Beneficiary Decisionmaking: The Impact of Labeling Health Plan Choices

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One critical health plan decision concerns choosing an original Medicare plan or a Medicare managed care plan. Evidence suggests that people are confused by the phrase "Original Medicare plan." Using focus group and Q-sort methodology, the authors sought to identify a name for the Medicare fee-for-service (FFS) product. Two key insights were gained. First, participants used the word "Medicare" to name the FFS product. Second, participants did not choose between two plans. Rather, they decided between supplemental insurance and a managed care product. These factors should influence how CMS "brands" not only the FFS product but also the overall Medicare program.

INTRODUCTION

The Balanced Budget Act (BBA) of 1997 expanded health insurance options by creating Medicare+Choice. Besides traditional FFS coverage, the three primary alternatives were coordinated care plans (e.g., managed care plans), private FFS plans, and Medicare savings accounts (Health Care Financing Administration, 1999a). Although some of these plans never materialized, Medicare managed care plans became quite successful and quickly grew to cover about 16 percent of the Medicare population. To support the new programs and help people with Medicare make more informed health care decisions, CMS initiated the National Medicare Education Program (NMEP) called "Medicare & You." Although BBA created new health care options beyond the traditional FFS, this occurred in the context of already-available supplemental insurance policies called "medigap" policies. Ten types of medigap policies have been defined by CMS (plans A-J) and are offered by private insurance companies. People with Medicare can purchase a medigap policy to supplement the coverage they receive from Medicare's original FFS program. Currently, approximately 30 percent of Medicare enrollees rely on an individually purchased private medigap policy (Health Care Financing Administration, 1999b). Medigap education is not part of the NMEP and the relationship of medigap plans to the Medicare+Choice program can be a source of confusion.

The NMEP seeks to educate people with Medicare and help them make more informed health care decisions (McCormack et al., 2001). The primary objectives of the NMEP are to ensure that people with Medicare:

- Receive accurate and reliable information.
- Have the ability to access information when they need it.
- Understand the information needed to make informed choices.
- Perceive the NMEP as a trusted and credible source of information (McMullan, 1996).

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Table 1

Number of Focus Groups Held, by Type of Coverage, Phase, and Location

Phase and Location	Type of Coverage	
	FFS	Managed Care
Phase One		
Mokena, IL	2	2
Tucson, AZ	2	2
Phase Two		
Baltimore, MD	1	1
San Diego, CA	1	1

NOTE: FFS is fee-for-service.

SOURCE: Centers for Medicare & Medicaid Services: Center for Beneficiary Choices, Beneficiary Education and Analysis Group, 2000.

One key element of informed choice is the ability to differentiate among the different health plan options, and this is a challenge for the Medicare population (Davidson, 1988; McCall, Rice, and Sangl, 1986). Informed choice will be even more critical in 2003, when people with Medicare will be "locked in" to their health plans for a full year (Neuman and Langwell, 1999). In the *Medicare & You 2001* handbook, CMS uses the label "The Original Medicare Plan" to denote traditional FFS coverage, but several years of focus group and indepth interview findings reveal that people with Medicare are confused by this label. Indeed, when people with Medicare are asked to define that phrase, the most common response is that "The Original Medicare Plan" is what Medicare was like back in 1965. Because of this confusion and because deciding on the type of coverage is an important decision, CMS embarked on a consumer-focused research project to help determine a more appropriate label for the FFS product. Consumer-focused research views Medicare enrollees as customers and asks for their direct input to Medicare communication efforts. This consumer focus offers the opportunity to understand Medicare enrollees' particular needs and beliefs and may aid in creating better strategies and messages that are understood by people with Medicare (Andreason, 1995; and Weinreich, 1999).

Our research project sought to assess Medicare enrollees' perceptions of the programs and benefits that Medicare offers and enrollees' level of understanding of the similarities and differences between both traditional FFS and Medicare managed care. Specifically, we sought to identify a new label for the traditional FFS product by focusing on three areas:

1. How do members of the target audience make decisions about Medicare?
2. What "cognitive maps" reflect the target audience's understanding and positioning of the Medicare program and its products?
3. How can CMS better name, position, and communicate the FFS product?

