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CHOOSING A HEALTH PLAN: PROVIDING MEDICARE BENEFICIARIES WITH THE RIGHT TOOLS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

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CHOOSING A HEALTH PLAN: PROVIDING MEDICARE BENEFICIARIES WITH THE RIGHT TOOLS

WEDNESDAY, MAY 6, 1998

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 2:02 p.m., in room SD-562, Dirksen Senate Office Building, Hon. Charles Grassley, (chairman of the committee), presiding.

Present: Senators Grassley, Jeffords, Breaux, and Wyden.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. Good afternoon, everybody. I am Senator Grassley, and I am glad to have all of you here for a very important hearing.

I will have colleagues coming along shortly, although there is a very important IRS bill on the floor of the Senate. So we may not have as much participation as we usually have.

I also want to welcome witnesses. A lot of you, I have met. I appreciate that opportunity to meet you, and thank you for taking time out of your busy schedule to come and testify at this very important hearing.

This is actually the second hearing that the Senate Special Committee on Aging has had on this topic since I have become chairman. We held a similar hearing last April prior to the passage of the Balanced Budget Act, which led to Senator Breaux and myself introducing legislation regarding Medicare consumer information entitled the Medicare Beneficiary Information Act, S. 789.

As you probably know, many of our provisions from S. 789 were included in the Balanced Budget Act signed by the President last August.

We are holding this hearing today to examine the implementation of our information requirements enacted in the Balanced Budget Act to make sure that Medicare beneficiaries will be provided with the most useful information, which will be starting this fall and in the years to come.

Health insurance is complicated, and it is confusing enough without all of the new Medicare choices that seniors will be given. Congress has an important oversight role, and it has a responsibility to make sure that we are providing Medicare beneficiaries with in-

formation that is objective and that consumers consider understandable.

I feel particularly responsible for ensuring our seniors are able to navigate the Medicare system not only as chairman of this committee, but also as a Member of the Finance Committee, which is also true of Senator Breaux, the committee that oversees Medicare legislation. Most importantly I feel responsible because both Senator Breaux and myself are authors of the consumer information requirements that the President has signed into law.

I would now like to show a brief video. This videotape has been provided by Susan Kleimann of Kleimann Communications, who will be testifying later today, and also by the National Academy of Social Insurance and the California Health Care Foundation.

What you are about to see are clips of Medicare beneficiaries who participated in a series of focus groups talking about their experience with making health plan choices in the California market. I would ask you to proceed with the video.

I think that is the end.

You can see that a lot of people find choosing a Medicare Plan a very confusing decision to make. Our hearing that we held a year ago emphasized this as well. That is why Senator Breaux and I were successful in getting the legislation included in the BBA.

So this afternoon's hearing is going to provide members with information on where the Health Care Financing Administration is in the process of the information campaign, what they intend to provide beneficiaries with this fall, and recommendations on the way to present this material and other resources to seniors. The hearing will also provide a forum for HCFA to demonstrate how they intend to use the 95 million appropriated this year for the first educational campaign and how they will use resources Congress appropriates in the future.

I want to point out to my colleagues here today the importance of providing HCFA and intermediaries such as the Insurance Counseling Assistance programs, with adequate resources to educate Medicare beneficiaries. The success of the Medicare+Choice program and future reforms of this program, like the one Senator Breaux and Senator Mack have proposed through the FEHBP-style program—that is the Federal Employees Health Benefit Program—all of these choices are resting upon seniors' ability to understand the program and what their choices are.

We have to put our money where our mouth is, and information has a price tag to it. That is why Senator Breaux, Senator Glenn, and myself recently sent a letter to the Appropriations Committee asking for full funding authorized under the BBA for HCFA to use for the information campaign and the toll-free phone number and funding for Insurance Counseling Assistance programs, one of the intermediaries that seniors call when looking for information and answers for their questions.

I would like to submit for the hearing record a letter of support from the National Association of Insurance Commissioners for our appropriations request to provide the Insurance Counseling Assistance program with the funding.

[The information referred to follows:]

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National
Association
of Insurance
Commissioners

May 6, 1998

The Honorable Ted Stevens
Chairman
Committee on Appropriations
2-128 Capitol Building
Washington, D.C. 20510-6025

Dear Senator Stevens:

On behalf of the National Association of Insurance Commissioners' (NAIC) Special Committee (EX) on Health Insurance, I would like to take this opportunity to ask you to support increased funding for a public-private program that has already provided needed assistance to millions of older Americans: the Health Insurance Information Counseling and Assistance Programs (ICA) administered by the Health Care Financing Administration (HCFA). We are concerned that the ICA programs are not sufficiently funded to provide information and assistance to more than 38 million Medicare beneficiaries on the options available to them under the new Medicare+Choice program.

The NAIC's 55 members are the chief insurance regulatory officials of the 50 states, the District of Columbia, and four U.S. Territories. The NAIC's Special Committee on Health Insurance is composed of 41 state insurance regulators and was established as a forum for NAIC members to respond to Congressional and federal requests for technical assistance.

<u>What are the ICA Programs</u>
The Omnibus Budget Reconciliation Act of 1990 established federally funded, state-managed and volunteer staffed ICA programs for Medicare beneficiaries as part of the Medicare supplement insurance (Medigap) reforms included in that act. The purpose of these programs is to assist Medicare beneficiaries to secure adequate and appropriate public and private insurance coverage and to assist them in resolving their Medicare and health insurance related problems.

The national ICA program is comprised of 53 state and territorial ICA programs, nearly 1,000 program sponsors and sub-contractors, and over 14,000 volunteer counselors who serve Medicare beneficiaries in all 50 states, the District of Columbia and U.S. Territories. Their

The Honorable Ted Stevens
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mission is to ensure that Medicare beneficiaries have a consumer-focused network of staff and volunteers who provide accurate and objective information through community programs.

The NAIC has continuously provided significant support of the ICA programs since their beginning. Training and information pertaining to Medicare supplement and long-term care insurance are just some of the ways the NAIC supports these local programs. The ICA program provides strong leadership through state units on aging and state departments of insurance for administration of the local programs.

The Role of the ICAs in Medicare+Choice
Currently, the ICA programs provide beneficiaries with objective information and assistance with regard to benefits, options, enrollment and problem resolution. They are the only HCFA-funded direct consumer link that provides in-depth, consistent health plan information services.

This year, HCFA is required by the Balanced Budget Amendment of 1997 (BBA) to establish a national "800-number" telephone information system by November to answer consumer questions about the changes planned for Medicare and the new options for health care delivery. The ICA programs are an integral part of the referral system planned to assist consumers with the shift to Medicare+Choice. They will be hard pressed to provide the local, hands-on counseling that many seniors will need. It is anticipated that the numbers of senior citizens asking for assistance will dramatically increase due to the expanded referral system created by this new outreach.

Funding for ICAs
Individual ICA programs are funded by grants to the states, either through a state's insurance department or agency on aging. The level of funding has remained stable at $10 million for the last seven years. Beginning in FY 1999, there will be a greatly increased burden placed on these programs with the advent of Medicare+Choice.

In October, HCFA will announce the Medicare+Choice program with a mass mailing to Medicare beneficiaries. The mailing will contain information about many of the new programs available to beneficiaries through Medicare+Choice. In November, HCFA will bring their "800-number" information program on line. These efforts will result in markedly increased numbers of inquiries to local ICA counseling programs. It is expected that the "800 number" information program will even more dramatically increase the number of referrals. Medicare beneficiaries tend to want further explanation of any material they receive through the mail or via the media, and they want answers to specific questions from **someone they trust** in their local area. The combination of these efforts will greatly increase the demand for ICA assistance. In the two-month peak period, the ICA programs could receive many times more inquiries than they typically receive all year. The programs will need to put more effort than ever before into recruiting and training volunteers to handle the new influx of inquiries. This effort will require more staff resources.

The NAIC believes that Congress should appropriate at least $20 million dollars for support of the ICA programs. Any appropriation should be specifically identified as "Grants to states for ICA program expansion," thus adding to HCFA's current level of funding for the ICA activities rather than supplanting it.

Congress needs to increase the funding for this program. The ICA programs provide vital assistance to older Americans in sorting through the complex maze of 800 numbers, modern telephone technology and confusing and conflicting information that senior citizens receive from all sectors regarding their health care and insurance planning. This is a most cost-effective program that makes highly effective use of a large network of highly trained volunteers.

If you have any questions or need more information, please contact Jon Lawniczak, Manager Federal Affairs/Health, in our Washington office at 202-624-7790.

Sincerely,

Glenn Pomeroy
Chair, (EX) Special Committee on Health Insurance
President, National Association of Insurance Commissioners
Commissioner, North Dakota Department of Insurance

Cc: Appropriations Committee
Special Committee on Aging
Nancy-Ann Min DeParle, Administrator, HCFA

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The CHAIRMAN. So, of course, you get what you pay for. If Congress provides inadequate funding, we will create more confusion. We will not have the resources needed to deal with all the questions seniors will have. They will blame us, their representatives, for this confusion, and we could have a backlash like we did a few years ago when we passed catastrophic coverage.

My hope is that this hearing will provide HCFA and Congress with recommendations on ways to avoid problems before they occur and to anticipate the information needs of Medicare beneficiaries to the best of our ability.

With that in mind, I look forward to hearing the testimony from our distinguished witnesses this afternoon. I now turn to our colleagues, starting with our distinguished ranking member, Senator Breaux.

OPENING STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Well, I think you have set it up very well, Mr. Chairman. I congratulate you once again for having a hearing which I think is extremely important, and today's subject matter is about the information that seniors get.

Health care is complicated enough as a subject. It does not have to be written in Egyptian hieroglyphics, and I think, particularly for a lot of our seniors and people who are concerned about their well being, we find out that this huge about of material that we give seniors is not always necessarily the best information. It may be the most information, but it is not necessarily the best information in the way it is presented.

It is very important that Medicare—and particularly because of the new programs in Medicare+Choice that we have the people in this country understand what the options are. It seems to me—and your film I think indicated that—that there is just so much confusion that the people do not know what choice to make, and you can never make the right choice if you do not understand what the choices are.

I want to give you an example. Behind us is the first choice that we talked about—my time is up?

The CHAIRMAN. No, no.

Senator BREAUX. The first choice we have, behind the dais, is an example of the Federal Employees Health Benefit Plan, and I have always felt and have argued that we as Members of Congress have a much better deal than about everybody else in the country, and it is not just for us. It is for all 9 million Federal employees. I think we get more choices. We get more information. We get better comparisons. There is a lower rate of increase in the price, and the OPM, Office of Personnel Management, actually negotiates on the price. Medicare cannot do any of that.

In terms of information and how it is set out, this is what—we had the staff go down—where did you all go? Charles County? On the Federal plan, we got these from the Government. The other ones are from a senior center in Charles County, MD.

These two charts detail the prescription drug benefits that the Federal Employees Health Benefit Plan provides, just two examples of two plans. What you notice about these, these are two different plans with two different types of coverage for drugs, but the

information is put out in a format that is the same so you can compare A to B. You can compare apples and oranges here because you have it set out in the same format as far as what is covered, what is not covered, and what you get from a pharmacy.

You can see—and you may not be able to read the fine print on the chart, but the members have copies of the charts up here—as to what is covered in Plan A, you know, drugs, vitamins, minerals. The other plan has drugs, including those for smoking cessation met by Federal law, that the United States requires a doctor's prescription, insulin, diabetic, diagnostic, and it just actually lists what is covered in Plan A, what is covered in Plan B. Equally important, it tells you what is not covered in Plan A and what is not covered in Plan B.

What is not covered, medical supplies such as dressings and antiseptics. The other plan does not cover medical supplies such as dressings and antiseptics, and it goes right down the list so that everybody can put it in their hand and say, "Well, Plan A does not cover this. Plan B does. Therefore, I think Plan B is better for my family, and I am going to go with Plan B."

In comparison, let me give you an example of what information is given out by Medicare risk plans. These are Medicare+Choice plans, actually—Medicare Risk current plans. We have got A, B, and C, and if you can put it in front of Senator Wyden, or preferably behind Senator Wyden, Chart C.

These are three examples of Medicare plans that are being offered to eligible seniors. Look at the difference in the formats. These are copies of pages from marketing materials detailing the prescription drug benefit. Because HCFA does not require standardized benefit summaries, it is difficult to compare benefits from different plans.

I mean, you tell me how you find out what is covered and what is not covered and what you can get from a pharmacy which is clear in the Federal Employees Health Benefit Plan, but under the largest program in the United States, which insures 39 million Americans, it is very difficult to get the right information to make the legitimate comparison as to which is the best choice.

My argument is you cannot make a best choice or the right choice if you do not have the right information, and I would suggest that when HCFA presents their comments—these are not HCFA presentations. This is just information that HCFA collects and approves. The individual health plans then send it out to Medicare beneficiaries who have to choose among the plans. I can point to some things in the code and the regulations that would give HCFA the authority to require plans to put it in the same form, which I think would be very helpful to seniors so they can make the right choice.

This is not rocket science. I mean, this is fairly simple. Put benefit summaries in the same format and let people make the right comparison.

I congratulate the chairman for once again having hearings that I think are particularly useful to people who participate in these programs.

Thank you.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

Along with new choices in Medicare comes the need for accurate, easy-to-understand comparative information to help beneficiaries understand how they differ and how to judge the quality and performance of health plans.

Many beneficiaries do not understand the way Medicare works and have little or no working knowledge of managed care. Many beneficiaries, for example, believe that to join an HMO, they have to leave Medicare. A recent Department of Health and Human Services report found that over a quarter of all beneficiaries in a Medicare HMO did not know they had appeal rights. That indicates that the baseline of knowledge is not where it should be, especially with the many changes occurring in the program.

Fortunately, the balanced budget agreement (BBA) contained specific requirements regarding the information beneficiaries should receive about their health plan option. Under BBA, the Health Care Financing Administration (HCFA) is required to publicize plans' disenrollment rates, enrollee satisfaction measures, health outcome measures, and records of compliance with certain requirements. HCFA is also required to provide beneficiaries with comparative information on plans' benefits, premiums, service areas, and supplemental benefits.

But there is a difference in simply sending out loads of information and providing simple, easy-to-understand, and useful information that will enable seniors to successfully navigate the healthcare system.

Since these information provisions in BBA were based largely on legislation Chairman Grassley and I introduced last year, we have a special obligation to ensure that beneficiaries are provided with useful, understandable information and that they know where to get answers to their questions. While providing the Medicare population with new options is a positive step the information provisions of BBA must be implemented the right way in order to avoid a situation where beneficiaries don't understand their program and are overwhelmed and frustrated.

One part of a successful strategy must be to harness and coordinate all resources, such as senior centers and area agencies on aging. Another resources is the Insurance Counseling Assistance (ICA) program. The ICA program, run by state insurance offices and state and area agencies of aging, provides one-on-one assistance to beneficiaries who have questions about the Medicare program. Currently, many beneficiaries receive information about health insurance from friends or the health plans themselves, which may not guarantee unbiased, objective information.

Providing comparative information about health plans is not a new idea. The Federal Employees Benefits Program, for example, provides enrollees with the results of its customer satisfaction survey in a simple, straightforward manner. It is my understanding that HCFA plans to do a similar survey for the Medicare population this year.

Good comparative information for Medicare beneficiaries is especially important because the benefits offered by health plans varies considerably. As we will hear from the General Accounting Office today, the prescription drug benefit can be especially confusing for beneficiaries shopping around the right health plan.

The provisions in BBA relating to information about health plans is vital to the success of the Medicare+Choice program. I look forward to hearing from our witnesses. I want to extend a special welcome to HCFA's new Deputy Administrator, Mike Hash, who is appearing before the Senate Aging Committee for the first time.

The CHAIRMAN. Thank you. I have already complimented you for your leadership on our legislation that we got passed, but we do have a responsibility now to make sure that we get it implemented right.

Senator Wyden is the next Senator.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. I, too, want to commend you and Senator Breaux for your addressing these issues.

Let me say, I think this is one of the most important moments in the history of the Medicare program. I have been involved in working with this program and with seniors since my days as co-director of the Gray Panthers, and I could tell you that the changes that are envisaged by Medicare today are absolutely monumental.

In communities all across this country, there has not been this array of choices in the history of the Medicare program, and for millions of seniors, this is going to be a very dramatic change in terms of their health care options. So it is absolutely critical that it is communicated to seniors and families in a comparable and sensible kind of fashion what the choices and what the options are, and if it is not done right, I would say that it is going to be very, very difficult to play catchup ball later on. In other words, families and seniors are going to be watching this critical period very, very closely, and that is why I think the work that you are doing, Mr. Chairman, and the work that Senator Breaux is doing is so important.

Let me also say that in my contact with senior advocates in the field, I am troubled that already reports are coming in that some key points in the aging services network are being missed, and, in particular, I am concerned about the area agencies on aging.

Under the older American statute for, again, millions of older people, this is the primary vehicle for getting out information about health choices, and you can be certain that in the months ahead, those area agencies on aging are going to be asked to do a lot of face-to-face counseling. My office has already been contacted by those area agencies on aging that they believe that they are not going to have the information that they need to be able to guide seniors and families to the right sources for assistance or the resources to provide counseling.

So I am looking forward to our witnesses. I think that the last point that Senator Breaux made is absolutely correct as well. We are seeing that in other areas of health care delivery, we are getting information out in an understandable kind of way, and the challenge now is to get it done for Medicare.

Let me also say, Mr. Chairman, that you have at the witness table one of the people that I trust most with respect to how you advocate for patients. I have known him for years, since my work on the Health Committee in the House, and it is a pleasure to have him. I am glad you have chosen him to be before the committee today, and I yield back.

The CHAIRMAN. Well, we thank you for your participation. You are always very loyal to this committee. I do not think you hardly ever miss a meeting, Senator Wyden. I appreciate that very much.

At this time, we have our first witness already at the table. Michael Hash is the deputy administrator of HCFA. Previously, Mr. Hash was principal with Health Policy Alternatives, a Washington-based consulting firm. He was a health policy staff person on the Subcommittee of Health and Environment of the House Energy and Commerce Committee.

Deputy Administrator Hash will discuss HCFA's plans to provide beneficiaries with information regarding the new choices available to them under the Balanced Budget Act and how the agency intends to use the appropriated funds.

Thank you, Mr. Hash.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. HASH. Thank you, Mr. Chairman.

Senator Breaux, Senator Wyden, I appreciate this opportunity to come before you to discuss our plans for informing our beneficiaries about their new choices that are resulting from the enactment of the Balanced Budget Act last year.

We want to particularly thank you, as the chairman and others have noted here, that you all have particularly played a leadership role in helping us to shape our plans for educating our beneficiaries through your hearing last year and through conversations with your staff, and most importantly, we greatly appreciate your assistance in supporting our request for adequate funds to meet the responsibilities we now have under the Balanced Budget Act. For that, we are most grateful.

I would like to make two points in my opening remarks here, and the rest of our testimony is, of course, available for the record. First, what we have before us is an extremely important task, and, second, as I indicated, we cannot succeed without sufficient resources.

Educating our beneficiaries about their new options is an extremely challenging task. Few now know about Medicare+Choice. Even their knowledge of the current Medicare program, as many of you know, is quite limited.

We just had a survey result of about a year ago in which a third of our beneficiaries knew nothing about their appeal rights under the current Medicare program. Beneficiaries need to know that it is their choice now under the Medicare+Choice program. If they are happy where they are in terms of their health care delivery system, they need not make a change. The choice is theirs.

They also, though, need to know and understand what their new options are, and they need to know the consequences, as Senator Breaux said, of the choices they may make.

They need to know that in the future, under the law, their opportunity to disenroll from managed care plans will be limited to specific periods. We have a time before we get to that, but, eventually, there will be limitations on the periods in which beneficiaries may disenroll from our managed care plans.

They need to know that their ability to obtain private supplemental Medigap insurance, if they return to the fee-for-service program after disenrolling from a managed care plan, may not be on the same basis as their original opportunity to get those private supplemental plans without preexisting conditions and without other limitations, and they need to know that some of the options that are available under Medicare+Choice, such as medical savings accounts and the private fee-for-service plans, do not include Medicare standard financial protection, that is to say, protection for out-of-pocket expenses that is a part of the basic Medicare program.

We will be sending to every beneficiary this fall a handbook with basic information about the traditional Medicare program, about the private supplemental policies that are available to the traditional program, and, of course, about the options under Medicare+Choice, including for the first time, comparative information along the lines of that displayed in the charts brought by Sen-

ator Breaux about the options available to beneficiaries in their specific marketplace.

As all of you know, not every plan will be available to every beneficiary. So we are tailoring our handbook in such a way that when the beneficiary receives it, it will have information that is relevant to the area or neighborhood in which they live, and we think that makes this document much more useful.

We are, of course, setting up, as the law requires us, a toll-free 800 number so that beneficiaries can access individuals to give them personal assistance as they confront the choices they will have, and I think as Senator Wyden pointed out, we are trying to work with many other partners in community-based organizations including the area of aging organizations to help provide a point of access for our beneficiaries to understand more about their choices, and, of course, we are partnering with a large number of groups. In my prepared testimony, I list our various private sector partners and public sector partners who are helping to participate in our educational efforts.

We are also conducting a special survey called the Consumer Assessment of Health Plan Survey, which provides a consumer's-eye view of the plans that can be used by beneficiaries to rate their personal experiences with the plan. This is a consumer satisfaction tool that we think will be very useful in terms of gaging individual experiences in our health plan choices, and we will provide more information through the Internet for the seniors and their families who are able to access that media outlet.

For example, this fall on our web site, we will release comparative information on the managed care plans performance measures, in fact, such as things like mammography rates of our contracting plans and data on enrollee satisfaction, again, in a comparative form on the Internet.

We have made a great deal of progress in developing our program, I think, since we discussed this issue with you last year, and we think we have learned a lot over the past year.

Let me just say a little bit about how we are planning to use our resources for this year and in the coming year. In fiscal year 1998, the year we are in now, we are spending about 114 million on our Medicare education program. Ninety-five million comes from those user fees that you helped to get appropriated for us that are being paid by our health plans, and we are adding about 19 million in additional funds from our discretionary program management budget.

Our handbook costs, the thing we are mailing out this fall, are estimated to be about 35 million. In addition, we have about 10 million in some other printing costs associated with new beneficiaries, but essentially about 45 million for this printing exercise and for getting the handbooks mailed out.

Our 1–800 number, we anticipate costing about 45 million in this fiscal year. That is only the initial investment. We are going to have to be spending considerably more to get the phone line up fully during fiscal year 1999, which begins in October.

With regard to our cost on the 800 number, we are certainly unsure about the extent of that expense because we are unable to predict how many people will call, what the length of their call may

be, and, of course, our contract obligations are, in part, related to the volume of calls and to the length of individual calls.

Another 24 million of our funds this year will be used to help support that Internet site I referred to, to continue our support to local counseling agencies, the health insurance advisory programs, to continue our enrollee satisfaction surveys and the like.

For fiscal year 1999, we are budgeting about 173 million. We are depending on, or relying on, the full 150 million that the statute authorizes in user fees for fiscal year 1999, and then we are augmenting that, again, with about 23 million of our own discretionary program money.

We need more money next year because we will be completing our investment in the 800 number, and we have some other additional expenses associated with the growth in managed care activity.

Let me just say, because I know my time is up, in the future we know the statute authorized 100 million a year for continuing these Medicare education operations in fiscal year 2000 and beyond. We need to make clear that we may need to revisit this number because we are not sure that will be sufficient over time to maintain the processes and the systems that we are putting into place to make sure that our beneficiaries are truly able to make informed choices.

Again, let me say how much we appreciate the support of this committee not only for our resources, but in the actual design of the activities we have underway. We intend to continue our close collaboration with you, and I would be happy to respond to any question, Mr. Chairman, that you or other members of the committee may have.

Thank you.

The CHAIRMAN. Thank you.

Let me make an announcement for this panel and every other panel. You might expect questions to be submitted in writing by those of us who are here, but also Senators who could not attend this hearing. So I hope you will respond to those within 2 weeks.

Also, everybody's statement, as probably all statements are longer than 5 minutes, will be printed in the record, and we ask you to summarize your statement in that 5-minute time limit.

First of all, I commend you for what you are doing to meet the Balanced Budget Act deadlines and all the requirements of the law.

I also want to take an opportunity before asking you questions to clarify that I support the appropriations to HCFA to implement the education program, but I also want to make clear that I did not specify in the letter to the Appropriations Committee how the Appropriations Committee should or would fund this program. The money does not have to come from user fees, and that is a decision that appropriators will have to make, but I wanted to lend my support as a member of the Finance Committee and as chairman of this committee for the amount that we authorized in the Balanced Budget Act.

As you know, the Balanced Budget Act required printed comparative information to be distributed to Medicare beneficiaries on their health plan options. Senator Breaux and my legislation required that this information be presented in a chart-like format.

The Balanced Budget Act does not specifically say that you have to produce charts. However, the purpose of the charts is so that the beneficiary can make an easy comparison across plans.

Does HCFA have any plans to use charts in the printed material for comparing benefits across plans and survey satisfaction results?

Mr. HASH. Mr. Chairman, we are now reviewing a draft of our handbook that we are planning to mail this fall, and we want to actually say right now that we would like to come up and meet with your staff and with other members that might be interested to get some of your reactions to how we have actually developed the format in this handbook.

I will tell you that we do use some chart presentations. We are planning to. We have also been testing this with focus groups like the ones we saw on the video in order to make sure that we are actually effectively communicating what amounts to some very complicated information, but in the end, we want our handbook to actually facilitate comparisons across the options that beneficiaries have. We would be anxious to solicit your staff and your help in designing that.

The CHAIRMAN. I presume that has got to be, then, within just the next few weeks?

Mr. HASH. Yes, sir, it does.

The CHAIRMAN. The very near future.

Mr. HASH. Our printing deadline in order to have this document into the mails in the fall will be sometime in the month of June.

The CHAIRMAN. OK. Well, my staff would be very happy, and I presume Senator Breaux's staff would be very happy, to sit down with you and, in fact, consider it an obligation to make sure that congressional intent is met.

The Balanced Budget Act requires that a summary of how physicians are compensated by the managed care plan can be obtained by the beneficiary upon request. What are the agency's plans to inform beneficiaries how they can get this information from the plans?

Mr. HASH. I am not sure I can answer that specifically right now, Mr. Chairman, but I will certainly get back to you with a more— I believe—

The CHAIRMAN. You can answer in writing.

Mr. HASH. In our handbook, I believe we will indicate that that information is available upon request, and, therefore, we will try to inform beneficiaries of their rights through this handbook.

The CHAIRMAN. If there is other information, submit that in writing.

Mr. HASH. Yes, sir.

The CHAIRMAN. Thank you.

The General Accounting Office has recommended that HCFA require plans to use standard terminology and formats in marketing material in the information that they submit to you. According to the General Accounting Office, new contract information requirements which could incorporate this recommendation are not targeted until the year 2001 or later. Do you plan on using the standard format and terminology sooner, and if not, why?

Mr. HASH. Mr. Chairman, with regard to standard formats, we are clearly, as I indicated, using standard formats in our handbook,

on our web site, in relation to the information that we are putting out to our beneficiaries about Medicare+Choice and traditional Medicare for that matter.

With respect to requiring the individual contracting plans to make sure that their material, their marketing and other informational material is formatted in a uniform and standard fashion, you are correct that we have plans to do that. We believe we have the authority to do that, but I think we need to take a look at our time table because I can tell obviously that it would be more desirable to have the standardized material that plans are actually using sooner rather than later. I think, to some degree, it may be a resource question for us, but there is no question about our interests in bringing more uniformity and consistency to what the plans print up in the way of their own information about their offerings.

The CHAIRMAN. It is my understanding that the CAHPS survey surveys individuals currently enrolled. Are you going to also interview beneficiaries who have left the plan to see why they disenrolled?

Mr. HASH. Yes, Mr. Chairman, we are. We have actually developed a special subset of that CAHPS survey specifically for the purpose of surveying a sample of Medicare beneficiaries who have disenrolled, and we are doing that later this year.

The CHAIRMAN. While the Balanced Budget Act does not require disenrollment data to be published until the fall of 1999, this information is something you collect now and have talked about publishing prior to the enactment of our legislation last year. When do you anticipate HCFA publishing disenrollment data by market areas as recommended by the General Accounting Office, and will this be published in printed material and not just via the Internet?

Mr. HASH. Mr. Chairman, I believe—and I will follow up also for the record on this—that our intention is, as you stated, that this information will be part of our handbook printing for 1999; that is, next year, for October of next year.

Meanwhile, I want you to know that we clearly have been working on improving the methodology for actually displaying this information.

To be honest with you, we do, of course, have disenrollment data on our current risk contractors. We are using that data internally as a monitoring tool and as a signaling tool for where we need to focus our oversight of our current risk contractors to make sure they are in compliance with all requirements, but in terms of public disclosure for purposes of plan comparison, we believe that we do not have as yet the proper methodology that will make that information usable and not misleading to the public because, as I know you recognize, there are many reasons why individuals might disenroll from plans. We have to make sure that when we show a disenrollment rate that it relates to problems individuals have had with their plan as opposed to other events like moving out of the area or leaving their plan for some other reason, because they wanted to go to another plan that had better benefits.

