also felt unqualified to choose among plans and would like the process to be easier. Beneficiaries wanted to make well-informed and financially sound decisions but did not feel confident in their ability to do so under the current system. While they tried to compare costs, coverage, and provider networks, beneficiaries found the process frustrating and confusing. Many said they wanted advice from experts, so they relied on input from an insurance agent or a plan representative, or suggestions from family, friends, and medical professionals. Our focus groups identified a high demand for clear, concise, and easily comparable information presented in a digestible format focusing on the factors most important to consumers, namely cost, provider networks, and coverage. Few described the materials they have received as easy to use, and even fewer said they would turn to Medicare Compare during the next open enrollment period. Making it easier for beneficiaries to compare and switch plans, when it is in their interest to do so, would help achieve the goal of having consumers choose a plan that best meets their individual needs and preferences. In addition, if more beneficiaries switch to lower-cost plans, the result could be lower costs for themselves and for the Medicare program.

Introduction

Several leading Medicare reform proposals are predicated on the assumption of a well-functioning marketplace, where beneficiaries are offered a choice of competing health plans and choose a specific plan that is most likely to meet their individual needs and preferences. The proposals are further based on the supposition that as plans change, or beneficiaries' needs change, beneficiaries will re-evaluate health plan options available to them and change plans as necessary to optimize their coverage. These ideals are critical elements for a dynamic, competitive marketplace of private plans, and are the underpinnings of Medicare Part D and Medicare Advantage.

The plan environment in Medicare today is quite unlike that of 10 or 20 years ago, when the vast majority of seniors was enrolled in traditional Medicare and may only have had to decide whether or not to purchase a Medigap supplemental policy. In recent years, the Medicare plan landscape has been transformed, with dozens of private Medicare Advantage and Part D drug plans available to most people on Medicare. With so many plans and options to review, beneficiaries have many choices to make when they enroll in the Medicare program.

If they choose traditional Medicare, they often need to choose a specific stand-alone Part D prescription drug plan (PDP), and perhaps a supplemental Medigap plan if they are not otherwise receiving supplemental coverage under a retiree health plan or Medicaid. If instead they choose coverage under Medicare Advantage, they often face a myriad of plan choices, including HMOs and PPOs, with different provider networks, benefits, and premiums. Medicare Part D plans and Medicare Advantage plans are both subsidized by the Medicare program. Each year, plans may change their premiums, benefits, and other features and beneficiaries have the opportunity to assess these changes and, if deemed necessary, switch plans during the annual open enrollment period.

However, many studies show that few beneficiaries revisit their coverage decisions each year to determine which option is best for them based on their individual needs and the specific features of the plans available to them.² At the same time, analyses indicate that for PDPs, premiums and formularies have changed over time.³ Medicare Advantage plans' premiums, out-of-pocket limits, and provider networks have also changed over time.⁴ Based on these studies, most seniors seem to prefer to stick with their original plans despite changes in costs, coverage, and providers.

Further, several studies have shown that most beneficiaries who are enrolled in a Part D plan are not in the lowest cost PDP available to them.⁵ Similarly, many Medicare Advantage enrollees are not enrolled in the lowest premium Medicare Advantage plans, with significant geographic variation in the preference for zero-premium plans.⁶ It would appear that Medicare Advantage enrollees are attracted to plans with high quality ratings,⁷ but it is not clear whether the ratings are the reason for beneficiaries' plan enrollment or if it is a coincidence. Overall, beneficiaries may be enrolling in plans for reasons other than premiums or out-of-pocket costs, which could have important implications not only for beneficiaries' costs but also Medicare spending to subsidize plans.

In light of these critical issues, KFF partnered with PerryUndem to conduct a series of focus groups with seniors about their health plan decision making. These focus groups were undertaken to shed light on the following questions:

1. What factors drive seniors to choose one plan over another when they first go on Medicare? How do they decide between traditional Medicare and Medicare Advantage, and once they make this decision, how do they choose among available Part D or Medicare Advantage plans in their area?
2. Why do most seniors stay in the same plan year after year, rather than review and switch plans during the annual open enrollment period, even when they may face higher costs by remaining in the same plan?
3. Among the minority of seniors who switch plans in a given year, what prompted them to change plans?

The aim of these focus groups was to understand the experiences of beneficiaries today, assess whether the Medicare Part D and Medicare Advantage marketplaces are working as envisioned from the beneficiary perspective, and identify potential opportunities for policymakers to improve the marketplaces and make it easier for beneficiaries to assess and choose Medicare Advantage and Part D plans.

Methods

The focus group participants included Medicare beneficiaries ages 65 or older who make health coverage decisions for themselves and/or their spouse. Participants included beneficiaries in traditional Medicare, with Part D stand-alone plan coverage, and beneficiaries enrolled in Medicare Advantage plans. Because the study focused on decisions around health plans, we excluded beneficiaries with retiree coverage from a former employer or union and beneficiaries dually eligible for Medicare and Medicaid.