METHODS

Focus Group Methodology

Data for this study were collected using focus groups. This methodology offers the ability to obtain detailed information about people's opinions that is often missing in survey data (Greenbaum, 1988). One primary goal of focus groups is to understand motivations and reactions of a target audience. In general, focus groups help address why people believe things, rather than what the prevalence of such beliefs is. Care should be taken, however, to not generalize focus group findings to the Medicare population at large.

Study Population and Sites

The research project was conducted in two phases (Table 1). The first phase (consisting of eight groups) focused on exploratory issues related to Medicare enrollment, comparisons of FFS and managed care, and perceptions of the Medicare program. One additional aim of these groups was to develop and test labels,

concepts, and product strategies for the traditional FFS product. The second phase (consisting of four groups) focused on possible names for the traditional FFS product, using a Q-sort methodology. Because we were interested in levels of understanding from both FFS and managed care participants, we conducted one-half of the groups with people enrolled in managed care plans and the remaining groups with people enrolled in FFS. To increase the homogeneity within the groups and to avoid debates among participants, we divided FFS and managed care Medicare enrollees into distinct groups. We conducted these groups in areas where there was managed care penetration to ensure that choice of health care coverage was relevant for these participants. As expected, all but one of the FFS participants had a supplemental policy (only 11 percent of FFS enrollees lack supplemental coverage [Health Care Financing Administration, 1999b]). Participants ranged in age from 65 to 83. There were slightly more females than males. We also recruited a mix of black persons, Hispanic persons, and white persons.

Q-Sort

The second phase of research used the findings from phase one to develop a list of potential names and statements for the FFS product and tested them using Q-sort methodology. Q-sort measures holistic attitudes and is often used to develop names, identity, and positioning themes. It also provides rich data for audience segmentation. Q-sort synthesizes data into a few "points of view" that represent various perspectives. As a tool, it enables us to understand how people are similar and different in their views, based on their rankings of identity themes, slogans, and names (Brown, 1986, 1996; Cragan and Sheilds, 1981; Stephenson 1975). Q-sort analysis rank-orders statements and then correlates and analyzes the data according to factors. Participants that sort statements similarly cluster together on a factor. A factor represents a point of view or attitude held by the people associated with that factor.

In terms of applying Q-sort findings to labeling, positioning, and branding strategies, consensus items are the names or messages that will appeal (or be unappealing for negative consensus items) to all points of view, i.e., most people. Items that score high on one factor (reflecting one point of view) and poorly on other factors are items to use to connect to the audience holding that particular point of view (i.e., loading high on that factor, in statistical terms).

RESULTS

Phase One: Exploratory Groups

Most participants reported first thinking about Medicare at about age 62 or 63, typically when they started to think about retirement or when a spouse retired. Participants thought about Medicare at a general level at this time, and they often asked friends about it. Some participants stated that they could not afford health insurance when they retired prior to age 65, and these participants looked forward to enrolling in Medicare because they had had to do without insurance until they turned 65. Those who had insurance prior to age 65 generally viewed Medicare as an alternative to the private insurance that they had while they or their spouse worked. Most perceived Medicare as very important "security" to them.

A noticeable distinction between the FFS and managed care groups was the perceived choice offered by FFS coverage (keep in mind that all but one person had a

supplemental policy, and for these participants, when they spoke of FFS, they typically meant both). For all participants, choice was defined as the ability to select one's own physician and hospital. Not surprisingly, the FFS groups saw any limit on their ability to choose a doctor or hospital as negative. Managed care participants, however, also reported that they had choice. They realized that they could not see any doctor but reported that "almost any of the hospitals and doctors [were] on the list," and that the list of approved doctors offered them a choice.

Participants with managed care coverage rated affordability and general cost savings as the most important reason for selecting this type of coverage. In some respects, managed care participants tended to view their managed care insurance as a less expensive form of supplemental insurance. Many managed care participants said they switch health plans when their doctor switches plans, suggesting a stronger allegiance to their doctor than to the managed care plan. Other reasons given for selecting a managed care plan included ease of participation in the plan because of minimal paperwork, no complex bills to deal with, and coverage of some medications. Some managed care participants stated that they want paperwork to track their health care costs and monitor fraud. The lack of paperwork also led some HMO participants to be unaware that Medicare was in fact contributing substantially to their health insurance (i.e., capitation).