So we are trying to shape a methodology that will really be useful to beneficiaries in terms of evaluating whether the disenrollment rate truly reflects problems in the plan or some particular feature in the marketplace.

The CHAIRMAN. What are HCFA's plans to utilize the ICA's and the AOA's, and is the ICA program going to receive any additional allocations, more than the current 10 million it receives from your contractor's budget?

Mr. HASH. I do not, again, have an exact figure. I do know that we are continuing to support the ICA's. We will continue through the resources that we have available. I can get back to you with some specifics.

I believe that I was just informed that our 10 million amount is being increased to 15 million in terms of grants support to what we now believe called the Health Insurance Advisory program, which is the successor, really, to the ICA's.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. It is no wonder nobody understands. We talk in alphabets, ICA's, HCFA's, ABC's, XYZ's. No wonder people cannot understand us.

To what extent are you going to require the health plans themselves to present the information to the eligible Medicare recipients in a standardized form?

Mr. HASH. Our plans are that not this year or next, but the following year we will be in a position to actually do that.

Senator BREAUX. Why cannot we just tell health plans to do it now?

Mr. HASH. Well, I think there is some sense that we have not actually had the experience we are about to have with our handbook this fall where we have already moved to a standardized format, and in some ways, we would like to gather the experience from that mailing this fall before we decide exactly what formats we want to tell people that they need to use for their own information of materials to beneficiaries.

Senator BREAUX. The problem is going to be that you are going to have a standardized Medicare handbook going out to the people, but when they get the information directly from the companies they are going to get many different formats. How many choices are they going to get?

Mr. HASH. Well, of course, Senator, it will depend on the marketplace.

Senator BREAUX. I understand that.

Mr. HASH. In some places, there may be only one or two Medicare+Choice plans, and in others, there may be 17 or 20.

Senator BREAUX. You may have 50.

Mr. HASH. Or 50.

Senator BREAUX. You are going to have a Medicare recipient who is trying to make a choice. He is going to have 50 different proposals from 50 different companies written in 50 different languages.

Mr. HASH. Well, we hope it will not be that bad, but you raise a good point, and we are sensitive to the issue of trying to bring standardization and uniformity to the plans on materials. We need to take a look at our timetable, and perhaps we need to be more aggressive, but definitely—

Senator BREAUX. The Office of Personnel Management for the FEHB program requires that if you want to do business you have to present the information in a standardized format. Why couldn't HCFA say, "Look, here is the format we want you to present it in.

If you want to do business with 38 million potential customers, you are going to have to present it in a standardized format"? Now, why does that take 3 years?

Mr. HASH. You make a good point, Senator, and I do want to emphasize that we are now recommending the standardization in common terminology in our process for reviewing the marketing materials that are submitted to us by plans who are participating with us. So we do, as you know, have an opportunity to see their materials. We are working with them in what you might describe as a voluntary mode now to get greater standardization, and with the idea that we want to move to a more rigorous approach later on.

Senator BREAUX. Does HCFA feel it has the authority to require the companies to present standardized information or not?

Mr. HASH. We do, sir. We do believe we have the authority.

With respect to FEHBP, we have a lot to learn from them, and they have been at this business of standardized comparisons a lot longer than we have, and I think this is the first requirement, really, for us to have such a wide array of plan choices that we need to describe more accurately. We want to work with you to try to see how we can accelerate our efforts to do this.

Senator BREAUX. Will there be any comparison information in the materials provided by the plans that are trying to do business with the Government? Will there be a grading system of any type?

Mr. HASH. In our material, Senator, or in the material of the plans?

Senator BREAUX. In the materials of the plans.

Mr. HASH. I am not actually aware of how they are going to report their own data.

We are reporting comparative data that will be available both in our handbook and at our web site.

Senator BREAUX. We do not do that now under the existing Medicare program, do we, under fee-for-service?

Mr. HASH. Actually, on our web site today is comparative information on some performance measures on our existing HMO risk contractors.

Senator BREAUX. If you do not have a computer, you do not have access to it, though.

Mr. HASH. That is correct, sir.

Senator BREAUX. You said something about the handbooks not being available to everyone. Who would they not be available to?

Mr. HASH. I did not mean to say that. I should correct, if I did.

The handbook will be mailed to each Medicare beneficiary household in the United States, ultimately all 38 million beneficiaries.

Senator BREAUX. Now, the user fees, you mentioned, and printing the materials and running the 1–800 number will be paid by what user?

Mr. HASH. By the health plans who are participating in our program—

Senator BREAUX. OK.

Mr. HASH.—which is pursuant to the BBA requirement.

Senator BREAUX. You are starting off in new unchartered waters for HCFA, but others have been doing this for a number of years. We are way behind, but I encourage you. I want you to have the

materials and the wherewithal to do all of this, and that is why a number of us, including Senator Grassley, have argued for enough money be provided to HCFA for them to carry out these provisions of the BBA because I think, in the long term, we will be much better off.

You do not have authority under Medicare+Choice to negotiate on benefits and prices, do you?

Mr. HASH. We do not, Senator.

Senator BREAUX. From my standpoint, wearing another hat, I think that is one of the things that we really absolutely have to get to. We have 38 million people and no ability to negotiate on prices and coverage of services.

When you have that many people and are not being able to negotiate, it is one of the fatal flaws of the existing Medicare program, in my opinion.

Mr. HASH. As you may know from the BBA, we are going to pursue what we call a competitive pricing demonstration where we are going to pick some markets and actually—

Senator BREAUX. Yes, only because we made you.

Mr. HASH. Well, actually, Senator, we tried.

Senator BREAUX. I know. You all have been trying. It has been a very difficult thing to overcome.

Mr. HASH. Yes, sir, and we appreciate your—

Senator BREAUX. I appreciate it. Stick with it. We are going to get it. We will get it.

Mr. HASH. Yes, sir.

Senator BREAUX. Hang in there.

Mr. HASH. We need all the help you can give us.

Senator BREAUX. It is coming.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Mike, maybe just walk us through this for a minute. If you are a senior in rural Oregon or rural Iowa, for example, you get this booklet in the mail. You are frail. You are not feeling well. You see the 800 number. You can call the 800 number, but you have had bad experiences with 800 numbers, and you want something where you can like really talk to a human being face to face. How does it work?

Mr. HASH. Well, we are hoping that our partnerships with the counseling agencies around the country, with the AAA's, with beneficiary advocacy groups, the Center for Beneficiary Rights and so forth, these kinds of groups around the country are partnering with us to provide access for those kind of one-on-one counseling services. Actually in our 800 number, while the first step, as you might expect, is a voice-activated series of voices, that if you want to speak to a customer representative, a real person who has been trained about our options, you can actually get to a person and talk about your questions.

Senator WYDEN. So, with your first call, if you want to talk to somebody who is going to give you some more time, your intent is to be able to get into the system that way.

Mr. HASH. That is certainly one way. I do not want to underestimate the role of these organizations with whom we are partnering

in order to expand our resources to provide counseling and communication to beneficiaries because it is an enormous task.

In addition to the area agencies and the ICA's, we are also trying to train our contractors in the traditional program, the carriers and the intermediaries to be prepared to help with this, as well as the peer review organizations which as you know are the locally based physician groups around the country, to use their resources as also a point of contact with our beneficiaries.

Senator WYDEN. Are you going to try to get some information out to those who actually visit with seniors in their home? I know in rural Oregon, and I suspect a big part of the rural United States, that may be one of the best ways to get people comfortable with that, and I have not heard anything about in-home services being made a part of this whole effort.

Mr. HASH. I think we should talk with you and your staff about that and see where—in case we are not already doing that or do not have an access point for those kinds of people, particularly isolated, rural beneficiaries, because we would like to provide a better access for information for them as well.

Senator WYDEN. One question in terms of cost, and you are absolutely right. This is going to work both ways. Congress has got to make sure that the agency has the tools to do this. At the same time, for us to be able to make that case, we have got to make sure that funds are being well spent.

Do you have any information you can give us at this point about how Medicare has tried to hold down the costs, for example, of running the toll-free line? We have gotten reports from some plans about the cost per call, and some have said it is high and others have raised questions about whether there has been competitive bidding for these contracts. What can you tell us about how the agency is trying to hold down the cost?

Mr. HASH. Well, I think we have been falling, as I understand it, the generally accepted Government procurement requirements for contracts in both printing, handbook area, as well as the 800 number.

I would like to get back to you and maybe give you more specific information about how that has proceeded, but at least I am led to believe—first of all, you can imagine on the 800 number that there are not a lot of contracts out there who could actually meet our service expectations, and probably the folks in the communication business know that. Whether we have been able to exercise as much level of negotiating power with that contract as we might want to, I cannot speak to that specifically, but we do feel like now we have a contractor for our phone number who is committed and capable of handling the reasonable volume of calls that we are anticipating.

To be frank with you, we have never tried this before on this scale, and this year, as the Congress I think wisely provided in the BBA, a lot of the things that we are doing are kind of in a dress rehearsal mode because the real choices and opportunities for Medicare beneficiaries are probably going to be most fully available beginning in November 1999. So we are trying to learn as much as we can this year about a lot of the questions you are raising, and I would like to talk to you more about it.

Senator WYDEN. Can any of those good people in back of you give us some information with respect to the cost per call at this point?

Mr. HASH. I am informed that based on an estimate, I think, of about a 7-minute average phone call, it is between $5 to $7, average, for an average 7-minute phone call.

Senator WYDEN. I was out of the room for a moment, but tell us what kind of plans you have for using the Internet. I heard you touch on it in your testimony, and I intend when we get to the Older Americans Act—as you know, that is a priority for the Congress this year—I am going to offer an amendment to expand the role of the Internet and the delivery of services to older folks because I am convinced that this is, again, a tool that we have got to use in the 21st century, and it was not part of the Older Americans Act originally. It would be helpful to learn of your plans to use the Internet on this project.

Mr. HASH. I am glad you asked that, Senator Wyden, because I failed to say when this issue came up, as I think Senator Breaux mentioned, that a lot of seniors do not have access to computers.

We have actually just recently donated 500 computers to senior centers around the country to at least provide some assistance in getting access to the Internet and the information that is there. So we are trying to take steps to increase access to computer-based learning for seniors and to get our material.

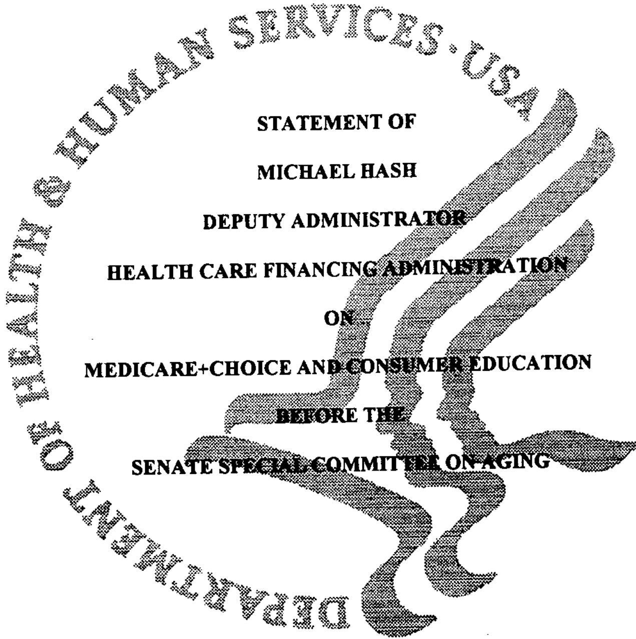
Senator WYDEN. It is absolutely correct that a lot of seniors do not have access to the Internet today, but I think when we talk about families—and, literally, every week, I get a call from somebody who is in their forties who is a lawyer or an accountant saying, "I am working with my mother's Medicare. Where do I go to get good information?" If you all can really make a difference with the Internet now in Medicare, I think this is going to have significant applicability to the whole network of aging services.

So, remember, you are speaking when you use the net, not just to the older people, but to their families, and we need you to make as aggressive a campaign as possible over the net.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Wyden, and thank you, Mr. Hash.

[The prepared statement of Mr. Hash follows:]



STATEMENT OF

MICHAEL HASH

DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON

MEDICARE+CHOICE AND CONSUMER EDUCATION

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

MAY 6, 1998

TESTIMONY
MICHAEL HASH, DEPUTY ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
MEDICARE+CHOICE AND CONSUMER INFORMATION
SENATE AGING COMMITTEE
MAY 6, 1998

I am pleased to be here today to describe our plans to inform Medicare beneficiaries of their health plan options under the Balanced Budget Act of 1997 (BBA) and to assist them in making the right choice for their needs. Ensuring that beneficiaries are adequately informed of their options has been a major focus of this committee. You played a leadership role not only in defining the scope of the information campaign in the BBA but also in ensuring that it is adequately funded. Without adequate funding, beneficiaries will not have the tools they need to make the right choices.

We testified before your committee last year on this same issue. At that time, we described our various initiatives and I am pleased to report that we have made significant progress since then.

- We are in the process of gathering our first comprehensive picture of enrollee satisfaction through the Consumer Assessment of Health Plans Study (CAHPS) instrument. It is designed to provide a consumers-eye view of how health plans really work, and allow beneficiaries to make apples-to-apples comparisons between plans. Results will be available to Medicare beneficiaries by November 1998.

- We are finalizing plans for our first nationwide mailing of basic and comparative information on Medicare+Choice options, original fee-for-service Medicare, and private supplemental coverage "Medigap" policies available to beneficiaries.

- We are also finalizing plans for toll-free telephone service and local counseling services to assist beneficiaries in making informed choices.

- We will this fall release, via the Internet, comparative information on the Health Plan Employer Data and Information Set (HEDIS) measures for 1996 which were adapted for Medicare and include information on plan performance, such as mammography screening rates. Our new Internet site, Medicare.gov, will provide basic comparison information on Medicare plan options by zip-code through Medicare Compare.

As you know, the BBA expands health care options available to Medicare beneficiaries through the creation of the Medicare+Choice program. Under this program, Medicare beneficiaries will

be able to choose to receive their Medicare benefits either through original Medicare, as the current Federally-administered fee-for-service program is now called, or from an array of Medicare+Choice private options such as Health Maintenance Organizations, Preferred Provider Organizations, Provider Sponsored Organizations, as well as Private Fee-for-Service Plans and Medical Savings Account Plans. These choices are designed to offer Medicare beneficiaries options similar to those available in the private sector to people with employment-based health insurance. Medicare+Choice also is designed to expand access to managed care options for Medicare beneficiaries in rural and other areas where these options have been lacking.

The BBA added new challenges to making sure Medicare beneficiaries have what they need to make informed choices.

- **Phased lock-in:** To date, beneficiaries could enter and drop out of managed care plans on a monthly basis. Under BBA, beginning in 2002 beneficiaries will be locked into most Medicare+Choice options for six months. Starting in 2003, the lock-in period will be nine months. And beneficiaries enrolling in Medical Savings Accounts (MSAs) will be locked in for one year starting in 1999.

- **Changes in enrollee costs:** Some new options involve changes in enrollee costs. Medicare provides protections to limit beneficiaries out of pocket health care costs. However, under BBA, beneficiaries will be offered options which alter these protections. Private fee-for-service plans under BBA have no limits on premiums that can be charged to beneficiaries. Plans are free to negotiate their own payment rates, and providers can bill up to 15% beyond the plan's rates. With MSAs, beneficiaries must negotiate their own payment rates, and there are no limits on what providers can charge.

- **Benefits not standardized:** The BBA did not include provisions that would have made it easier to explain options to beneficiaries. It did not standardize commonly offered additional benefits, which would have made it easier for beneficiaries to compare Medicare+Choice and Medigap options. The BBA also did not include provisions to limit preexisting condition exclusions and expand open access for Medigap options for both disabled and elderly beneficiaries so that they can more freely move back into traditional fee-for-service Medicare. Without these provisions, it will be more of a challenge to help beneficiaries understand the consequences of some choices and whether specific options will meet their specific needs and desires.

We are doing our best to meet the challenges posed by the BBA within the limited discretion we have under the law, and I would like to summarize for you today our plans and the challenges that we face.

The National Medicare Education Program

While the Medicare+Choice program expands choice, as indicated above, the context for this choice will be significantly different than under Medicare's previous risk-contracting program. Besides weighing the value of additional benefits such as prescription drugs and low copayments that plans may offer, beneficiaries will also have to be aware of the potential for higher out-of-pocket expenses, variable supplemental benefits, and the implications of lock-in. The complexities added by the scope of options in the BBA are a concern because our research has shown us that, even before the BBA changes, many beneficiaries were confused about their basic Medicare benefits and, therefore, did not use the program to their full advantage.

Many beneficiaries do not understand the basics of the original Medicare fee-for-service program or their current HMO options, according to surveys by us and the HHS Inspector General. And beneficiaries with some understanding often have only superficial knowledge.

- For example, one third of beneficiaries reported knowing little or nothing about original Medicare benefits or out-of-pocket payment for services.

- Over 40 percent indicate that they know little or nothing about private supplemental policies.

- About one-third of beneficiaries do not understand that if they disagree with a payment or coverage decision, they have the right to appeal it.

- Perhaps most critically, 6 out of every 10 beneficiaries report knowing little or nothing about managed care.

In recent focus group testing of Medicare+Choice materials, we found that few beneficiaries have any knowledge of the Balanced Budget Act or the Medicare+Choice initiative. When we have shown beneficiaries the options they will have under Medicare+Choice, many become overwhelmed by the number of choices, and even well educated beneficiaries have difficulty understanding them all.

Clearly, beneficiaries will need assistance to understand the implications of the expanded Medicare choices under the BBA and how to use the HCFA-developed information tools that will be available annually through the Medicare Handbook and via the World Wide Web. We also need to make sure beneficiaries understand that they can choose to do nothing and continue to receive care through original fee-for-service Medicare or their current managed care plan.

To respond to this need, HCFA is embarking on a National Medicare Education Program, the purpose of which is to ensure that our beneficiaries receive accurate, easily understandable information about their benefits, rights, and health plan options to assist them in becoming more active participants in their health care decisions.

We are establishing extensive partnerships in this effort. We have 23 partners on our coordinating

committee. They includes the American Association of Health Plans, the American Association of Retired Persons, the federal Administration on Aging, the American Society on Aging, the AFL-CIO, the Consumer Coalition for Quality Health care, the Department of Defense TRICARE Marketing Office, Families USA Foundation, the Health Insurance Association of America, the Health Resources and Services Administration, the International Longevity Center, the Medicare Rights Center, the National Asian Pacific Center on Aging, the National Association of Area Agencies on Aging, the National Association of Community Health Centers, the National Association of State Units on Aging, the National Council of Senior Citizens, the National Institute on Aging, the National Institute on Diabetes and Digestive and Kidney Disease, the National Organization for Rare Disorders, the U.S. Office of Personnel Management Office of Insurance Programs, the Visiting Nurses Association of America, and Watson Wyatt Worldwide.

We have 15 organizations participating on task forces. They include the American Academy of Family Physicians, the American Hospital Association, the American Music Therapy Association, the American Nurses Association, the Employers' Managed Health Care Association, the General Services Administration Consumer Information center, the Georgetown Institute for Health Care Research and Policy, Hewitt Associates, Indian Health Services, the National Alliance for Caregiving, the National Osteoporosis Foundation, the People's Medical Society, Resource Connectors Ltd, the Spry Foundation, and Towers Perrin.

We have 28 organizations helping us as educational affiliates. They include the 60 Plus Association, Aging Services Inc., the Alliance for Aging Research, the American Academy of Family Physicians, the American Medical Rehabilitation Providers Association, the Association of Jewish Aging Services, the Ball State University Center for Gerontology, the Eastman Kodak Co., Iona Senior Services, the National Agricultural Library, the National Association of Insurance Commissioners, the National Association of People with AIDS, the National Association of Retired Federal Employees, the National Association of Social Workers, the National Coalition for the Homeless, the National Committee to Preserve Social Security and Medicare, the National Consumers League, the National Library of Medicine, the National Rural Health Association, the Office of Disease Prevention and Health Promotion, the Office of Minority Health Resource Center, the Partnership for Prevention, the Department of Labor President's Committee on Employment of People with Disabilities, the Substance Abuse and Mental Health Services Office of Managed Care, the Summit Health coalition, the United Auto Workers, the United Cerebral Palsy Institute on Disability and Managed Care, and the United Senior Health Cooperative.

We also intend to work closely with Health Insurance Advisory programs (formerly known as Health Insurance Information Counseling and Assistance programs), and hope to coordinate efforts with local agencies on aging.

Through this program, we want to educate Medicare beneficiaries so that they can make informed health plan decisions rather than making decisions based on inaccurate, misleading, or incomplete information.

The National Medicare Education Program will employ a number of strategies to educate beneficiaries regarding:

- Medicare program benefits
- health plan choices
- their rights, responsibilities, and protections
- health behaviors and health promotion

As part of this program, HCFA will provide access -- via the Web, a toll-free call center, and in print materials -- to general program information and specific comparative information about Medicare+Choice options. The information comparing plan options is crucial to empowering beneficiaries with the knowledge that will help them evaluate Medicare+Choice options along with the original Medicare program and make informed decisions based on their individual needs. Equally important is the need to make clear that HCFA's provision of local comparative data is intended neither to encourage or discourage beneficiaries from choosing one health care plan over another nor to favor a choice of a Medicare+Choice plan over original fee-for-service Medicare.

The National Medicare Education Program will use a phased educational approach moving from *awareness to understanding to use* of information by beneficiaries to make personal decisions about the best value health plan option for them.

In 1998 and 1999 we will begin the initial phases of the program during which we will: make beneficiaries aware that new health plan options are coming; prepare them for making an informed choice; and help them understand HCFA's role and mandate as it relates to Medicare. In all, we want to emphasize that the choice is theirs -- that is, they do not have to change if they are satisfied with the benefits and care that they are currently receiving.

During the next phase of the program (in 2000 and beyond), we want to help beneficiaries understand the importance of both making an informed choice and assessing the quality of services received under Medicare. We also want to emphasize to beneficiaries that they should make their choices based on their individual needs. For beneficiaries, their families, and others working on their behalf, we want to strive to assure that they: are aware of the resources and tools to use to help in the choice-making process; understand that Medicare cares about quality; and perceive that the Medicare program is a reliable and credible information broker about health care plans and coverage.

Through the program, we want to assure that our beneficiaries develop skills and acquire knowledge to make informed choices, including making use of comparative quality measures and assessing the appropriateness of available options given their individual medical needs. This activity is part of a larger effort to educate Medicare beneficiaries about ways to improve their health through healthy living and appropriate use of benefits.

The National Medicare Education Program is a five-year effort. We will be constantly learning

from our efforts. A program assessment will be integrated into the design and implementation of the program. The assessment will provide information to: 1) improve practices and procedures, 2) add or drop specific program strategies and techniques, and 3) replicate successful aspects of the program elsewhere. The focus of the program assessment will be whether the "right" actions are being taken in the "right" way, and whether the desired outcomes are being achieved.

1998 Objectives

HCFA's objectives for the National Medicare Education Program in 1998 include:

- Building alliances with other consumer centered organizations to work with HCFA in disseminating information and educating our beneficiaries and our other partners who work on beneficiaries' behalf. HCFA has invited a broad array of public and private sector organizations to join an Alliance Network to foster cooperation among these groups nationally and at the local level to enable Medicare beneficiaries to make informed health care decisions. These groups can choose to participate at three different increasingly active levels of involvement and leadership ranging from supporters in information dissemination to national leadership partners.

- Test-marketing alternative information broadcast approaches focusing on various Medicare managed care markets. We are formally testing information which will be presented in print and over the Internet with groups of beneficiaries to assess their understanding of the intent of the information and the usefulness of the style of the presentation.

- Developing a national community-based customer service strategy that leverages the existing community-based organization network and lays the foundation for future support from a broad base of public, private, and volunteer community-level support. While Medicare is a national program, beneficiaries interact with the health system locally. A sustainable community-based infrastructure is essential to support the counseling needs of beneficiaries. We are seeking approaches to develop and leverage existing networks of community-based organizations that can be used to assist beneficiaries. HCFA Regional Offices will take the lead in this effort beginning with developing local strategies for the special information campaign in 1998. We are also working with foundations to identify opportunities to fund development of innovative community programs.

- Educating and training principal information intermediaries, such as Health Insurance Advisory programs, advocacy groups, and community-based organizations. We are planning an intensive training program targeted to our contractors and our partners who will be actively involved in providing information and counseling to beneficiaries and those who work on their behalf. We will provide training regarding the program changes resulting from the Balanced Budget Act and the tools and resources that will be available to them in working with beneficiaries.

Spending Plan for the National Medicare Education Program

For the 1998 fiscal year, HCFA plans to spend about $114 million on the National Medicare Education Program. This includes $95 million collected in user fees, provided for in the BBA, and about $19 million from our program management and peer review organization (PRO) accounts, which will fund activities that would have been funded without the BBA but which will be folded into the comprehensive National Medicare Education Program. The lion's share of the money is devoted to the beneficiary handbook/plan comparisons and the 1-800 toll-free information line. Let me briefly outline our spending plan.

Medicare Handbook/Medicare+Choice Comparisons - In FY 1998, we estimate that the costs to design, print and mail the combined Medicare Handbook/Medicare+Choice Plan Comparisons will be about $35 million, or just under $1.00 per beneficiary. An additional $10 million will be spent on related Medicare+Choice program printing needs, including the costs for printing and mailing the initial enrollment package to individuals who will soon be eligible for Medicare. Only one handbook will be mailed per household. The per person cost for the handbook is higher than in previous years because the health plan comparative information is being provided. We are currently estimating that there will be over 500 different versions of the plan comparison section of the handbook. Each version will be tailored to the options available in the market in which the beneficiary resides. The 1999 version of the book will be mailed to beneficiaries in the fall so it can be used during the November open enrollment period. The information included in plan comparisons will be expanded over time to include HEDIS performance measures, enrollee satisfaction results and disenrollment rate information.

1-800-MEDICARE - We estimate that the cost for the 1-800-MEDICARE toll-free call center will be just under $45 million in FY 1998. Needless to say, we are not as confident of this estimate because of the tremendous uncertainty regarding how many beneficiaries will utilize this service and how long the average call will last. Callers to the service will first reach an automated response unit that could be either touch-tone or voice activated. Spanish language and hearing impaired service will be provided. This service will be available 24 hours a day, 7 days a week and will allow callers to order Medicare publications, request a disenrollment form or hear recorded answers to frequently asked Medicare+Choice questions. Callers also will be able to talk to customer service representatives from 8:00 a.m. through 4:30 p.m. local time, Monday through Friday, about more complex questions and to obtain comparative information about local health plan options. Once the service is operational nationwide, we estimate that over 2,000 service reps will be needed during peak call times.

Community Support/Information Infrastructure - The remaining $24 million will fund a host of other activities, including (1) the Internet site, which will provide comparative information to beneficiaries and those who counsel with them, (2) the Health Insurance Advisory Program activities, (3) surveys of enrollee satisfaction, (4) a national publicity campaign which will feature health fairs, (5) development of information materials to be used by beneficiary counselors, and (6) evaluations and other projects to monitor and improve how we communicate this important

information to our beneficiaries.

FY 1999 Request - For fiscal year 1999, we are estimating that we need about $173 million --the full amount of user fees authorized in the BBA ($150 million) and $23 million from our program administration and PRO accounts, which will fund activities that would have been funded without the BBA but which will be folded into the comprehensive National Medicare Education Program. Most of the increase is devoted to a much larger projected cost for the 1-800-MEDICARE toll-free line. In both FY 1998 and FY 1999, some of the funds are needed for start-up costs, such as training and management information systems. We anticipate that in FY 2000 when start-up activities are completed, the line item for this activity will be less than it is in FY 1999.

Specifically, for FY 1999 we are again projecting about $45 million for the handbook and other printing needs. We estimate $80 million for the toll-free service; about $33 million for HIA, beneficiary satisfaction surveys, a national publicity campaign featuring health fairs, the Internet site, and evaluation of the consumer information activities; and reserving about $15 million in a contingency fund, given the uncertainty of the demand for toll-free call center services.

We appreciate the support of this Committee for the appropriation of the full amount authorized for the 1999 user fees. We should point out that since $23 million in funding is coming from other sources, it is imperative that both HCFA's full FY 1999 appropriation request and our request for authority for user fees for other parts of the program be approved. We also want to call to your attention to the fact that the BBA authorizes $100 million in user fees for consumer education and information activities in fiscal years 2000 and beyond. Given the current uncertainty over beneficiary demand for Medicare+Choice options, we may need to revisit the adequacy of this funding level once we have a better understanding of the type of information beneficiaries find useful.

CONCLUSION

While we support broader choices for Medicare beneficiaries, implementing the Medicare+Choice program presents HCFA with many new challenges. Key among them is to ensure that Medicare beneficiaries receive accurate, easily understandable information about their benefits, rights, and health plan options so that they can make informed health plan decisions. We are committed to giving beneficiaries accessible information so that they can avoid making decisions based on inaccurate, misleading, or incomplete information. This is an extremely important task, and we know that we cannot succeed without adequate resources. We trust that this Committee will continue to play a leadership role in trying to ensure that beneficiaries have the tools that they need to make informed choices.