The focus groups were conducted in four cities: Baltimore, Maryland; Memphis, Tennessee; Seattle, Washington; and Tampa, Florida. The selection of cities was based on several criteria, designed primarily to reflect the variation in Medicare marketplaces across the country, including:

- the number of Medicare Advantage plans available to beneficiaries. In 2013, the average Medicare beneficiary could choose from 20 Medicare Advantage plans, 31 PDPs, as well as a multitude of Medigap plans;⁸
- the extent to which Medicare Advantage enrollment was concentrated within a small number of companies, as an indicator of the amount of Medicare marketplace competition among insurers. In 2013, three firms or affiliates accounted for 55 percent of Medicare Advantage enrollment, and similarly, 3 firms accounted for 50 percent of enrollment in PDPs, indicating that enrollment is highly concentrated in many Medicare Advantage and PDP markets;⁹
- Medicare Advantage penetration rate, to reflect the diversity of beneficiaries' familiarity, comfort and experience with respect to Medicare Advantage plans; and
- the percentage of enrollees in Medicare Advantage plans with prescription drug coverage (MA-PDs) that charged a monthly premium, to help examine whether premiums played a larger role in plan selection in some areas than others. In 2013, 87 percent of Medicare beneficiaries had access to a MA-PD with no monthly premium, but only 55 percent of Medicare Advantage enrollees were in a plan with no premium, with large variations across counties in the share of enrollees in plans with premiums.¹⁰

In addition, to ease focus group recruitment efforts, we identified cities with high percentages of individuals ages 65 and older, and relatively low percentages of beneficiaries dually eligible for Medicare and Medicaid (who were not included in this study) (Table 1).

Table 1. Profiles of Focus Group Sites

Site	Number of stand-alone prescription drug plans (PDPs) offered	Number of Medicare Advantage (MA) plans offered	Share of enrollees in plans offered by the largest MA Insurer	Largest MA Insurer	MA penetration rate	Share of MA enrollees paying plan premiums	Share of population ages 65+	Percent of beneficiaries dually eligible
Baltimore, MD (Baltimore County)	29	17	66%	Cigna	10%	93%	15%	16%
Memphis, TN (Shelby County)	33	15	32%	Cigna	21%	35%	11%	13%
Seattle, WA (King County)	30	21	34%	Group Health Cooperative	32%	63%	12%	15%
Tampa, FL (Hillsborough County)	34	46	42%	Humana	43%	3%	12%	17%

SOURCE: Medicare Advantage penetration rates, number of plans, enrollees by insurer, and percent of enrollees paying plan premiums from KFF analysis of CMS enrollment files, 2013. Percent of beneficiaries dually eligible from KCMU and Urban Institute analysis of FY2008 MSIS. Percent of population ages 65 and older from American Fact Finder, U.S. Census Bureau, 2012.

The focus groups were conducted in November of 2013, in order to overlap with the Medicare open enrollment period, which starts October 15 and ends December 7 of each year. Each focus group included 6-8 participants, differing by age, gender, race/ethnicity, and health status. After an initial screening, we separated participants into groups of Medicare Advantage enrollees, and beneficiaries covered under traditional Medicare. In total, we conducted 9 focus groups in 4 cities, and each focus group lasted 90 minutes (Table 2). In some instances, groups were stratified by income, with the groups comprised of only lower income beneficiaries (below \$25,000/individual or \$50,000/couple) or higher income beneficiaries, to test whether different income levels would alter the process by which beneficiaries select plans. Additionally, all Medicare Advantage focus groups included participants enrolled in plans offered by different insurance companies and paying different monthly premiums, with the exception of the focus groups in Tampa where all beneficiaries were enrolled in zero-premium plans.

Table 2. Focus Group Characteristics

Site	Traditional Medicare	Medicare Advantage	Income
Baltimore, MD	✓		Lower income
Baltimore, MD	✓		Higher income
Memphis, TN		✓	Mixed income
Memphis, TN	✓		Mixed income
Seattle, WA		✓	Mixed income
Seattle, WA	✓		Mixed income
Tampa, FL	✓		Mixed income
Tampa, FL		✓	Lower income
Tampa, FL		✓	Higher income

What factors lead beneficiaries to not be enrolled in the “lowest cost” health plan?

Seniors in this study were asked to think back to when they last chose a Medicare Part D plan or a Medigap policy (if in traditional Medicare) or a Medicare Advantage plan. They mentioned a number of factors they weighed in their decision making, with costs usually at the top of the list. Other considerations included staying with a particular provider, familiarity with the insurance company, the plan’s marketing efforts, staying in the same plan as a spouse, and the plan’s coverage.

This was the first one that I’d ever had, you know, the first time I was on Medicare with the Part D and I was young and impressionable when I made the decision and it was purely based on the fact that 95 percent of my medications were zero co-pay.
-PDP Beneficiary (Baltimore, MD)

BENEFICIARIES DEFINE “LOWEST COST” DIFFERENTLY

IT OFTEN BUT NOT ALWAYS MEANS THE PREMIUM. Beneficiaries are concerned about the cost of health care because most live on fixed incomes with limited savings.¹¹ When they think about costs, the first thing

A couple of scripts are like “Phew. It’s the meds or the car payment, what do I do?”

-PDP Beneficiary (Baltimore, MD)

that comes to mind for most beneficiaries is a plan’s monthly premium, because it is a predictable, monthly expense that they will incur regardless of their health needs. However, many beneficiaries, particularly those in poorer health also consider

deductibles, co-pays, and other out-of-pocket expenses they might incur. Focus group participants who interacted more with the health care system tended to be more sophisticated in their thinking and calculations around cost. For beneficiaries in Medicare Advantage, they examine the premium and may also look at the deductibles and out-of-pocket costs for different services, such as hospitalizations, especially if they have needed those services in the past. For those in Part D plans, they look at the premiums and deductibles, and may consider the cost of a specific drug if they take one that is particularly costly or one that is particularly important for treating a chronic health condition. Some beneficiaries in poorer health said they tried to anticipate what health care they might need in the future, and defined the lowest cost plan as the one that placed them at the lowest financial risk, while healthier beneficiaries tended to focus more on the premiums, particularly beneficiaries in PDPs.

I look at the cap and then I want to look at the hospitalization. What I care about is if I have a major issue and go in the hospital and my out of pocket [is] \$2,500 dollars or \$5,000 dollars.