Participants deciding which type of insurance to get generally focused on two factors: the amount of coverage and the cost. Participants with limited means reported being drawn to managed care programs because of perceived cost savings and additional coverage. Those with more means were drawn to traditional FFS Medicare with supplemental coverage because of the perceived independence. Some participants who changed from FFS to managed care often noted that their doctor was "listed in the book," and therefore the participants did not see the ability to choose any doctor as an issue for them. FFS participants tended to see their primary Medicare decision as which supplemental plan to buy. In addition to independence and the ability to see virtually any doctor, the amount of coverage and the cost of the plan were key drivers in how the participants made their decisions.

In summary, the key variables that appear to influence beneficiaries' health insurance decisions are:

- Ability to see any doctor (strong positive among FFS participants).
- Ability to see own doctors (strong rationale among managed care participants).
- Monthly out-of-pocket costs (supplemental policies too burdensome for managed care participants).
- Ease of dealing with "the system," including lack of paperwork (strong positive among managed care participants).

In both FFS and managed care groups, all these variables seem to coalesce into a sense of security that participants would receive good health care when they need it.

Cognitive Maps

Participants were asked to define features of each type of health care coverage and then name each group. The Venn-like diagram we used to simplify the Medicare program worked well to convey participants' beliefs that, in general, people with Medicare make two primary choices when deciding on coverage. First, people choose between two types of coverage (FFS or managed care). Second, FFS enrollees decide on a specific type of supplemental

insurance, and managed care enrollees select a particular managed care plan. The diagram also served as an effective summary and contrast of the key features of each product.

With facilitation, each group identified what they perceived as the three primary components of the Medicare program—FFS, managed care plans, and supplemental insurance, though they did not naturally categorize Medicare and their health insurance in terms of these three components. For the most part, participants effectively identified key features of their own type of insurance coverage. To help achieve our research objectives, we intentionally limited discussions of key features in the Q-sort groups to three things: (1) choice of doctors, (2) out-of-pocket costs (percent versus fixed amount), and (3) referrals to specialists. Managed care participants frequently added the benefit of expanded coverage (for prescriptions, eye care, etc.) and slightly less often mentioned the lack-of-paperwork benefit.

Most participants could contrast FFS and managed care features with some help, although participants were usually much less aware of the features of the insurance that they did not have. This was particularly true of managed care participants, who appeared to be less knowledgeable or less concerned about the FFS product.

Generally, all participants were able to come up with names for two of the three primary components of the Medicare program; health maintenance organizations (HMOs) (rarely called "managed care"), and supplemental insurance (rarely called "medigap" or "secondary insurance"). Participants had a more difficult time, however, naming the original FFS (Parts A and B). "Medicare" was the most frequently suggested name. The term "fee-for-service" was never suggested as a name for this type of insurance.

Participants were also asked what they call the whole program—FFS, managed care, and supplemental combined. For the most part, "Medicare" was not mentioned as a term that they associate with one that encompasses all three plans. Rather, participants tended to refer to the whole program as "health insurance" or "senior health insurance." Participants tended to view Medicare as being only the traditional FFS product. When this discrepancy was pointed out, they seemed to appreciate the need to differentiate between the Medicare "system" and the FFS product.

Projective Questioning Methodology

To further understand how participants think and feel about Medicare and its products, we used a projective technique that encourages creative thinking about a topic. Participants were asked to compare Medicare and the insurance types to different modes of transportation and types of music to better understand their perceptions. What is most important is not what they report (e.g., "Medicare is like a Volvo") but the reason why (e.g., "because it's dependable"). This kind of feedback is useful for thinking through implications of various name options and potentially for informing the development of an integrated positioning platform for CMS, Medicare, and various Medicare products.

What follows is a summary of the perceived relationships between Medicare and the various products, including a synopsis of the results gained by our projective questioning methodology.

Traditional FFS Coverage

This is a singular offering that is not a brand or a product. Many perceive it as the "system." It is most often labeled

"Medicare," perhaps by default. FFS participants stated that they understand that Medicare pays most of their health care bills.