The CHAIRMAN. I now call our second witness in our second panel, Dr. William Scanlon. He is the director of Health Financing and Systems Issues at the General Accounting Office (GAO), and I always say that we cannot have an official meeting of the Aging Committee without having Dr. Scanlon here. The GAO is a valuable resource for us.

Dr. Scanlon will provide recommendations on how HCFA can improve the collection and distribution of new information to Medicare beneficiaries and discuss two reports, one of which is being released today on disenrollment information on Medicare managed care plans. The other report, which should be available soon, examines how plans provide information on their prescription drug benefits.

Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCE AND SYSTEM ISSUES AREA, GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the committee. I am very pleased to be back here again today to discuss this important question of how to assist Medicare beneficiaries in making informed choices about their health plans.

This issue has assumed even greater significance than when we met before now that the Balanced Budget Act has passed and has established the Medicare+Choice program in which new plan options besides HMO's are going to be authorized to serve Medicare beneficiaries.

Medicare+Choice's success in achieving program efficiencies while enhancing beneficiaries' options for obtaining higher quality and more comprehensive health care is predicated on a foundation of sufficient information, information that will encourage plans to genuinely compete with one another.

Over the past 3 years, we have testified and reported on the difficulties that beneficiaries have in trying to compare benefits and performances across plans.

Today, I would like to draw on some of our issued work as well as some of the new new consumer information work that we are doing for this committee.

Since we last testified on this topic, there has been progress made in making information available, and we have heard about much of that today. HCFA has posted on the Internet summaries of its health plans, premiums, out-of-pocket costs, and benefits. As you heard from Mr. Hash, HCFA's national Medicare information program will reach a wider audience by providing a printed version of this comparative information in the Medicare handbook that will be mailed directly to every beneficiary. Plus, there will be the 1–800 number that will be available to assist beneficiaries seeking additional information.

While we regard these steps as valuable, they do not—and as you have noted—address an important portion of the information that consumers use to make choices among health plans. Comparative information by necessity is brief, and when individuals have narrowed their choices and are seriously considering a few plans, they generally are going to rely on individual plan materials. For such

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materials, we have not seen the progress that we would hope for in terms of implementing the recommendation we made in 1996 that HCFA require plans to standardize the format and the terminology in their marketing and other plan materials.

As Senator Breaux noted with the graphics, we as members of the Federal Employees Health Benefit Program enjoy the luxury of being able to compare plans using materials that are prepared with standard terminology and standard formats. The same is not true for a Medicare beneficiary.

I am sure you both remember last year the array of plan descriptions that was tacked up over here on the wall that a beneficiary in Los Angeles would have to cope with to compare the health plans that they had available to them.

The same situation is true today. In working for this committee, we have visited Tampa, FL, and looked at the eight HMO's that exist there and discovered that we could create a smaller wall, because there are only eight of them rather than the 14 in Los Angeles, but a very similar wall of plan brochures that a beneficiary would have if they were seeking information on the Tampa HMO's.

I would like to illustrate the consequences that are facing an individual in Tampa as they try to choose plans because of that nonstandardized information and also indicate why we believe that HCFA should give higher priority to moving toward standardized information and format in plan material.

In the Tampa brochures in describing prescription drug benefits, some of the plans have omitted important caveats and provided dollar benefit limits whose actual value could not be determined without further investigation.

For example, some plans used the term "formulary," but did not explain that it meant that most comprehensive coverage was generally limited to a specified list of drugs. Prospective enrollees may not understand that a drug not on the formulary could cost them substantially more out of pocket.

In addition, the document specified annual dollar limits or caps on the use of the prescription drug benefit, but the actual dollar value of those limits could not be calculated with the information given. For example, beneficiaries might assume that an HMO that offers a $1,200 annual cap on coverage has a more generous benefit than one offering a $1,000 cap on annual coverage. However, plans differ in how they price drugs in calculating whether the cap has been reached. Some use retail prices. Some use wholesale prices. Some use a discount from wholesale prices. A $1,000 cap based on a discounted wholesale price could be worth considerably more than a $1,200 cap based on retail prices.

We believe that standardization of the terms and formats in plan material would not only benefit consumers, but would benefit HCFA and the health plans as well. Currently, the agency staff have wide discretion in their decisions to approve or reject plan marketing materials.

For example, one reviewer may require a plan to use the term "contracting provider" instead of "participating provider," even though both terms are approved by HCFA's marketing guidelines and a prior reviewer approved the use of the term "participating

provider." Rework caused by inconsistent reviews is time consuming and costly for both HCFA and the plans.

The plans pointed out to us that corporate purchasers often require them to use standard language and that Medicare information standards could reduce the amount of time that they and HCFA staff spend reviewing and reworking marketing materials.

All of the plans' representatives that we spoke to said that they would favor such standards if HCFA could develop them jointly with the plans and other interested parties.

Regional HCFA staff we spoke with similarly noted that receiving standardized information from plans could make it easier to produce the comparison charts and to check marketing materials for accuracy.

Perhaps even more important, we believe standardizing information from plans could reduce the number of beneficiaries who are confused in trying to compare plan brochures and who may turn first to the 1–800 Medicare number for help. The potential cost of such calls is an issue, but in addition, the calls may be frustrating for beneficiaries in that the 1–800 Medicare staff may not be prepared to answer the very detailed questions about specific plans that beneficiaries have at that stage of their decisionmaking.

Let me note in conclusion that we recognize that HCFA faces considerable responsibilities and challenges in implementing Medicare+Choice. We know that the agency is working on several fronts to produce useful consumer information. However, we believe that setting the information standards for marketing materials that plans provide is a step that HCFA has the discretion to take and would be a win for all the parties involved, for beneficiaries as they seek to evaluate their options, for health plans and HCFA staff as they seek to get plan documents reviewed and approved expeditiously and to assist beneficiaries seeking information.

That concludes my statement. I would be happy to answer any questions you or any member of the committee may have.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

GAO

Testimony

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MEDICARE MANAGED CARE

Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-98-162

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss steps the Health Care Financing Administration (HCFA) could take to help beneficiaries make more informed choices among Medicare health plans. In 1996[1] we reported to you that beneficiaries received little or no comparative information on Medicare health maintenance organizations (HMO). Among other things, we recommended that HCFA produce plan comparison charts, require plans to use standard formats and terminology in key aspects of their marketing materials, and publicize readily available plan performance indicators such as disenrollment rates. In addition, Medicare+Choice provisions under the Balanced Budget Act of 1997[2] (BBA) authorize new health plan options for Medicare beneficiaries and mandate that HCFA provide beneficiaries with comparative information about the Medicare+Choice options.

My remarks today will focus on the extent to which HCFA's Medicare+Choice information development efforts are likely to (1) enable beneficiaries to readily compare benefits and out-of-pocket costs using plan brochures and (2) facilitate the agency's approval of plans' marketing materials and other administrative work required of both HCFA and the health plans. I am basing these remarks on our ongoing work for this Committee. I will also discuss the findings from our recent report[3] on HMO disenrollment rates and how data that HCFA already collects, but does not publish, may be useful to beneficiaries.

In summary, HCFA has begun making certain plan-specific information available to beneficiaries. For example, in March of this year, HCFA posted summary information on health plans' premiums, out-of-pocket costs, and benefits on the Internet. HCFA is also working to provide a printed version of this information directly to beneficiaries and meet other BBA information dissemination requirements.

These efforts, however, do not address the problem beneficiaries face in trying to carefully evaluate their health plan choices using the plans' summaries of benefits and other marketing materials. These materials are a major source of health plan information. Currently, plans use widely varied formats and definitions of benefits in the materials they distribute to beneficiaries. As we reported in 1996, this lack of common formatting and language made it difficult, if not impossible, for beneficiaries to rely on HMOs' marketing literature to compare benefits and premiums. Preliminary results from our current work

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[1]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

[2]P.L. 105-33.

[3]Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment (GAO/HEHS-98-142, May 1, 1998).

on HMOs' prescription drug benefit–a benefit that attracts many Medicare beneficiaries to managed care–suggest this situation continues to exist. Our current work also suggests that critical information is sometimes missing from plans' marketing materials.

The diverse formats and terms also cause problems for health plans and HCFA staff. Without HCFA's specifying common standards for plans' marketing materials, agency staff have wide discretion when deciding to approve or reject these documents. Plan representatives and HCFA staff we spoke with said that this latitude leads to inconsistent HCFA decisions, unnecessary delays, and extra costs. The lack of required standards similarly affects the efficient development of comparative benefits information. Under current circumstances, agency staff must comb through dissimilar information submitted by plans for HCFA's contract approval process and contact the plans to clarify the information before producing benefit comparison summary charts.

To help beneficiaries evaluate their health plan options, HCFA could move faster to publish readily available plan performance indicators such as plans' disenrollment rates. With this information, beneficiaries could then decide to seek more information about a plan before enrolling.

HCFA could better serve beneficiaries, reduce burdens on health plans, and leverage its own resources by setting information standards for health plans' marketing literature. We believe, therefore, that HCFA should adopt the recommendations we made in 1996 and require plans to use standard formats and terminology in their benefit descriptions. In addition, HCFA should use plan performance data it already collects to help inform beneficiaries' health plan decisions.

BACKGROUND

Most beneficiaries live in areas where they can choose to receive Medicare benefits either through a managed care plan or through traditional fee-for-service Medicare. Of the 6 million beneficiaries enrolled in Medicare managed care, approximately 90 percent are in "risk-contract" HMOs.[4] Medicare pays these HMOs a fixed, per beneficiary fee, regardless of what the HMO spends for each beneficiary's health care. These plans are called "risk" HMOs because the HMO assumes the financial risk of providing care for the amount Medicare pays.

Although HMOs are required to cover all traditional Medicare benefits, many also provide additional services, such as outpatient prescription drugs, routine physical examinations, and hearing aids. In addition, plan costs can vary: some HMOs charge a monthly premium (in addition to Medicare's part B premium), but others do not. Except

[4]Approximately 700,000 beneficiaries are enrolled in HMOs that are reimbursed by HCFA on a cost basis or in another form of managed care.

for emergency services, HMO enrollees must generally receive all covered care through health care professionals designated by their plans.

The number of Medicare beneficiaries enrolled in risk HMOs has more than doubled in the last 3 years, from 2.3 million in December 1994 to 5.2 million in December 1997. The number of Medicare risk HMOs also increased, from 154 to 307, in the same time period. The growth in Medicare managed care enrollees and plans is expected to continue, fueled in part by the BBA, which provided for new types of Medicare managed care plans and increased plan payments in many areas that previously lacked a fee-for-service alternative.

Unlike other large health care purchasing organizations, HCFA has not routinely provided plan-specific information directly to beneficiaries. However, the BBA now requires HCFA to distribute comparative information that can help beneficiaries interested in managed care select a health plan. In addition, HMOs will continue to advertise and distribute summaries of benefits as part of their marketing efforts to enroll new members.

HCFA, through its regional offices, approves the HMOs' marketing materials before plans use them. HCFA regional offices also oversee HMO marketing and enrollment efforts by reviewing plans' sales practices and responding to beneficiaries' complaints. HMOs must include certain explanations in their marketing materials, such as provider restrictions, but otherwise have wide latitude in what information is included and how it is presented.

Each year, as part of the contracting process, HMOs submit to HCFA detailed information on their proposed benefits, premiums, and other beneficiary out-of-pocket costs. HCFA's central office reviews these proposals for compliance with Medicare regulations and approves the contracts.

STANDARD BENEFIT DESCRIPTIONS COULD HELP BENEFICIARIES COMPARE PLANS' BENEFITS AND EASE BURDEN ON PLANS AND AGENCY STAFF

Although HCFA has efforts under way to publish comparative information on Medicare+Choice plans, it has not taken the steps needed to enable beneficiaries to make similar comparisons using individual plans' marketing materials. The absence of standards for format and terminology used to describe benefits and out-of-pocket costs limits the usefulness of these materials for comparison purposes. Such standardization would help beneficiaries in comparing health plans and lessen the administrative burden on both HCFA and the plans. Extending these standards to the information that plans provide to HCFA in their contract submissions would facilitate the agency's efforts to assemble comparative information.

HCFA Has Efforts Under Way
to Disseminate Information
on Medicare+Choice Plans

Until this year, HCFA produced little comparative information on Medicare HMOs. In March 1998, HCFA made available a database it calls "Medicare Compare," which posts summary information on the Internet comparing health plans' benefits and out-of-pocket costs. HCFA intends to update the database and add plan performance indicators as they become available in the coming months and years. In addition, HCFA plans to include comparison charts in the next Medicare Handbook to be mailed to beneficiaries. Agency staff are also conferring with seniors' advocacy groups to determine how best to inform beneficiaries of their new Medicare+Choice options.

Lack of Standard Format and Terminology
in Marketing Materials Hinders Ready Comparison
of Plans' Benefits and Costs

Federal employees and retirees can readily compare benefits among health plans in the Federal Employees Health Benefits Program (FEHBP) because the Office of Personnel Management, which administers FEHBP, requires plan brochures to follow a common format and use standard terminology. In contrast, HCFA does not require Medicare HMOs to use standardized formats or terms, including definitions, in their marketing materials. Consequently, Medicare beneficiaries cannot easily use plans' marketing materials to compare benefit packages.

Neither HCFA's Medicare HMO/Competitive Medical Plan (HMO/CMP) Manual nor its supplemental Medicare Managed Care National Marketing Guide requires standardization in plan materials. In fact, the manual, which provides guidance on the contents of plans' marketing materials and HCFA's process for reviewing these materials, specifically states, "HCFA does not mandate a format or style for . . . marketing materials other than requiring that the member rules be written and that the marketing materials . . . be understandable to the average beneficiary." HCFA's marketing guidelines do contain model language and documents HMOs can adopt, but plans are not required to use the models. Without required standards from HCFA, HMOs are left to their individual discretion, as we reported in 1996.

We recently asked the eight Medicare HMOs serving the Tampa, Florida, area to send us their marketing materials. We received a wide array of brochures, pamphlets, and other written documents. Although all plans provided benefit summaries, the formats and benefit categories varied considerably from plan to plan. This lack of consistency may impair a beneficiary's ability to compare benefits and related costs. For example, we found that only five Tampa plans mention mammograms in their benefit summaries—even though all plans covered mammograms. Most plans listed mammograms under the benefit category of preventive services. One plan, however, listed mammograms under

hospital outpatient services. Consistent presentation is important because beneficiaries may rely on plans' benefit summaries for coverage and out-of-pocket cost information. Beneficiaries typically do not receive more detailed benefit descriptions until after they enroll in a plan.

The HMOs we reviewed also differed in the terms they used to describe the same benefit. Some plans used technical terms but did not define them. Consequently, beneficiaries could misinterpret important out-of-pocket costs or benefit restrictions. For example, some plans used the term "formulary"[5] in describing their drug benefit but did not explain what it meant. Beneficiaries reading a plan's marketing materials may not understand that use of nonformulary drugs may result in substantially higher out-of-pocket costs. To learn what "formulary" means when it is not defined in the marketing literature, beneficiaries would have to ask plan representatives or read the plan's "evidence of coverage"–a document normally provided to beneficiaries after they enroll in a plan.

Lack of Standards for Marketing Materials
Can Result in Misleading Comparisons

Seemingly straightforward benefit comparisons may be misleading because plans' marketing materials sometimes omit key details. Plan descriptions of prescription drug coverage, a benefit offered by many HMOs, illustrate how missing information can lead to erroneous conclusions about the value of plans' benefits.

Under the best of circumstances, the relative value of plans' prescription drug coverage may be hard to compare. For example, plans that have formularies often set one copayment amount for formulary drugs and another, higher copayment for nonformulary drugs. Beneficiaries' out-of-pocket costs for such plans depend both on the specific drugs included in the formularies and the two copayment amounts.

Beneficiaries may use a plan's stated annual dollar limit, or cap, to judge the drug benefit's consumer value. For example, beneficiaries may assume that an HMO offering prescription drug coverage up to a $1,200 annual cap has a more generous benefit than another HMO offering coverage up to $1,000. This comparison may be misleading, however. Plans differ in how they calculate the dollar amount of drugs used by beneficiaries. Some plans use retail prices to compute this amount. Others may use

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[5]In general, a formulary is a list of drugs that health plans prefer their physicians to use in prescribing drugs for enrollees. The formulary includes drugs that plans have determined to be effective and that suppliers may have favorably priced for the plan.

drugs' average wholesale prices (AWP) or a lower price discounted from AWP to calculate a member's total drug usage in dollars.

One HMO gave us an illustration of how the value of a drug benefit depends on whether drug cost is measured by retail prices, AWP, or discounted AWP. The HMO used the drug Prilosec for the example because it is one of the brand-name drugs most commonly prescribed for its Medicare members. According to the plan, the retail price of Prilosec is $123 and the AWP is $101. The HMO said it computes the dollar amount of a member's Prilosec usage using a discounted AWP of about $91 per prescription. If the plan used AWP, or the even higher retail price, members would receive fewer prescriptions before reaching the annual dollar coverage limit. The consumer value of a drug benefit could vary substantially between two HMOs with the same annual cap if they used different prices to compute drug usage.

In addition, HMOs' marketing materials do not always disclose key details that beneficiaries need to make accurate comparisons. For example, marketing materials from several Tampa HMOs did not mention what prices plans used (that is, retail, AWP, or some price below AWP) to compute the dollar amount of members' drug use. One-half of the plans did not disclose that their prescription benefits involve formularies. Similarly, plan materials often failed to inform members that they face higher out-of-pocket costs if they choose a brand-name drug when a generic drug is available.

Lack of Standards Slows HCFA Review of Plans' Marketing Materials

HCFA's lack of standards for benefit descriptions also complicates HCFA's review of marketing materials and delays their distribution. HMO officials said that HCFA's Medicare Managed Care National Marketing Guide provides broad criteria for plan materials sent to beneficiaries. It does little to ensure that HCFA's regional office staff will review plans' marketing materials consistently and uniformly nationwide–a problem we noted in 1996 when the guidelines were being developed.

Individual HCFA staff have wide discretion in approving and rejecting plans' marketing materials. HMOs report that this discretion leads to inconsistent decisions and unnecessary delays in the development and distribution of plan materials. For example, plans report that HCFA reviewers frequently require changes to materials that were previously approved by other HCFA reviewers. These changes may delay printing or limit the use of materials already printed and increase plans' costs. Plans report being particularly disturbed by inconsistent HCFA decisions based on individual reviewers' preferences. For example, one reviewer may require a plan to use the term "contracting provider" instead of "participating provider," even though both terms are approved by HCFA's marketing guidelines. The rework caused by inconsistent reviews is time consuming and costly for both HCFA and the plans.

HMO representatives reported that corporate purchasers often require plans to use standard language. The HMO representatives suggested that Medicare information standards could reduce the amount of time HCFA and plan staff spend reviewing and reworking marketing materials. All of the plans' representatives we spoke with said that they would be in favor of such standards developed in conjunction with all relevant parties.

Standard Format and Terminology in Plans' Contract Submissions Could Facilitate HCFA's Development of Comparative Information

The lack of standards for benefit descriptions in plans' contract submissions hinders HCFA's efforts to produce benefit comparison charts and complicates the agency's reviews of plans' marketing materials. As part of the normal Medicare contracting process, HMOs regularly submit to HCFA detailed information on their benefit packages. HCFA's Center for Health Plans and Providers (CHPP) reviews these packages and approves plans' Medicare contracts. However, HMOs are not required to conform to standard formats, language, or descriptions in their contract submissions. Consequently, it is difficult for the Center for Beneficiary Services (CBS), HCFA's new unit responsible for providing information to beneficiaries, to develop benefit comparison summaries from these contract submittals. Instead, CBS has to recontact HMOs and request benefit information for its own use. Moreover, HCFA regional offices, which must review plans' marketing materials for accuracy, cannot easily rely on contract submissions to confirm required premiums, copayments, and benefits.

HCFA recognizes that the agency needs to standardize the information that plans submit for contract approval. HCFA staff said this would reduce the administrative burden on health plans and the agency. It addition, the agency could more readily produce comparison charts and check HMOs' marketing materials for accuracy. According to HCFA staff, the agency has a group working on revising the contract approval process. Implementation of new contract information requirements, however, is targeted for 2001 or later.

ANALYSIS AND PUBLICATION OF DISENROLLMENT RATES AND OTHER HCFA DATA COULD AID CONSUMER DECISION-MAKING

HCFA collects a considerable amount of data for program administration and contractor oversight that can indicate beneficiaries' relative satisfaction with HMOs in their market. These indicators include statistics on beneficiary disenrollment and complaints. Of these indicators, disenrollment rates may be most useful to beneficiaries trying to distinguish among plans. Our analyses, contained in our 1996 report and our most recent report, showed that disenrollment rates vary widely among HMOs that serve the same market. However, HCFA has not systematically analyzed or published Medicare

HMOs' disenrollment rates. Nor has HCFA yet surveyed beneficiaries who disenrolled from HMOs to learn why some plans have relatively high disenrollment rates.

HCFA Could Move More Quickly to Publish HMOs' Disenrollment Rates and Other Plan Performance Indicators

Relative disenrollment rates may serve as broad indicators of HMO enrollee satisfaction even though they cannot pinpoint the causes of disenrollment. They cannot distinguish, for example, disenrollment caused by quality or service problems from disenrollment caused by price or value competition. Nonetheless, beneficiaries who are considering joining a managed care plan and know relative disenrollment rates may want to seek explanations for plans' high disenrollment rates.

Ten years ago, we first reported that some Medicare HMOs had high disenrollment rates.[6] In 1995, we recommended that HCFA publish HMOs' disenrollment rates. HCFA took no action on our recommendation, even though the agency already collects, for plan payment purposes, the data necessary to calculate disenrollment rates. In 1996, we reported that HMOs' disenrollment rates varied widely in the two market areas we studied: Miami and Los Angeles. We also restated our recommendation that HCFA publish plans' disenrollment rates.

Our most recent report shows that many HMOs nationwide had relatively high voluntary disenrollment rates.[7] In many markets, the highest disenrollment rates exceeded the lowest rate by more than fourfold. In a few markets, the range in disenrollment rates was even wider. For example, in Houston, Texas, the highest disenrollment rate was nearly 56 percent, while the lowest rate was 8 percent.

The BBA includes provisions requiring HCFA to publish plans' disenrollment rates. HCFA officials told us they intend to meet that requirement by publishing rates sometime in 1999. HCFA could act sooner, however, to provide this information to beneficiaries. Because HCFA already collects the necessary data, plans would not be burdened by providing additional data. HCFA could publish disenrollment rates this year. In fact, some HCFA regional offices have periodically distributed these data to HMOs. Medicare

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[6]Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

[7]These rates represent voluntary disenrollment, that is, they exclude beneficiaries who moved out of their plans' service areas, died, or lost their Medicare part B eligibility. For a complete description of our methodology, see GAO/HEHS-98-142, May 1, 1998, which lists voluntary disenrollment rates for nearly every Medicare HMO operating in 1996.

HMOs would have a strong incentive to improve their performance if HCFA published the disenrollment rates for all plans.

Rates of complaints to HCFA from HMO enrollees can also indicate relative satisfaction levels. Some states and large purchasers routinely publish plan rankings based on complaint rates. This information would be relatively simple for HCFA to compile and publish. Although some HCFA offices track the complaints they receive, no HCFA office publishes HMO-specific complaint rate statistics.

Full Assessment of Beneficiary Satisfaction
With HMOs Unavailable for at Least 2 Years

HCFA's initial efforts to assess beneficiaries' satisfaction with individual Medicare HMOs may be seriously flawed. Recently, HCFA sponsored a survey of HMO members, known as the Consumer Assessment of Health Plans Study. HCFA intends to release the results later this year to help beneficiaries compare the plans' ability to satisfy their members. Shortcomings in the survey's sampling methodology, however, will greatly limit the usefulness of the results and preclude accurate comparisons.

The consumer assessment study includes only beneficiaries who have remained in the same health plan for at least 12 months. Beneficiaries who left dissatisfied or left for other reasons are excluded. A survey of only those beneficiaries who are satisfied enough to remain enrolled in their health plans may yield biased results. For example, we spoke with representatives of one HMO that conducted an annual member survey. Because the survey showed that 90 percent of its members were satisfied, HMO officials did not understand why their plan had a 40-percent disenrollment rate. When the HMO conducted a survey of disenrollees, however, it discovered that many beneficiaries had left to obtain better benefits at other HMOs.

HCFA is planning to survey Medicare HMO disenrollees in the future. If designed appropriately, such a survey could help explain why some HMOs have high disenrollment rates. For example, survey results may indicate whether disenrollees left because of quality or access problems or because competing HMOs offered more generous benefits. The disenrollee survey instrument and methodology have not yet been defined, and, according to HCFA staff, the results will not be available until 2000 at the earliest.

CONCLUSIONS

HCFA faces many new responsibilities and challenges in implementing Medicare+Choice. The success of the program depends in part on the agency's ability to set priorities and use resources efficiently. Although HCFA is working to produce information to help beneficiaries compare their health plan options, the agency could leverage its resources by setting information standards, especially for plans' marketing materials. The benefits would accrue not only to the beneficiaries making comparisons

but also to health plans and HCFA staff in the review and approval of plan documents. Similarly, HCFA could also take immediate advantage of the data it already collects to publish such performance indicators as annual disenrollment rates.

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Mr. Chairman, this concludes my prepared statement. I am pleased to answer any questions you or other members of the committee may have.

RELATED GAO PRODUCTS

Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment (GAO/HEHS-98-142, May 1, 1998).

Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits (GAO/T-HEHS-97-133, May 19, 1997).

Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information (GAO/T-HEHS-97-109, Apr. 10, 1997).

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Health Care: Employers and Individual Consumers Want Additional Information on Quality (GAO/HEHS-95-201, Sept. 29, 1995).

Medicare: Increased Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Federal Employees Need Better Information for Selecting a Health Plan (MWD-76-83, Jan. 26, 1976).

(101721)

The CHAIRMAN. Thank you for your statement.

I could accommodate Senator Jeffords if he needs any accommodation now. Do you need any accommodation because of time? I could do that right now.

Senator JEFFORDS. No. I can be here until 3:30.

The CHAIRMAN. OK.

Senator JEFFORDS. Thank you for your consideration.

The CHAIRMAN. We will make sure you get done by 3:30.

Dr. Scanlon, in your testimony, you recommend to HCFA that they require plans to use standard terminology and formats for their marketing materials and submission of benefits to HCFA. How difficult is it to do this, and what resources are available to HCFA, and what should HCFA do to ensure consistency in the information beneficiaries receive from all different sources available to them?

Mr. SCANLON. We recognize that this is not a simple task, given the complexity of health benefits. We do not want to underestimate the chore that HCFA would face in terms of specifying the standardized terms that they would be requiring. However, we think it is an investment that is going to have a considerable payoff.

At this point in time, HCFA has to deal with the information that plans provide in three different activities: first, when they are negotiating contracts with a plan; second, when they are reviewing the plan's marketing material; and, finally, when they are trying to use the plan's marketing material to assemble the comparative information for the Medicare handbook and the Internet.

At each of those steps, they have to struggle with varying terminology and format in order to understand whether or not they want to accept proposed contract terms, whether or not they want to approve the marketing materials, and then, finally, for comparative purposes, to translate them into something that is roughly comparable for their own product.

The payoff, if you could do these tasks in a simpler way, would justify the investment at the front end. We think that is the key here, not that it is going to be a simple task to develop the standardized definitions and formats.

Only, I think, by having such standards are you really assured that you can create true comparative information because, even the best-intentioned individuals, when faced with different terms for the same thing may have very great difficulty deciding what is the nuance that different individuals mean by those terms.

The CHAIRMAN. You have just issued your new report to this committee on the importance of disenrollment data as a consumer tool for Medicare beneficiaries to assess plan performance and quality. Your findings indicate that in more than half the markets with four or more HMO's, the highest disenrollment rate was greater than four times the lowest rate in that market.

If you were an administrator of HCFA, how would you report and use this data, and if you were a beneficiary, how would you use this information?

Mr. SCANLON. As an administrator at HCFA, I would be very interested at this point in using that information in the materials that we provide beneficiaries because I think at this point it is perhaps the strongest indicator we have of plan performance.

We agree with Mr. Hash that there are many reasons that people leave HMO's, including the availability of other plans in the area and people dying and moving out of the area.

It is very easy to adjust those statistics for deaths and for people who move out of the area. We cannot do anything about people choosing to move to another plan because it offers better benefits. However, if you were a consumer, wouldn't you like to know that people find that better benefits are available in their market, and that, therefore, they have choosen another plan?

So we think that it is a very valuable piece of information, and as administrator, I would want to encourage that it be available to consumers.

Again, HCFA has plans to do this, but we think that you an accelerate those plans; that the information can be put into a reliable format and that beneficiaries would be able to use it in a responsible and reasonable way.

As a beneficiary, I am not sure I would make a decision on which plan to choose solely on the basis of the disenrollment data, but it certainly would be a very, very strong indicator to me that I should seek more information about a plan with a higher disenrollment rate before I chose to enter it rather than a plan with a lower disenrollment rate.