-Medicare Advantage Beneficiary (Memphis, TN)

COST IS IMPORTANT BUT OTHER THINGS ARE MORE IMPORTANT TO BENEFICIARIES

MANY SENIORS WANT TO HAVE ACCESS TO SPECIFIC HEALTHCARE PROVIDERS.

For people considering Medicare Advantage plans, a top issue is whether their doctors are part of the plan’s network. In most cases, people are concerned about maintaining access to their primary care physician. Many of those with specific health needs, however, are often more concerned about having access to a specialist they are used to seeing. While some seem willing to give up their regular doctors to have a more affordable plan, others are not. It seems to depend (at least to some extent) on the strength of the relationship between the doctor and patient.

I want the choice. I like the PPO because I have a choice. I might not like this doctor always and want to go someplace else.

-Medicare Advantage Beneficiary (Seattle, WA)

Importantly, people are not only concerned about whether their plan allows access to their preferred doctors; access to certain hospitals or health centers also matters. Some mentioned specifically that they wanted to be sure they could go to the best hospital in their area or that, if they were diagnosed with cancer, they could go to the best treatment center in their area.

When we travel ... we like the idea that CVS is up there, the networking is there. [It is] very easy to walk in and you're just like an old friend, because you're with that program.
-Medicare Advantage Beneficiary
(Tampa, FL)

Many people with stand-alone Part D plans said having access to the pharmacy they are familiar with or that is close to their home is very important to them, and often more important than drug prices. Some have strong relationships with their pharmacists and do not want to give that up.

FAMILIARITY WITH THE NAME OF THE INSURANCE COMPANY IS IMPORTANT TO MANY

BENEFICIARIES. Names matter to beneficiaries. Some are drawn to certain plans and turned off by others simply because of the name. At a most basic level, a plan from a company with a recognizable name seems most important. Some expressed hesitation about the idea of going with a plan from a company they had never heard of, even if that plan was cheaper than their current one.

I wouldn't go to Bob's discount liquor and used clothing store/Part D insurance coverage.
-PDP Beneficiary (Memphis, TN)

Reputation Matters. Apart from simple name recognition, reputation matters – and people make certain (good and bad) associations with specific names. For example, several people said they decided to go with a plan through AARP because they knew AARP and trusted that it would be a good plan. Others, however, were turned off by AARP plans because they did not agree with the organization politically. People also associate certain reputations with big insurance companies like Blue Cross Blue Shield, United Healthcare, and Aetna. Some have impressions of certain companies being good or bad and this influences their willingness to look into their plans.

When I chose my current one I chose it because of the credibility of AARP; they were bound to be my advocate.
-PDP Beneficiary (Memphis, TN)

A few expressed commitments to certain companies and this helped them narrow down their choice of plans. For whatever reason, some had decided they wanted a plan from a specific company a priori and when it came time to choose a plan, they only considered plans offered by that company.

Some seniors stay with the same company through which they had employer-sponsored insurance or other insurance prior to going onto Medicare.

A few people mentioned that they decided to go with a specific insurance company because they had insurance through them before they were enrolled in Medicare. They were already familiar with the company and with the customer service, so it seemed relatively easy to just stay with them. One man, for example, was with Humana when he was employed. When it was time to enroll in Medicare, he went to Humana's office and they helped him choose a new plan and sign up the same day.

In my case my husband retired from AT&T so we had United Healthcare for years. So the plan that they offer is the Advantage plan so we didn't have a whole lot of choice.
-Medicare Advantage Beneficiary
(Memphis, TN)

PLAN REPRESENTATIVES AND MARKETING INFLUENCE PLAN CHOICES. While not a top factor in choosing plans, the extent to which beneficiaries feel like they are receiving good customer service matters. This is especially true when they are choosing their initial Medicare plan. If a company has good customer service and can answer their questions about plans in a clear way, this makes beneficiaries more likely to go

When I went to Humana I just went in and sat with a rep in the office. They went over everything and it seemed to look like what I was looking for and encompassing a lot of different things so I went ahead and selected that.
-Medicare Advantage Beneficiary
(Tampa, FL)

with that company. If they have a bad customer service experience early on, they are turned off.

Many enroll in plans after talking with a plan representative at an information session or having one over to their home to discuss the details of plans. This face-to-face interaction is important to many, and it often seals the deal.

SOME WANT TO MAKE SURE THEY HAVE THE SAME PLAN AS THEIR SPOUSE. When choosing a plan, some married beneficiaries say they make sure they and their spouse have the same plan (or at least the same company). In most cases, this seemed to be a matter of convenience and practicality. They say it is easier to keep track of information, rules, changes, and the like for a single plan rather than two. It helps avoid confusion and makes life easier. In a few cases, the spouses seemed to have very different health needs, but they still felt the convenience of having a single plan outweighed the potential benefits of having separate plans that might better meet their health needs.

[Unlike me] my husband has quite a bit of problems ... My being in the same plan, this gives us the same doctors so they know me and they know him. It's more of a combined knowledge there so they know exactly the whole family.
-Medicare Advantage Beneficiary
(Tampa, FL)

Same plan, same doctor, same household, same everything.
-Medicare Advantage Beneficiary
(Seattle, WA)

Not all married people see things this way. Many explained that one spouse had very different needs than the other and that having the same plan did not make financial sense for them. For example, one spouse might have a chronic condition that requires a lot of care and medication while the other is healthy. Many people with spouses explained that in a case like this, they would not prioritize having the same plan; however, in a few cases, spouses taking different prescription drugs preferred to be in the same PDP despite their different health needs.

HAVING GOOD COVERAGE FOR DRUGS AND NEEDED MEDICAL SERVICES IS AN IMPORTANT FACTOR FOR MANY. Coverage is important, particularly when prescription medications are involved. When it comes to Part D plans, they want to know first and foremost that their current medications are going to be covered. Many are also often checking for more general coverage information like the extent to which brand name versus generic drugs are covered.