HMO participants typically viewed FFS plans as high-end cars, "too expensive to buy and run" or "good if you could afford it—expensive, but have lots of perks." "When you hear choice and freedom, it feels good if you can afford them, secure . . . you have peace of mind, fewer worries" (this may reflect an inability of the HMO participants to distinguish that there is an FFS element that exists without supplemental coverage). FFS participants (almost all of whom had supplemental coverage) compared their coverage to classical music and smooth jazz. "It makes you feel good," or "it's a good arrangement" were terms used to describe it.

Managed Care Plans

For many participants, managed care plans are an alternative to Medicare and not part of Medicare. Many managed care participants perceived their managed care plan as providing more than Medicare (i.e., the FFS product). Some participants knew that Medicare paid the managed care plan for each beneficiary, but most did not. Because many managed care participants thought that they were no longer part of Medicare, and because they did not know that Medicare paid managed care plans additional money, managed care plans appear to get credit as the exclusive provider of participants' health care benefits.

Participants in managed care plans viewed this type of insurance more favorably than did FFS participants. HMO participants often compared managed care plans to classical or orchestral music, saying that it was "relaxing" and "soothing." When prompted, they also noted some of the negatives to managed care plans (e.g., premiums tend to rise and doctors may not give you enough time, so "you feel like you're on an assembly line"). FFS participants, on the other hand, focused overwhelmingly on the negative aspects, comparing managed care plans to rock-and-roll or heavy metal music, which "hurts their ears," is "discordant," and "gets on their nerves."

Supplemental/Medigap

This type of coverage was viewed as an expensive necessity for people that have the traditional FFS product. As with managed care plans, the product is comprised of a variety of brands, which often differ as to what services are covered.

FFS and managed care groups compared supplemental insurance to high-end, luxury cars, using terms such as "relaxed," "safe," "secure," "lucky," and "well-protected."

Medicare (Program)

Many participants did not appear to think beyond their own health insurance plan, and many do not think about Medicare as a system or program. When prompted to do so, most referred to the program as the "senior health care system," analogous in scope to the overall health care system for non-beneficiaries.

Overall, participants felt that Medicare was good because it made them feel secure and was generally dependable. Managed care groups tended to be somewhat more positive about Medicare, often comparing it to fast and smooth transportation options, such as luxury cars, jets, or yachts. FFS groups were slightly more focused on the negatives, such as bureaucratic issues or non-coverage of prescriptions. FFS groups also compared Medicare to lower end cars that were not high-end or even to a city transit system, "where you spend a lot of time waiting."

Table 2

Q-Sort Factor Arrays of Names and Messages Tested, Sorted on Factor A

Names and Messages	Factor[1]		
	A	B	C
Medicare – A Life Line to Basic Medical Care	3	1	1
Medicare – The Basic Health Insurance Plan for America's Seniors	3	0	0
Medicare – The Original Health Insurance Plan for America's Seniors	3	-1	0
Medicare – The Original Health Plan Choice	2	1	-2
Medicare – Good Basic Health Coverage.	2	0	-1
Basic Medicare – For Most of Your Health Care Needs	2	-1	-2
The Medicare Choose Your Doctor Plan	2	-2	3
The New Medicare	1	0	0
Medicare – The Traditional Health Plan Choice	1	0	-3
The Medicare Basic Benefits Plan	1	-1	0
Medicare – The Basic Health Plan Choice	1	-2	2
The No-Referral Plan	1	-3	3
The Medicare Original Plan	0	2	2
The Original Medicare Plan	0	2	-2
The Original Medicare Option	0	1	-1
Original Medicare Benefit Plan	0	1	-1
Medicare – Basic Health Insurance Entitlement	0	0	1
Medicare – Original Government Insurance Plan	0	-1	2
Basic Medicare	-1	3	-2
The Traditional Medicare Plan	-1	2	-3
The Basic Medicare Option	-1	0	0
Medicare – Parts A&B Only	-1	-1	3
The Automatic Medicare Option	-1	-2	-1
Original Medicare	-2	3	1
Traditional Medicare	-2	3	0
Medicare	-2	2	1
Regular Medicare	-2	1	1
The Medicare Limited Plan	-3	-2	-3
The Medicare Pay 20% Insurance Plan	-3	-3	2
Medicare Fee-for-Service Option	-3	-3	-1

[1] Scores for points of view (factors) range from -3 (worst label) to +3 (best label).