The CHAIRMAN. The Balanced Budget Act requires that printed comparative information be distributed to beneficiaries on their health plan options. The legislation that Senator Breaux and I introduced last year required that this information be in a chart-like form. The act does not specifically require that HCFA produce charts. However, the purpose of the charts is so that the beneficiary can make an easy comparison across plans.

Do you have any recommendations regarding format for this printed material?

Mr. SCANLON. Not a recommendation with respect to the specifics of the format. I would think that a chart would be the most effective means of presenting this kind of material for easy comparison.

There are certain issues of how the visual aspects of a chart can contribute to better comprehension on the part of the people using it. That is an area of expertise that we do not have at GAO, or at least not in my group at GAO. We know that HCFA is concerned about obtaining assistance in that area and we encourage them to do so.

The CHAIRMAN. Thank you, Dr. Scanlon.

Senator Breaux.

Senator BREAUX. Thank you, Dr. Scanlon, for your work, your continued work with the committee. I appreciate it.

I was looking at the two books that you referred to, the one for FEHBP and the one for Medicare. They are both about the same size. In terms of the amount of information and the understandability, if that is a word, they are like night and day.

Also you heard the testimony from HCFA as to how they planned to try to move toward standardizing health plan's marketing materials. Is there any doubt in your mind that they have the authority to ask the providers to both standardize the information present plans HCFA and also the plans marketing materials?

Mr. SCANLON. No. We do not believe that there is any problem with the authority to do that.

Senator BREAUX. They have the authority to do it.

Now, it would seem to me that under FEHBP, companies are already used to standardized marketing materials. It would seem to me that it should not take 3 years as we heard Mr. Hash suggest if a company is already used to providing this type of information.

Mr. SCANLON. We have found that they are not only used to supplying it to FEHBP, but that for some of the private employers that they deal with, they also are required to supply standardized information. So plans are used to comply with these kinds of requirements.

Now, there may be a need, and we would certainly be sympathetic to the need, to tailor that information specifically to Medicare plans, and that is a new task for HCFA.

In the work we have been doing since the Balanced Budget Act has passed reviewing activities of HCFA, we are very appreciative of the fact that they have a huge number of tasks as the result of that act, and that this is but one of them. But our concern is that this is one that deserves very high priority.

Medicare+Choice is, in part, going to be successful if it is successful early. You do not want to create an expectation about managed care and the ability to choose among plans that will not be realized and then to have beneficiaries not be willing to try it again for a long time. So we think that getting this information out in the right form earlier rather than later is very important.

Senator BREAUX. How much competition would be involved among the various Medicare+Choice plans? Do you see any or is it pretty much going to be standard price, standard plan?

Mr. SCANLON. No, I would anticipate that there will be competition among the plans. We do see competition now in terms of variation in benefits in some areas and in terms of provider networks. In other areas, there is a lot of overlapping of the provider networks. Regardless of what plan you join, you may end up with the same providers.

We will also have new competitors as the result of the Balanced Budget Act which are the provider-sponsored organizations and the preferred provider organizations. How the entities form and what they look like relative to current HMO's is something that will add to potential competition but how much, it is hard to predict at this point.

Senator BREAUX. I have heard the argument by some that, well, you know, you are dealing with a group of seniors who as they get older are not capable of making the same choices. So, if you give them all these choices, it is going to be very confusing and difficult for them to make the right choices.

I would counter that argument with the point that now they are asked to make complete and total choices with very little information. I mean, they now can pick any doctor they want to go to, any hospital they want to go to, and with very little information on price or on quality or success of these various institutions.

The way that the choices are made now are either by a very competent eligible person or by working with their children and having their children or grandchildren help them make the choice of the

doctor or some organization or senior group that can help them make those choices.

So, from my perspective, I do not think that giving them more choices accompanied by more information is negative at all. I think it is a vast improvement over the things that we require them to do now. Would you agree or disagree?

Mr. SCANLON. We would agree wholeheartedly. I believe that we can only benefit by competition and that genuine competition where plans are having to compete on the basis of the quality and the value of the services they offer is something that is going to improve the health care that is available in the market.

If we were to try and prescribe what plans should do and what benefits should be available in each plan, I think, would be very handicapped by the limited knowledge that we have today. We really do need to learn more and, in some respects, experimentation is a key, but that is the way markets work.

When a market is working well with information available, then sort of the better quality services, the better quality product are going to prevail. That is what we need here, and we have not had it to date.

Senator BREAUX. I think your points are well taken. Your report is well written.

I think, Mr. Chairman, that in order to have people make the right choices, they have to be comparing apples to apples and oranges to oranges. Under the current system, where you have so many different ways of presenting the products that a particular company is offering, it is almost impossible to really compare which one is the best because one company will phrase it this way, and like you pointed out, you do not know exactly what is being covered, what the copayments or discounts are and so forth. It is very difficult to compare when you are not comparing the same thing. I think that one of the good things about FEHBP is that you can compare exactly what is covered, what is not covered, and what the price is. Hopefully, we will be moving in that direction.

Thank you.

The CHAIRMAN. I do think that we are going to get an opportunity, Senator Breaux, in the next month on the offer of our previous witness, Mr. Hash, that he would consult with us and our staff on trying to meet the intent of our legislation, and that would be an opportunity for input of everything you have said during this hearing.

Senator Jeffords. Thank you for coming.

Senator JEFFORDS. Thank you, Mr. Chairman. I am chairman of another committee which deals in these areas. That is why I am here, because the question of standardization of language applies not only to Medicare, but also as we move into some guidance to HMO's about requirements for information that they provide which is understandable, as well as moving to measure quality and to have some standardization.

My questions involve whether or not, and with the Federal employee health plans as well, will the intent will be to have a cross-informational guidance to the various agencies that are going to standardize these terms? Do you figure they ought to come to you?

Or is the administration trying to get some cross-fertilization among all the various areas where we are using this?

Also, it is AHCPR, who will be trying to gather information and standardize it? So this is a great moment right now as we move into a new era as far as health care goes.

Mr. SCANLON. Well, as much as we have studied this issue, and I think very clearly identified the need for standardization, we have not developed a model of standard terminology or format.

I imagine, and I am very confident, that HCFA is already consulting with the FEHBP staff in terms of their experience in order to be able to adopt aspects of their work for Medicare.

My sense also is that it is very important that HCFA is, I think, reaching out to the private sector in terms of large employers who offer choices and have been leaders in terms of trying to give their employees information so that they can make wiser choices.

There is also a need to reach out to the communications industry. It is not clear that anyone, either private employers or FEHBP, has done this to the best that we can to inform beneficiaries. We need to be sensitive to trying to make this very, very complex question something that is easier for people to address.

We are hoping that HCFA will bring in all of those resources. We would be happy to participate in the dialog. I just would not expect to be able to lead them in this process.

Senator JEFFORDS. We are preparing legislation in the quality area to try and provide people of this country with better information on plans and making sure they understand what they are getting in their health plans. So we certainly will be working with you and HCFA to try to make sure that whatever we do will be of assistance rather than confusion.

Mr. SCANLON. As consumers, we will be very happy to work with you as well as members of the GAO.

Senator JEFFORDS. OK, fine. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Jeffords.

Dr. Scanlon, thank you very much for your testimony.

The CHAIRMAN. I would ask Susan Kleimann, Geri Dallek, and David Abernethy to come to the witness table while I introduce you.

Our third panel consists of Susan Kleimann, President of Kleimann Communications Group. Her testimony will highlight the need for clear and easy-to-use information. She will discuss the difficulty many beneficiaries have in understanding their benefits. She also demonstrated this through the videotaped discussions that you saw earlier with Medicare beneficiaries who participated in a focus group in the California market.

Ms. Kleimann, along with the National Academy of Social Insurance and the California Health Care Foundation conducted this series of focus groups to evaluate beneficiaries' understanding of the Medicare program.

The next witness will be Geri Dallek, project director at the Institute for Healthcare Research and Policy at Georgetown University. Her testimony will highlight the need for beneficiaries to have access to clear and objective information. She will also discuss concerns about existing resources being inadequate to meet the needs

of beneficiaries, and that local agencies will be underfunded to meet the challenges of the Balanced Budget Act's education campaign.

The final witness is David Abernethy, senior vice president, Public Policy and Regulatory Affairs, at the HIP Health Plans. He will give the perspective of a health plan that is preparing to provide seniors with increased information on choices available to them and discuss how HIP informs its members and potential enrollees of their benefits, rights, and responsibilities.

Would you go, Dr. Kleimann, Ms. Dallek, and then Mr. Abernethy.

STATEMENT OF SUSAN KLEIMANN, Ph.D., KLEIMANN COMMUNICATION GROUP, LLC

Ms. KLEIMANN. Senator Grassley, Senator Breaux, and Senator Jeffords, I am Susan Kleimann, and I am president of Kleimann Communication Group. We are a small business that works with clients to communicate complicated information so that they can use it. I want to come back to the use of the word "use" as opposed to "understand." It is a major difference that I would like to draw your attention to.

With me today is Jill Bernstein and Michael Gluck of the National Academy of Social Insurance with whom I worked on these focus groups, and I am pleased to be here today to testify on the results of the focus groups that we conducted with people on Medicare for the Academy and the California HealthCare Foundation.

The changes Medicare will undergo require that beneficiaries can make informed decisions about their health care in order to create and sustain an efficient and market-driven system.

As you can tell from the video that you showed earlier, the people we spoke with are dignified, thoughtful, and concerned. I have enormous respect for the voices we heard in our groups, and I make a point of saying that as a context for my comments today.

Despite the differences of these people, they shared at least one sentiment about their health care choices because they do understand the consequences for them of choosing poorly.

As one beneficiary put it on the film, "It is scary, so scary to make a choice," and the consequences for us if they choose poorly are a bit scary, too. Medicare+Choice simply will not work.

For today, I would like to address the challenges of sharing information with Medicare beneficiaries so they can act upon that information in their own best interest. Let me summarize my written statement into a few basic messages.

First, if the idea behind Medicare+Choice is to allow active beneficiaries to make informed decisions about health care so that the result is a competitive market-driven system, then people have to have usable information to make these decisions, not merely the right information and not merely all of the information. They have to have usable information.

Now, let's assume that we can get that part of it right. The task that remains before us is still a daunting task, and it is daunting because of what the research tells us about a profile of a Medicare beneficiary and how difficult this task of making information usable really is.

First, few of these people will have experience in choosing plans. Either they had no health care when they were in the working population, as was true with many of our focus group members, or they worked in a firm that offered no choice. They could choose between one and one. That was it. So they do not have the experience or what we researchers like to call a cognitive map, a schema in their brains of how to go about making their choice, what to weigh, what to discard, how to just balance this whole process out.

Second, few understand the differences between managed care and traditional health care. Even in California, a place with a long-standing managed care tradition, our beneficiaries were confused. They could not tell the difference in some of the benefits that they could get.

Now, why is this important? Well, if we all learn, and we all do learn by building these different cognitive maps, we are not going to be able to complete a task or complete it efficiently if we do not have this map.

Let me give you an example. Last April, during the big spring high school vacation break when we are descended upon with tourists, I took the subway downtown. When I approached the subway station, it was crammed with all these people trying to figure out how to use our subway system. They had their money out. They were willing to put their money into the machine, if they could only find the slot to use, if they could only remember what station am I now at and where is it that I am trying to go.

They put their money in. They figure out how much to put on the ticket, and then they had to figure out where is the button that I push that gives me my card, and you could see them scanning the machine, hoping they were going to guess which slot the card came out of.

Now, all the commuters walked in, put their money in, got the card out, walked over, slid it into the turnstile, and walked in. The difference was not that they were smarter people or that they were more important people or more knowledgeable people, except in this one instance: They had a cognitive map on how to use our system, and the tourists did not.

In addition, most of these people will have a decisionmaking process that is overwhelmed by too much information. Decisions scientists tell us what is counter-intuitive. If we have more information, we think we can make a better decision. In fact, if we do not have cognitive maps for using that information, what happens is we are overwhelmed by that information, and we short-circuit that decision. We throw out relevant information and go back to the information that we are familiar with and comfortable with.

In the National Adult Literacy Study, 98 percent of the people over 65 could not find the time the next bus came on a bus schedule. Now, we are not talking about a very difficult task, and what we are giving Medicare people is not a simple bus schedule, but information that looks like this, reference to and this is before we get all the information that HCFA has to supply to these people.

The people we were working with, as much as I respect them, are not going to be able to deal with all of that information. They already get this information. They simply had no cognitive map to use it.

In addition, they do not read. They skim information, and they skim information looking for answers to their questions.

They are not going to read, and we cannot count on the fact that they will read every page of a Medicare handbook. They are simply not going to be able to do it.

I realize I am now out of time, and I am not quite done. Let me try—

The CHAIRMAN. Take maybe 2 more minutes.

Ms. KLEIMANN. OK, I can do that.

When I gave that subway example, I was only talking about the people who got to the subway. There are lots of people who never even got to the subway. They said, "This is too hard. I am going to drive downtown," or they said, "I am simply not going to go. I will stay here. I will go to the places I am familiar with." So that is part of the mind-set that we are going to be dealing with, as we expand the Medicare choices that people will have.

There is just too much information out there. It is not that we want to deprive people of information, but if you give them too much, they simply do not use any of it, or they will use only selective parts of it, and that does not make for an informed decision.

HCFA is in a very strategic point in the evolution of Medicare, and to succeed, there are a number of things they have done which previous testifiers have already talked about, but for me, one of the most important things they need is they need to test the usability of these documents, not merely do cognitive testing, which is important, not merely do focus group testing, which is also important, but they have to test the usability; that is, can people make decisions using these materials or do they simply toss them away.

People in our focus groups left information we provided them because it was still too much information. Because nearly all of the research supports that beneficiaries want to talk to somebody, HCFA has to focus on training the information, counseling, and assistance (ICA's) centers and many other intermediaries to get this information out, and they need to look at a basic feasibility.

In our group, we brought up the idea of the Internet. Most seniors do not have access to the Internet, and many of them are quite frightened of it. Can they get over it? Of course, but you have to get them to the point of being able to get over it, and as other people have said, HCFA must have the resources to be able to fund all of this.

The success of the Medicare+Choice plan depends on beneficiaries making informed decisions. They have the capability of doing so, but the information has to be staged or the beneficiaries will do what they have done in the past. They will muddle through, and the efficient market-driven system that is your intent will be unable to evolve, and at best—at best, we will be back where we began.

I would be happy to answer any questions.

[The prepared statement of Ms. Kleimann follows:]

K L E I M A N N

COMMUNICATION GROUP, LLC

Inundated by Information:
Consumer Information Provisions of The Balanced Budget Act of 1997

Statement of
Susan Kleimann, Ph.D.
President
Kleimann Communication Group, LLC

Before the

Senate Special Committee on Aging
Dirkson Senate Office Building
Room 562

May 6, 1998
2:00 p.m.

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Testimony of
Susan Kleimann, Ph.D.,
Kleimann Communication Group, LLC
before the
Senate Special Committee on Aging
May 6, 1998

Mr. Chairman and Members of the Committee:

Good afternoon. My name is Susan Kleimann and I am President of Kleimann Communication Group, a small business that works with clients to communicate complicated information so that people can use it. I am by accompanied by Jill Bernstein, Ph.D. from the National Academy of Social Insurance (NASI). I am pleased to be here today to testify on the results of focus groups that we conducted with Medicare beneficiaries for the National Academy of Social Insurance and the California HealthCare Foundation. Before I begin, I'd like to show you a videotape of some of the beneficiaries with whom we spoke. These beneficiaries are typical of the people who participated in our groups, which were evenly distributed by age, race, income, and education.

[Show videotape of Making Medicare Choices in California.[1]]

The focus groups research was conducted in support of a larger project, **Restructuring Medicare for the Long Term**, underway at NASI. The focus groups, conducted in three different areas of California in February 1998, provided an opportunity to hear in some detail about the experiences of individuals who are already dealing with a complex Medicare marketplace that offers an array of choices among managed care options and physician groups contracting with numerous health plans.[2] These groups, therefore, can provide some insight into the new environment that will be created by the implementation of the Medicare+Choice options established in the Balanced Budget Act of 1997. The groups were structured to address two major topics: beneficiaries' understanding of and experiences with Medicare and the Medicare managed care options available to them in California; and their views about the future of Medicare, including the expansion of plan options, cost sharing, and individual and family responsibilities for health care now and in the future.

The changes that are planned for Medicare require that beneficiaries take a more active role in their health care planning and decisions--a more active role that could have dire consequences for them if they misunderstand the information they are given or are merely befuddled by the information. As you can tell from the videotape, the beneficiaries we spoke with are dignified, thoughtful, and concerned. I have enormous respect for the voices that we heard in our groups, and I make a point of saying that, as a context for my

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[1] Making Medicare Choices in California, videotape, National Academy of Social Insurance, 1998.

[2] Five focus groups were held in the Los Angeles, three in San Jose, and two in the Sacramento area. Seven were comprised of Medicare beneficiaries aged 65 or older; of these, two were conducted in Spanish, and one in Chinese (Cantonese); three groups were comprised of people aged 50-64 (predominantly not beneficiaries, but included several disabled persons in each group who were receiving Medicare benefits). The groups included low and middle income beneficiaries (about one-third with incomes under $9,000).

comments today. These people had a wide range of education, levels of activity, and willingness to learn, but they shared at least one sentiment about their health care choices, because they do understand the consequences of choosing poorly: "It's scary, so scary to make a choice."

For today, I would like to address the challenges of sharing information with Medicare beneficiaries so that they can act upon that information in their own best interests. I'd like to address four areas in this statement: (1) cognitive maps and the difficulty of changing maps, (2) the issue of information overload; (3) what our focus groups told us about the level of proficiency and knowledge among Medicare beneficiaries--somewhat experienced with choice; and (4) the implications for information given to these beneficiaries about the changes to Medicare.

Cognitive maps and the difficulty of changing maps

Let's start with cognitive maps. We learn to do things by building a pattern in our minds (what we researchers like to call a schemata or cognitive map). We do this, so that we can approach the same task or a similar task more easily the next time we encounter it. As we do a new task, we look in our mind's bag of maps for similar task maps and we build on those task maps if we can. If we can't find an appropriate map, we build a new schema or map, so that we can use it the next time. We all build maps and we all do this each time we encounter something new to do. On my way downtown this past April, I used the subway. As I approached the fare card machines, I noticed small crowds of tourists looking befuddled as they tried to understand the process of buying a fare card and how much cash they should put on the ticket. They read the instructions, they pulled out money, they looked around for a fare schedule, they read the schedule (after checking the name of the station they were at), they inserted their money, some of them upside down, they reinserted their money, they waited for the ticket to come out and they scanned the machine, looking at every slot waiting for the fare card to pop out. The commuters, the old hands, not necessarily smarter nor better-educated nor even better-tempered folks, these people tapped their toes impatiently while the tourists figured out the process or they approached the turn stile with card in hand and confidently breezed through the turnstile and down to the platform. They had developed a cognitive map for the Washington subway system; the tourists had not.

When we face an unknown task, it doesn't matter how smart or how educated or how important, we lose our ability to be competent until we have built a cognitive map for how to complete the task. So, the big question here is do the elderly (do Medicare beneficiaries) have a cognitive map to deal with the choices that soon face them? Let's assume for now that the choices are fairly simple—Plan A or Plan B.

First, they would need a cognitive map for making a choice. Some beneficiaries have had no experience selecting among plans because they have had no health insurance at all. In 1996, 13.6 percent of Americans aged 55-64 had no health insurance.[3] (See Chart 1.) Many of today's Medicare beneficiaries (and the baby boomer crowd behind them) have worked in small enterprises where no insurance was offered or only one plan was offered. Of the 95 million Americans with employment-based coverage, almost 40 percent work

[3] Deborah J. Chollet and Adele M. Kirk, The Alpha Center, Understanding Individual Health Insurance Markets, Prepared for the Henry J. Kaiser Family Foundation, March, 1998, 103-116.

in establishments with fewer than 200 employees. Only about one in five workers in small firms that do provide health insurance have any choice of health plans at all, and less than one in 10 have the opportunity to choose from three or more plans.[4] Even among larger firms, a significant proportion offer only a very limited choice of health care plans.[5] So, most beneficiaries do not have a cognitive map for choosing a health plan.

Second, they would need a map about what an HMO is and how it differs from traditional health insurance. Much of the information is new to them: they have little experience with managed care, little experience with networks and the other activities of managed care. HMOs have begun only recently to be available to people in many parts of the United States. In fact, much of the current research indicates that many people, not just Medicare beneficiaries, know very little about these differences, even in markets that have had managed care options for a while. Certainly, our research with people who have had more exposure to managed care than most other Americans, shows that they had very mixed levels of knowledge, some of it accurate, some of it quite faulty. So, in general, most beneficiaries will not have a map for judging differences among types of health plans.

Third, for beneficiaries to take an active role, they would need to weigh all of the factors about choice and make a decision that considers multiple factors. Much of the research on decision-making suggests that as humans we are lousy decision makers--even when we are trying very hard. We assume that more information is better for making decisions, that if we collect enough information, or more information, eventually we will be able to make the "best" decision or find the "truth." What decision researchers tell us, however, is that this is not true. In fact, too much information distorts the decision-making process. We tend to cope with too much information by short-circuiting the decision-making: we fail to consider all of the factors, fixate on a few factors, and make our decisions based on these factors, often the factors with which we are most familiar. As a result, the multiplicity of choices that will face Medicare beneficiaries could well overwhelm their decision-making process—even before we consider that most of the beneficiaries will not have cognitive maps about choosing a health plan from multiple choices or about choosing among traditional or managed care alternatives.[6]

Information overload

Next, let's consider information overload. Let me not cite the statistics about how fast the amount of data is expanding nor the statistics about how many pieces of information each of us face each day; we only need to look at our own in-boxes to assess that. Instead let's consider how well people are able to cope with some of the simpler tasks of life, like reading a bus schedule. If you'll look at Figure 1, you'll see a bus schedule. It's not

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[4] Jon. R. Gabel, Paul B. Ginsburg, and Kelly A. Hunt, "Small Employers and Their Health Benefits, 1988-1996: An Awkward Adolescence," *Health Affairs* 16(5) September/October. 1997: 103-110.

[5] Center for Studying Health System Change, *Data Bulletin Number 10*, Winter, 1998. The proportion of employees who actually choose among health plans is, moreover, actually even lower than these figures suggest, because high levels of employee cost-sharing, particularly in small firms, leads a sizable proportion of employees who could chose among plans (about one third in small firms) to decline coverage altogether.

[6] John Payne, Jim Bettman, and Eric Johnson, Adaptive Decision Maker, Cambridge University Press, 1993.

particularly intimidating to most of us. However, according to the National Adult Literacy Survey, document tasks, such as reading this bus schedule are not well-handled by most people. In fact, of those between the ages of 55-64, 90% could **not** figure out how long they would have to wait for the next bus, if they missed the 2:35 bus on a Saturday.[7] Of those 65 and older, 98% could not figure out the same task. If we assume that the task of choosing a health plan is no more difficult than finding the time of the next bus, if we assume that comparative charts such as Figure 2 (this is the comparative chart provided to California Medicare recipients) are as simple as a bus schedule, then we're looking at a staggering number of people who will not be able to use charts like these.[8]

Let's look now to see how much information that Medicare beneficiaries will have to sort through. When I spoke about cognitive maps, I said let's assume a simple choice of Plan A and Plan B. In fact, Medicare beneficiaries will be faced with a far more complicated choice. According to regulations, beneficiaries will choose among Coordinated Care Plans, "including but not limited to health maintenance organizations plans (with or without a point of service options), plans offered by provider-sponsored organizations) and preferred provider organization plans. In addition, they can select a combination of a MSA plan and contributions to a Medicare+Choice medical savings account (MSA) and a private fee-for-service plan." Now even if we have only one of each, our Medicare beneficiary is choosing among six plans. In fact, in northern California, (I refer you back to Figure 2), a fairly well-developed managed care market, beneficiaries are choosing from 17 plans.

Do we have information overload yet? Before we decide, let's also consider the information that the Balanced Budget of 1997 (P.L. 105-33) Act specifies that the Health Care Financing Administration (HCFA) provide to beneficiaries to help them chose a Medicare plan:

> (3) GENERAL INFORMATION- General information under this paragraph, with respect to coverage under this part during a year, shall include the following:
>
> (A) BENEFITS UNDER ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION- A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including--
>
> (i) covered items and services,
>
> (ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and
>
> (iii) any beneficiary liability for balance billing.
>
> (B) ELECTION PROCEDURES- Information and instructions on how to exercise election options under this section.
>
> (C) RIGHTS- A general description of procedural rights (including grievance and appeals procedures) of

[7] Irwin Kirsch, Ann Jungebluf, Lynn Jenkins, and Andrew Kolstad, Adult Literacy in America, National Center for Education Statistics, Office of Educational Research and Improvement, 1993, p.117.

[8] Medicare Managed Care 1997 Benefits Comparison Chart -- Northern California, HCFA.

beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

(D) INFORMATION ON MEDIGAP AND MEDICARE SELECT- A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

(E) POTENTIAL FOR CONTRACT TERMINATION- The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(4) INFORMATION COMPARING PLAN OPTIONS- Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) BENEFITS- The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) PREMIUMS- The Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium.

(C) SERVICE AREA- The service area of the plan.

(D) QUALITY AND PERFORMANCE- To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under

parts A and B in the area involved), including--
(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),
(ii) information on medicare enrollee satisfaction,
(iii) information on health outcomes, and
(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).
(E) SUPPLEMENTAL BENEFITS- Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

We are well beyond the amount of information that cognitive psychologists say that we can process and hold in our short term memory —seven plus or minus two.

So now let's assume that we can get all of this information into charts or a booklet, in a font size that the elderly (or any of us who have hit middle-age) can read. We still need to consider how people read—or rather how they don't read. In fact, when adults read functional documents, that is documents which are not for pleasure, they read by skimming the text for answers to questions, their questions. If they can't find the answers or if they are intimidated by the size of the document or how it looks, they simply quit.[9]

Even if reading charts is not a problem, the contents of the charts may be. We heard over and over from our focus group participants that the "devil is in the details." It's the information about specific things that make a big difference to them -- whether specific drugs are included in the HMO formulary, which diabetic supplies are covered, how much they would actually have to pay for a major dental procedure, what is really covered, and what is not, when they go to buy a pair of glasses – and is far too specific to be included in the most complicated chart. Even if we spread this information over an entire booklet, we are beyond the amount of information that most of the beneficiaries can handle.

From these facts, what is the picture of the Medicare beneficiary that is emerging?

- a person who has no cognitive map for choosing a health plan (having had little or no choice before),
- a person who has no cognitive map for selecting between managed care and traditional care (having had little experience with managed care),
- a person with typically short-circuited decision-making processes,

[9] J.C. Redish, Reading to Learn to Do, *The Technical Writing Teacher*, xv(3), 1988, 223-233.

- a person who has trouble reading documents like a bus schedule, and
- a person who doesn't read, but skims a document in search of answers to questions, but quits if the task is too difficult or there's just too much information.

Again, we are not talking about a minority of the Medicare beneficiaries, but as much as 98% of the population. As the videotape indicates, these people are overwhelmed by the information overload. And our participants were able-bodied, mobile, and motivated enough to come to our group (we had a 100% show rate for all of these groups). What if they were ill or bed-ridden or wheel-chair bound? What if they were dealing with a life-threatening illness of their own or of a spouse of 50 years? How would we expect them to process this information and to act upon it? The answer is obvious.

What these focus groups told us about the level of proficiency and knowledge among Medicare beneficiaries

Research has shown that people have never really understood the features of Medicare; managed care adds another layer. People in our focus groups did not know if they were in traditional, fee-for-service Medicare or not; they sometimes thought that they were not in Medicare if they were in an HMO; they thought that the $43.80 withheld from their social security checks was the full payment for HMO services. Because they thought they were no longer in Medicare, some were convinced that they had to deal with the HMO entirely on their own -- they did not know that Medicare HMO beneficiaries have rights that can be enforced by the Medicare program. Beneficiaries who were also eligible for MediCal (Medicaid) were confused about what benefits they could actually receive. This was a serious problem for some beneficiaries who said they could no longer get prescriptions that were covered under MediCal through their HMOs.

Now, in each group, it's true that there was at least one incredibly active information gatherer. These people used the Internet, called the HMO and got the doctor's credentials, or went to hospital education classes and choose her doctor based on the doctor who most often spoke. But the majority of the beneficiaries were not active like this. They wanted information presented by people like us who were unattached to the plans and were giving them a chance to talk and twere providing them with information. They thanked us for being allowed to come and for giving them information. Face-to-face interactions like these are essential if people are to truly understand the issues and options that come with Medicare choices.

Implications for Medicare+Choice

Providing Medicare beneficiaries with information they need and that they can use to make good choices about enrolling in health plans is a daunting task. Tens of millions of beneficiaries have never really done anything quite like this--and HCFA hasn't either. There is some time -- beneficiaries won't have to make choices, or be bound by their choices, for a few years. But to handle the enormous education process that Medicare has committed itself to, it is crucial that there be a workable plan.