When looking at Medicare Advantage plans, they want to make sure the healthcare services they may need are covered. Among those with specific health needs, they are looking to make sure they can get the care they know they will need. Among those without many current healthcare needs, some look for plans that cover any and everything

The fact that Medicare Advantage had everything included in it such as the drug plan, Part A, Part B. That really was good for me because I just didn't want to think about all these other plans.
-Medicare Advantage Beneficiary
(Tampa, FL)

they might need in the future. Others, however, want to make sure they are not going to end up paying to cover services they do not expect to use.

Among those with Medicare Advantage plans, the ability to get vision and dental coverage is a major draw. The addition of other services like the Silver Sneakers (exercise and gym) program is also attractive to many. They like feeling like they are getting a lot of services out of the plan, even if they do not use them.

MEDICARE'S STAR RATINGS DO NOT INFLUENCE DECISIONS VERY MUCH (IF AT ALL). Most are unaware of consumer tools like the star ratings that Medicare provides and as a result do not use them in making their decisions. Overall, people seemed to think the star rating system could provide them with some helpful, additional information but did not suggest that it would be a decisive factor for anyone; instead, it would be another piece of information to consider. Focus group participants wanted to know more about how the rating system actually worked. For example, they wanted to know who creates the rating, based on what criteria, and how often it is updated.

I've never used [star ratings] because I presume that they are doing some weighting of these factors to get to those stars and my only factor that I care about is cost. It's like those lists of best places to live. You don't know what they are weighting.
-Medicare Advantage Beneficiary
(Tampa, FL)

Some have seen these ratings and considered them, but explain that they did not play a major role in their decision-making process. Likewise, among those who were unfamiliar with the ratings, the general sense was that they would look at the ratings, but they would not likely weight them heavily in their decision. New, outside information about their plan does not necessarily make them question their initial choice. This is especially true if they already have personal experience with a plan; in most cases, their personal experience would outweigh the star rating.

If they are generally satisfied, they are not likely to consider changing plans even if they learn about others' negative reviews of the plan. For example, most say that learning that a friend has had a bad experience with the same plan would not make them consider changing. They say that this is one person's experience, not theirs. Likewise, if they found out that their plan only had three stars in Medicare's rating system, they would not necessarily start looking for a plan with more stars. They view the ratings as based on other people's experiences, which are not necessarily relevant to them. But when asked what they would think if they found out their plan had a very low rating (say, less than 3 out of 5 stars), many said they would at least look into it to see why.

There was one notable scenario when the star rating system was relied on by focus group participants, or in this case, the absence of a star rating altogether. One man mentioned that he ruled out a plan because instead of having a star rating, it said "plan is too new to be rated." This made him feel like the plan might be risky since it was so new.

BENEFICIARIES FIND IT TOO DIFFICULT TO COMPARE PLANS

THEY RECEIVE AND COLLECT A LOT OF INFORMATION FROM VARIOUS SOURCES. Some beneficiaries say they have gone to the Medicare Compare plan finder website on Medicare.gov to learn more about plans and make comparisons, but most have not. Among those who have gone to Medicare.gov, a few found the information to be helpful at a general level, but most say that once you get into the details of plans, the information on the site is confusing. They think the language is too technical and the comparisons are not very helpful because the information is not standardized. Additionally, many explain that they are not very savvy with the computer and navigating the website is just too much for them.

Some have called Medicare's 800 phone number with mixed results. A few say they had good experiences and received customer service that helped them with the information they needed. Others complained of long wait times or less than helpful customer service.

I can't find anything that makes any sense. When I call about it and ask for information I get such strange ideas about how I should get information from different providers and then analyze it and compare it like I'm some kind of computer or something. I can't do that.
-PDP Beneficiary (Baltimore, MD)

Everyone recalls receiving the "Medicare and You" handbook. It seems that most people look at it initially but do not use it to choose a plan.

Focus group participants also received booklets and information from health plans. People said they use them to see if their doctors and prescriptions are covered in the plans they are considering. But this is often the extent to which these materials are used. People say they are not easy to read, and are not always up to date with the current lists of physicians accepting specific plans.

Beneficiaries explain that they receive and seek a lot of information about plans when they first enroll in Medicare. Sources of information include the following:

- "Medicare and You" handbook sent out by the Centers for Medicare and Medicaid Services
- Information from insurance plan websites
- Plan materials sent to their homes
- Informational sessions hosted by insurance companies
- Infomercials on television

Many mentioned that they do at least look over the information for their current plans during open enrollment to make sure they are aware of any changes that might be taking place. Many people with Part D plans, for example, will review their formularies to make sure their prescriptions are still covered. But this is done more as a housekeeping task, not necessarily as a step toward changing their plan. If any red flags are raised in this process, however, they may consider looking into other options.

SENIORS SAY THEY HAVE TRIED TO COMPARE THE COSTS, COVERAGE, AND PROVIDER NETWORKS OF PLANS, BUT FIND IT FRUSTRATING AND CONFUSING.

For those who do not engage very frequently in the healthcare system, their monthly premium is the main cost they consider – often looking for the lowest premium and either not paying attention to or not worrying about deductibles and co-pays because they do not expect to need much healthcare. This was especially true among many Medicare Advantage enrollees, who explained that they had plans with very low premiums. The trade-off was higher co-pays (especially for hospital stays), but many felt that the tradeoff was worth it given how little they expected to use healthcare services.