SOURCE: Centers for Medicare & Medicaid Services: Center for Beneficiary Choices, Beneficiary Education and Analysis Group, 2000.

Phase Two: Identifying an FFS Name

Phase two used findings from phase one and developed 30 potential names and statements for the traditional FFS product that reflected those findings and tested these names and statements using Q-sort methodology. Forty focus group participants sorted these 30 items (names and messages) from "best label" to "worst label." Three factors or points of view emerged from the subsequent correlation and factor analysis. Nineteen participants were loaded on Factor A, nine on Factor B, and five on Factor C. Nine participants did not load. This adds to more than 40 because of confounded Q-sorts (i.e., Q-sorts loaded on more than one factor). Because almost one-half of participants held the Factor A point of view, we considered it the dominant factor (Table 2). To make it easier to understand the point of view captured by Factors B and C, the items are sorted again, based on scores for each (Tables 3 and 4, respectively).

Factor Profiles

We reviewed the composition of the people holding each point of view. There were no significant demographic differences by factor (e.g., age, education level, race, or sex), with two exceptions. First, females were slightly more likely than males to load on Factor B. Second, although managed care and FFS participants were loaded on all three factors, Factor B primarily represents an FFS point of view. There were no significant differences on factors by "view toward Medicare (i.e., negative, neutral, mixed, or positive)," by "making ends

Table 3

Q-Sort Factor Arrays of Names and Messages Tested, Sorted on Factor B

Name and Message	Factor[1] A	B	C
Original Medicare	-2	3	1
Traditional Medicare	-2	3	0
Basic Medicare	-1	3	-2
The Medicare Original Plan	0	2	2
Medicare	-2	2	1
The Original Medicare Plan	0	2	-2
The Traditional Medicare Plan	-1	2	-3
Medicare – A Life Line to Basic Medical Care	3	1	1
Regular Medicare	-2	1	1
The Original Medicare Option	0	1	-1
Original Medicare Benefit Plan	0	1	-1
Medicare – The Original Health Plan Choice	2	1	-2
Medicare – Basic Health Insurance Entitlement	0	0	1
Medicare – The Basic Health Insurance Plan for America's Seniors	3	0	0
The New Medicare	1	0	0
The Basic Medicare Option	-1	0	0
Medicare – Good Basic Health Coverage	2	0	-1
Medicare – The Traditional Health Plan Choice	1	0	-3
Medicare – Parts A&B Only	-1	-1	3
Medicare – Original Government Insurance Plan	0	-1	2
Medicare – The Original Health Insurance Plan for America's Seniors	3	-1	0
The Medicare Basic Benefits Plan	1	-1	0
Basic Medicare – For Most of Your Health Care Needs	2	-1	-2
The Medicare Choose Your Doctor Plan	2	-2	3
Medicare – The Basic Health Plan Choice	1	-2	2
The Automatic Medicare Option	-1	-2	-1
The Medicare Limited Plan	-3	-2	-3
The No-Referral Plan	1	-3	3
The Medicare Pay 20% Insurance Plan	-3	-3	2
Medicare Fee-for-Service Option	-3	-3	-1

[1] Factor scores range from -3 (worst label) to +3 (best label).

SOURCE: Centers for Medicare & Medicaid Services: Center for Beneficiary Choices, Beneficiary Education and Analysis Group, 2000.

meet," by perception of "the affordability of medical care," or by "frustration when dealing with health care needs."

Summary of Viewpoints

There were no strong positive consensus items from the Q-sort that point to a name for the FFS product across points of view. Therefore, we looked for patterns across points of view to discern the elements of items that consistently scored well and elements of items that consistently scored poorly. We emphasize Factor A, as it was clearly the dominant factor, reflecting the point of view of about one-half of the participants. Based on the focus group discussions in phase one, the Q-sort activity, and prior research, the 10 items that provide the best potential for serving as the basis for Medicare names are listed in Table 5. All of these items were rated highly (+2 or +3) on Factor A or B—the largest factors, without being scored negatively (-2 or -3) on Factor A. These findings could be synthesized to develop recommended names for the Medicare program and FFS product. Recommendations and the rationale for how to use elements of each item are described under each item.