First, HCFA needs to decide what audience it is trying to reach. Active, informed consumers can take care of themselves. Too much information is, for most beneficiaries, wasted effort and time. HCFA needs to worry about the vulnerable population -- people who cannot sort through mounds of definitions and facts and figures, and who will be

overwhelmed by too much information. Unfortunately, this is probably 98% of the beneficiaries. For people with low literacy skills, cognitive impairments, problems with vision, people who do not speak English or do not feel comfortable dealing with complicated issues in English, understanding Medicare options will be especially intimidating. HCFA needs to begin the education efforts with this in mind:

Start with the most essential, basic messages that beneficiaries need:

1. There are new options in Medicare;

2. You don't need to decide what sort of Medicare plan you will sign up with immediately, but you will need to find out about these options sometime; and

3. There are places you can call and people you can talk with to get more information.

Second, work out a strategy that will generate the kinds of information people can actually use. An educational effort like this requires a great deal of technical expertise and skill, and targeted research and testing. HCFA has done an excellent job with "cognitive testing", which is designed to ensure that the materials it sends out can be understood. But in addition, HCFA needs to do "usability" testing, which can tell them whether people can actually use the materials to make decisions. This kind of testing includes actually watch people working through a pamphlet or other document with a task to complete, and seeing if they can apply the information in the document to the task at hand. Understanding is a prerequisite for use, but the one does not automatically follow the other.[10]

Third, find ways to get the detailed information that consumers might need into the hands of people who can use it, or who can help others use it. The research evidence consistently shows that most Medicare beneficiaries prefer to get information on-on-one, from individual counselors, or in small groups where they can get answers to their specific questions. The Information, Counseling and Assistance (ICA) program has been providing beneficiaries in every state with help in dealing with Medicare questions about a range of complicated program issues, including Medigap insurance, since 1990.[11] Organizations, such as these and other community based organizations that provide assistance to seniors and persons with disabilities, could be valuable resources for Medicare+Choice. To provide objective and useful information to beneficiaries, however, these organizations would need training about Medicare plan options, and access to up-to-date and complete information on plans (including all the information required by the Balanced Budget Act, e.g. benefits, cost-sharing, quality and satisfaction measures, etc.). They also need to be able to use on-line data bases to provide tailored reports that answer individuals' particular questions. Developing education and training programs for intermediaries who can help beneficiaries who need help (in person, over the telephone, via automated kiosks in shopping malls, and so on) should be a priority. This data base development and training will require a considerable investment in time and resources.

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[10] Joseph S. Dumas and Janice C. Redish, A Practical Guide to Usability Testing, (1993) Ablex Publishing Corporation, Norwood, New Jersey and Karen Schriver, Dynamics in Document Design: Creating Text for Readers, John Wiley & Sons, 1996.

[11] National Academy of Social Insurance, *Structuring Medicare Choices*. Final Report of the Study Panel on Medicare Capitation and Choice. Washington, DC: April, 1998.

Neither HCFA nor local community groups can take on a huge task like this without additional resources, both funding and people.

In conclusion, I would like to thank the Committee for allowing me come here to share some of the challenges in communicating information so that Medicare beneficiaries can use it to help them make choices that will be "a good deal" for them. I know that HCFA has been working hard to prepare for Medicare+Choice. I hope that the work that we have done has helped to bring the enormity of the task ahead into some perspective, and can help provide direction for the work that needs to be done. I would be pleased to answer any questions you may have.

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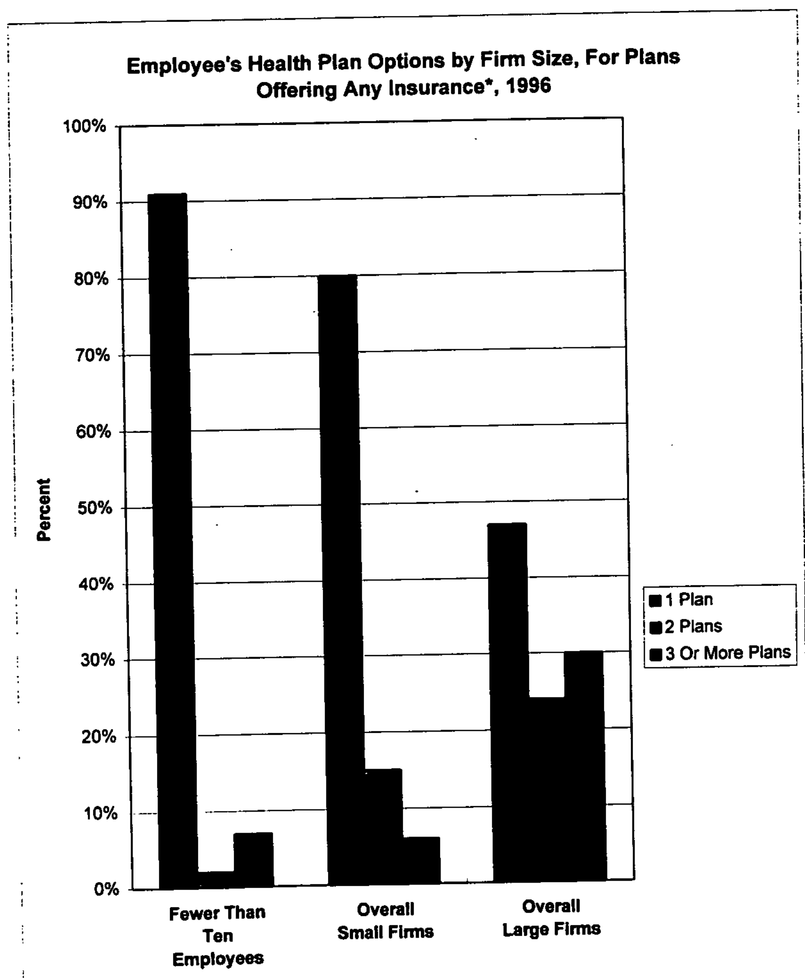
Chart 1



*49 percent of small firms offered employees health insurance in 1996.

Note: Some columns may not add to 100 percent because of rounding.

Source: Gable, J., Ginsburg, P., Hunt, K., "Small Employers And Their Health Benefits, 1988-1996: An Awkward Adolescence," *Health Affairs* 16(5): 103-110, Sep./Oct. 1997.

Figure 1: Document Level 4 Task

On Saturday afternoon, if you miss the 2:35 bus leaving Hancock and Buena Ventura going to Flintridge and Academy, how long will you have to wait for the next bus?

ROUTE 5 — VISTA GRANDE

This bus line operates Monday through Saturday providing "local" service to most neighborhoods in the northeast section.
Buses run thirty minutes apart during the morning and afternoon rush hours Monday through Friday.
Buses run one hour apart at all other times of day and Saturday.
No Sunday, holiday or night service.

You can transfer from this bus to another headed anywhere else in the city bus system.

	OUTBOUND from Terminal						INBOUND toward Terminal					
	Leave Downtown Terminal	Leave Hancock and Buena Ventura	Leave Citadel	Leave Rustic Hills	Leave North Carefree and Oro Blanco	Arrive Flintridge and Academy	Leave Flintridge and Academy	Leave North Carefree and Oro Blanco	Leave Rustic Hills	Leave Citadel	Leave Hancock and Buena Ventura	Arrive Downtown Terminal
AM							6:15	6:27	6:42	6:47	6:57	7:15
AM							6:45	6:57	7:12	7:17	7:27	7:45 Monday through Friday only
AM	6:20	6:35	6:45	6:50	7:03	7:15	7:15	7:27	7:42	7:47	7:57	8:15
AM	6:50	7:05	7:15	7:20	7:33	7:45	7:45	7:57	8:12	8:17	8:27	8:45 Monday through Friday only
AM	7:20	7:35	7:45	7:50	8:03	8:15	8:15	8:27	8:42	8:47	8:57	9:15
AM	7:50	8:05	8:15	8:20	8:33	8:45	8:45	8:57	9:12	9:17	9:27	9:45 Monday through Friday only
AM	8:20	8:35	8:45	8:50	9:03	9:15	9:15	9:27	9:42	9:47	9:57	10:15
AM	8:50	9:05	9:15	9:20	9:33	9:45	9:45	9:57	10:12	10:17	10:27	10:45 Monday through Friday only
AM	9:20	9:35	9:45	9:50	10:03	10:15	10:15	10:27	10:42	10:47	10:57	11:15
AM	10:20	10:35	10:45	10:50	11:03	11:15	11:15	11:27	11:42	11:47	11:57	12:15
AM	11:20	11:35	11:45	11:50	12:03	12:15	12:15	12:27	12:42 p.m.	12:47 p.m.	12:57 p.m.	1:15 p.m.
PM	12:20	12:35	12:45	12:50	1:03	1:15	1:15	1:27	1:42	1:47	1:57	2:15
PM	1:20	1:35	1:45	1:50	2:03	2:15	2:15	2:27	2:42	2:47	2:57	3:15
PM	2:20	2:35	2:45	2:50	3:03	3:15	3:15	3:27	3:42	3:47	3:57	4:15
PM	2:50	3:05	3:15	3:20	3:33	3:45	3:45	3:57	4:12	4:17	4:27	4:45 Monday through Friday only
PM	3:20	3:35	3:45	3:50	4:03	4:15	4:15	4:27	4:42	4:47	4:57	5:15
PM	3:50	4:05	4:15	4:20	4:33	4:45	4:45	4:57	5:12	5:17	5:27	5:45 Monday through Friday only
PM	4:20	4:35	4:45	4:50	5:03	5:15	5:15	5:27	5:42	5:47	5:57	6:15
PM	4:50	5:05	5:15	5:20	5:33	5:45	5:45	5:57	6:12	6:17	6:27	6:45 Monday through Friday only
PM	5:20	5:35	5:45	5:50	6:03	6:15						
PM	5:50	6:05	6:15	6:20	6:33	6:45						Monday through Friday only
PM	6:20	6:35	6:45	6:50	7:03	7:15						

Source: Irwin Kirsch, Ann Jungeblut, Lynn Jenkins, and Andrew Kolstad, Adult Literacy in America, National Center for Education Statistics, Office of Educational Research and Improvement, 1993, p.91.

MEDICARE MANAGED CARE 1997 BENEFITS COMPARISON CHART – SOUTHERN CALIFORNIA

Figure 2

Description	Foundation Health "Senior Value" (800) 643-7589	Health Net "Seniority Plus" (800) 935-6565	InterValley "Service to Seniors" (800) 251-8191
Counties served	5,7,8,9,10,14	3,5,7,8,9,10,11,12,14	5,7,8,9,14
Monthly Premiums**	$0	$0 - 3,5,7,8,9,10,14 $15 - 11,12	$0
Hospital Coverage First 60 days Day 61-90 Day 91-150 Over 150 days	covered in full unlimited days	covered in full unlimited days	covered in full unlimited days
Physicians & Specialists	#14-$5/visit; others $0/visit	$0/visit - 3,5,7-10; $5 - 11,12,14	$0 per visit
Skilled Nursing Facility Prior Hospitalization First 20 days/benefit period Day 21-100/benefit period Over 100 days/benefit period	no requirement no charge no charge not covered	no requirement no charge no charge not covered	no requirement no charge no charge not covered
Home Health Care	no charge	no charge	no charge
Emergency Care In-area emergency Out-area emergency/urgent Worldwide Coverage	$35; waived if admitted $35; waived if admitted $5 urgent ctr./MD office $35; waived if admitted	$20; waived if admitted $20; waived if admitted $20; waived if admitted	$20; waived if admitted $20 ER; $0 urgent care no charge
Preventive Health Svcs. Annual Preventive Exam Eye-glasses Routine Eye exam Routine Hearing Exam Hearing Aids	$10 per visit #14-$20 copay; others $10; #14-$55 credit/2 yrs; others $55/yr. $5 per visit $5 per visit not covered	$0/visit - 3,5,7-10; $5 - 11,12,14 $0copay on $60 frames/2yrs $0/visit - 3,5,7-10; $5 - 11,12,14 $0/visit - 3,5,7-10; $5 - 11,12,14 not covered	$0 per visit $25 copayment $5 annual exam $0 per visit not covered
Outpatient Pharmacy Benefit **Annual Cap:**	$5/prescription 14 - $1,500 annual limit others : $1,500 brand limit, and no annual limit on generic drugs	$7/generic; $8/preferred; $10/brand $2,500 = 11,12 $3,000 = 3,5,7,8,9,10,14	$7/formulary prescription $12 non-formulary no annual limit
Routine Dental	coverage offered	coverage offered	coverage offered
Mental Health Coverage Inpatient (psych. hospital) Outpatient	no charge 190 lifetime days $10 per visit	no charge 190 lifetime days $20 per visit	no charge 190 lifetime days $25/visit; medically necessary
Point of Service Option ***	not available	not available	not available
Chiropractic Coverage ***	#14-$10/visit; covered per Medicare others: $5/visit, $750 annual limit	covered per Medicare guidelines	$5/visit; up to 20 visits/year
Routine Podiatric ***	#14-$5/visit; covered per Medicare others: $5/visit, 1 visit/month, 12/yr.	1 visit per month w/ copays: $0-#3,5,7-10; $5-#11,12,14	covered per Medicare guidelines

*** Point of Service (POS): The POS option is offered by some risk plans to allow greater flexibility in choice of providers. POS options will differ for each HMO, so please contact the HMOs to get a thorough understanding of this option.

Chiropractic Coverage: Medicare helps pay for manual manipulation of the spine to correct subluxation that is demonstrated by x-ray.

Podiatric Coverage: Medicare helps pay for medically necessary and reasonable routine foot care for specific conditions related to diabetic and systemic foot disease.

MEDICARE MANAGED CARE 1997 BENEFITS COMPARISON CHART - SOUTHERN CALIFORNIA

Blue Shield of California "Shield 65" (800) 495-7887	CareAmerica "65 Plus" (800) 488-8000	Cigna "Health Care for Seniors" (800) 747-8688	FHP "Senior Plan" (800) 225-4347
5,7,8,9	5,7,8,9,14	2,5,6,7,8,9,10,14	1,3,4,5,7-10,12-14
$0	$0	2,6 - $35; others $0	$0
covered in full unlimited days	covered in full unlimited days	covered in full unlimited days	covered in full unlimited days
$3 per visit	$3 per visit	#2,6 - $10/visit; others - $0	$0 per visit
3 days; may be waived no charge no charge not covered	no requirement no charge no charge covered to 150 days	no requirement no charge no charge not covered	3 days may be waived no charge no charge not covered
no charge	no charge, and 80 hours respite care/year	no charge	no charge
$25; waived if admitted $25; waived if admitted $25; waived if admitted	Pay lesser of: $25 or 20% copay $10; waived if admitted $10; waived if admitted	$25; waived if admitted $25; waived if admitted $25; waived if admitted	$25; $0 if admitted, $25 ER; $0 if admitted, $0 urgent MD visit $25; $0 if admitted,
$3 per visit $100 allowance for lenses,frames every 24 months $3 per visit $3 per visit $500 allowance per unit; limit 2 units/24 months	$3 per visit $10 copay lens/yr.; select frames($100 value)/2yrs $5 per visit no charge discounted	no charge $10 copay,1pr./2yrs. no charge #2,6-$10/visit; others $5 discounted	$0; 1 visit every 2 yrs. $20 standard frames, clear vision lenses/2 years $5; every 2 years $0 annual visit discounted
Pharmacy: $6/generic; $12 brand (30-day) Mail Order: $12/generic; $24 brand (90 day) $2,000	$7/prescription $3,600/yr. brand cap; $900/qtr. w/ $450/qtr. rollover generic drugs = no annual limit	$5/prescription $3,000	$6/prescription $3,500; carry-over 50% unused to next yr.
coverage offered	coverage offered	coverage offered	coverage offered
no charge 190 lifetime days $3 per visit	no charge 190 lifetime days $3 per visit	no charge 190 lifetime days $10/20 visits, $20/addl.	no charge 190 lifetime days $10 per visit
not available	not available	not available	not available
$3/visit; up to 20 self-referred visits per year to plan chiropractor	$3/visit; covered per Medicare guidelines	#2,6-$10/visit; others $3/visit as medically necessary	$5/visit; up to 20 self-referred visits/calendar yr.
$3/visit; up to 12 self-referred visits per year to plan provider	$3/visit; covered per Medicare guidelines	#2,6-$10/visit; others $3/visit per Medicare guidelines	$0/visit; covered per Medicare guidelines

Counties: Please note that only some parts of some counties may be covered.

nperial	5 - Los Angeles	9 - San Bernandino	13 - Tulare
2 - myo	6 - Mono	10 - San Diego	14 - Ventura
3 - Kern	7 - Orange	11 - San Luis Obispo	
4 - Kings	8 - Riverside	12 - Santa Barbara	

Employer groups may offer different benefits. Please consult group information for exact benefits.

MEDICARE MANAGED CARE 1997 BENEFITS COMPARISON CHART – SOUTHERN CALIFORNIA

Description	Traditional Medicare (800)772-1213	Aetna U.S. Healthcare "Senior Choice" (800) 366-4355	Blue Cross of California "Blue Cross Senior Secure" (800) 765-2585
Counties served	ALL	3,5,7,8,9,14	3,5,7,8,9,10,11,12,14
Monthly Premiums**	Part B - $43.80	$0	$0
Hospital Coverage			
First 60 days	$760	covered in full unlimited days	covered in full unlimited days
Day 61-90	$190		
Day 91-150	$380 per reserve day (60 lifetime days)		
Over 150 days	not covered		
Physicians & Specialists	20%, $100 deductible*	$0 per visit	$5/visit - 11,12; others $0/visit
Skilled Nursing Facility			
Prior Hospitalization	3 days	no requirement	3 days; may be waived
First 20 days/benefit period	no charge	no charge	no charge
Day 21-100/benefit period	$95 per day	no charge	no charge
Over 100 days/benefit period	not covered	not covered	not covered
Home Health Care	no charge	no charge	no charge
Emergency Care			
In-area emergency	20%, $100 deductible*	$25; waived if admitted	$20; waived if admitted
Out-area emergency/urgent	20%, $100 deductible*	$25; waived if admitted	$20; waived if admitted
Worldwide Coverage	not covered	$25; waived if admitted	$20; waived if admitted
Preventive Health Svcs.			
Annual Preventive Exam	not covered	$0 per visit	$5/visit - 11,12; others $0/visit
Eye-glasses	not covered	$25 per pair/2 yrs	no charge for 1 pr. lenses/24 months up to $75 for frames/24 months
Routine Eye exam	not covered	$5 per annual visit	$5/visit - 11,12; others $0/visit
Routine Hearing Exam	not covered	$0 per visit	$5/visit - 11,12; others $0/visit
Hearing Aids	not covered	discounts available	discounted
Outpatient Pharmacy Benefit	not covered	Prescriptions: $6/formulary; $20/non- formulary	Brand: $7/prescription; then $10/prescription for generic
Annual Cap:		$2,000	Brand: $1,000 - 11,12; $2,000 others; after that, unlimited generic
Routine Dental	not covered	discounted services	coverage offered
Mental Health Coverage			
Inpatient (psych. hospital)	see hospital (above) 190 lifetime days	no charge 190 lifetime days	no charge 190 lifetime days
Outpatient	50%, $100 deductible*	$10 per visit	$10 per visit
Point of Service Option ***	not applicable	not available	$25/visit to select physicians; up to 3 visits/year; physician office visit only
Chiropractic Coverage ***	20%, $100 deductible* see *** below	covered per Medicare guidelines	$5/visit self-referral to contracted providers; up to 12 visits/year
Routine Podiatric ***	20%, $100 deductible* see *** below	covered per Medicare guidelines	#11,12-$5/visit; others- $0; self-refer to select providers; up to 1 visit/month

* 20% co-payment is on Medicare approved charges. The $100 deductible is met only once per year and applies to all Part B benefits.

** Plan members must continue to pay Medicare Part B premium. Beneficiaries without Medicare Part A must purchase it either through Social Security or through the plan.

This chart contains basic benefits information. Please contact plans for availability of optional supplemental benefits and/or availability of higher/lower levels of coverage.

Employer groups may offer different benefits. Please consult group information for exact benefits.

MEDICARE MANAGED CARE 1997 BENEFITS COMPARISON CHART - SOUTHERN CALIFORNIA

Kaiser Foundation "Senior Advantage" (800) 443-0815	Maxicare "Max 65 Plus" (800) 392-6565	Pacificare "Secure Horizons" (800) 228-2144
3,5,7,8,9,10,14	5,7,8,9	3,4,5,7,8,9,10,11,12,13,14
$0	$0	$0-3,5,7,8,9,10,14 $10 - 11,12; $20 - 4,13
covered in full unlimited days	covered in full unlimited days	covered in full unlimited days
$3 per visit	no charge	3,14-$3;11,12-$5;4,13-$10;others $0/visit
no requirement no charge no charge not covered	no requirement no charge no charge covered to 150 days	3 days no charge no charge not covered
no charge	no charge	no charge
covered, reg. copay applies covered, reg. copay applies no charge	$20; waived if admitted $20; waived if admitted $20; waived if admitted	$20; waived if admitted $20; waived if admitted $20; waived if admitted
$3 per visit $60 frame credit; $0 lenses/2 yrs. $3 per visit $3 per visit not covered	no charge $25 copay lenses/12 mos. $75frame allowance/24 mos. no charge no charge 15% discount program	3,14-$3;11,12-$5;4,13-$10;others $0/visit $20 copay/2 yrs 3,14-$3;11,12-$5;4,13-$10;others $0/visit 3,14-$3;11,12-$5;4,13-$10;others $0/visit not covered
$7/prescription no annual limit	$3 generic/$7 brand Brand: $1,000/6 months Generic: no annual limit	$7/$10: generic; $10/$20 brand #3,11,12,14-$2,500;#4,13-N/A #5,7,8,9,10-no annual limit
coverage offered	coverage offered	#4,13-not covered;all others = covered
$0 for 190 lifetime days, and 45 days/yr when 190 exhausted; Group: 20 visits/yr. @ $10; $22 thereafter Individual: 20 visits/yr. @ $20; then $44	no charge 190 lifetime days $10 per visit	no charge 190 lifetime days $10 per visit
not available	not available	not available
$3/visit; covered per Medicare guidelines	self-referral up to 20 visits/yr.	covered per Medicare guidelines
$3/visit; covered per Medicare guidelines	covered per Medicare guidelines	covered per Medicare guidelines

ntles: Please note that only some parts of some counties may be covered.

1 - Imperial
2 - Inyo
3 - Kern
4 - Kings
5 - Los Angeles
6 - Mono
7 - Orange
8 - Riverside
9 - San Bernandino
10 - San Diego
11 - San Luis Obispo
12 - Santa Barbara
13 - Tulare
14 - Ventura

MEDICARE MANAGED CARE 1997 BENEFITS COMPARISON CHART – SOUTHERN CALIFORNIA

Description	Prudential Senior Care (800) 641-4778	SCAN Health Plan (800) 247-5091	United Health Plan for Seniors (800) 544-0088
Counties served	3,5,7,8,9,10,11,14	5,7,8,9	5,7,9
Monthly Premiums**	$0	$0	$0
Hospital Coverage First 60 days Day 61-90 Day 91-150 Over 150 days	covered in full unlimited days	covered in full unlimited days	covered in full unlimited days
Physicians & Specialists	$3 per visit	$3 per visit	no charge
Skilled Nursing Facility Prior Hospitalization First 20 days/benefit period Day 21-100/benefit period Over 100 days/benefit period	no requirement no charge no charge not covered	3 days, may be waived no charge no charge not covered	no requirement no charge no charge up to 150 days/year
Home Health Care	no charge	no charge	no charge
Emergency Care In-area emergency Out-area emergency/urgent Worldwide Coverage	$35; waived if admitted $35; waived if admitted $35; waived if admitted	$25; waived if admitted $25; waived if admitted $25; waived if admitted	no charge no charge no charge
Preventive Health Svcs. Annual Preventive Exam Eye-glasses Routine Eye exam Routine Hearing Exam Hearing Aids	$5 per visit $20 copay, $75 frame allowance/2 yrs., lenses every 12 months $5 per visit $5 per visit not covered	$3 per visit $20 copay over 2 yrs. $5 per visit $5 per visit $150/unit; 1 per 24 months or 2 units every 3 years	no charge 1 pair every 2 years no charge no charge not covered
Outpatient Pharmacy Benefit Annual Cap:	Preferred-$5/generic;$10/brand Non-preferred-$20/generic or brand Generic pref-$3,000max #11; no max all others Non-pref generic/brand-$1,500 combined max	$3.50 generic/$10 brand no annual limit	$5/prescription $2,400; limited to $200/month
Routine Dental	coverage offered	coverage offered	coverage offered
Mental Health Coverage Inpatient (psych. hospital) Outpatient	no charge 190 lifetime days $15 per visit	no charge 190 lifetime days $10 per visit	no charge 190 lifetime days no charge
Point of Service Option ***	not available	not available	not available
Chiropractic Coverage ***	$5/visit; 12 self-referred visits/year	$3 copay per visit	$5/visit 25 in-network self-referrals/yr.
Routine Podiatric ***	$5/visit; 12 self-referred visits/year	$3 copay per visit	no charge

The CHAIRMAN. Thank you, Dr. Kleimann.

Ms. Dallek.

STATEMENT OF GERALDINE DALLEK, MPH, PROJECT DIRECTOR, INSTITUTE FOR HEALTHCARE RESEARCH AND POLICY, GEORGETOWN UNIVERSITY

Ms. DALLEK. Mr. Chairman, Senator Breaux, and Senator Jeffords thank you for the opportunity to testify today.

Prior to coming to DC., 2 years ago, I was director of a program in Los Angeles that provided education, counseling and assistance to Medicare beneficiaries, one of those ICA's that you have been talking about today. My testimony is based on my experience at both answering questions about Medicare and Medicare HMO on the program's hotline, as well as making Medicare educational presentations to thousands of beneficiaries around Los Angeles County.

Based on that experience, I have come to two conclusions. One, the job of explaining Medicare+Choice is daunting. Two, neither HCFA nor Medicare community organizations, HCFA's partners, currently have adequate funding to respond to beneficiary questions about the Medicare+Choice program.

You have already heard this afternoon that beneficiaries do not have an adequate understanding of the Medicare program. Let me briefly describe two soon to be released studies that are about to come out in this observation.

A study by University of Oregon researchers conducted for AARP examined Medicare beneficiaries' understanding of the differences between Medicare and Medicare HMO's. Researchers found that a large minority of beneficiaries could not answer enough questions to even participate in the survey.

The second study comes from a Kaiser Family Foundation-sponsored survey of focus groups of ICA counselors. One counselor noted that, "I deal with a lot of people that come in thinking that if they go into managed care, they are going to lose their Medicare. People just do not understand this program." Despite this profound lack of understanding, we are expecting the population to be able to compare Medicare+Choice plans which will differ not just on the terminology. We heard a lot today about how the terminology differs, and I agree this needs to be standardized. But plans will also differ on their benefit packages, on their cost-sharing, and on how they are structured. How can we expect beneficiaries to make an informed decision on the tradeoffs between these plans and traditional Medicare?

Add to this fact that according to one study, 53 percent of the Medicare elderly population fall into the lowest literacy level where a person could not read at all or could locate only one piece of specific information in a short uncomplicated text, and we could have a real big mess on our hands. It takes a leap of faith to think that the educational challenges of Medicare+Choice will be met without a great deal of time, effort, and money to help beneficiaries understand the consequences of their choice.

I am thinking of my 79-year-old mother. My mother is going to get a mailing in November, and she is not going to have a clue about what it means. Now, she is going to be OK because she will

call me, and no, I am not giving my number out to anybody. But what about the millions of other Medicare beneficiaries that will not have a family member they can call or their family members will be as confused as they are? We must have places for these folks to call to get answers to their questions.

Some beneficiaries will be frightened by the Government's mailing, and without intending to be a sound alarmist, I am concerned what will happen come November. My experience tells me there will be a lot of questions. We need to make certain that someone is available to answer those questions.

Unfortunately, current funding is really in short supply. As you know, Congress appropriated 95 million for HCFA to provide education on Medicare+Choice. This translates into $2.44 per beneficiary. With these funds, HCFA must send out their mailing, establish a hotline, which at its peak is expected to handle 7.9 million calls, and maintain an Internet site. Limited or no funds at all are available to help beneficiaries who have poor literacy skills, who do not speak and read English, or who are cognitively impaired. How do we help those folks make an informed choice? Even the hotline is only going to have Spanish available. What about the other languages that people need?

The hotline staff will have approximately 7 minutes per call. I have counseled Medicare beneficiaries, and I am telling you, 7 minutes is not enough time sometimes to understand what the questions are, let alone to provide any answers.

A unknown number of beneficiaries will be referred to the ICA's and Area Agencies on Aging. My written testimony provides a number of examples of how these agencies do not have the resources to meet any new demands for help.

For example, the Area Agencies on Aging in Arlington, Alexandria, Fairfax, Prince Williams, and Loudon Counties each receive an annual $4,000 ICA grant. Even with additional funding, these programs are maxed out.

One of the best ICA programs, the Council on Aging in Tucson, AZ, receives ICA funding for a half-time position. They have a 15-year-old telephone system, and without added funding cannot provide additional help to beneficiaries.