That's what gets me, they wait until we retire to make it complicated. [...] now all of the sudden I have all of these Advantage programs and I have to do a spreadsheet.
-Medicare Advantage Beneficiary (Memphis, TN)

For those who see doctors often or take a lot of medication, determining their total expected costs can become quite complicated. This is a very frustrating aspect of sifting through plan information and trying to make a choice. It may be that no Part D plan, for example, covers all the medications they need, so they have to figure

I went online. I had papers taped together, it was six feet wide, of the different companies and circles and arrows.
-PDP Beneficiary (Baltimore, MD)

out what their out-of-pocket spending would be for several plans. A few people explain that they make spreadsheets to lay out all of this information. Most, however, either just do the best they can or enlist the help of insurance agents, adult children, or others to help them figure it out.

SENIORS RELY ON INSURANCE AGENTS AS TRUSTED ADVISORS. Following the advice of an insurance agent seemed to be the most common way that people chose their plans. They trust agents as valuable sources of information who can help them figure out the best plan for them. Many have agents they have worked with before enrolling in Medicare and stick with them. Others find new agents through referrals or because an agent proactively sought them out as a customer.

Few seem to have concerns about insurance agents' objectivity or potential biases. They view them as knowledgeable professionals who can help simplify what feels like a very complicated decision-making process.

...all our insurance comes under our agent and we've had him for 20 years, so we just kind of accepted the recommendation for it. But I do believe that he has researched the other companies and made available what we should know.
-PDP Beneficiary (Memphis, TN)

MANY RECEIVE SUGGESTIONS FROM FRIENDS. Most say that they would not blindly follow a friend's recommendation. They recognize that what is good for one person may not be right for another. But they often

We have a lot of friends who do research, so we did a lot of networking. It works.
-PDP Beneficiary (Baltimore, MD)

take friends' experiences into account as starting points to look into certain plans. Also, if they hear that a friend is getting a good deal (a low premium, for example), this may spark their interest to look into that plan.

MANY GET SUGGESTIONS FROM PHARMACISTS AND DOCTORS' OFFICES. Many beneficiaries say they start narrowing down their plan options by asking their pharmacist or doctor's office what insurance they accept. This is a way for them to make sure they are looking into plans that would allow them to continue using their pharmacy and keep their doctor. Very few talk about these issues with their doctors directly, however. Most view their doctors as not knowing much about insurance.

*I've asked my doctor some questions about what he can do, and he says, "Well consult your book."
- Medicare Advantage Beneficiary
(Seattle, WA)*

MANY ENROLL IN THE LOWEST COST PLAN INITIALLY BUT DO NOT SWITCH AS COSTS RISE AND NEEDS CHANGE

While most seniors say they heavily weighed costs when selecting their plans initially, costs do not seem to be as important after they are enrolled. A number of seniors in this study acknowledged that their costs had risen since they first enrolled but that they still had not considered changing plans. They offer a number of reasons for this, including wanting to avoid the frustrating process of choosing a new plan, fears that they will be worse off in a new plan, and an expectation that costs are going to increase regardless of which plan they choose.

Why do Medicare beneficiaries tend to stay in the same health plan from one year to the next?

In each focus group a few people had either changed plans at some point or were considering changing plans soon, but the vast majority had not and were not considering doing so. There was general consensus that they are resistant to changing plans. Choosing plans is an unpleasant task they try to avoid. Additionally, they view changing as risky. Focus group participants did not think the “grass was greener” in other plans and were wary of unknown aspects of other plans. Even if they were not 100% satisfied with their plans, they felt more comfortable staying with what they knew.

For the most part, people seem to be satisfied (enough) with their plans. Many invested some time and effort in making their initial choice and would need a major reason to revisit that choice. Most have various complaints about their plans, but very few have issues that seem major enough to make them reconsider their options and go back to square one.

There are days when I look at a plan, or look at my plan, and I think about possibly making a change, depending upon what's out there for me ... I've reached the age of 78 and I'm saying to myself, "I'm too goddamn tired to investigate this."
-PDP Beneficiary (Baltimore, MD)

COMPARING AND CHOOSING PLANS THE FIRST TIME WAS FRUSTRATING ENOUGH, AND THEY ARE RELUCTANT TO DO IT AGAIN

CHOOSING INSURANCE PLANS IS A FRUSTRATING, OVERWHELMING PROCESS FOR MOST.

Beneficiaries describe the choice process as difficult and overwhelming. They receive lots of information from Medicare, insurance plans, insurance agents, friends, and others, and they do not know how to navigate through it all. They find it difficult to compare plans because there are so many details and the information across plans is not presented in a standardized way.

Many say they do not feel confident to make the right choice and just do the best they can. Most would like more help from trusted sources in the process and are grateful for the help they receive from knowledgeable people, especially in-person help from insurance agents and plan representatives.

For most, choosing their initial plan was a very complicated process. The thought of doing all of that again was not appealing. Even the savviest of beneficiaries admit that they find all of the plan information overwhelming

And because I feel that I did my homework to the hilt initially, that should remain good for me. If it is up and pricey, that's okay. I don't gamble. I am not a gambler.
-PDP Beneficiary (Baltimore, MD)

and are not sure how to go about choosing another plan again. People who have relationships with insurance agents seem less resistant to change for this reason; they have someone who they feel like they can call and just ask, “Is there something better out there for me?” But even these people are resistant to the idea of changing if there is no major issue with their current plan.

OPEN ENROLLMENT IS NOT TYPICALLY VIEWED AS AN OPPORTUNITY TO FIND A BETTER QUALITY OR MORE AFFORDABLE PLAN. Open enrollment is viewed by many as a time to change plans only if they are unhappy with their current plan. Even though the focus groups occurred during open enrollment, most admit they were not reviewing their plan choices and intended to stay put in their current plans. To consider changing plans, it seems that beneficiaries need to be frustrated with some aspect of their current plan. Only then would most people look into other options.