DISCUSSION

Our overarching goal of the exploratory and Q-sort phases of our research was to identify a name for the FFS product that would clearly communicate what it is, while also distinguishing it from managed care, supplemental plans, and the overall Medicare program. Two key insights were

Table 4

Q-Sort Factor Arrays of Names and Messages Tested, Sorted on Factor C

Name and Message	Factor[1]		
	A	B	C
The Medicare Choose Your Doctor Plan	2	-2	3
The No-Referral Plan	1	-3	3
Medicare – Parts A&B Only	-1	-1	3
Medicare – The Basic Health Plan Choice	1	-2	2
The Medicare Original Plan	0	2	2
Medicare – Original Government Insurance Plan	0	-1	2
The Medicare Pay 20% Insurance Plan	-3	-3	2
Medicare – A Life Line to Basic Medical Care	3	1	1
Medicare – Basic Health Insurance Entitlement	0	0	1
Original Medicare	-2	3	1
Medicare	-2	2	1
Regular Medicare	-2	1	1
Medicare – The Basic Health Insurance Plan for America's Seniors	3	0	0
Medicare – The Original Health Insurance Plan for America's Seniors	3	-1	0
The New Medicare	1	0	0
The Medicare Basic Benefits Plan	1	-1	0
The Basic Medicare Option	-1	0	0
Traditional Medicare	-2	3	0
Medicare – Good Basic Health Coverage	2	0	-1
The Original Medicare Option	0	1	-1
Original Medicare Benefit Plan	0	1	-1
The Automatic Medicare Option	-1	-2	-1
Medicare Fee-for-Service Option	-3	-3	-1
Medicare – The Original Health Plan Choice	2	1	-2
Basic Medicare – For Most of Your Health Care Needs	2	-1	-2
The Original Medicare Plan	0	2	-2
Basic Medicare	-1	3	-2
Medicare – The Traditional Health Plan Choice	1	0	-3
The Traditional Medicare Plan	-1	2	-3
The Medicare Limited Plan	-3	-2	-3

[1] Factor scores range from -3 (worst label) to +3 (best label).

SOURCE: Centers for Medicare & Medicaid Services: Center for Beneficiary Choices, Beneficiary Education and Analysis Group, 2000.

gained regarding how beneficiaries think of Medicare and its components and how they make decisions, which clearly has an impact on how they perceive the traditional FFS product:

- Participants did not consider or have a name for the overall Medicare program. For them, "Medicare" was the term for the traditional FFS product. When asked, participants described the overall Medicare program as "senior health insurance."
- Participants did not make a choice between traditional FFS coverage and managed care. Rather, they perceived the decision as one between supplemental insurance and a managed care plan. The primary factors determining the decision are the cost and the coverage benefit. Those with the resources to decide between these two options tended to see the freedom to select a provider as important.

Summarizing the Q-sort Findings

Of the three points of view (labeled Factors A, B, and C), Factor A clearly emerged as the dominant point of view, reflecting the opinion of 19 of 40 participants. Factor A appears to reflect a warm, somewhat emotional point of view. It is the point of view that probably best captures the feeling of security that many participants attribute to Medicare. The language in the highly ranked items was somewhat more casual or colloquial as well. Very short names such as "Original Medicare" and items with an explicit reference to cost, such as "Medicare Fee-for-Service Option,"

Table 5

Summary of Recommendations for the Top 10 Measured Items

Medicare—A Life Line to Basic Medical Care
- Capture feeling of security.
- Consider "basic medical care" as part of name.
- Use "lifeline" notion in overall Medicare positioning.

Medicare—The Basic Health Insurance Plan(s) for America's Seniors
- Begin the name with the word "Medicare."
- Consider "basic health insurance plans" as part of name.
- Make plan plural to emphasize overall program.
- Use "for America's Seniors" in overall Medicare positioning.