It seems that in a program the size of Medicare undergoing such a profound change, a substantial up-front investment in education and counseling is needed. Without this investment, a large number of Medicare beneficiaries will be both frightened by the changes they do not understand and frustrated by their inability to get help with their questions.

I know it sounds alarmist, but it could be that choice will mean chaos if we do not do this right. I know this committee is very supportive of trying to get more money out there for counseling and education.

Thank you very much.

[The prepared statement of Ms. Dallek follows:]

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

Testimony Before the

Special Committee on Aging
United States Senate

on the subject of

"Consumer Information in Medicare+Choice"

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May 6, 1998

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INTRODUCTION

Mr. Chairman, Senator Breaux, and member of the Senate Special Committee on Aging, thank you for the opportunity to testify before you today on implementation of the consumer information provisions of the Balanced Budget Act of 1997. In February of this year, I began working at the Georgetown University Institute for Health Care Research and Policy as a Project Director of a Medicare+Choice implementation project. Prior to coming to the Institute, I was Director of Health Policy at Families USA and for five years, from 1991 to 1996, Director of the Los Angeles-based Center for Health Care Rights (CHCR). CHCR provides education, counseling and assistance to Los Angeles County Medicare beneficiaries, and is funded, in part, by the Health Insurance Counseling and Assistance (ICA) program.

In its 32-year history, Medicare has been largely dependent on traditional fee-for-service medicine. With the exception of the recent growth of Medicare contracting Health Maintenance Organizations (HMOs), the market oriented changes affecting the commercial health care industry have largely bypassed the Medicare program.

This is about to change. Provisions of the Balanced Budget Act (BBA) of 1997, especially those related to the Medicare+Choice program, will profoundly alter the Medicare program. The BBA establishes a Part C, Medicare+Choice program. Beginning later this year, beneficiaries will be able to obtain care from the existing Medicare fee-for-service program or a wide array of Medicare+Choice (Medicare+Choice) plans:

1. a coordinated care plan—an HMO with or without a point-of-service (POS) option, a Preferred Provider Organization (PPO), a Provider Sponsored Organization (PSO);
2. a private fee-for-service plan (PFFS plan); and
3. a medical savings account (MSA) and Medicare+Choice MSA plan.

In addition, the BBA authorized a substantial increase in Medicare capitation rates in local markets that could not previously attract HMOs, increasing the capitation rate by as much as 60 percent in some communities. These higher payments should significantly increase market penetration of Medicare HMOs (and the formation of other Medicare+Choice plans) in some parts of the country, providing the Medicare population for the first time with alternatives to the fee-for-service system.

Thus, the Balanced Budget Act of 1997 ushers in a new world for Medicare beneficiaries, one that affords more choice and market competition. In passing the BBA, Congress hoped that choice and competition would result in more informed individual purchasers, more competition between plans based on quality and costs, and a better functioning market. The degree to which this hope is realized will depend in part on whether consumers have the information they need to make an informed choice of plans and whether they are adequately protected from inappropriate marketing.

INFORMATION

The Medicare+Choice program is built on the assumption that beneficiaries will be able to make a choice of plans based on information on costs and quality. If the Medicare+Choice information is inadequate and/or confusing, or if plan marketing or insurance agents misrepresent or fail to adequately explain what plan enrollment means, then large number of beneficiaries could find themselves in Medicare+Choice plans not suited to their needs. Although for the next five years the Medicare population will be able to disenroll at any time from a Medicare+Choice plan, uninformed and misinformed enrollment causes serious disruptions in care.

The job of educating the Medicare population about the new choices that will be available is daunting. Understanding even basic differences in the benefits offered by HMOs in the current market is difficult. For example, a recent General Accounting Office report noted that "HMO brochures make comparisons difficult by using a variety of terms—such as 'preferred drugs,' 'covered drugs,' 'formulary drugs,' 'legend drugs,' and 'authorized drugs'—in describing their prescription drug benefit."[1] Further, the information provided by plans on benefits and contracting providers has sometimes been inaccurate or misleading.[2]

In addition to understanding differences in benefits and cost-sharing, beneficiaries will need to grasp how the different plans are structured and what plan design differences will mean for their health care. This requires a sophisticated analysis of Medicare+Choice options. How then will beneficiaries with poor literacy skills or with limited or no English proficiency handle this task?

BBA INFORMATION REQUIREMENTS

The BBA dramatically changes the amount of information beneficiaries will have to make a choice of plans. It requires the Secretary of Health and Human Services (the Secretary) to "broadly disseminate information" to "promote an active, informed selection" among Medicare+Choice plans.

> **BBA Information Requirements**
>
> - Requires annual HCFA publicity campaign (called a health fair) and mailing that includes comparisons of Medicare+Choice plans;
> - Requires Medicare toll-free hot line;
> - Requires Medicare web site plan comparison information; and
> - Requires Medicare+Choice plans to provide information.

At least 15 days before the annual November election period (and for new enrollees, 30 days before enrollment), the Secretary must mail to all 39 million Medicare beneficiaries general information on: (1) benefits, cost sharing and balance billing in Medicare fee-for-service; (2) election procedures; (3) beneficiary rights, including appeals and grievance procedures; and (4) Medigap and Medicare Select.

The mailing must also include a comparison of plans available to residents of the area for: 1) supplemental benefits; 2) premiums, cost-sharing and balance billing; 3) the service area covered by the plan; 4) access to out-of-network providers; and 5) quality and performance measures (disenrollment rates for the previous two years; Medicare enrollee satisfaction survey results; health outcomes; and plan compliance with BBA requirements). With this information, beneficiaries for the first time will have access to a range of quality of care indicators.*

Finally, the BBA requires the Secretary to establish a toll-free hot line number to respond to beneficiary questions about Medicare+Choice plans and to establish an Internet site where the public can obtain plan comparison information.

Medicare+Choice plans must supplement information provided by HCFA by giving enrollees and prospective enrollees information on the plan's service area; plan benefits and supplemental benefits; the number, mix and distribution of plan providers; out-of-network coverage (if any) and

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*Except for the enrollee satisfaction information, the quality and performance data will not be available during HCFA's first publicity campaign in November 1998. During this first year, the enrollee satisfaction data will only be available to enrollees through HCFA's Internet site.

any POS option; emergency services; prior authorization rules; plan grievance and appeals procedures; and a description of the plan's quality assurance program.

On request, plans must also provide information on how they control utilization and expenditures; the number of grievances, redeterminations, and appeals and their disposition; and a summary of how the plan compensates participating providers.

INFORMATION ISSUES FOR CONSUMERS

The need for unbiased information about Medicare+Choice plans and help for Medicare beneficiaries confused about the program may not be met because of:

- lack of HCFA resources to meet beneficiary information needs;
- lack of resources for community groups to provide education and counseling; and
- lack of critical information needed for informed enrollment.

Lack of HCFA Resources to Meet Beneficiary Information Needs

A great deal of education and counseling is needed to ensure informed choice. The Medicare+Choice program is complicated and many Medicare beneficiaries do not currently understand the traditional Medicare program. A recent survey by University of Oregon researchers conducted for the American Association of Retired Persons examined Medicare beneficiaries' understanding of the difference between Medicare HMOs and traditional Medicare in a number of markets with high Medicare HMO enrollments. The survey found that many beneficiaries lack the most basic knowledge about the program. One-third of respondents didn't know enough about traditional Medicare and Medicare HMOs to even minimally respond to the survey.[3] The challenge of providing simple information about complicated Medicare+Choice options will not easily be met.

Results from recent focus groups held by the National Academy of Social Insurance show that Medicare beneficiaries do not systematically compare their choice of plans; are generally recruited by direct sales approaches, including in-home sales presentations and breakfasts and luncheons sponsored by a particular plan; and tend to make decisions based on advertisements in newspapers and on information provided by people they know.[4] To move from this rather

haphazard system for choosing a plan to one where beneficiaries carefully compare their options requires significant education.

Unfortunately, the resources for this educational effort are not currently available. Although Congress initially authorized $200 million to educate Medicare beneficiaries in Medicare+Choice's first year, it appropriated only $95 million. This translates to approximately $2.44 cents per beneficiary per year. The required October mailing to all beneficiaries alone will cost approximately $25 million.

Literacy Skills Among the Elderly

Fifty-three percent of the Medicare elderly population fall into the lowest literacy level, where a person cannot read at all or can locate only one piece of specific information in short, uncomplicated text. Only two percent have the ability to explain, summarize, and interpret multiple pieces of information in lengthy and complex materials.

Source: U.S. Department of Education, *National Adult Literacy Survey*, 1992.

Out of the $95 million, *little or no money has been set aside for outreach and education to Medicare beneficiaries with low educational and literacy skills or who do not read English, for whom the mailing and Internet site will be meaningless.*

The potential number of Medicare beneficiaries seeking assistance to understand the array of new choices available may well inundate whatever systems have been established to help in this endeavor. For example, HCFA projects 7.9 million calls to the new HCFA Medicare+Choice hotline during October and November, 1998. To handle these call, HCFA hotline contractors will need to hire approximately 2800 to 3000 people.[5] This leaves approximately *seven minutes per call*, not enough time to answer the questions of many confused and perhaps frightened beneficiaries. Community organizations that currently operate their own Medicare hotlines report that it often takes seven minutes or longer to understand the exact concerns of the Medicare caller, let alone respond to these concerns.

Although many of the calls to the HCFA hotline will be referred to Medicare+Choice plans and to local community groups, training and quality control of hotline staff will be challenging.

Lack of Resources for Community Groups to Provide Education and Counseling to Medicare Beneficiaries

An unknown number of hotline calls, perhaps as many as two or three million, will be referred to local and state ICA programs, local Area Agencies on Aging and other non-profit

organizations that provide assistance to the disabled and elderly Medicare population. However, most of these organizations have very small staffs and a few volunteers and, even the best funded of them, are not able to handle the current demand for their services. The Center for Health Care Rights often receives more calls than it can handle by 11:00 A.M. and the New York-based Medicare Rights Center's hotline is available to take calls only four hours a day, four days a week.

The National Association of Area Agencies on Aging similarly reports that its agencies do not have the resources to meet the expected demand for Medicare+Choice education and counseling. For example, the Area Agencies on Aging in Arlington, Alexandria, Fairfax, Prince Williams, and Loudoun counties each receive an annual $4,000 ICA grant to fund their Medicare education and counseling services. The Arlington Triple A reports that its ICA grant funds one staff for *5 hours a week*. When this staff person is sick or on vacation, there is no one at the agency who can respond to calls or refer callers to volunteers for help. The Director of the Agency believes that Medicare+Choice calls could be the proverbial "straw that breaks the camel's back."[6]

The Pima Council on Aging in Tucson, Arizona similarly reports that it does not have the staff to currently respond to all Medicare beneficiaries inquiries. The program's ICA grant funds one staff member for eight hours a week, another for 12 hours a week. Although the program receives funding from other sources, according to one staff, the agency is "maxed out" and lack of resources and a 15-year-old telephone system will make it impossible for the agency to adequately serve the expected increase in Medicare callers.[7]

Both the Institute of Medicine[8] and the National Academy of Social Insurance have emphasized the importance of ICAs and organizations like them in translating Medicare information to beneficiaries. Their use of volunteers to provide one-on-one counseling is especially effective in educating elderly clients.

Lack of Some Critical Information to Make an Informed Choice

The BBA requires the Secretary to provide a range of information not previously available to the Medicare population to promote informed choice. The comparison chart or "report card" of Medicare+Choice plans is especially important. Beneficiaries will have, for the first time, information on disenrollment rates, enrollee satisfaction and some quality-of-care measures.

However, the BBA does not require Medicare+Choice plans to provide information that is critical to enrollees and prospective enrollees, especially those with chronic and disabling conditions. Specifically, plans are not required to provide an up-to-date listing of all contracting providers with information on their specialty, their ability to see new enrollees, and whether they speak languages other than English. Nor are they required to provide information, upon request, about whether a specific prescription drug is in a plan's formulary. Finally, the BBA does not require plans, as do a number of state managed care consumer protection laws, to provide upon request the clinical guidelines and protocols for the treatment of specific illnessess and chronic diseases.

MARKETING

Inappropriate marketing can undermine even the most thoughtful educational efforts. Problems with HMO marketing have long plagued the Medicare program. Advocacy organizations,[10] the General Accounting Office,[11] and the Inspector General[12] have time and again raised concerns about HCFA's failure to institute reforms to ensure that marketing problems are kept to a minimum. Plan marketing agents have lied about the "advantages" of Medicare HMO enrollment, obtained beneficiary enrollment signatures under false pretenses, forged signatures, and in other ways misled beneficiaries into joining an HMO.

Plans With the Highest Disenrollment Rates

- plans with small enrollments;
- newer plans;
- for-profit plans.

Source: Families USA, *Comparing Medicare HMOs: Do They Keep Their Members?* (Washington D.C.) December 1997.

High disenrollment rates and high "rapid disenrollments" are signs of marketing problems. Rapid disenrollments are disenrollments that occur within three months of enrollment. Medicare HMOs vary dramatically in the percent of enrollees who quit a plan and who do so within three months of enrollment. However, one recent study found that some plans have excessivly high churning rates—with almost as many Medicare beneficiaries quitting a plan as joining.[13] Learning to market to the Medicare population, a significant proportion of whom have never been in a managed care plan, takes time and resources. Add to this mix the fact that insurers will be marketing a range of plans they have never marketed

before to a population with a significant numbr of individuals with low literacy levels and cognitive and physical impairments and we could see an explosion of marketing problems.

BBA Marketing Requirements

The BBA continues the current HCFA practice of allowing plans to market directly to enrollees. Plans must submit marketing and "application forms" to the Secretary for review 45 days before distribution. If no action is taken, these materials are deemed approved. Marketing and application forms will be "disapproved" if they are "materially inaccurate or misleading or otherwise make a material misrepresentation."

If one regional office approves marketing materials, they are deemed approved for all other areas in which the plan markets, except for information, such as premiums or cost-sharing, specific to the area. The Secretary may, but does not have to, prohibit plans or their marketing agents from completing any portion of the application form on behalf of an individual. Finally, plans may not offer cash or rebates as an inducement for enrollment.

BBA Marketing Requirements

- Allows plans and the marketing agents in their employ to market directly to beneficiaries and may allow marketing by independent insurance agents;
- Approves marketing materials for all areas covered by the plan unless disapproved within 45 days;
- Prohibits plans from offering money to encourage enrollment;
- Allows, but does not mandate, the Secretary to prohibit plans and plan marketing agents from completing application forms; and
- Mandates a three-year demonstration project to evaluate the use of an independent contractor for Medicare+Choice enrollment and disenrollment.

The BBA does not address whether independent insurance agents can market Medicare+Choice products directly to beneficiaries, as they currently do with Medigap and long-term insurance policies. It does, however, mandate the Secretary to conduct a three-year demonstration project to evaluate the use of a third-party contractor to conduct Medicare+Choice enrollment and disenrollment functions.**

**Because of serious marketing fraud in the Medicaid managed care program, a number of states currently prohibit plans from directly marketing to Medicaid beneficiaries. Large employers and employer purchasing alliances also generally assume the role of providing information to their employees and coordinating enrollment.

MARKETING ISSUES FOR CONSUMERS

The BBA legislation fails to address a number of potential marketing concerns:

- direct marketing by plans and individual insurance agents;
- review of marketing materials; and
- marketing to vulnerable and cognitively-impaired Medicare beneficiaries.

Direct Marketing by Plans and Independent Insurance Agents:

As noted above, direct marketing to Medicare beneficiaries by plans and their marketing employees has been problematic. In addition, the Secretary has indicated that she may remove the current prohibition on reimbursement to independent insurance agents marketing in the Medicare+Choice arena.[14] Based on the history of marketing fraud in the Medigap and long-term care insurance markets,[15] permitting marketing of Medicare+Choice products by independent insurance agents may undermine efforts to promote informed enrollment.

Review of Marketing Materials

The proliferation of plans will make it difficult for HCFA's regional offices to adequately review the application forms and the range of marketing materials and print, radio and television advertisements submitted to them. HCFA's regional offices have different levels of experience in assessing marketing materials. The new BBA provision that permit marketing materials to be used in all HCFA regions if they have been approved by only one regional office will tie the hands of other regional offices that find a particular piece of approved marketing material or advertisement inaccurate or otherwise objectionable.

Marketing to Vulnerable and Cognitively Impaired Medicare Beneficiaries

Medicare faces two opposite and equally serious problems in the marketing of Medicare+Choice plans to the disabled and chronically ill Medicare population. On one hand, the program is concerned that plans will "cherry pick," marketing only to the healthier Medicare population.

> **What's in a Name?**
>
> The names given to HMO Medicare products, such as "Golden Medicare Plan," "Senior Secure," "Shield 65," "Golden Outlook," and "Secure Horizons," imply that these plans only enroll the elderly, excluding the under 65 Medicare disabled population.

Indeed some evidence exists that HMOs subtly encourage healthier middle- and upper-income Medicare beneficiaries to join, while discouraging enrollment of disabled and lower-income beneficiaries. A recent study of HMO marketing and advertising indicates that plans appear to market to the physically-active Medicare population, ignoring under-65 disabled beneficiaries. The report also documents examples of marketing presentations conducted in buildings that are not handicap accessible nor accessible by public transportation.[16] These findings indicate that HMOs may be in violation of HCFA marketing guidelines requiring that "beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach."[17]

On the other hand, advocates who work with the frail elderly and disabled Medicare population worry that this population will be improperly enrolled by marketing agents who receive a commission for each new enrollee. Informed enrollment is also more difficult for the large number of Medicare beneficiaries with low literacy or English proficiency skills.

The enrollment of the dual-eligible Medicare/Medicaid population in Medicare+Choice plans poses significant educational challenges. Many dual-eligibles, as well as the Medicare+Choice plans that enroll them, will not understand how the two programs coordinate care. How premiums will be paid, whether Medicare+Choice plans can charge a dual-eligible enrollee co-payments, and how a dual-eligible enrollee will obtain coverage for prescription drugs or dental care once the Medicare+Choice plans' limits on these benefits is reached, is not clear. Advocacy organizations report that even HMOs that have been enrolling Medicare beneficiaries for a number of years do a poor job of coordinating between Medicare and Medicaid.[18]

In focus groups of California Medicare beneficiaries sponsored by the National Academy of Social Insurance, dual-eligible participants reported that they believed they had to disenroll from managed care plans so they could get Medicaid prescription drug benefits.[19]

The BBA fails to include one basic protection for vulnerable beneficiaries who join a plan without understanding the implications of their enrollment—retroactive disenrollment. Medicare currently permits Medicare beneficiaries to "retroactively disenroll from an HMO if they did not understand, or were misinformed about, the terms of enrollment. A retroactive disenrollment is like an annulment. The marriage (or, in this case, the enrollment) never took place. Retroactive

disenrollment returns the beneficiary to traditional Medicare effective the first day of HMO enrollment, thus voiding the enrollment altogether.

CONCLUSION

The Medicare+Choice program offers the opportunity to provide Medicare beneficiaries for the first time with information needed to make an informed decision about their health care. Unfortunately, with this opportunity comes risk—the risk of information overload, the risk of large numbers of Medicare beneficiaries confused about their choices, and the risk of misinformed enrollment and marketing abuse. These risks can be reduced by a carefully calibrated and coordinated educational and monitoring effort. If this effort is unsuccessful, we could find that "choice" really means chaos.

INFORMATION AND MARKETING RECOMMENDATIONS

FUNDING

✔ Congress should provide the additional funds recommended by Senators Grassley, Breaux and Glenn of the Senate Aging Committee to HCFA and to the ICAs for expanded Medicare+Choice education and assistance.

INFORMATION

✔ The Secretary should consider requiring the standardization of all terms used in marketing.

✔ The Secretary should consider requiring plans to provide enrollees (and prospective enrollees on request) with:

- ✔ a list of participating providers, updated quarterly, that includes their specialty, their ability to accept new Medicare+Choice enrollees, and languages spoken other than English. In addition, the Secretary should require plans to provide this information, updated weekly, on their web sites;
- ✔ plan procedures for approving a non-formulary drug, and, on request, information about whether a particular drug is on a plan's formulary. The Secretary should also

consider requiring plans to provide a list of covered prescription drugs on their web sites;

- ✔ on request and to the extent available, plan clinical guidelines or protocols for the treatment of specific diseases or illnesses.

MARKETING

✔ If funding is available, the Secretary should provide all HCFA regional staff with training on how to review the Medicare+Choice marketing materials.

✔ If the Secretary allows independent insurance agents to market directly to Medicare beneficiaries, Congress and the Secretary should assess which of the Medigap insurance marketing reforms, including limits on agent commissions, might be appropriate for the Medicare+Choice program.

✔ The Secretary should prohibit marketing and insurance agents from filling out Medicare+Choice application forms.

✔ The Secretary should consider a range of regulations to prevent marketing problems:

- ✔ prohibit agent compensation until a beneficiary has been enrolled in a Medicare+Choice plan for three months;
- ✔ require standardized training of anyone selling a Medicare+Choice product;
- ✔ mandate independent verification of Medicare+Choice enrollment; and
- ✔ require plan enrollment forms to be translated in a beneficiary's primary language.

OTHER

✔ The Secretary should continue the current practice of allowing Medicare+Choice enrollees to retroactively disenroll if they did not understand or were misinformed about the terms of enrollment.

✔ The Secretary should consider establishing specific rules relating to the education and enrollment of dual-eligibles Medicare/Medicaid beneficiaries.

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The CHAIRMAN. Thank you.
Mr. Abernethy.

STATEMENT OF DAVID S. ABERNETHY, SENIOR VICE PRESIDENT, PUBLIC POLICY AND REGULATORY AFFAIRS, HIP HEALTH PLANS

Mr. ABERNETHY. Mr. Chairman, Senator Breaux, it is a pleasure to be here. I represent HIP Health Plans, which was founded 51 years ago as the Health Insurance Plan of Greater New York. Everybody else called us "HIP," so we decided we might as well call ourselves that, too.

We have been in the Medicare business virtually since the inception of Medicare. We are also in the Medicaid business. We have health plans in New York, New Jersey, Florida, and Pennsylvania. We currently serve about 110,000 Medicare beneficiaries. We also serve almost 100,000 Medicaid beneficiaries, and I guess I should note, given the way the conversation has gone, we have about 50,000 Federal employees in our health plans.

We have been very successful in the recent past in marketing our Medicare product. It has grown very rapidly. I was noting the statistics in the GAO book seem out of date as we have gone from about 65,000 Medicare beneficiaries about a year ago to about 110,000 today.

We are aware of the changes in the Balanced Budget Act, but I might note that with the perspective of 30 years of activity in Medicare, there are currently 11 HMO's offering Medicare risk products in New York City. There are nine in South Florida. We have had a lot of choices out there in front of the senior citizen population, and at least thus far a disaster has not appeared to occur.

Marketing to the Medicare population is a difficult problem, however. We already have an extensive education and marketing program to ensure that our beneficiaries understand their benefits and rights under the Medicare program. We are working hard to make any necessary changes to ensure that beneficiaries will be informed about their choices once Medicare+Choice becomes operational.

We recognize that a well-educated member benefits both the plan and the beneficiary. Quite frankly, with the focus on disenrollment rates, it is very penny-wise and pound-foolish to a health plan to spend the kind of money that is required to market to senior citizens only to have them disenroll very quickly after you have signed them up. So it is very, very important to assure that beneficiaries understand very, very clearly what those rights and responsibilities are.

For example, in New York City, HIP has been characteristic, traditionally, a group model HMO. Most of our services have been provided through HIP-operated medical centers. If the beneficiary does not understand that and assumes that they are going to be able to continue to see the doctor they have perhaps seen in the past, when they join HIP they are going to be unhappy. So we work very hard to make sure that before you sign up with our health plan, you understand what the limitations and restrictions of it may be.

HIP provides all Medicare beneficiaries with a handbook, which I hope you have before you, explaining how to get services within an HMO and an explanation of benefits. Our member handbook is

written in plain English and, I might note, seven other languages, including Russian, a couple of dialects of Chinese, Japanese, Korean. I cannot quite recall. If you see on the back, if you can read all that, you will know which languages it is in. I think Polish might be one of them. It is designed to help a new member understand our system.

It tells the beneficiary about choosing a primary care physician, accessing emergency services, disenrollment procedures, methods for accessing mental health coverage, prescription drug benefits, and preventive health services.

In an effort to assist members with any question he or she might have after enrollment, we operate a toll-free number which is 1–800 HIP-TALK, which is operational from 8 a.m. to 8 p.m., Monday through Friday. This hotline is staffed with customer service representatives who are trained to answer any question a beneficiary may have.

In addition to our member handbook, we provide our Medicare members with other information to make them feel comfortable in the system. These items include a Medicare question and answer book, a list of participating physicians, a copy of the Medicare contract, and guides to dental, optical, and prescription drug benefits. Our goal is to assure that our members have the information they need to access all essential health services.

Our advertising includes a strong educational component. We use television, radio, and direct mail, all of which are approved by the Health Care Financing Administration.

Our direct mail efforts are our most comprehensive marketing tool and provide the beneficiary with the most information. We send several mailings to beneficiaries in our service areas. They are designed to be concise, easy to read, and educational in content. We do not put a lot of specific substantive information, but rely upon the transmission of prominently displayed 800 numbers for beneficiaries to call for additional information.

We work hard to ensure our sales representatives are ethical. We track them very carefully, and, incidentally, we track disenrollment rates by marketing representative in order to assure that we are not having somebody going out and saying the wrong things. We also send supervisors out on a periodic scheduled with our marketing representatives to listen specifically to what they have to say.

Let me just conclude by saying that given the way the conversation has gone, we certainly would not object to the idea of working out standard descriptions and standard formats to describe our benefits, to describe how we deliver our benefits, so that beneficiaries could compare our health plans to others. We would have no objection to working with the Health Care Financing Administration to develop an FEHBP-type format, similar to the booklets that all Federal employees receive and with which we have experience.

I might note a major difference between FEHBP and HCFA is that in the case of Federal employees, we work with OPM to develop the booklet. We have the right to review the content of the booklet—and we argue back and forth somewhat about it, but our advertising, unlike Medicare, is not approved by OPM. So there is a difference there. We would have no objections to a comparative

chart, and we would have no objections to trying to work with the Health Care Financing Administration on common graphic description of benefits.

We have a longstanding history through our trade association, and it's Medicare Industry Council of meeting with the Health Care Financing Administration to work out precisely these kinds of details, and, again, I do not believe that anyone would have an objection to working that through.

Thank you, Mr. Chairman. I appreciate the opportunity to testify and I hope I am able to answer any questions.

[The prepared statement of Mr. Abernethy follows:]

DAVID S. ABERNETHY
Senior Vice President
Public Policy and Regulatory Affairs

STATEMENT

OF

DAVID S. ABERNETHY
SENIOR VICE PRESIDENT
PUBLIC POLICY AND REGULATORY AFFAIRS

HIP HEALTH PLANS

BEFORE

THE SENATE SPECIAL COMMITTEE ON AGING

MAY 6, 1998

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INTRODUCTION

Mr. Chairman, My name is David Abernethy and I am Senior Vice President for Public Policy and Regulatory Affairs of HIP Health Plans. I am in charge of HIP's government relations and regulatory affairs, including overseeing compliance with Medicare marketing rules. I am very pleased to be here today to talk about issues relating to beneficiary education and marketing to Medicare beneficiaries.

HIP Health Plans is a not-for-profit HMO that was formed 51 years ago as the Health Insurance Plan of Greater New York. Everyone has always referred to us as HIP, so we have adopted that as our name. We operate in New York, New Jersey, Florida, and Pennsylvania. In New York and New Jersey, HIP operates as a mixed-model HMO providing care to our members through freestanding medical centers and through neighborhood physicians. In Florida and Pennsylvania, HIP operates as an independent practice association model HMO contracting with individual doctors serving in private practice. We have more than 1.1 million members in our system.

HIP has a great deal of experience in Medicare having participated in the program since the late 1960s. HIP Health Plan of New York received its Medicare risk contract in 1987, HIP Health Plan of Florida received its risk contract in 1995 and HIP Health Plan of New Jersey was approved as a risk contractor in 1996.

Through its risk contract, HIP offers our members benefits that fee-for-service Medicare does not provide, including prescription drugs, eyeglasses, dental care, and transportation to doctor visits without the added premiums of a Medigap policy. We have found these products to be very popular among the public. HIP has seen its enrollment in Medicare risk contracts increase in the past two years from 67,000 to almost 100,000 members. The number is growing each month and we expect that trend to continue.

The enactment of the Balanced Budget Act of 1997 and the implementation of the Medicare+Choice program offers great opportunities for both health plans and beneficiaries by greatly expanding consumer choice. Under Medicare+Choice, beneficiaries have the option of staying in the traditional Medicare fee-for-service program or choosing to join an HMO, a provider sponsored organization (PSO), medical savings account (MSA), preferred provider organization (PPO), or a private fee-for-service plan.

While expanding options will give consumers more choice, it will also require health plans and the Health Care Financing Administration (HCFA) to do more to differentiate our products to Medicare beneficiaries. Consumers will need to understand the differences between the new offerings so that they can determine which product works best for them. HCFA plans to start an open season and beneficiary education process in November 1998 which should help inform Medicare beneficiaries about their new health care options. HIP already has an extensive education and marketing program to ensure that our beneficiaries understand their benefits and rights under the Medicare program. We are working hard to make any necessary changes to ensure that beneficiaries will be informed about their choices once Medicare+Choice becomes operational.