OPEN ENROLLMENT IS ONLY ONCE PER YEAR AND TIMING MAY NOT BE IDEAL. It is important to point out that timing matters when it comes to changing plans. While many people have complaints about their plans, often times the issues arise when the open enrollment period is still in the distant future. In the

I think the older you get, the more resistant you are to change in general. There's that comfort level, also. I wouldn't want to keep going from one plan to another. There would have to be a big reason.
-PDP Beneficiary (Seattle, WA)

meantime, they cope – they swallow the extra cost, they find a tolerable workaround, they go without seeing a particular doctor, and so on. For some, it seems that by the time open enrollment comes around, they are not as concerned about the issue as they were initially. They become accustomed to managing and as a result may not end up changing plans. If problems arise or persist during open enrollment, it seems people are much more open to considering changing plans. It becomes a top of mind issue that they feel like they can address immediately.

Change is not perceived as a good thing. Changing plans potentially disrupts their care, which may cause anxiety. Seniors who use a lot of services are used to going to their preferred pharmacy, their chosen providers, and obtaining the medications they need. They do not want to risk upsetting a pattern of care that is working well for them, even if there are problems with their plans. There is a feeling among many seniors that they will be worse off if they leave their current plans.

Newer isn't always perceived as better. When it comes to changing plans, many express a view along the lines of “the grass isn't always greener on the other side.” They say there will always be trade-offs and no plan will meet all of their needs all of the time. Given this reality, it is better to avoid the hassle of changing plans and to stick with what they know.

At our age as we get older we learned that the grass is not really greener on the other side. We're very cautious about changing to something else that is unfamiliar when we have that [which we] know in front of us.
-PDP Beneficiary (Tampa, FL)

BENEFICIARIES ARE MORE LIKELY TO CHANGE THEIR CARE BEFORE THEIR PLAN

MOST WILL GO TO CONSIDERABLE LENGTHS TO MAKE THEIR EXISTING PLAN WORK. Beneficiaries seem willing to do just about anything to make their existing plans work. When problems arise, they seek workarounds. This seems especially true for people with Part D plans. For example, if a medication they need is not covered, they will try a number of workarounds, including the following: asking their doctor for an alternative drug or a generic version, seeking samples from their doctor's office, applying for discounts from drug manufacturers, making appeals to their insurer, and ordering medications from Canada or online.

If you can find an alternative [drug] through your doctor, try something else. Then you make the decision whether you need to change your plan.
-PDP Beneficiary (Baltimore, MD)

I figure if someone has gone through medical school and has their diploma on the wall, chances are they know enough about what is wrong with me to treat me. I'm not that committed to one particular doctor. Now if I get some serious ailment I may change my mind overnight.

*-Medicare Advantage Beneficiary
(Tampa, FL)*

Many focus group participants in Medicare Advantage plans were also willing to give up their primary care physician. Some said that if their doctor was no longer in their network, they would probably just find another doctor rather than change plans. They explained that if they were happy with the other aspects of their plan, this was something they could live with. Additionally, a few made the point that which doctors participate in which networks changes so often that it would be impossible to follow your doctor around all the time.

COST INCREASES ARE EXPECTED

MOST SENIORS VIEW COST INCREASES AS INEVITABLE. They are not surprised by increases in premiums or co-pays. They expect this. Most seem very willing to tolerate increases in monthly costs (be it for

*Get mad and pay.
-Medicare Advantage Beneficiary
(Seattle, WA)*

The cost of a lot of things and these plans keeps creeping up. It is a matter of when our own personal circumstances reach that point.

-PDP Beneficiary (Baltimore, MD)

their premium, co-pays on medication, or other costs) up to a point. When the increase starts reaching around \$75 more a month, most say they would consider looking into new plans. The tolerance for cost increases seems particularly high among those with PDPs.

SOMETIMES THEY VIEW LOWER COSTS WITH A SUSPICIOUS EYE. Most explain that they would be suspicious if there was ever a reduction in their premium from one year to the next. They are accustomed to price increases. A decrease would alarm them and make them think it is a sign of changes made to the plan like less coverage, higher co-pays, or limitations on their choice of pharmacies or providers.

Additionally, some beneficiaries associate higher prices with higher quality and therefore assume that if a plan costs more, you must be getting more for your money. Indeed, some in traditional Medicare say they are suspicious of \$0 premium plans; they say it raises red flags about the quality of the plan. It is important to note, however, that many people with Medicare Advantage plans had \$0 premium plans and did not express these types of concerns.

MANY ARE NOT AWARE OF THEIR OPTIONS

AMONG PEOPLE IN TRADITIONAL MEDICARE, MANY WERE NOT AWARE OF THE CHOICE BETWEEN TRADITIONAL MEDICARE AND MEDICARE ADVANTAGE PLANS. It seems that most just ended up in

traditional Medicare or a Medicare Advantage plan without having made a conscious choice between the two options, and low levels of knowledge remain a problem. Those with traditional Medicare seemed particularly unaware of the choice; most did not know anything about Medicare Advantage plans. A few had heard negative things about them, such as the belief that many doctors do not accept them. Many seem resistant to the idea of having a limited network and giving up some choice on providers. Others feel that Medicare Advantage may be worth looking into as long as their primary care physician or other valued doctors participate in it.

*Heard of [Medicare Advantage], but I know nothing about it.
-PDP Beneficiary
(Baltimore, MD)*

There was more awareness of the choice among people who had Medicare Advantage plans, although many also seemed to have just landed in their plan without having necessarily deliberated the difference between this option and traditional Medicare. In many cases, they chose their plans based on the recommendation of an insurance agent or friend. Some of these beneficiaries express frustration with their limited network, but most are satisfied and say they like having everything in one plan and having access to centers where they can get all the care they need in one place. Many also like having the option to get dental and vision coverage and the extra benefits like gym access through Silver Sneakers.