Medicare—The Original Health Insurance Plan(s) for America's Seniors
- Begin the name with the word "Medicare."
- Use "for America's Seniors" in overall Medicare positioning.
- Consider "health insurance plans" as part of name.[1]

Basic Medicare—For Most of Your Health Care Needs
- Use "health care needs" to reflect a consumer-oriented perspective.
- Use the word "basic" as the key descriptor in the name of an FFS product, which would also allow for effective positioning of other potential FFS products.[2]

Medicare—The Original Health Plan Choice
- Begin with the word "Medicare."
- Consider "health plan choice" as part of name.
- Build on Medicare+Choice.

Medicare—Good Basic Health Coverage
- Begin the name with the word "Medicare."
- Consider the word "good" as a consistent descriptor of FFS product.
- Consider "health coverage" as part of name.

The Medicare Choose Your Doctor Plan
- Begin the name with the word "Medicare."
- Recognize that some HMO beneficiaries perceive that they have the option of choosing their doctors, albeit from a list (meaning this does not differentiate HMO from FFS enough to serve as the FFS name).

The Medicare Original Plan
- The word "plan" works for Factor B.

Basic Medicare
- Two words that squarely capture Factor B perspective.

The Traditional Medicare Plan
- The word "traditional" is worse than "original."
- The word "plan" works for Factor B.

[1] We exclude "original" because of focus group discussions and lack of positioning value.

[2] Does not describe product attributes but builds on current usage of Medicare term as FFS without supplemental.

NOTES: FFS is fee-for-service. HMO is health maintenance organization.

SOURCE: Centers for Medicare & Medicaid Services: Center for Beneficiary Choices, Beneficiary Education and Analysis Group, 2000.

were ranked as particularly poor labels for the FFS product. An important finding is that some of the highest ranked names do not differentiate among the different products or the overall Medicare program. Followup discussions with participants after the sorting activity found that, although many participants rated the items that contained the phrase "America's Seniors" highly, they would agree that these items did not distinguished the FFS product from the managed care product or particularly from the Medicare system overall. The same applies to the item that contained the phrase "life line." These terms, however, are emotionally appealing and seemed to capture the value of security, which was a very important psychological benefit for this group. This general finding may be useful when developing a

positioning platform for the Medicare system as well as in more general communications about the system as opposed to a particular kind of coverage.

In terms of a name for the FFS label, data point to the Factor A point of view. These include beginning the name with the word Medicare, followed by a two-part phrase. Part one would have a modifier, such as the words "basic" or "original," though "basic" was perceived as a better product descriptor both in phase one and in the post-sorting discussions of phase two. Part two of the phrase would have a product description, such as "health insurance plan" or "health coverage."

Factor B, in contrast to Factor A, reflects a short, to-the-point, and unemotional view. The highest rated statements are all simple and straightforward, usually in the form of the word "Medicare," preceded by a qualifier (i.e., "Original Medicare," "Traditional Medicare," and "Basic Medicare"). Interestingly, "Medicare" was also strong within this point of view. The richer, more descriptive names that ranked highly in Factor A were mostly neutral or somewhat negative in the Factor B point of view. Most of the strongly negative items were, as with the Factor A point of view, about cost (e.g., "Medicare Fee-for-Service Option") or about specific features of the FFS product (e.g., "The No-Referral Plan").

Based on discussions in phase one and after the ratings in the Q-sort focus groups in phase two, it appears that Factor A and Factor B participants gave names for the overall Medicare program that they equate with the traditional FFS product. A review of the Factor B names shows that the names that use "Medicare" as the subject (e.g., "Basic Medicare") make them more appropriate descriptors for a system or overarching program, rather than using "Medicare" as a modifier (e.g., "Medicare Basic") for a specific product.

The participants representing Factor C appear to prefer a feature-oriented and technically accurate point of view. This point of view is difficult to interpret. The highest ranked items corresponded to the features listed in the FFS element prior to doing the Q-Sort activity (e.g., "Medicare B Parts A&B Only" and "The No-Referral Plan"). In terms of the focus on features, we posit two explanations. First, participants holding this point of view were extremely compliant with our instructions to rank the items by how well they distinguish the FFS product from managed care product and from the overall system (an artifact of the design). Or, second, participants really felt that the feature-specific items did the job well and would serve as the best names for the FFS product. Because of this confounding, we did not engage in much analysis of Factor C.