HIP BENEFICIARY EDUCATION PROGRAMS

Traditionally, HIP's Medicare population has consisted mainly of people who have "aged in" to our Medicare product. This means that they were long-time HIP members who switched from a commercial or individual product to Medicare upon becoming eligible for Medicare. These people are familiar with HIP and require little education about navigating our system.

As the popularity of Medicare HMOs has increased in recent years, we have started to enroll a larger number of Medicare members who are new to HMOs and therefore not familiar with the HIP system. HIP is committed to ensure that its products are represented in an ethical manner. Our sales force is trained to focus on educating the beneficiary about the HIP system prior to enrollment. We recognize that a well-educated member benefits both the plan and the beneficiary. Our sales representatives help explain to beneficiaries about the basics of an HMO including the role of the primary care physician, the need to get many services within our network, and the benefit package offered by HIP.

HIP provides all Medicare beneficiaries with a handbook, which you have before you, explaining how to get services within an HMO and an explanation of benefits. Our member handbook is written in plain English and is designed to help a new member under the HIP system. The handbook tells the beneficiary about choosing a primary care physician, accessing emergency services, disenrollment procedures, and methods for accessing mental health coverage, prescription drug benefits, and preventive health services.

In an effort to assist members with any question he or she might have after enrollment, HIP operates a toll free number, 1-800-HIP-TALK, which is operational from 8 a.m. to 8 p.m. Monday through Friday. This hotline is staffed with customer service representatives who are trained to answer any question a beneficiary may have.

In addition to our member handbook, HIP provides its Medicare members with other information to make our beneficiaries feel comfortable in the HIP system. These items include a Medicare question and answer book, a list of participating physicians, a copy of the Medicare contract, and guides to dental, optical, and prescription drug benefits. Our goal is to ensure that our members have the information they need to access all essential health services.

MARKETING ACTIVITIES

HIP believes that marketing can only be successful if it also educates the consumer about managed care and we design our marketing activities to have a strong educational component. Our marketing activities in Medicare include the use of television, radio, and direct mail and are all approved by the Health Care Financing Administration (HCFA).

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Our direct mail efforts are our most comprehensive marketing tool and provide the beneficiary with the most information. Under the direct mail campaign, an initial mailing is sent to all eligible Medicare beneficiaries followed by a mailing to the people who did not respond to the initial mailing. A third piece is mailed to respondents who met with a representative, but did not enroll. All mailings are designed to be concise, easy to read and educational in content. We do not overload the materials with information because we find this confuses the beneficiary and is not effective. Instead, we prominently display an 800 number which beneficiaries can call to obtain additional information. These 800 numbers differ based on the location of advertising campaign to ensure that beneficiaries receive easy and accurate answers to their questions.

The representatives on the 800 number use approved HCFA telemarketing scripts to respond to inquiries. While they can answer many basic questions, customer service representatives can also arrange one-on-one meetings with a plan representative to address specific questions and personal issues the beneficiary may have. We find these sessions very effective because they allow more time to help educate the Medicare beneficiary on the HIP system and permit the person to compare their existing coverage with our benefits.

HIP works hard to ensure that our sales representatives have the highest ethical standards. We review all applicants on the basis of previous employment and experience with a product focussed on individuals and senior citizens. HIP places a great deal of emphasis on the training of sales representatives and we work hard to ensure its comprehensiveness.

New sales representatives start their instruction with a one-month program consisting of State Licensure Training, which must be received prior to field sales work, followed by a week of intensive product training. This program includes instruction in HCFA marketing guidelines, HIP marketing guidelines, plan designs, senior sensitivity training, educational presentation techniques for both group and individual settings, and many other components that will aid in the professionalism and effectiveness of a representative marketing to Medicare enrollees.

Upon graduation from these initial courses, HIP sales management will spend the next two weeks working individually with the new sales representative. Field sales supervisors will accompany the new representative during this period and monitor their presentation to ensure consistency with the guidelines that HCFA and HIP have established as best practices.

Once the sales representatives are in the field, HIP has a tracking system, which permits the plan to track its sales representatives by region, territory, product line, and individual representative. This information allows us to monitor the individual areas of the sales cycle from disenrollment prior to effective date, rapid disenrollment, and the number of grievances filed against an individual representative. It is essential to monitor these results monthly to ensure that representatives are working within established guidelines of the company and are not engaging in unethical activities. Any unusual results in any area or by a particular representative could be the sign of a problem and would trigger an inquiry. If a problem is discovered, the marketing representative would either be required to undergo further training or could be terminated depending on the gravity of the infractions.

NEW INITIATIVES

HIP has found that our current activities, while thorough, are not comprehensive enough to make some members feel comfortable in an HMO setting. HIP has determined that we need to continue to stay in contact even after a member has signed up and been a plan member for some period of time. In an effort to be more customer friendly, we have developed and are in the process of implementing a multi-pronged approach to help educate our members and make them feel at home in the HIP system.

Upon enrolling as a HIP Medicare member, the new enrollee will receive a call to welcome them to the plan and answer any questions which may have arisen since the person decided to join. Thirty days after enrolling, the person will receive another call to ensure that the person has chosen a primary care physician, is receiving all necessary care, and answer any questions which have arisen since enrollment. Sixty days after enrolling in HIP, the person will receive yet another follow-up call. These calls serve as an opportunity for us to provide needed customer service and to provide any assistance the beneficiary needs.

HIP is also establishing New Member Orientation meetings, which will be offered on top of our other education programs. This orientation will be designed to walk the member through the operations of the plan and explain the best and most convenient ways to access services. We plan to discuss the role of a primary care physician, methods for obtaining referrals for services, utilization of our health care centers, access to the new and expanding network of community based providers, and many other things that are routinely raised by our members. We expect this New Member Orientation to add another level of comfort to our new members.

RECOMMENDATIONS

Beneficiary education programs are an important part of any successful Medicare product. With over 30 years experience, we have learned a great deal about the best way to inform Medicare beneficiaries about our products. As Congress and HCFA work on ways to inform beneficiaries about the new options available to them under Medicare+Choice, we have some suggestions on how you can best inform them about their options.

1. Keep It Simple – Medicare beneficiaries consume large amounts of health care services and are fairly knowledgeable on the subject. However, that does not mean you should give them brochures with lots of technical terms or overload them with information. We have found that our materials are best received when they are concise and to the point. Medicare enrollees are very good about calling when they need more information than is provided in a handbook or brochure.

2. 800-Number – It is important for senior citizens and other Medicare eligibles to have someone to call should they have questions about their choices. Our 800 number has been well received and has given Medicare enrollees a comfort level that someone is there to answer their questions. It is important that the 800 number be staffed with people who are courteous and are able to answer questions. Nothing frustrates people more than being given a number that does not provide the information they are seeking.

3. Flexibility – In the information age, technology and methods of communication change rapidly. The Internet, television, radio, and specialized magazines give people much more information about their health care choices than in the past. This plethora of information requires health plans to be more innovative than ever in its beneficiary education program. HIP is constantly working to update and improve our marketing and education program. Any beneficiary education effort from HCFA has to be designed in a way that will allow for easy modifications so that it can keep up with changes in technology and communication.

4. Evaluation - It is important that any beneficiary education program be evaluated to determine its effectiveness. We conduct surveys of our members to measure our customer service including marketing and education programs. It is important that any beneficiary education program HCFA develops undergo a similar evaluation from the GAO or another outside source to ensure that it is accomplishing its goal.

CONCLUSION

With Medicare+Choice becoming operational within the next six months, it is more important than ever that both health plans and HCFA give Medicare enrollees good, accurate, and helpful information so that they can make informed choices. We believe that HIP's 30-plus years of experience in Medicare gives us a unique perspective on educational and marketing materials and we hope you found our insights and observations helpful. We look forward to working with you, as the Medicare+Choice program becomes operational. I would be happy to answer any questions you might have.

The CHAIRMAN. Mr. Abernethy, you already have answered a couple of questions I had for you. So I will start with Ms. Dallek.

In your experience running the Insurance Information Counseling and Assistance Program in California, what do you think HCFA can do to help ICA's with the new information campaign?

Ms. DALLEK. You know, I came from one of the better educated—probably the largest ICA in the Nation. It was funded in part by the State as well as the ICA Federal program.

I think that there does need to be an educational campaign for the ICA's so that they have the information by which to educate and counsel Medicare beneficiaries. Remember, most of these ICA's use volunteers, and there needs to be a fair amount of lead time to educate the volunteers to provide the information and counseling to beneficiaries. But I honestly believe right now that without extra funding, these ICA's will not be able to do a good job.

My old program sometimes has more calls that it can handle by 11 a.m. in the morning. When this happens the program takes some additional calls, and refers them out to the volunteers. But when a Medicare beneficiary calls, it is not good enough to get back to them in 3, 4, 5 days. The center for Health Care Rights would get back to callers the same day, and they were very grateful for that same-day response.

There does need to be some more money out there in the community because folks are going to be calling with questions. I do not see how we are going to provide adequate assistance to the monolingual population and the hard-to-reach population, who will receive a mailing from their government and not know what it means.

The CHAIRMAN. Dr. Kleimann, you discussed information overload in your testimony. I think you made that very clear. Certain beneficiaries in urban areas have a choice of 17 plans. How do you recommend the information from these plans be presented in what you consider a simple and understandable manner, then? You have heard Senator Breaux and I advocate the use of comparative charts that from your point of view were still probably too complicated.

Ms. KLEIMANN. Yes. I think there is a variety of ways that you want to approach it, and I want to flip your question from the design issue to the testing issue.

The testing that—HCFA has invested a great deal of money in testing things cognitively. What that—and it is an important step because what it helps us to see is whether or not people understand the concepts. That is the whole idea behind standardizing the language and trying to make sure that at least some of the terms are going to be exactly the same.

When we do usability testing, we really try to set people up in a way in which they are actually using the materials and we are in a position to observe without interrupting them, without probing, "What are you thinking about," "What are you doing right now." We are watching them use this information, and then we debrief them on how they have used it.

The idea of using charts and tables certainly is probably the most useful way to present that information, but the detail that goes into planning a chart or a table can be as subtle as whether or not this is highlighted, what kind of a font we have, how large

is the font, is the information set up within a box, parallel, across the different types of plans or across the different plans, have we grouped plans into fee-for-service or HMO or POS. So there is a lot of information.

It is not that the idea of a table in and of itself is complicated. It is all of the real minute detail that has to go into this to be able to make it comparable.

Now, I am working with the Harvard Medical School and RAND Corporation on the CAHPS project that people have referred to. We are trying to get the same kind of information from one health plan to the next health plan to the next health plan, so that it is even in parallel form so that we can get it in parallel form. It is truly a daunting task.

So the charts are an important way of going, but we do have to go back and test this in terms of usability to make sure that we have chosen the design elements correctly.

I hope that answers your question.

The CHAIRMAN. Very much so, and it surely clarifies one of the misunderstandings I had from your testimony. I thought that you did not think a chart was the appropriate manner to present some of the information Medicare will provide.

Ms. Dallek, regarding your concern with direct marketing due to fraud in the Medigap program, do you think that HCFA should be the sole distributor of information regarding Medicare+Choice? HCFA does not have the resources to do it all. What other options could you suggest regarding the distribution/marketing of material? This question obviously considers your point that more money needs to be made available.

Ms. DALLEK. I am concerned about the potential for marketing problems. Disenrollment studies—and I did one last year when I was at Families USA—show vast differences in disenrollment rates by plans. Florida and Texas, for example continue to have very high disenrollment rates. When you look at the data, some plans have very high disenrollment rates, lots of churning, people enrolling, but disenrolling again very quickly, which implies that there is a serious marketing problem.

I am also concerned that independent insurance agents will be allowed to market Medicare+Choice plans, and that we could begin to see some of the same problems we saw with Medigap and long-term care insurance marketing.

So what would I like to see? Under the Balanced Budget Act, there is going to be a test of an enrollment broker for Medicare where the enrollment broker will be doing the enrollment. I would like us to consider that as an option. A number of States have used an enrollment broken in their Medicaid program. Sometimes it has worked well. Other times, it has been more problematic, but I would like us to really look at this option. Short of this, I would like us to think about ways we can address the issue of inappropriate marketing. There is training that could be done. HCFA could prohibit marketing agent from receiving any commission unless someone stayed enrolled for 3 months. This provision would make marketing agents more careful about what they told beneficiaries. I have a lot of recommendations in my testimony.

The CHAIRMAN. Thank you, Ms. Dallek.

Senator Breaux.

Senator BREAUX. Well, I thank all three. I want to, first, Mr. Chairman, put in a letter from the Ochsner Health Plan of Louisiana, which comments on what we are talking about and make it a part of the record.

The CHAIRMAN. We will include—

[The information referred to follows:]

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May 5, 1998

The Honorable John Breaux
Ranking Member
U. S. Senate Special Committee on Aging
628 Hart Senate Office Building
Washington, DC 20510

Re: HCFA Educational Efforts

Dear Senator Breaux:

Ochsner Health Plan (OHP) appreciates the opportunity to provide comments to you and the U.S. Senate Special Committee on Aging. We are encouraged that you, as the Ranking Member of the Special Committee, have solicited our input.

OHP supports the efforts of the Health Care Financing Administration to inform Medicare individuals of the choices they have regarding their Medicare benefits. It is our position, that for Medicare individuals to benefit from the expanded options available to them, they must truly understand these options. Ochsner Health Plan feels that an uninformed choice is really no choice at all.

We are pleased to report that OHP has a favorable voluntary disenrollment rate. One reason for the favorable disenrollment rate is the effort we exert to fully inform our members of how to access benefits through Total Health 65 (OHP's Medicare HMO). We submit the following comments and suggestions as the largest Medicare HMO in Louisiana with over three years of experience.

Educating Members

OHP takes great care in educating our Medicare HMO prospects and members. During a consultation with a Medicare individual, our sales representatives will often spend up to an hour or more explaining the benefits of Total Health 65. Then, once we receive an application from a prospective member, we conduct a phone verification of each applicant to confirm awareness of what a Medicare HMO entails. Finally, once an applicant is confirmed as a member, they are then invited to attend a new member orientation. During the orientation, the member is once more informed of how to access services through our Medicare HMO. In spite of these multiple explanations of plan procedures, we encounter members who do not access services properly.

Senator John Breaux
Page 2.

During focus group discussions with members and Medicare individuals, we have found that one reason why members do not access services properly is that programmatic jargon confuses them. For example, while HCFA prefers the use of "enrollment" and "disenrollment" in literature to explain how members can join and disjoin a Medicare HMO, the focus groups found that people better understood the terms "beginning" and "canceling."

Explaining Greater Choices

In light of the above, OHP encourages and supports HCFA's role in informing Medicare individuals of the choices they currently have and the expanded choices they will have in the near future. However, we are concerned that Medicare individuals may become overwhelmed by the enormous quantity of material and information that may be required to inform them of all their options. Medicare individuals will need to consider more options than ever before, including the following: 1) the traditional Medicare program, 2) Medicare supplemental coverage, 3) Medicare Select, 4) Medicare HMOs, 5) Social Medicare HMOs, 6) Medicare PSOs, 7) Medicare MSAs, and 8) other Medicare demonstration projects.

While the increased options provide for greater coverage opportunities for Medicare individuals, they also create a significant challenge for HCFA and plans participating in the Medicare program to communicate these options adequately and without confusion. The legal and programmatic language that is often used to explain health coverage issues is confusing and unintelligible to Medicare individuals and the general public alike.

Confusion Leads to No Choice

If Medicare individuals are overwhelmed by information, both the local Social Security offices and the plans will be inundated by inquiries from Medicare individuals and members who may be troubled by the information they receive. When this large amount of information is combined with the complexity of the options and the extreme personal nature of health coverage, it is easy to understand how overwhelming the information may become.

OHP has found through focus groups and through individual contact with our members and Medicare individuals that if they are confused or overwhelmed, they tend to make no choice at all other than to continue with the traditional Medicare program. Therefore, the outcome of the increased informational campaign may actually lead to less Medicare individuals exercising their new choices instead of more individuals taking advantage of these new options.

Senator John Breaux
Page 3.

Start with an Overview

The experience OHP has had in the Medicare HMO market tells us information should be presented in a clear and concise manner that avoids programmatic jargon. Additionally, we have found it is best to provide a more general overview to introduce a complex concept and then to follow-up with more detailed information. For example, our member handbook provides a general overview, in the introduction, explaining how Total Health 65 works. Then, using a reference index, the handbook provides further details of the plan in the following chapters, once the member has been exposed to the general concepts.

Given the above experience, we suggest that HCFA provide Medicare individuals with a general reference guide regarding the options available to them. This guide could then refer them to other materials that would provide more detailed information on whichever subject they choose. This approach would allow Medicare individuals to focus on the options that most appeal to them without having to process extraneous information. This approach should allow Medicare individuals to direct their attention to the information that will best lead them to an informed choice.

Summary

In summary, OHP supports the dissemination of information that assists Medicare individuals in making an informed choice. However, overwhelming Medicare individuals with a profusion of extraneous information can negate the benefit provided by greater choice.

We appreciate the opportunity you have given us to provide comments on this critical topic. If you or your staff have any questions, please let me know. I can be reached at either the address listed on the letterhead or by calling me directly at (504) 836-6615.

Sincerely,

George Renaudin, II
Vice President of Government Programs

Senator BREAUX. They point out, I would add, in their letter what we have been talking about. Ochsner Health Plan has found through their focus groups and through individual contact with there members and other Medicare beneficiaries that if they are confused or overwhelmed, they tend to make no choice at all other than to continue with the traditional Medicare program. Therefore, unless its done right the outcome of the increased information campaign may actually lead to fewer Medicare individuals exercising their new choices, instead of more individuals taking advantage of these new options.

I agree with Ochsner's statement. If you overwhelm beneficiaries with too much information and if it is written in Egyptian hieroglyphics and you are not an Egyptian, you are not going to know which choice to make, so you do not make any choice, Ochsner's second point is, that if you give them too much information, they may end up not making a choice at all and be just so confused that they just stay in their traditional fee-for-service.

I think that the question is how we present the information. I mean, if you present it carefully—in a standardized form—people can make choices and comparisons and do what is best for it for their own personal health. I think, ultimately, we will have a better system, if this happens.

I was impressed, David, with how HIP presents its information. In addition, you are able to offer a lot more than Medicare. What are the things that you offer in your plan, that is over and above what you get in traditional fee-for-service? Do you have prescription drugs?

Mr. ABERNETHY. We have prescription drugs up to a limit in New York, without a limit in Florida, no copays, deductibles, except a minimal one.

Senator BREAUX. Eyeglass services?

Mr. ABERNETHY. Eyeglass, hearing aids basically, and it is a zero-premium product as well in all of our regions.

Senator BREAUX. The Medicare HCFA people came in and said they are going to start a 1–800 Medicare number which is great and wonderful. You already have that.

Mr. ABERNETHY. I think you would find, in fact, that most health plans have a 1–800 number.

Senator BREAUX. The only people who do not have it is the people who buy the largest amount of insurance in America, which is Medicare.

Mr. ABERNETHY. That does make a good point. If you look at this chart, you would think in a 200-billion health care program, we could afford colored print, and there is a concern that if the Government is the only source of information, it tends to come out in this sort of gray and black as opposed to any sort of imagination or creativity.

Now, maybe HCFA can bring that to the table, but so far, at least, they have not.

Senator BREAUX. Well, I think that the point you make is valid. The point I was trying to make is on standardization is that it is extremely difficult for the average person, if not totally impossible, to make an informed choice if they cannot compare A versus B versus C, and the question is standardization. HCFA said it will

take maybe up to 3 years to get the companies to put their information in a standardized form so people can compare it. You said that you all could conform to a standardized presentation. You provide your own information in addition to it, but you could provide a standardized form of what is covered and what is not covered and how you get the coverage, could you not?

Mr. ABERNETHY. Well, as you pointed out earlier, we already do it for FEHBP, and presumably most of our risk contract competitors do so as well. Our only desire would be that the effort to develop the formats, the definitions, et cetera, would be a cooperative one in which the plans are consulted in a very detailed way because we believe—as I said, we have been in Medicare for 30 years. We have been in the risk contracting business for over a decade, and we think we have an important contribution that we can make to a process of assuring understanding on the part of beneficiaries.

Senator BREAUX. Well, I thank all three of you.

The points you make, Mr. Abernethy, Ms. Dallek, and Dr. Kleimann, are very much on the point. We have a system today that in my opinion is ever much as complicated as it will be under Medicare+Choice because today that senior—and I have said this before—who is in fee-for-service Medicare, they have got to figure out which doctor to go to out of thousands and which hospital to go to out of hundreds, and a lot of times they have to call an ICA to say where do I go, or they are going to call their children or grandchildren and say give me some advice on where I go. That is difficult and complicated for seniors. So they have a lot of choices now. It is going to be even more difficult when they have got to do the whole choice on all of their plans.

I should ask Mr. Abernethy if he is going to help serve as a resource. I would just mention that the chairman of the board of HIP, Anthony Watson, is a member of the Medicare Commission, and they will be involved as a resource in a major, major way, but it shows, I think, what can be done when it is done properly, the information in a comparative form that is standardized so people can understand. Your contributions have been very helpful.

The CHAIRMAN. I thank the panel. Before you go, I want to suggest that perhaps as we take advantage of Mr. Hash's offer to work with Senator Breaux and me and our staff that I would hope that people like you would be available if we need to pick your brain, get your ideas, that sort of thing. I would also invite the other members of this committee to invite their staff to join in these discussions we have with Mr. Hash and HCFA because over the next month there could be some very important decisions made.

Senator Breaux and I want to make sure that we follow congressional intent as much as we can, and any leeway within the Balanced Budget Act, which would enable to achieve the intent of our original bill that was included in BBA. That would be my goal. I sense from your comments, it would be your goal as well.

So thank you all very much. The meeting is adjourned.

[Whereupon, at 4 p.m., the committee was adjourned.]

APPENDIX

NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING
1112 16th Street, NW, Washington, DC 20036
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STATEMENT OF

THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

ON

NATIONAL MEDICARE EDUCATION PROGRAM

SENATE SPECIAL COMMITTEE ON AGING

MAY 6, 1998

INTRODUCTION

Mr. Chairman, the National Association of Area Agencies on Aging (N4A) is pleased to have this opportunity to comment on the Health Care Financing Administration's (HCFA) implementation of the new "National Medicare Education Program" (NMEP). N4A would like to thank you, Mr. Chairman, and Senator Breaux for calling this hearing and for the leadership you and this Committee have shown in bringing issues surrounding the implementation of the Medicare+Choice program to the attention of Members of Congess and the public.

N4A's 655 Area Agencies on Aging and 229 Title VI Native American Aging Grantees were established under the Older Americans Act and are located in local communities throughout the nation. A large number of requests our member agencies handle concern health care choices. A recent N4A health insurance counseling survey shows a majority of N4A respondents (75%) are involved in educational activities surrounding health care choices. N4A's history of serving older and vulnerable adults has led us to conclude that no one, single educational approach will reach all older and disabled persons served by the Medicare program. We believe the success and effectiveness of the Medicare+Choice information campaign hinges upon its ability to offer a wide range of information options tailored to the needs of diverse groups of beneficiaries.

The National Association of Area Agencies on Aging (N4A) has agreed to participate at the highest level of HCFA's effort to implement the education and

information campaign for Medicare+Choice as part of the coordinating committee of HCFA's newly formed "National Alliance Network." The N4A has also played a leading role in HCFA's newly formed, Beneficiary Advocacy Group meetings that bring issues concerning beneficiaries to the attention of the leadership at HCFA.

On behalf of the millions of beneficiaries our agencies serve, we have these comments to share regarding the direction in which the NMEP program is moving. We stand ready to work with the distinguished members of this Committee and other Members of Congress to ensure appropriate steps are taken to build upon the strengths of HCFA's current efforts in implementing the National Medicare Education Program. More importantly, N4A urges this Committee to take a leadership role in ensuring that Congress appropriates sufficient funds for the types of beneficiary education that will be most meaningful for older persons and persons with disabilities.

NATIONAL MEDICARE EDUCATION PROGRAM

When Congress created a new Medicare+Choice program under the Balanced Budget Act of 1997 (BBA), it hoped to offer Medicare beneficiaries many new health plan options, information about their health plan choices and to promote greater competition among Medicare plans. The Medicare+Choice program has the promise, for the first time ever, of making both public and private health care systems more accountable to the needs of beneficiaries. Medicare+Choice proposes giving beneficiaries a wealth of information and tools

with which to make informed health care choices that were never before available.

To that end, HCFA has been charged by Congress with providing Medicare beneficiaries with accurate, timely, relevant, easily accessible and understandable information about their health care options. However, the original amount requested by the Administration and HCFA of $300 million to provide this information was reduced by Congress to $95 million with clear directives on the priorities for use of these funds.

In response to congressional mandates, HCFA is implementing a number of new initiatives in its effort to help Medicare beneficiaries make informed and appropriate health care choices. Some of these projects, such as the Medicare Internet site (www.Medicare.gov) will provide current information about local plan options by zip code. For the first time ever, persons with access to the Internet who have the wherewithal to ply through 33 proposed variables of "layered" information and with patience enough to compare plans two at a time, will have a fairly comprehensive picture of which plans offer high value to Medicare beneficiaries.

Younger retirees with computer experience may get their information directly from the Internet -- and the rate of computer ownership among seniors is rising rapidly (at a rate of about 15 percent per year, Adler, 1996). Still, older persons (age 55 to 75) make up only 1% of all Internet users (Joyce Philbeck, Seniors and the Internet, referencing a survey conducted by SeniorNet, Nov. 1997, East Carolina University). Some beneficiaries, especially those with

diminished capacity who experience more decision-making difficulties will need face-to-face, personal contact. This is just one example of the complexity of the tasks facing HCFA in implementing the NMEP.

Another initiative is HCFA's effort to provide written information to beneficiaries through an annual mailing to beneficiaries. HCFA is making every effort to reduce the confusion of this mass communication to 38 million beneficiaries by making the materials as clear as possible. One of the strengths of the mailing is HCFA's commitment to reinforce the message that beneficiaries do not have to make any new choice at all if they wish to remain in traditional Medicare.

Many well-informed beneficiaries will be able to make their selections based on this mailing. Still, this information alone will not be sufficient to meet the needs of all beneficiaries, some will review this material and have questions, others will not be able to read it without interpreting services since it will only be printed in English and Spanish. Other questions may be easily answered by picking up the phone and making a call. The mailing is also likely to generate questions from persons with more complex questions and health needs that will require more personalized face-to-face assistance. Furthermore, because of the volatility in the Medicare marketplace including frequent mergers, plan closings or other changes in the local market, a mass mailing may quickly be out-of-date.

The NMEP is relying on a toll-free number that will primarily be a "voice mail" system and HCFA is relying heavily on informal caregivers and providers as "information intermediaries" in assisting beneficiaries with education and

information about their health care choices. While we believe it is important to reach out to these groups as well as to beneficiaries, we are concerned that this alone will not meet the needs of many of the most vulnerable Medicare beneficiaries.

Even in instances where a frail person is assisted by an informal caregiver, more than half of all care recipients (54 percent) live alone. Given the pressures of caregiving which include physical, emotional and financial strains, combined with the growing number of caregivers who must remain in the workforce (52 percent full-time and 12 percent part-time), HCFA's expectations in meeting the needs of frail populations through their caregivers may not be realistic.

The magnitude of the tasks facing HCFA and the limited funding for education and information under the Medicare+Choice program places enormous pressure upon HCFA. Several different approaches are underway at HCFA to meet these information mandates in a timely manner. However, as you can see from the illustrations above, these may not represent the most effective means of reaching the largest number of beneficiaries and making certain they understand their choices.

N4A recommends that before HCFA leaps forward with a nationwide program, that more consulting be done with the groups that have a strong history of serving seniors. In fact, Congress may instruct HCFA to consider demonstrations that test a number of different approaches before deciding which

one(s) work best for a broad range of Medicare beneficiaries with different information and health care needs.

In our view, the BBA timelines are causing HCFA to out-source a number of BBA-mandated activities. As a result, HCFA is relying, some critics might say, too heavily, upon external consultants, contractors and subcontractors to meet target dates and deadlines. There is growing concern among the beneficiary community that these organizations do not have a tradition of serving older persons and persons with disabilities, and therefore, may not be the most appropriate advisors to HCFA on items related to beneficiary needs.

For example, HCFA is currently allocating approximately $45 million in FY '98 to implement a national toll-free number to be staffed by approximately 2700 service representatives at peak times so beneficiaries can get information about their Medicare+Choices. Yet, there is already a toll-free number which could be expanded at a much lower cost to taxpayers. N4A administers the Eldercare Locator funded by the Administration on Aging, a toll-free helpline that operates between 9:00 a.m. and 8:00 p.m. (Eastern Standard Time). Trained information specialists provide information connecting older persons and their caregivers to local AAAs and home and community-based services. Since its inception in mid-1991, the Eldercare Locator has assisted more than 325,000 callers. While the Eldercare Locator currently operates on a much smaller scale than that proposed for the Medicare+Choice hotline, many older persons and their caregivers are already familiar with the Eldercare Locator as a reliable source of information and

its serves as their initial contact for senior information. The entire program operates on a budget of $750,000 annually.