For most, the amount of information ends up being overwhelming and difficult to sift through. They do not feel as though they can make sense of it all and make a good decision on their own, so they seek help from other sources.

SOME ARE SIMPLY UNINFORMED ABOUT THEIR PLAN OPTIONS. Some people seem uninformed about the choices they have. A few people, for example, do not understand that they are allowed to change plans during the open enrollment period. Some think that there are not many differences across plans except in terms of cost; they think most plans offer the same coverage and services. And as previously mentioned, most people in traditional Medicare do not know much (if anything) about Medicare Advantage plan options.

What drives some people on Medicare to switch plans?

If beneficiaries decide to change plans (or to at least look into new options), the way they go about this is similar to the way they chose their initial plan. They collect information during open enrollment and engage trusted sources to help them navigate it all and make a decision. As during their initial plan selection process, insurance agents play an important role for many.

BENEFICIARIES' NEEDS CHANGE

SOME BENEFICIARIES CHANGE PLANS AFTER INCURRING HIGHER COSTS OR NOT GETTING THE CARE THEY THOUGHT THEY NEEDED.

For those who have changed Part D plans in recent years, increasing costs seem to be the main driver. For example, a few people sought new Part D plans because they kept falling into the coverage gap ('donut hole') and wanted to find new plans that would help limit their out-of-pocket expenses for medications. Others switched Part D plans because a medication they needed to take regularly was not covered and they could not figure out any workarounds. A few people with Part D plans explained that they eventually switched plans once their premiums had increased year after year.

Cost is also an important driver for people with Medicare Advantage plans to change plans. The most common cases mentioned in our focus groups seemed to be situations in which people were looking to save money by either switching to a plan with a very low premium but relatively high co-pays (if they did not use many healthcare services) or moving away from such a plan (if they ended up needing more healthcare than they had originally anticipated). In other words, among this group of beneficiaries, their decision to change plans was more often about choosing a plan that made the most financial sense for them and not usually a reaction to an increase in costs.

*When my wife fell and broke her leg she was in rehab and [the insurance company] shut her off. They refused to cover her. So we both said "Forget this Charlie."
-Medicare Advantage Beneficiary (Tampa, FL)*

PLANS CHANGE

HIGHER DRUG COSTS, TOUGHER UTILIZATION MANAGEMENT RESTRICTIONS, AND LIMITED PHARMACY NETWORKS CAUSE PEOPLE TO CHANGE PLANS.

Many seniors in this study relied on medications to maintain their health. They often had strong preferences when it comes to their medications – and where they obtain them.

*They wanted me on a less expensive statin and I would not change. I would not change. I would not change. So they kept elevating the price until I finally left them.
-PDP Beneficiary (Baltimore, MD)*

Changes in their plan's drug formulary or which pharmacies are covered are reasons a number of seniors say they would consider changing plans. Seniors also said that they would change plans if the costs of their drug goes up too much, it is more difficult to obtain their drug due to preauthorization requirements or other restrictions, or if their drug was no longer covered by their plan.

LEARNING THAT A VALUED DOCTOR OR HOSPITAL IS NO LONGER COVERED IN THE PLAN IS A MOTIVATING FACTOR TO CHANGE PLANS.

While not as common of a motivator as costs, for people in Medicare Advantage plans, finding out that a preferred doctor or hospital is no longer covered by a plan has motivated some people to change or consider changing plans. In some cases, this is about losing access to a primary care physician with whom they have a long-standing relationship. In other cases, it is about losing access to a valued specialist for a chronic condition. Learning that they can no longer access a specific hospital – even if they do not have current needs to go there – has also raised red flags for some people. Some are concerned about infection rates in hospitals as well as making sure they can get the best care for a given condition (again, even if they do not currently have it). One Floridian woman, for example, explained that she was concerned that a particular plan was no longer referring patients to a specialty cancer center even though she did not have cancer.

While most are not that vigilant when it comes to reviewing their plans and considering other options, some are more sensitive to changes in their plans than others. For example, people who have a chronic illness, take multiple medications, or see many specialists are much more aware of the details of their plans and more sensitive to plan changes in coverage and costs. They still tend to be resistant to changing plans, but if a strongly preferred doctor or hospital is no longer covered, they would consider changing. Likewise, if increases in costs pass a tolerable threshold, they are more likely to consider changing.

What do beneficiaries suggest to improve the system?

The following are ideas suggested by the seniors in this study for improving the decision making process in Medicare. While acknowledging that they are resistant to change and reluctant to engage in the decision making process after their initial choices, many seniors feel that Medicare could do more to facilitate plan choice.

Increase access to in-person help for choosing plans. Beneficiaries want to sit down with someone face-to-face to discuss their options and have their questions answered. Currently, insurance agents and plan representatives are filling this role. While most beneficiaries do not seem concerned about their objectivity or potential biases, beneficiaries would appreciate alternatives to these sources.

*Seniors need [...] support. They need help that's not just a matter of getting phone numbers and how to work the computer. They need actual, personalized help, that doesn't cost money.
-PDP Beneficiary
(Seattle, WA)*

Explain more clearly how people might benefit from a change in plans (or the cost of inaction).

Focus group participants do not necessarily think there is anything to gain by revisiting their choice of insurance plans and suggest that it could help to have someone explain how the process could benefit them. Giving real examples of how people benefited after switching plans could be helpful. It could also be helpful to remind people that their health situations change as do plans, and it is worth making sure they are getting the most out of their insurance.