Assessing Current Names

We also looked at phrases currently used in the *Medicare & You* handbook in addition to the word "Medicare" (refer to Table 6 for factor scores associated with these elements). Each of these is described in the following sections.

"Medicare" Alone

This is the default label most often applied to the traditional FFS product, reflecting the lack of distinction between the traditional FFS product and the Medicare program. "Medicare" alone received a strong negative score on Factor A, though it was positive on Factor B, and neutral on Factor C. It would

Table 6

Q-Sort Results for Current Names of Fee-for-Service Products

Name	A	B	C
Medicare	-2	2	1
Original Medicare	-2	3	1
Medicare Fee-for-Service Option	-3	-3	-1

SOURCE: Centers for Medicare & Medicaid Services: Center for Beneficiary Choices, Beneficiary Education and Analysis Group, 2000.

not be a suitable name for the traditional FFS product because the Medicare program consists of other choices. The equity in the word "Medicare" suggests, however, identifying the traditional FFS product with a name that begins with "Medicare" but is hard to abbreviate to just "Medicare."

Original Medicare

As with the name "Medicare," "Original Medicare" was strongly negative on Factor A and strongly positive on Factor B. Focus group discussions revealed that few recognize "Original Medicare" as the current name of the traditional FFS product and that it is unclear what "original" is supposed to mean. Most beneficiaries presume that Medicare has changed a great deal since its inception, a belief that compromises the strategic value of the word "original." It does not describe a feature or benefit of the FFS product the way "basic" communicates an important message about the scope of coverage. Lastly, both the Q-Sort data and positioning principles suggest that the name of the traditional FFS product should begin with "Medicare," not the descriptor.

Fee-for-Service

Virtually no beneficiaries referred to the traditional FFS product as "fee-for-service." When asked about the term, most people did not know what it meant and felt it just added to the confusion. The Q-sort results confirm the lack of value of this item as a name for the FFS product, as it was one of the strongest negative consensus items.

CONCLUSION

Findings from this study suggest that the FFS name should reflect an "organization-brand-product" relationship that will work equally well with other products, including managed care plans, a modernized FFS product, and private FFS plans. It also needs to be consistent with the overall Medicare/CMS identity and positioning platform. To be effective, these conditions suggest that managed care plans should use Medicare in their name, perhaps with proprietary branding first (e.g., "'Secure Horizons Medicare HMO"). To that end, here is a list of possible names that summarize findings from this research project:

- The Medicare Basic Health Plan.
- The Medicare Basic Insurance Plan.
- Medicare Basic Health Coverage.
- Medicare Basic Medical Care.

In considering these names, it is useful to think about parallel names for HMO products, e.g., the Kaiser Medicare Senior Advantage, Medicare Secure Horizons, Blue Cross Medicare Medigap, Blue Shield Medicare Supplemental Plus. It may lead to specific "co-branding" requirements, which should benefit CMS, the HMOs and supplemental insurers, and most importantly, beneficiaries.

One key question is whether the FFS product can be named without first branding and positioning the Medicare program. This issue may increase in importance as the Medicare program begins to offer more insurance options. Without a broader Medicare entity, this research reinforces earlier findings that many managed care participants in a Medicare managed care plan do not perceive themselves as

being part of the Medicare program. This argues for establishing a broader and cohesive Medicare identity and positioning strategy that supports a diverse product line of health insurance plans.

Because this is an initial finding, more research needs to be done to fully understand the primary "cognitive maps" structures that shape beneficiaries' thinking and decisions about Medicare. Naming the traditional FFS product effectively will require CMS to make a commitment to develop a strong and strategic identity for the Medicare program overall. It also means establishing a positioning platform that governs all Medicare-related communications, including how managed care plans brand their Medicare products. If the commitment is made, and at a high level within CMS, then naming the FFS product as part of an overall Medicare identity building and positioning effort could prove very powerful indeed.

This study researched people with supplemental insurance (with one exception) and people enrolled in a Medicare managed care plan. More research should be conducted with people who have Medicaid as a supplemental insurance and those who only have the traditional FFS plan. In addition, this study did not consider disabled or end-stage renal disease enrollees, nor did we account for the full diversity of the Medicare population. Further studies are needed to obtain information from these populations as well as a quantitative survey to get a representative reaction to the naming options.

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