BENEFICIARY ASSISTANCE

With the first mailing less than six months away, there seems to be little recognition by HCFA or Congress concerning the demand for information that will be generated through mailings from HCFA and individual health insurance plans. There is no funding specifically appropriated by Congress, and to this point, no funding requested by HCFA, for personalized assistance to support the increased demand.

N4A believes Congress should reevaluate its directives to HCFA. Instead of focusing on toll-free numbers and the internet, funding might be used instead to prepare basic information which local health insurance counselors (such as AAAs, social service organizations, legal aid groups and other insurance counseling and assistance programs) can customize with accurate and timely comparative information about local options. This information could then be distributed at local sites through trained and certified staff and volunteers. These sites ideally would be places where older persons and persons with disabilities already seek information in local communities.

N4A and others are especially concerned about Medicare beneficiaries with more complex health care, social and supportive needs who, because of diminished capacity, may not be able to make decisions independently. It is on

their behalf that we express our concerns regarding current funding priorities for NMEP.

In a December 3, 1997, Information and Education Networking Meeting hosted in Alexandria, Virginia, by IQ Solutions, Inc., a significant number of the fifty-three organizations representing different beneficiary groups strongly expressed their concern that certain beneficiaries would require face-to-face counseling and assistance. Less than 10.5 percent of HCFA's $95 million budget for information and education under Medicare+Choice is being used to support the Health Insurance Counseling and Assistance Program which barely scrapes the surface of the current need.

Many of the representatives at the December 3, 1997, IQ Solutions networking meeting stressed the importance of providing materials and counseling that is sensitive to the cultural and ethnic needs of diverse groups of Medicare beneficiaries. That's why delivery of Medicare+Choice information must be performed at the local level allowing it to be tailored to accommodate the unique needs of populations in local communities. The interests of these individuals with unique needs must be well represented as decisions are made that will have a long-term impact upon them.

Congress must provide adequate funding for face-to-face, personalized assistance for older persons and persons with disabilities to ensure the success of the Medicare+Choice program. Congress and HCFA should provide funding to enhance beneficiary advocates' participation in the design, implementation and monitoring of the NMEP program. To make the best use of limited resources, we

recognize HCFA's need to utilize existing national organizations and their state and local affiliates as a cost-effective means of providing information and assistance to older persons and persons with disabilities. But without providing additional resources to help strengthen the existing local networks and organizations that already provide assistance and access to services, many of these organizations will be stretched to the breaking point. In fact, N4A is concerned about the expanded role our affiliates will play in the NMEP without additional funding.

Congress and HCFA should make it a priority to fund the activities of local organizations that are known by older persons and persons with disabilities and that are already accepted as reliable, trusted sources of information about health care choices. Many of these organizations are operating on "shoe-string" budgets and we believe the success of the entire NMEP hinges upon the involvement and expertise of these local organizations, especially those with a history of serving special needs populations.

CONCLUSION

HCFA conservatively estimates that close to 8 million Medicare beneficiaries will need assistance and about 3.2 million will need local assistance under Medicare+Choice. These are individuals who are likely to have complex health, social and other cultural needs that can only be addressed locally.

HCFA has already begun referring Medicare beneficiaries to these local organizations in publications, on its Website and on beneficiary information lines.

When HCFA prints these local numbers in its mass mailing to 38 million beneficiaries, some sources at HCFA have indicated the number of calls to local and state assistance groups will "quadruple." Funds must be allocated to support choice counseling and other essential beneficiary-centered activities of these community organizations. Funds should also be made available to create formal mechanisms at HCFA for greater beneficiary involvement in the development of policy and programs that will effect Medicare beneficiaries, particularly those with greater social, economic, health and cultural needs.

As funding is made available, emphasis should be placed on assuring groups assisting persons with disabilities, minorities, and other special needs populations are given top priority. Otherwise, these organizations may not survive the resource and financial challenges facing them in meeting the beneficiary needs generated by the Balanced Budget Act.

The National Association of Area Agencies on Aging (N4A), established in 1974, is a 501(c)(3) private, non-profit organization assisting the aging community and, through its Center for Aging Policy, a 501(c)(4) private nonprofit legislative advocacy arm, advocating for programs important to older persons and their families. N4A members comprise a network of 655 local Area Agencies on Aging (AAAs) and 229 Title VI Native American Grantees dedicated to helping older Americans remain independent in their own homes and communities for as long as possible. N4A membership includes AAAs, Title VI Native American Grantees and other private entities interested in protecting services for older Americans and their families.

N4A has received two grants to study the aging network's role in managed care. The Helen Bader Foundation funded a two-year project in three states. The Bader grant is aimed at helping enrollees and their families through the bewildering changes and choices about their health care and influencing the development of managed care systems which are responsive to the special needs of frail older adults and their families. The American Association of Retired Persons helped fund a survey of AAAs nationwide which showed a majority of AAAs responding are heavily involved in educating and assisting enrollees about evolving managed health care systems.

NATIONAL ASIAN PACIFIC CENTER ON AGING

Leading the Way to Serve APA Seniors

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EXECUTIVE DIRECTOR
Clayton S. Fong

Statement of
Clayton S. Fong
Executive Director
National Asian Pacific Center on Aging

I am respectfully submitting this statement and requesting that it be included as part of the record of the May 6th Senate Special Committee on Aging hearing, "Choosing a health plan; Providing Medicare Beneficiaries with the right tools". I would first like to state that the Medicare beneficiaries are a diverse group of older persons and the nature of its diversity is growing exponentially. As a public insurance program, Medicare is responsible to its customers to assure information and service access, quality care and efficient service organization for every member. I had the benefit of reading the prepared remarks of Susan Kleimann who testified before the Committee on May 6, 1998. Her remarks were very germane to the concerns of the National Asian Pacific Center on Aging. I shall refer to her remarks as an outline of our points.

Most of us are familiar with the complexity of the existing Medicare system, which in some parts of the country has 17 plans for a Medicare beneficiary to pick from. With the advent of Medicare+ Choice the complexity will significantly increase. According to a HCFA deputy director, the number of plan options will expand exponentially. Fortunately, no one expects the number of choices to expand immediately but as the plan options multiply it will be critical to have the information available not only for the beneficiaries but for the organizations that will ultimately be called upon to bridge the knowledge gap between seniors and Medicare+Choice.

Ms. Kleimann's prepared statement makes for very sobering reading particularly from the perspective of a national organization that represents the elderly Asian Pacific American community. Particularly relevant were her discussions of the unique problems of vulnerable populations and the concepts of information overload and cognitive maps.

If those who read and understand English have difficulty understanding the current Medicare program how are people supposed to navigate through all of the new options if they don't read and speak English, or lack the cognitive maps (understanding and experience with managed care) that Ms. Kleimann also refers to in her research?

Delivery of services to our community has always been problematic. Among APAs, the overall likelihood that an elder speaks a language other than English as their first

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language is 70 percent. Elderly living in the largest APA communities across the country have consistently underutilized services due to lack of knowledge about services, lack of service availability or accessibility, and/or cultural and language barriers.

The task of distributing new information, relative to the Asian Pacific American community is daunting for a number of reasons. Even though APAs are grouped as a class, they represent a culturally diverse community of at least 26 census-defined Asian and Pacific Islander sub-ethnic groups, some of which have been in the U.S. since the 1850s, while others have arrived more recently over the past 20 years.

APA elderly are the fastest growing racial group over the age of 60 in the US. Elderly APAs over 60 will have nearly tripled by the year 2010 (from 653,000 in 1990 to 1,889,000) and nearly triple again by 2040 (to 5,263,000). As a percentage of the US population age 65 and older they will account for 7.4 % of all elderly by the year 2050.

In addition, there are significant problems currently in the Managed Health care field as evidenced by the multitude of Consumer Bills of Rights in state legislatures and Congress. For APA elders there is an added dimension since most health services and insurance programs are developed primarily to a mainstream America and aren't culturally competent to serve diverse communities like ours. By that we mean access to care isn't provided to a patient in his or her own language nor is there respect or even an understanding of a patient's expectations relative to the form of health care provided.

The Health Care Financing Administration has determined it will develop materials and information to explain these new programs for only English and Spanish speaking groups. That makes the task of informing other audiences, such as APAs, extremely difficult, if not impossible. Organizations such as NAPCA have been asked to assist in this effort and we will do what we can with the limited resources available to us but it won't be enough.

Seniors will turn to community based organizations who will bear the burden of what is really the responsibility of HCFA. HCFA , should at the minimum, provide translated materials and hopefully tangible support to the aging network and community-based organizations, who can be vital partners. Particular attention must be paid to the most vulnerable and isolated seniors, assuring fair access to all HCFA customers, including APAs.

With illiteracy rates so high, limited English speaking skills, and cultural diversity barriers, there are significant problems with serving our community. With the advent of Medicare+Choice and the growing population of our community who are eligible to receive Medicare services, there is added urgency to improve the delivery of information and services.

There is a cost to this but I believe there will be far greater long-term benefits. Through better information on the services and options available, we believe the delivery of health services to Medicare beneficiaries will be more appropriate, effective, timely and efficient.

We will have to work together to address these issues as well as the additional challenges that Medicare+Choice will bring. We hope Congress is willing to help by providing additional resources to HFCA. I trust that with additional funding for the agency will broaden its reach to those groups that are indeed the most vulnerable.

Rivet Hand Rehabilitation Center

Hand and Upper Extremity Rehabilitation
Functional Capacity Evaluation
Work Conditioning

[illegible] R. [illegible], LOTR, CHT, [illegible]
Lic. No. [illegible]

[illegible], LOTR, CHT
Lic. No. [illegible]

[illegible], PT
Lic. No. [illegible]

[illegible], LOTR, CHT
Lic. No. [illegible]

[illegible], LOTR, CHT
Lic. No. [illegible]

May 5, 1998

The Honorable John Breaux
Ranking Member
Senate Special Committee on Aging
U.S. Senate
Senate Hart Office Bldg. 628
Washington, DC 20510

Dear Senator Breaux:

I am an occupational therapy practitioner and owner of a small therapy company in Louisiana, the Rivet Hand Rehabilitation Center in Baton Rouge. My business employs 5 occupational therapists and a physical therapist.

Ours is a specialty practice in rehabilitation of hands after injury, surgery or other problems.

We are facing many issues with managed care in the private sector and I want to thank you for holding the hearing on May 6 regarding information to seniors about Medicare managed care.

In our work with patients, we find patients are just not aware of what services their health plans cover. Until a patient needs our services, they do not question whether or for how much rehabilitation therapy is covered. In addition, they are unaware of any rights--or limitations--under their plans or policies that could hinder their treatment.

For instance, many policies or plans in the private sector limit occupational and physical therapy to a 60-day period following surgery or injury. This defies medical necessity for some injuries; a tendon, for instance, needs at least 12 weeks to heal completely. Therapy during this entire time is critical to achieve full functioning. Note that President Clinton had four full months of intensive physical therapy to help him recover full function following his injury last year.

Beneficiaries will need information about such limits in their managed care plans to make good choices. They will need information not only about the services they need for their current health conditions but also about services they **do not yet know they need.** No one expects to break an arm or have an automobile accident and need extensive rehabilitation yet if it is not available, their recovery will be strictly limited.

Medicare beneficiaries need both information and legal protections, such as those contained in the Balanced Budget Act of 1997, regarding access to specialty providers and adequate staffing in managed care plans. Under the BBA requirements, plans must assure that they

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Senator Breaux
May 5, 1998
Page 2

have the professional and other resources to provide the services they promise. This includes access to specialty care, such as the distinct hand therapy which my business provides.

The BBA also created a serious problem for Medicare beneficiaries in rehabilitation. Medicare beneficiaries will be facing similar limitations next year when therapy from certain providers beyond a dollar limit of $1500 will no longer be a covered service. As the attached chart shows, this amount is inadequate to cover average needs for patients following a stroke or serious hand injury. Thus beneficiaries in the fee-for-service program of Medicare will also need adequate information and protections. I believe that this $1500 cap is arbitrary and interferes with medical decisionmaking in an inappropriate and harmful manner and should be repealed. But at a minimum, I urge the Aging Committee to assure that Medicare beneficiaries receive adequate information about this cap which will affect the majority of beneficiaries next year.

The dynamic and fluid nature of the health care system is being felt by patients and providers all over the nation--even in Baton Rouge. The federal government should take an active role in protecting patients and providers so that medical care can maintain its current high standards for successful health outcomes. I support bills such as the Patient Access to Responsible Care Act, introduced by Sen. Alphonse D'Amato, and the Patients' Bill of Rights Act, introduced by Sen. Tom Daschle, and urge you to do the same.

Thank you for your consideration of these issues. If I can be of assistance to you or provide recommendations to you on these or other issues, please do not hesitate to contact me.

Sincerely,

Lauren Rivet, L/OTR, CHT, FAOTA

Congressional Research Service • Library of Congress • Washington, D.C. 20540

Memorandum

May 5, 1998

TO : Senate Special Committee on Aging

FROM : Kathleen S. Swendiman
Legislative Attorney
American Law Division

SUBJECT : Authority Under the Balanced Budget Act of 1997 to Require Standardized Formats For Medicare+Choice Program Marketing Materials and Application Forms

This responds to your request for a legal analysis of the authority of the Secretary of the Department of Health and Human Services (HHS) to require that marketing materials and application forms distributed by Medicare+Choice organizations follow a standardized, uniform, format. There are two provisions from the Balanced Budget Act of 1997, P.L. 105-33, relevant to this analysis. The first, section 1851(h) of the Social Security Act, reads as follows:

> APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.-
> (1) SUBMISSION.- No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless--
> (A) at least 45 days before the date of distribution the organization has submitted the material or form to the Secretary for review, and
> (B) the Secretary has not disapproved the distribution of such material or form.
> (2) REVIEW.-- The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

Under this section the Secretary of HHS is required to issue guidelines for review of marketing materials and application forms which will be distributed by Medicare+Choice organizations. The Secretary's guidelines will include criteria for disapproval based upon consideration of whether the submitted material or form is "materially inaccurate or misleading or otherwise makes a material misrepresentation."

The second relevant section describes the Secretary's general authority to issue standards deemed necessary to carry out the provisions of the Medicare+Choice program. Section 1856(b) thus reads in part:

> ESTABLISHMENT OF OTHER STANDARDS.–
> (1) IN GENERAL.-- The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998.

While the specific standards set forth in Section 1851(h) restrict the Secretary's discretion for disapproving materials and forms submitted to the Secretary for approval, these standards do not necessarily limit the Secretary's authority to impose other standards upon Medicare+Choice organizations relating to administration of the program generally. The Secretary might set time limits for the dissemination of information to eligible beneficiaries, or might require that certain information be included in promotional materials, or the Secretary might require that Medicare+Choice organizations arrange marketing materials and forms withing a specific, uniform format. It might be argued that a standardized format would decrease potential confusion among eligible beneficiaries attempting to choose among different plans and options.

The applicable standard of review that a court would use in assessing the legality of the Secretary's issuance of a requirement such as described above is set forth in the Administrative Procedure Act (APA). The APA requires the reviewing court to "hold unlawful and set aside agency actions, finding and conclusions found to be (1) arbitrary, capricious, or which constitute an abuse of discretion, or otherwise not in accordance with law..."[1] This standard of review is a somewhat restrictive one, confining the court's review to whether the agency's interpretation was within the permissible scope of administrative judgment.

As a practical matter, in cases such as this, where Congress has vested considerable discretion in an agency head to establish standards to carry out a statutory program, the courts will usually defer to the agency's interpretation of its own enabling legislation.[2] In addition, particularly where there exist technical complexities in implementing a new program, the court's deference to agency interpretation is going to be substantial. This principle was recently reiterated by the Supreme Court in *Pauley v. Bethenergy Mines, Inc.*[3] In that decision the Supreme Court upheld the validity of Department of Labor regulations issued under the black lung benefits program. The Court stated that "(w)hen Congress, through express delegation or the introduction of an interpretive gap in the statutory structure, has delegated policy-making authority to an administrative agency, the extent of judicial review of the agency's policy determinations is limited."[4]

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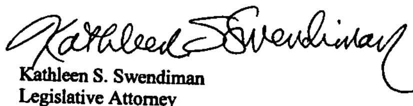
[1] 5 U.S.C. § 706(2)(B).

[2] *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).

[3] 510 U.S. 680 (1991).

[4] *Id.* at 697.

It is highly likely that a court would accord the same degree of deference to the Secretary's issuance of standards relating to Medicare+Choice organizations, particularly since Congress has expressly given such general authority to the Secretary in section 1856(b)(1) of the Social Security Act. A good argument may be made that this authority encompasses standards that would require such organizations to present their marketing materials and application forms in a uniform format, thus enhancing clarity for beneficiaries making choices among competing health insurance options. The Secretary's approval/disapproval function, which is to be solely based upon findings of inaccuracies or misleading or material misrepresentations, would arguably not be compromised by format requirements imposed prior to reviewing the content of marketing materials and application forms.



Kathleen S. Swendiman
Legislative Attorney

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUL 29 1998

The Honorable Charles Grassley
United States Senate
Washington, D.C. 20515

Dear Senator Grassley:

Thank you for your continued interest in the Heath Care Financing Administration's (HCFA's) plans for standardizing marketing materials used by Medicare health plans (Plans). We have had ongoing discussions with your staff about this issue and have been in touch with those affected by Medicare health plan marketing activities. There is universal acknowledgment that the time is right to move toward standardization of benefits information.

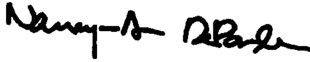
This Fall, HCFA will begin developing a standardized Summary of Benefits. The Summary of Benefits will be a stand-alone document that presents detailed benefit information in a standard format, and uses, to the extent practicable, standard terminology. As part of this process, we will be working closely with Plans, advocacy organizations, and other interested parties. By the Spring of 1999, we plan to complete our work. Medicare+Choice plans will then be notified of the requirement to provide a standardized Summary of Benefits to all prospective and current members during the November 1999 coordinated open enrollment period, and thereafter to all prospective members.

HCFA is committed to providing beneficiaries with important and easily understandable information so they can make informed choices about their health care. We will continue to explore additional options for standardizing other types of marketing materials. These efforts will complement activities that are part of our National Medicare Education Program (NMEP), such as the standardized health plan information on the Medicare Compare feature of our web site, www.medicare.gov.

Page 2 - The Honorable Charles Grassley

Thank you for your leadership in this important matter. We look forward to continuing to work with you and members of your staff on this issue and will keep you apprised of our progress. We have also notified your colleague on the Special Committee on Aging, Senator John Breaux, of our efforts in this area.

Sincerely,



Nancy-Ann Min DeParle
Administrator

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 26 1998

The Honorable Charles E. Grassley
United States Senate
Washington, D.C. 20515

Dear Senator Grassley:

Beginning in 1999, Medicare beneficiaries will be able to choose from an array of new Medicare health plan options or remain in original Medicare. New options in Medicare+Choice will include managed care plans such as Health Maintenance Organizations, Preferred Provider Organizations, Provider-Sponsored Organizations, as well as Private Fee-for- Service Plans and Medical Savings Account Plans. These choices are designed to offer Medicare beneficiaries a marketplace of options similar to those available to the non-Medicare population.

Given the array of new options that Medicare beneficiaries will soon have available to them, we are strongly committed to providing beneficiaries all the information they need to make the best possible decision about their health care. In the Balanced Budget Act of 1997, Congress directed us to embark on a broad educational effort, which we have named the National Medicare Education Campaign. This Campaign is designed to ensure that beneficiaries receive accurate and unbiased information about their benefits, rights, and health plan options. This is the largest, most complex, and ambitious educational effort in the history of Medicare. We want to work with beneficiaries and their families, members of Congress, aging advocacy organizations, providers, and other experts to ensure that our education program is the best that it can be. Like you, I believe that our first obligation is to Medicare beneficiaries, and maintaining their trust and confidence in Medicare.

The National Medicare Education Program has the following components:

- The Medicare handbook, *Medicare & You*, has already been focus-group tested with beneficiaries. We are doing more focus-group testing now. After that, we will launch a pilot of *Medicare & You* in five states: Arizona, Florida, Ohio,

Oregon, and Washington. These states are broadly representative of the Medicare population and Medicare managed care markets. About 5.5 million beneficiaries will participate in this initial effort. We plan to consult with beneficiaries in these states and use the information they give us to improve the handbook further. A new updated version of the handbook will be mailed to all beneficiaries in October 1999.

Our education program will help us learn from beneficiaries so that next year's handbook will meet the needs of all beneficiaries. The handbook must contain a great deal of complex information. We believe this incremental approach will allow us to avoid the confusion that would likely result from immediate national implementation and have the most understandable handbook possible for the next year.

- A mailing will be sent to all Medicare beneficiaries this Fall that has information about new health plan options, including the Medical Savings Account (MSA) demonstration, new preventive benefits, changes in Medicare, and how to find out more about health plans available to them.

- A national toll-free telephone service, 1-800-MEDICARE, will be tested beginning this October in the same five states to ensure that it meets customer needs and expectations. It will be operating nationwide by October 1999. Again, we will use feedback from beneficiaries and the hotline staff to improve the service.

- A consumer-friendly Internet site, *www.Medicare.gov*, is already in place. This web site offers information about Medicare, and includes a section called MEDICARE COMPARE, a database which enables beneficiaries or those who assist them to compare health plans' benefits out-of-pocket costs, and other important features.

- We have formed partnerships with national and community-based senior citizen organizations that will help us disseminate information to Medicare beneficiaries and those who assist them with health care decisions. We will provide comprehensive training to these partners on Medicare plan options and our education strategy.

- A Special Information Campaign will inform beneficiaries at the regional, state, and local levels about their choices as well as the resources available to help them make appropriate decisions, including one-to-one information and counseling services.

Page 3 - The Honorable Charles E. Grassley

We recognize that the scope and magnitude of our education campaign is unprecedented, and that's why we are staging it carefully before full-scale operation for the 1999 open enrollment period. In fact, the Institute of Medicine, in a June 22 letter to the Administrator of the Health Care Financing Administration, recommended a phased-in approach to our education campaign. Our approach is consistent with this recommendation. We believe we will learn a lot from beneficiaries, their families, and others involved in training so we can improve our national education campaign for 1999. We want it to be the best it can be in time for the annual coordinated elections period in fall 1999 when *Medicare & You* goes into effect.

We're also making sure that all beneficiaries will have access to information on changes in the program this Fall. We will ensure that the information we provide is accessible and useful. We realize that we will need to be as ambitious and creative as possible to do so. In accordance with our statutory obligation, we will mail information to all beneficiaries this Fall to inform them about their new health plan options, including the MSA demonstration, new preventive benefits, changes in Medicare, and how to find out more about health plans available to them. All new Medicare beneficiaries will get a copy of *Medicare & You* when they enroll. We will also make information available through *www. Medicare.gov*, HCFA regional offices, the State Health Insurance Advisory programs, and local community groups. We will work with local media to promote information about Medicare choices. Finally, we will be happy to make information and briefings available about Medicare choices to individual Congressional offices that desire such information so that staff will be aware of health plan options and opportunities in the particular local area.

I want to assure you that we are fully committed to making the implementation of Medicare+Choice a success. We take seriously our obligation to ensure that Medicare beneficiaries have access to, and understand, the new choices available to them. While we have shifted the focus of our education program somewhat for this year, we believe the entire program will be stronger as a result. We have increased focus-group testing of the handbook to improve it, strengthened our community outreach efforts, and enhanced the capacity of our Internet site.

On a personal note, I want you to know that I have no higher priority than ensuring that this enormous task is successful.

Sincerely yours,

Donna E. Shalala

8 Key Components of the 1998 National Medicare Education Program

I. Beneficiary Mailing

- *Medicare & You* 1999 handbook mailed to 5 pilot states (AZ, FL, OH, OR, WA) (11/98)
- *Medicare & You Bulletin* mailed to other states (11/98)

II. Toll-Free Telephone Services

- Medicare+Choice toll-free line (phased-in 11/98-10/99)
- 1-800 Medical Savings Account Plans assistance and new enrollee response line (11/98 - 8/99)
- Comparative information to be available to beneficiaries in non-phased-in states (11/98)

III. Internet Activities

- Medicare.gov established (3/98)
- 1998 plan comparison information available (3/98)
- 1999 plan comparison information available (10/98)
- Plan level satisfaction information (11/98)

IV. National Train-the-Trainer Program for Information Givers

- Regional training for 700 participants (7/98 - 9/98)

V. National Publicity Campaign

- Develop clear and consistent messages and communicate through partners *(6/98 and ongoing)*

VI. State and Community-Based Publicity and Outreach Campaigns

- Interventions include PSAs, health fairs, media call-in shows, and other innovative outreach activities (8/98 - 11/98)

VII. Enhanced Beneficiary Counseling from State Health Insurance Assistance Programs

- Increase funding for SHIP programs to provide one-on-one counseling to beneficiaries (7/98)

VIII. Targeted and Comprehensive Assessment of Education Model

- Test the system for educating beneficiaries about their health plan options; learn and modify
- Evaluate components of the National Medicare Education Program in 4 communities in 5 pilot states
- Pilot test other innovative approaches for informing beneficaries and their families

Challenges for the National Medicare Education Program

Purpose of the National Medicare Education Program (NMEP): to educate Medicare beneficiaries and their families and caregivers so that they can make informed decisions; and to protect Medicare beneficiaries, through a sustained community-based partnership, from making health care decisions based on inaccurate or misleading information.

Overall Population
- 39 million beneficiaries (36 million of whom are eligible for Medicare+Choice)
- 26 million currently have at least one managed care plan currently available in their area
- 16 percent of beneficiaries are eligible for both Medicaid and Medicare
- 88 percent are 65 or older (12 percent are over 85); the remaining 12 percent are disabled or have End-Stage Renal Disease
- 2.5 million people become eligible each year

Population Diversity
- Race: 83 percent are white, 9 percent are African-American, 6 percent are Hispanic, and 2 percent fall into other categories
- Language: 12 percent of those over 65 speak a language other than English; about 30 percent of this group speak Spanish
- Education: 38 percent have leass than 12 years of education, and more than one-fifth have less than 9 years of education
- Health insurance coverage: 17 percent are in Medicare managed care (26 percent of new enrollees), 74 percent are in fee-for-service with supplemental coverage (30 percent in employer- or union-based coverage, 16 percent have Medicaid, and 29 percent privately purchase Medigap), and 9 percent have fee-for-service with no Medigap coverage

Beneficiary Knowledge and Understanding
- According to the 1997 Medicare Current Beneficiary Survey and the 1995 OIG study "Medicare Beneficiary Interest in HMOs", 32 percent say they know little or nothing about Medicare; more than two-fifths know little or nothing about Medigap; more than three-fifths know little or nothing about Medicare HMOs; and almost two-thirds did not know whether they have an HMO available to them in their area.
- AARP recently found that one-third knew almost nothing about HMOs (half of this group was enrolled in an HMO!); and only 10 percent have sufficient knowledge of the difference between fee-for-service and managed care to make an informed choice.
- 7 percent of beneficiaries have access to the Internet, but more than one-third of those aged 50-64 own a PC.

Market Diversity
- HMO enrollment is lower among the Medicare population (17 percent, vs. 43 percent of commercially insured and 48 percent of Medicaid beneficiaries). However, the Medicare penetration rate has dramatically increased from only 9 percent in 1993.
- Two-thirds of managed care enrollees are in 6 states (AZ, CA, FL, NY, PA, & TX). In 33 states, less than one percent are enrolled in risk plans.

National Medicare Education Program Budget

Category	Activities	Expenditures and Source of Funds
Beneficiary Mailing	5-state *Medicare & You* pilot *Medicare & You* bulletin *Medicare & You* for new enrollees MSA brochure Printing for beneficiary outreach	$20.5 million - User fees $ 9.7 million - Program mgmt. ========== $30.2 million - Total
Toll-Free Telephone Services	SAIC contract Network management AT&T contract Arthur Andersen contract AdminaStar contract	$46.2 million - User fees $ 4.0 million - Program mgmt. ========== $50.2 million - Total
Internet	Medicare.gov, incl. Medicare Compare Partners section on HCFA.gov	$1.5 million - User fees
Program Development	Focus test *Medicare & You* Assess NMEP overall NMEP assessment at 4 sites Test alternative approaches in campaign Track beneficiary inquiries State Health Insurance Assistance Programs Consumer assessment of plans (CAHPS) Consumer information R&D Content conversion and training Project integration/mgmt. contract Business requirement analysis	$16.85 million - User fees $ 1.0 million - Program mgmt. $ 4.5 million - PRO funds ========== $22.35 million - Total
Community Outreach and Health Fairs	Community-based outreach Special Information Campaign Education campaign support	$ 9.9 million - User fees
Total, NMEP		$ 94.95 million - User fees $ 14.7 million - Program mgmt. $ 4.5 million - PRO funds ========== $114.15 million - Total

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