Create a user-friendly online tool to help beneficiaries narrow down their plan options. One of the biggest challenges identified by study participants in choosing a plan was the multitude of plans to consider and compare. Beneficiaries in this study liked the idea of a tool that could give them a shortlist of potential plans that could work for them based on a few pieces of information like their top plan selection criteria. They did not seem to think that the Medicare Compare plan finder website performed this task adequately. Beneficiaries complained that the current Medicare Compare plan finder uses complicated language and does not provide helpful plan comparisons. They suggested updating the site with more clear language and streamlined tools that allow apples-to-apples comparisons.

Advertise the star rating system, although beneficiaries say they still may not use it. Very few people know about the star rating system. While it is not likely to be a decisive factor in people's decisions, most think it would provide another piece of helpful information. Along with giving the star rating greater visibility, study participants also requested simple explanations of how the ratings are produced; beneficiaries want to know this information and say it will give more credibility to the ratings.

Retain plan choices: Abundance in the number of plan options is both a blessing and a curse. Study participants expressed some ambivalence about the amount of choices in plans. On the one hand, most believe that having a lot of plans to choose from leads to more competition and better quality and prices. On the other hand, they also find having too many choices to be overwhelming when it comes to actually sifting through the information and choosing a plan.

Overall, beneficiaries in this study were resistant to the idea of anyone (especially the government) limiting their choices. But they like the idea of developing tools to help them narrow down their choices based on certain criteria that are important or relevant to them.

Discussion

Many seniors on Medicare find the process of choosing a plan to be arduous and frustrating. They think they did their homework the first time, and should not need to revisit the decision. Unless they have a particularly bad experience with their plan – such as a substantial increase in costs, a loss of a valued benefit or provider, or a major change in their health condition that identified a mismatch between their needs and coverage – they are reluctant to compare or switch plans during the open enrollment period. The prevailing view is that it is not worth the hassle and the grass is not necessarily greener in another plan. Even in extreme circumstances (such as their drug plan dropping coverage of their prescription drug), beneficiaries will go to great lengths to adapt to their plan (by switching drugs or getting samples from their doctor) rather than make a change. When they feel they have no choice but to find another plan, seniors are eager to find shortcuts in making the selection with the least amount of stress and hassle, often preferring to get advice from a trusted advisor, such as an insurance agent or a plan representative, or suggestions from family, friends, and medical professionals. Focus groups identified a high demand for clear, concise, and easily comparable information presented in a digestible format focusing on the factors most important to the individual, namely cost, provider networks, and coverage. Few described the materials they have received as easy to use, and even fewer said they would turn to Medicare Compare during the next open enrollment season.

Seniors in our focus groups said they appreciate being able to choose among many plans, and do not want their number of choices to be limited; however, they would like to have additional help with selecting their plan. Many beneficiaries seek to make well-informed and financially sound decisions but do not feel confident in their ability to do so under the current system. Making it easier for beneficiaries to compare and switch plans, when it is in their interest to do so, would help achieve the goal of having consumers choose a plan that best meets their individual needs and preferences. In addition, if more beneficiaries switch to lower-cost plans, the result could be lower costs for themselves and for the Medicare program.

Endnotes

¹ For example, see Yaniv Hanoch, Thomas Rice, Janet Cummings, and Stacey Wood, “How Much Choice is too Much? The Case of the Medicare Prescription Drug Benefit,” *HSR* 44(4):1157-1168, August 2009; Jeffrey R. Kling, Sendhil Mullainathan, et al., “Comparison Friction: Experimental Evidence from Medicare Drug Plans,” *Quarterly Journal of Economics* 127(1): 199-235, January 2012.; Jason T. Abaluck and Jonathan Gruber, “Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program,” *American Economic Review* 101(4): 1180-1210, June 2011; Florian Heiss, Adam Leive, Daniel McFadden, and Joachim Winter, “Plan Selection in Medicare Part D: Evidence from Administrative Data” (No. w18166), National Bureau of Economic Research, 2012. Hoadley Jack et al., “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?” Kaiser Family Foundation, October 2013; and Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013; Shinobu Suzuki, “Medicare Part D’s Competitive Design: Do Part D Enrollees Switch Plans?” *Academy Health*, June 2013.

² For example, see Yaniv Hanoch, Thomas Rice, Janet Cummings, and Stacey Wood, “How Much Choice is too Much? The Case of the Medicare Prescription Drug Benefit,” *HSR* 44(4):1157-1168, August 2009; Jeffrey R. Kling, Sendhil Mullainathan, et al., “Comparison Friction: Experimental Evidence from Medicare Drug Plans,” *Quarterly Journal of Economics* 127(1): 199-235, January 2012.; Jason T. Abaluck and Jonathan Gruber, “Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program,” *American Economic Review* 101(4): 1180-1210, June 2011; Florian Heiss, Adam Leive, Daniel McFadden, and Joachim Winter, “Plan Selection in Medicare Part D: Evidence from Administrative Data” (No. w18166), National Bureau of Economic Research, 2012. Hoadley Jack et al., “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?” Kaiser Family Foundation, October 2013; and Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013; Shinobu Suzuki, “Medicare Part D’s Competitive Design: Do Part D Enrollees Switch Plans?” *Academy Health*, June 2013.

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⁴ Gold, Marsha, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, “Medicare Advantage 2014 Spotlight: Enrollment Market Update,” Kaiser Family Foundation, May 2014.

⁵ Chou Zhou and Yuting Zhang, “The Vast Majority of Medicare Part D Beneficiaries Still Don’t Choose the Cheapest Plans That Meet Their Medication Needs,” *Health Affairs* 31(10): 2259-2265, October 2012; Jason Abaluck and Jonathan Gruber, “Evolving Choice Inconsistencies in Choice of Prescription Drug Insurance,” National Bureau of Economic Research Working Paper 19163, June 2013; and Hoadley Jack et al., “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?” Kaiser Family Foundation, October 2013.

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THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters

2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and Barbara Jordan Conference Center

1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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